Body

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Personal Narrative:

Finding Healing Together

By Rachel Lerner

"Everyone should go to residential treatment," my 13-year-old daughter said to me as we drove home after nine weeks of residential treatment for depression and self harm.

It started with panic attacks in the year prior, although who knows when it actually started. When did my child feel so overwhelmed by emotion that she felt the need to cut herself to feel physical pain as a way of blocking out the emotion? Or when did she start thinking she had less value than others and deserved the scars on her skin?

I know I am lucky. My teenager asked for help, and when given the choice of residential or partial hospitalization, she asked for residential. She knew we needed to make a big change, and the intervention needed to be radical in order to break through the noise of the emotions. I dropped off a child who was ready to do the work and also anxious about what that meant.

It was my kiddo who did the real work of learning all the dialectical behavior therapy (DBT) skills in the book and applying them in the course of the day. She had individual therapy three times a week, group therapy daily and spent every waking minute within eyeshot of a professional adult. She did recovery boxing and wrote healing, vulnerable poetry. She struggled with events from our past, some of which I was a part of and some of which I was not.

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Body - גוף

Having her away while she was in so much pain was excruciating. For nine weeks, twice a week, I drove to do joint family therapy with her and my husband. We attended online groups five times a week for sessions on shame and resilience, parenting with DBT, multifamily group, parenting skills and a process group for parents.

As a result of those sessions, I never felt isolated or different. I understood there wasn't anything wrong with me or anything we did wrong. I was with a group of other parents who were going through the same thing, and I felt supported.

We also laughed together, a kind of humor born from a club none of its members had chosen to join.

I also learned real skills. I understood my flaws as a parent and my penchant for wanting to solve my kids' problems for them.

My husband and I became a chevruta — study partners — as we worked our way through articles and books and then attempted the more difficult work of actually applying the learning. We would look at each other across the kitchen when speaking with our other children who were still at home, hinting that the lecture should probably end, or the problem being described was something our kid needed to own, not us.

We are all continuing on this journey, together. Our kiddo was not "healed," but she certainly had changed routes. She came home with lots of tools to keep herself safe and a better understanding of herself. She continues individual therapy and still faces the struggles of life. Meanwhile, my husband and I continue to read lots of parenting books and to catch each other when we slip up. I'm not convinced everyone should go to residential treatment, but I did discover the power of sharing the experience of a loved one's pain and building our toolbox as a family unit. For us, it made all the difference.

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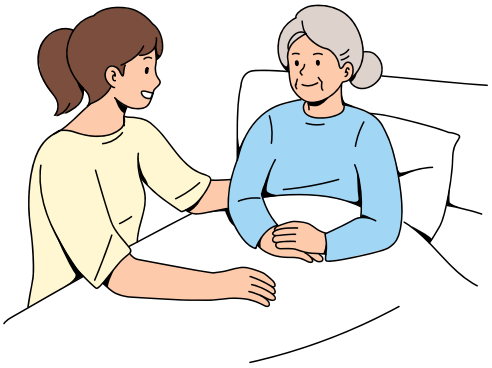
Middah - Refuah Shleimah

Healing and Wholeness

May the One who blessed our ancestors – patriarchs Abraham, Isaac, and Jacob, matriarchs Sarah, Rebecca, Rachel, and Leah – bless and heal the one who is ill: _____ child of _____ . May the Holy Blessed One overflow with compassion upon them, to restore them, to heal them, to strengthen them, to enliven them. The One will send them, speedily, a complete healing – a healing of the soul and a healing of the body – along with all the ill, among the people of Israel and all humankind, soon, speedily, without delay, and let us all say: Amen! *(Mi Sheberach Prayer)*

In Jewish tradition, visiting the sick is one of the greatest mitzvot someone can do for another person. According to the Talmud, even just visiting and acknowledging the pain of others allieves part of their suffering.(1) However, one of the great arbiters of Jewish Law, Rabbi Moshe Isserless, claims prayer is an essential part of the mitzvah:



"One who visited [a sick person] and did not pray for him has not fulfilled the religious duty [of visiting the sick]."(2)

(1) Babylonian Talmud, Tractate Bava Metzia, 30b
(2) Shulchan Aruck, Yoreh De'ah, Siman 335

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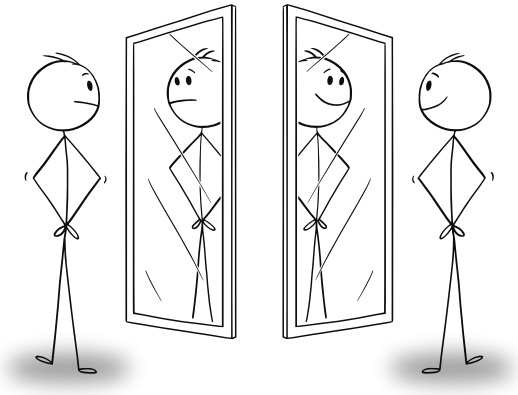
Whether we're a caregiver, a care receiver, or even just a friend of someone who is suffering, we sometimes find ourselves at a loss for words in the face of what feels like insurmountable pain and distress. In those moments, we can recall the inherited language and ritual the Jewish people have passed down for centuries—the mi sheberach prayer for a "refuah sheleimah/full healing." But the usefulness of this prayer comes not only in its ready application; it comes in the unique way it addresses a fundamental and painful truth about illness: There isn't always one thing that needs healing. But what is prayer, and what should we expect a mi sheberach?

On the subject of what prayer is supposed to accomplish, Rabbi Jonathan Sacks wrote: "Less than prayer changes the world, it changes us." This sentiment mirrors an observation by Rabbi Samson Raphael Hirsch, a 19th century rabbi who wrote about how the deeper meaning of the Hebrew word for prayer can be found in its etymology:



"Hitpallel, from which "tefillah" (prayer in Hebrew) is derived, originally meant to deliver an opinion about oneself, to judge oneself, or [to make] an inner attempt at so doing...it denotes to step out of active life to attempt to gain a true judgment of one's relationship to God and the world, and the world to oneself." (3)

(3) Horeb Part IV

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Tefillah, according to Rabbi Hirsch, is a reflective experience that consists of both speaking to God and to ourselves. When we pray, we are also reaffirming our belief in and concern for the values, ideas, and people we are praying for. When we've finished praying, we should be inspired to open our eyes and act, to the best of our abilities, in alignment with our prayers toward their fulfillment. This applies to all prayers, including ones for safety and livelihood as well as those for healing. Reciting a mi sheberach should be an opportunity for us to meditate on the people in our lives who need our thoughts, prayers, and support, and inspire us to reach out to them.

The mi sheberach for healing's unique formulation can also serve as a reminder of a crucial aspect of healing and illness; illness can affect more than our physical body. While physical conditions can improve, traumatic medical experiences can leave emotional scars on patients who we as caregivers and loved ones cannot always see. Inversely, mental health conditions can affect our physical bodies in ways that aren't immediately intuitive, causing things like fatigue, high blood pressure, and headaches. Recognizing this duality, Jewish tradition coined the phrase refuat hanefesh v'refuat haguf, a healing of spirit and of body, within the language of the Jewish prayer for healing, emphasizing the healing of both the inner and outer experiences of our patients and loved ones.

When you recite this prayer, recognize the people in your life who need healing, say their names out loud, and acknowledge their suffering, physically and/or mentally. Make mental space for God and each other, and say "Hineni - I am here," to both.

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Caregiving and its Impact on the Body

If your heart is broken, make art with the pieces.

Shane Koyczan

Deep breathing is our nervous system's love language.

Dr. Lauren Fogel Mersy

Judaism has a long tradition of recognizing that healing is not just physical; it is holistic. It has physical, mental, emotional, social, and spiritual components that are all interconnected. The Jewish tradition also emphasizes healing rather than curing. Even when mental illness is under control, healing and a return to wholeness is needed. Healing is a process that has many components and may be a lifelong journey.

For us humans, mental health is a truly holistic experience. We may never know where the mind stops and the body begins or how the soul drives it all. With all of this complexity, it is difficult to know what it means to "heal" from a mental illness. It is hard enough to get consensus on what a mental illness even IS (the last diagnostic manual took the better part of a decade to develop!) much less what it means to recover.

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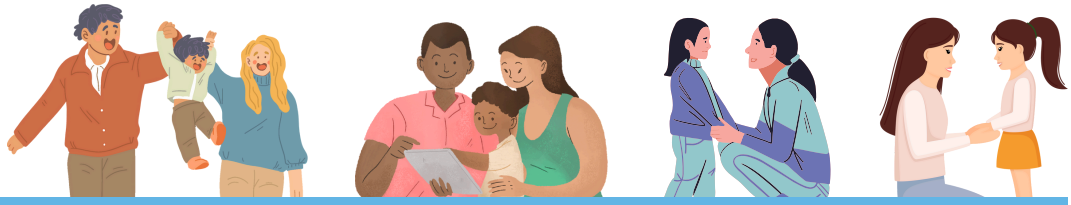
A MI SHEBERACH FOR PARENTAL CHOICES



May the one who blessed our first parents, Abraham, Isaac, and Jacob, Sarah, Rebecca, Rachel, and Leah, give you these blessings:

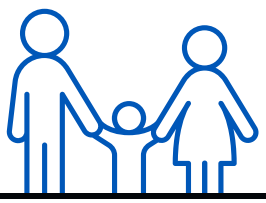
May you give yourself the space to make mistakes and learn from them.

May you find joy in the challenges and success, in the smiles and the tears.

May you have patience with those who help your family through all journeys — mental and physical.

May you trust yourself, that you are doing the best you can. Kein y'hi ratzon.

Unlike a physical illness or injury, a mental health challenge often does not "end" or resolve itself in a neat and distinctive way. Some medications may work for one person but not another; therapy protocols that are "evidence based" and endorsed as effective actually may only have a success rate of 25%-40%. For many people, mental illness can be managed rather than eliminated completely. Keeping this in mind, we encourage you to challenge your thinking around what it means to "recover." We also would like you to think about mental health from a holistic perspective and find a way to prioritize your own mental health as well as your child's.



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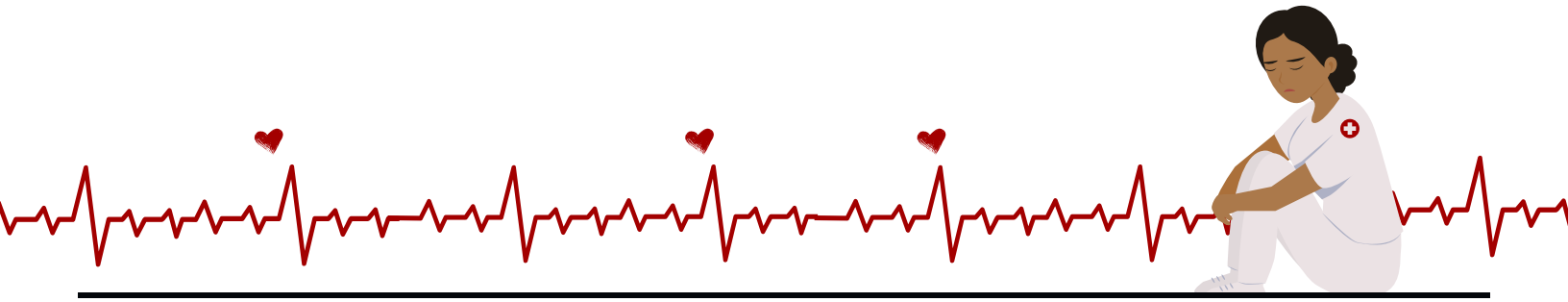
Any type of caregiving or other ongoing stress can take a toll on your body. Over time, you may notice you also are struggling — having difficulty sleeping, becoming irritable, and struggling with depression or anxiety. This is normal; however, if these symptoms become too severe in a caregiver, they can lead to burnout or compassion fatigue. We will discuss those more later in this section.

One of the most effective ways to manage stress as a caregiver is to become comfortable with prioritizing and setting boundaries. You will NEVER have enough time to get everything done the way you want, and there is no way you can control every situation or the feelings and behaviors of others. So in addition to working on the self-awareness and observation skills we discussed in the first section of this resource, we want you to apply these skills and combine them with communication strategies for setting effective limits and boundaries, not just with your child but wherever and whenever you need them.

From the very beginning of caring for a child, we are given the message that their needs must come first. Both our biology and our culture program us to drop everything when our baby cries and try our best to give them what they demand. We expect that once we have children to care for, we will no longer be getting enough sleep, going out at night with our friends, working, exercising, etc. Many of us are able to find a reasonable balance as we go and can move forward, gradually ceding caregiving tasks to the child as they grow. When you add the extra stress of a child with additional needs (such as a mental health condition), development may or may not follow the "normal" rhythm, and we can find ourselves dealing with more and more rather than fewer demands over time. Since most mental health conditions can affect our child's development, physical health, education and physical safety, we can be forced to ignore our own physical and emotional needs over time.



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Body - גוף

If it goes on long enough, it may develop into **compassion fatigue,** which generally has two main components:

- Burnout – the emotional and physical fatigue experienced by caregivers due to their chronic use of empathy in helping others in distress.
- Secondary traumatic stress – when individuals who don't experience a traumatic event directly feel the stress of the people they are supporting.

Though compassion fatigue was originally recognized as a condition that affected caregiving professionals in the medical field, the same process occurs in families where a significant mental health condition is present. With compassion fatigue, the very strengths that make us empathic, responsive parents can get in our way, leading us to deplete our physical, emotional, and spiritual reserves to the extent that we become ill as well.

People going through compassion fatigue tend to experience:

Helplessness, extreme fatigue, and feeling overwhelmed.

Frustration, cynicism, or anger and irritability.

Physical effects, such as shortness of breath, increased headaches, heart palpitations, trouble falling asleep or muscle tension.

Disorientation or confusion, memory disturbance.

SAMHSA - Compassion Fatigue

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It can be difficult for us to accept that we really and truly must take care of ourselves in order to be a good caregiver. We may "know" this on some level and might even advise our friends and family to do this if we notice them struggling. It can be much harder to apply it ourselves. For many, the belief that we do not deserve this type of self-care runs deep. It may come from our own history of mental illness, feelings of guilt, or internalized cultural messages. It also can feel like if we divert some of our energy into caring for ourselves, then our kids will suffer, which can create a vicious cycle. Overcoming this barrier is the most important and most difficult part of setting the boundaries necessary. In order to do it, we have to be willing (and able) to challenge the deeply held beliefs we have about ourselves; we have to believe we are worthy of support and respect, and, most important, the problems we and our child are facing are NOT OUR FAULT. (We know this is not a belief that will go away quietly; we will keep bringing it up so you can continue to challenge yourself.)

The Mechanics of Boundary Setting - Using the Elements of Communication

Setting limits can be simple; all it requires at its most basic level is the word "no." So why is it so difficult to do? It can be hard to separate negative associations from feeling mean or punitive. Many of us fear we will cause suffering, it will damage our relationship, or spark conflict that could aggravate the mental health condition. Most of us are not explicitly taught how to set boundaries, even though we've all experienced them being placed on us to varying degrees of effectiveness. At its core, setting limits is a form of communication — a combination of the words we do (and do not) say, how we say them, body language, and context.

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Body - גוף

Communication within the family system

Even under the best of circumstances, communication in a family unit is a challenge. As we stated before, it is nearly impossible to be completely objective when it comes to immediate family relationships. As you consider your role as a caregiver, we offer the following suggestions:

- **Know where your child is developmentally.** If needed, researching ages and stages can provide insight of how they might think and experience emotions. Can they process directions in multiple steps? (Most elementary age kids can't do more than a couple at a time.) Are they capable of understanding the consequences of their actions? (Most teens can't!) Can they put words to intense emotions? (Sometimes!)
- **Keep things simple and behavioral.** Use clear, everyday language and terms that are familiar to your family. For example, what exactly does "listen to me" mean? Or a simple command such as "adjust your attitude" or even "clean your room." Be as specific as possible when setting a limit, and be clear about expectations and next steps:
    - "When you clean your room this weekend, please make sure there is nothing on the floor, so I can run the vacuum; your dirty laundry is in the laundry room; and your dresser surfaces are clean.
    - I want to talk to you about what just happened, but it's hard for me when you roll your eyes and interrupt me.
    - I do not feel it is safe yet for you to keep a razor in your bathroom. Once we have a few more weeks without you cutting yourself, and when you and your therapist feel ready, we can try again.

Body - גוף

- **Stick to what you know, and avoid making assumptions.** If appropriate, share how you are feeling and reacting to a situation, and let your child express their thoughts and feelings. Our anxiety and trauma responses often brace us for the worst, and we tend to fear negative patterns will repeat themselves. Try to approach tense situations with an open mind, allowing the outcome to change. Think about behaviors you can observe, and be curious about them rather than trying to interpret them. Avoid value judgments about your child, and focus on changing the things that are within your control:
  - When you speak to me in that way, I feel defensive and find it hard to focus on what you are saying.
  - When you avoid speaking and shut down, I don't know what you are thinking or feeling, and it can be scary for me. Would you be willing to share a little bit, so I at least know if you're safe?
  - I don't feel that conversation went well. I was upset, and I think maybe you were too? Can we take a step back and try that again?
- **Keep your role as an adult in mind, and normalize the appropriate boundaries.** Being a grown up who has to make and keep the rules isn't fun. As the parent, that is your responsibility, and you don't need to justify or negotiate. Also, you will face some "adult" issues and topics that are not suitable to share in detail, e.g., details of a marital conflict, or financial or employment issues. Try to express this in a clear way rather than just sweeping it under the rug or avoiding the topic. Remember to keep it age appropriate.
  - I know the rules we have on your internet use are frustrating; we do it to keep you safe. I'm happy to listen to your frustrations, but that will not change the outcome
  - You've probably noticed I'm working late a lot more than usual and have been stressed. I want you to know it should be temporary, and I'm doing what I can to take care of myself.

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Body - גוף

- **Nonverbal communication.** Though a good amount of our nonverbal communication is outside of our control (we are human) it is worthwhile to notice and be mindful of HOW—in addition to WHAT—you are communicating. Things like eye contact, tone, volume, and gestures can affect how our words are received and can get in the way of our message.
- **Bottom line:** Communication is crucial in supporting someone. While it's important to communicate with intention and care when you can, perfection is not necessary. All you need is sincere communication said with intention. Beginning a conversation with a statement like "I have something important to say but might not say it the way I want to" can build the needed trust to be able to speak freely rather than pressure parents or kids to know the "right" things to say. If those existed, we'd have put them here and this guide would have been a lot shorter.

Communication Outside of the Family

Having a child with mental illness obviously affects more than just the immediate family. You probably interact with extended family, friends, teachers, coaches, etc. We don't always think about how these relationships affect us and our child as well as how external relationships affect us in turn. Family therapy can be a good way to discuss interactions with family and friends, how you are communicating, and how you feel about it. You may wish to explore how you all feel about things like confidentiality – what information do you feel is important to share and with whom? Discuss the different relationships you have outside of the family – friends, synagogue, grandparents, aunts and uncles, etc. Who gets to decide what information is shared? Are you sharing information on social media? How much detail? Also, think together about how you will communicate when you are out and about. How will you know if your child is struggling? What signals should you look for to decide if it's time to go? Who is and is not safe to ask for respite and support? How will we communicate the boundaries we decide, and what is the strategy if things don't go as planned?

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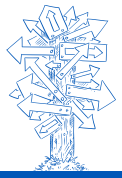
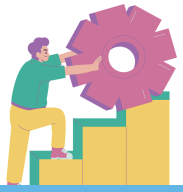
Reinforcement — Avoiding collusion.



The relationship between our children's behaviors and how we respond to them begins at a very early age. It's another form of communication, one that can be more powerful than speech. When there is a mental illness present, fear of the illness and its power can interfere with the things we know and believe. Mental illnesses, their intense emotions, inexplicable changes, and frightening behaviors can interfere with our ability to see patterns for what they are and move us to react out of fear rather than wisdom. For example, few things are scarier than when you have a child who has tried or wants to hurt themself. We often try to avoid aggravating situations that might bring those feelings or urges back. Unfortunately, avoiding these encounters may strengthen the illness and the power it has over the family rather than helping.

Control — Letting out the rope and pulling it back in.



The structure and safety needs for teens constantly change. The core developmental task of a teen is to begin the process of individuation, or separating from the parent in order to become more independent. This requires practice, patience, and learning from choices and mistakes. One of the best ways to make progress in mental health recovery is to practice being in challenging situations — exposing oneself to possible triggers, experiencing difficult emotions, and learning to tolerate distress. These skills benefit us as caregivers as well. Using the communication skills we have learned, we can have conversations with our kids about how to do this in the way that works best for them. Every child (and parent) has a window of challenge and distress they can tolerate and work through with the hope that over time, it will be possible to work through challenges that could prevent them from reaching their full potential, e.g., talking to or being around other kids who use substances, facing situations that have triggered anxiety/panic, pushing through a depressive episode.

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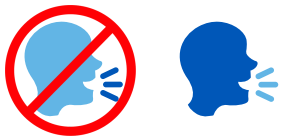
The structure and rules maintaining that window may change, with different stressors and variables affecting what they need at any given time. A constant flow is normal; but again, communication is key in preserving this structure, getting information about how they are doing, and responding with a framework and opportunities for independence that will build confidence over time.

Safety Issues - Addressing Suicide and Self-Harm

The structure and rules maintaining that window may change, with different stressors and variables affecting what they need at any given time. A constant flow is normal; but again, communication is key in preserving this structure, getting information about how they are doing, and responding with a framework and opportunities for independence that will build confidence over time.

How do we talk about suicide and suicidal ideation?



The language we use makes a difference. When talking about suicide or suicide-related behaviors, we stay away from “committed suicide” as well as “successful/unsuccessful suicide attempt.” It is a common, and harmful, idea that those who die by suicide “commit” something wrong — the way you would commit a crime, a sin, etc. — against themselves. This blame only furthers the stigma that already exists. Instead, we use terms like “suicide attempt,” “suicide survivor,” or “died by suicide.” We can also say someone is “living with suicidal thoughts/ideation.” By changing the way we speak about suicide, we can begin to eliminate the stigma and criminalization of suicidal behaviors.

It is common to be afraid to speak about suicide and suicidal ideation. Many of us grew up thinking suicide was a shameful word or action. But we now know when someone is struggling with mental health, it is not unusual to have some type of thoughts of suicide. It can be helpful to ask directly if a loved one who is struggling is having these thoughts. Therapists and practitioners distinguish suicidal thoughts, or ideation, as active or passive.

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Passive suicidal ideation is marked by thoughts about suicide or a preoccupation with death without intent to act on it immediately. Active suicidal ideation is marked by actual, imminent, or emergent detailed thoughts and plans to die. These two states exist on a spectrum and people may experience suicidality that moves between active and passive states.

Suicide and suicide attempts are not the same as what we often call self-harm. Self-harm or nonsuicidal self-injury (NSSI) refers to hurting oneself on purpose as a way to release painful emotions, distract from emotional pain with physical pain, express self-hatred or low self-esteem, punish oneself for perceived wrongs, or regain a sense of control. Self-harm is not a suicide attempt but rather a sign the individual is trying to cope with intense emotions. If an individual does not receive support, this behavior may become habit-forming. Many people who have overcome self-harm consider themselves in recovery. If left untreated, however, continual self-harm can lead to a greater risk of suicide.

What are the signs someone might be experiencing suicidal ideation?

Some of us are very aware when a friend or family member is experiencing a mental health crisis and/or suicidal ideation, while others are taken by surprise when they find out a friend or loved one has been struggling. Just as we strive to reduce the stigma for those who are suffering, we must not blame or shame ourselves or others for not seeing these signs. In order to best support those around us, we all need to recognize and be able to discuss concerns or red flags when we see them.

Cleveland Clinic: Suicidal Ideation

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Signs someone may be experiencing suicidal ideation can include a **change in language, behavior, or emotional states.** These behaviors or changes individually do not necessarily indicate suicidal ideation, but they should be taken seriously. They might indicate something is wrong and may even be signs of suicidal ideation. You know your loved ones best, and it is always wise to consult a professional if you have concerns. Common warning signs that may indicate suicidal thoughts include:

Language:
People who are struggling may or may not talk explicitly about taking their own lives. Concerning language includes the expression of hopelessness, apathy (lack of interest or enthusiasm), feelings of unbearable pain, extreme emotions, regret, or the wish not to be a burden on others.

Behavior changes:
Those experiencing suicidal thinking may behave in ways that are or seem to be out of character. For example, they may start to use or begin misusing substances, they might spend more money than they have, or they might eat more than usual. Within their communities or with their loved ones, they may withdraw from others or increase contact or dependency with those they think can help. They may stop engaging in activities they previously enjoyed, or they might start to say goodbye to friends and give away favored possessions. They may become aggressive or appear tired all the time, and they may have significant changes in sleep patterns.

Emotional changes:
Someone experiencing suicidal ideation may become more depressed and anxious, experience uncontrollable anger and irritability, or lose interest in things they have always cared about. They may feel significant shame about any of these feelings or the above behaviors or thoughts. Conversely, a person who has been depressed and is suddenly more energetic might also be at risk.

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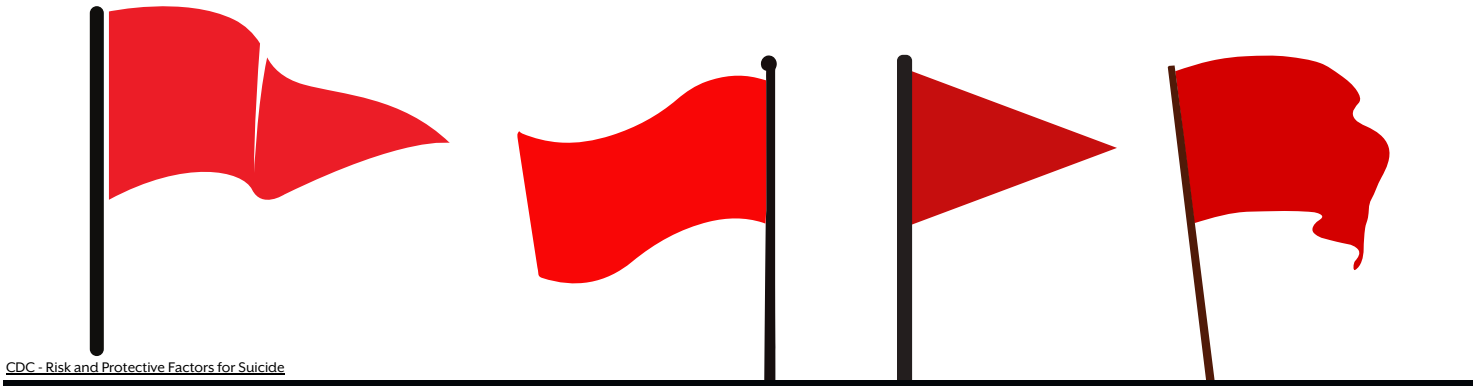
Body - גוף

These warning signs can be indicators of suicide risk but also of related or separate challenges or stressors, such as a new or untreated physical or mental health challenge, significant life changes like divorce or loss of financial stability, traumatic experiences like abuse or harassment, etc. We often don't know everything that contributes to an individual's mental health challenges.

"Warning signs" or "red flags" may also be called "risk factors," defined as something that increases the chance that someone is more adversely affected by a challenge.
Risk factors that may contribute to depression or suicidal ideation include:

- Previous suicide attempt
- Mental and/or physical health diagnoses, chronic pain, or illness
- Access to lethal means, e.g., firearms or drugs in the home
- High-stress occupations
- Financial or job insecurity, e.g., lower pay, layoffs, or decreased hours
- Prolonged and pervasive stress
- Sudden stressful or traumatic events
- A family member or friend lost to suicide
- Substance use disorder
- Adverse childhood experiences, such as abuse or neglect
- Social isolation
- Lack of access to appropriate mental and physical health care
- Legal challenges
- Societal oppression, current and historical, of marginalized people



CDC - Risk and Protective Factors for Suicide

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We also know some of the protective factors that may help protect people from suicidal behaviors or attempts. Just as risk factors add to the chance someone will be adversely affected by a challenge, protective factors decrease these chances. Protective factors include both internal resources and family and community supports, such as:

- Access to effective mental and physical health care
- Close connections with and support from, friends, family and community
- Skills for coping, distress tolerance, and problem-solving
- Safe space where there is no access to weapons or lethal substances
- Encouragement from one's religious, cultural, and/or social community to seek help
- A strong sense of purpose

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Body - גוף

Responding to **active and passive suicidal ideation and severe mental health challenges:**

- If you are concerned someone is experiencing suicidal thoughts, ask them directly.
  - "Are you thinking about killing yourself?" or "Are you thinking about suicide?" This might feel uncomfortable or challenging, but practicing out loud can help you feel more confident asking the question in real time.
  - If their answer is "yes" (active suicidal ideation), ask if they have a plan for how they would kill themselves and if they have decided on when they would do it. These questions can help distinguish the level of risk and help you decide what the next steps are in supporting that person.
  - If their answer is "no" (passive suicidal ideation), continue to ask questions and gather information about how you can support them.

- Have a plan ready if the person answers yes and does express suicidal ideation. You may need to help them take the next step, whether that is calling a crisis line, reaching out to a mental health professional, or taking them to emergency services.

- Be *direct and use the words "suicide" or "killing yourself"* when you talk with someone struggling with suicidal thoughts, even if it feels uncomfortable. Saying these words out loud reduces the stigma, lets them know you care, and may reduce the intensity of their own feelings. While it may seem counterintuitive, you will not plant the idea of suicide in their head by saying these words out loud. If you have gotten to the point where you are concerned, it may be that they have started to think about ending their life.

- I*f the person is actively suicidal*—they have a plan and are ready to carry it out—it is time to call for help. You can call, text, or chat 988 to reach trained counselors at the National Suicide Prevention Lifeline. Other options include calling 911, your local mobile crisis unit, your local or health plan's urgent mental health crisis line, or another suicide hotline. If you think the person is in danger, stay with them until help arrives. ***This is critical***. People experiencing active suicidal thoughts should **not** be left alone. If you can't stay, find someone who can.

Hogg Foundation for Mental Health: Language Matters in Mental Health

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- When someone experiencing suicidal ideation wants to discuss their thoughts, remember to practice empathetic and active listening. That sends the message that you want to hear what the person has to say and understand what the person is thinking. Keep the focus on the person you are talking to. The goal is not to "fix" them, change their thinking, or tell stories about others who have been through similar situations. The goal is to be with them as they determine their own next steps.

Some tips for engaging in these difficult conversations:

- *Let them know you care and want to listen and support them. Make sure you have the time and space to give. You may say, for example, "I'm here to listen. You are important to me, and I care about how you are doing."*
- *Validate their feelings and convey that you are listening carefully by naming or summing up what they say. For example: "I hear you are feeling [xxxxx]. Can you tell me more about that?"*
- *Validating feelings is different from validating the harmful behaviors they engage in or are considering. Use nonjudgmental language about those behaviors, e.g., "You've been in so much pain that you are harming yourself/drinking."*
- *Encourage conversation and ask open-ended questions like "When have you felt like this before?" followed by "When you have felt this way in the past, what has helped?"*
- *Let them know it is common to experience suicidal thoughts, they "do not need to be acted on," and you are there to explore alternatives and resources.*
- *Remember your loved one is giving you a gift—and being vulnerable— by sharing this part of their world with you. Acknowledge that: "This can be so hard to talk about. I really appreciate knowing what you're experiencing, and I'm so sorry to hear you're struggling."*
- *Reassure them by offering hope and pointing to their strengths. "I have seen you get through really hard things before. You have a lot of people here who love you and care about you."*
- *Show sympathy: "Asking for help is a hard and brave thing to do, but it is so important," and offer what is realistic, whether that is a listening ear, a hug, help with groceries or meals, help making calls or accessing care, etc.*

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- Depending on their situation, you can encourage them to find ways to help themselves and/or to seek professional help. Offer assistance in doing so. You might ask: "Would you like me to sit with you while we reach out to someone for help? Together, you can call their therapist, a suicide hotline, or a mobile crisis team. Long-term effective mental health support can take time. Provide reassurance and support for this process.
- Remind them they matter to you, and let them know all the ways in which they make a difference in your life.
- Depression and other mental health challenges can make it hard for someone to solve problems or think clearly. Offer to help them put together a list of ideas or resources for when they are struggling, including trusted friends to call, calming activities they enjoy, breathing or mindfulness exercises, and emergency hotlines.
- Do not promise to keep a secret in these situations. You can offer confidentiality, meaning you will only share information with appropriate people or resources, if you are concerned the person you're talking to may hurt themselves or others.
- These conversations with a friend or loved one can be challenging, and you may need your own sources of support. Consider calling a hotline or talking with your own therapist, doctor, or trusted friend.
- It is OK if you are not the best one to have this conversation with someone. If that's the case, help the individual find a person to whom they can talk to ensure they are safe.

People who are suicidal need to feel loved and accepted by friends, family, and colleagues. Things to **avoid** include:

- Saying or implying their feelings are wrong or silly or unimportant. That minimizes them.
- Ignoring their comments when they bring up hard topics.
- Analyzing or criticizing their thoughts and emotions.
- Insisting they "cheer up" or "focus on the positive," or instructing them on how to feel.
- Telling them what they should be grateful for or who they should live for.
- Saying it's all in their head or explaining away their experiences.

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Brene Brown teaches a bit about empathetic communication in this short video:
https://bit.ly/empathyvideobrenebrown

Please refer to the appendix to see the crisis resources available.

Specialized Mental Health Concerns

Substance Use Disorder

Personal Narrative:

I Didn't Cause It, I Can't Control It, I Can't Cure It

By Bella's Mom

I am a sixty-year-old Jewish doctor, and my daughter is a drug addict. She's alive and thriving, but not too long ago, I was afraid I would have to bury her.

When Bella was midway through twelfth grade, the school counselor called me into a meeting. She had been skipping classes, and they suspected drug use from what they were hearing. We put a tracker on her car and phone, we questioned her, we grounded her. Before I could figure out what to do next, she was arrested by city police for shoplifting. By the end of that week, she got kicked out of high school for vandalism.

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Before all this happened, I have to admit I was in denial. I believed my daughter was struggling like all teenage girls. Now I was scared to death and found it hard to wrap my head around what was happening. She had been seeing a psychiatrist and taking meds for ADHD her whole life. She had been in counseling since my divorce when she was young. She was in a private school with accommodations. I had been doing everything I knew to do. In truth, I was angry I had to deal with this drug problem now too.

When Bella was released from jail, I took her to the local public psychiatric hospital. The doctor recommended out-patient care at first. Once she got kicked out of school, they directed us to a ninety-day rehab program. I searched online first, not knowing what to look at. I was lost and so confused. I ended up sending her to a program they recommended.

At the same time, the hospital counselor said something very important: Addiction is a family disease, and I needed to go to Al-Anon.

Going to Al-Anon then, and still going now, has changed my life.
I came to understand my parenting did not cause this. Addiction runs in our family, so she is genetically predisposed. Her poor self-esteem issues and anxiety led her to self-medicate. She never felt like she fit in. She felt emotionally abandoned by her father. The circumstances of my divorce created stress in her life, and her wiring led her down this road. In high school, her friends kept changing. She spent more time alone in her room, and she wouldn't talk with me anymore. These were the circumstances of her life. I was doing the best I could. I was not to blame. I had no control over her choices.

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With help, I was able to choose a recovery program I believed could help us—an Enthusiastic Sobriety program with locations in Georgia and North Carolina. With the support of its staff, my husband and I confronted our daughter. I had no control over her behavior, but I had choices about mine. I came to believe that anything I provided to my daughter to keep her safe—a meal, some cash, a bed—actually was contributing to her using drugs for one more day. I could not keep her alive. She could overdose up in her room as well as out on a street.

I finally chose tough love, because I could not live with the daily dramas and anxiety. We took her phone and her car, which belonged to us, changed the locks on the house and gave her the choice of rehab or a bus pass. Her choice was help or homelessness. She knew I was serious this time. I had defined my boundaries for my mental health.

She chose help. She was belligerent and defiant. The drugs were in her system for months, distorting her thinking. The pain and anxiety she had been numbing out with drugs were in full force. She had a tough road to recovery. We emphasized she had to choose the life she wanted for herself. We couldn't live her life for her. She made that journey and is the wiser for it. She understands her struggles and where she gets tripped up, and she has tools and strategies to cope. She found through the recovery community she was loved for exactly who she was no matter how that looked.

The wisdom, faith, sponsor support, and tools of the twelve-step program of Al-Anon got me to this point of influence in my daughter's life. I had to let go and get out of her way.

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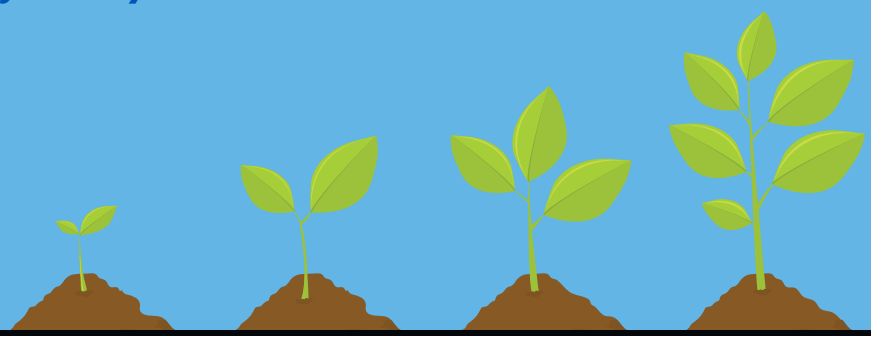
I had to have faith that a loving God was looking out for her, that she has her soul's journey to make. I learned loving detachment. I learned to live in the moment, not futurizing disasters that might not come or rehashing past moments with guilt or shame. I learned to take care of myself emotionally and spiritually. I learned to be grateful for what was and appreciate the small daily miracles. I learned to live my life joyfully, regardless of my daughter's choice. I found a community of parents who understood and did not judge me by her actions.

Teasing out what is parenting and what is enabling my child was the most difficult lesson I have ever had to learn. This has led us both to be independent of each other yet have a close adult-to-young adult relationship we both treasure. She can call for advice and then choose to do what she wants. My happiness is not dependent on her actions.

Bella has completed college and is working in an industry she loves. From completing the twelve steps, I am emotionally and spiritually healthier than I've ever been.

I am happy and content in all aspects of my life, whether there are challenging circumstances or not on any given day. We have grown our souls through this journey.



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Addiction - What is it exactly?

Addiction is defined by the CDC as a chronic disease characterized by compulsive use and seeking of a substance or harmful behavior despite the adverse consequences. It is a treatable medical condition involving complex interactions among brain circuits, genetics, environment, and life experiences. Substance use disorder (SUD) is a related term, indicating continued substance use despite significant problems.

Addiction is a unique situation in terms of how we think about it, understand it, and treat it. It often occurs as a result of an attempt to self-medicate for an underlying mental health condition, and this must be addressed in order for recovery to occur and last. Certain circumstances can be physically and medically dangerous, resulting in a life-threatening overdose or requiring medically supervised detox. A person struggling with addiction is likely to act very out of character, and many of their behaviors will be harmful to themselves and their loved ones.

Caring for a teen who is struggling with addiction differs in many ways from caring for one with other mental health conditions. The addiction can change who your child is and who you are as a parent. It can make you question your reality, and often the "right" thing to do in a given situation feels wrong or is incredibly difficult or distressing to do. It is essential to seek guidance and support. There are many frameworks to think about and approach addiction, each with its pros and cons. We encourage you to educate yourself as much as possible about different options and find the best fit for your family. We recommend that you start with a reputable information source - SAMSHA.gov is a good place to start.

Supporting children/youth with addiction

Having a conversation with your teen who is struggling with addiction should be handled with thought and consideration. We recommend that you have support and a plan in place. This chart from the SAMHSA website(4) has helpful tips for navigating this difficult conversation:

(4) Starting the conversation Guide | SAMHSA

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SUPPORTING A LOVED ONE DEALING WITH MENTAL AND/OR SUBSTANCE USE DISORDERS

STARTING THE CONVERSATION

When a family member is drinking too much, using drugs or struggling with a mental disorder, your support can be key to getting them the treatment they need. Starting the conversation is the first step to getting help.

How You Can Help

1. **IDENTIFY AN APPROPRIATE TIME AND PLACE.** Consider a private setting with limited distractions, such as at home or on a walk.
2. **EXPRESS CONCERNS AND BE DIRECT.** Ask how they are feeling and describe the reasons for your concern.
3. **ACKNOWLEDGE THEIR FEELINGS AND LISTEN.** Listen openly, actively, and without judgement.
4. **OFFER TO HELP.** Provide reassurance that mental and/or substance use disorders are treatable. Help them locate and connect to treatment services.
5. **BE PATIENT.** Recognize that helping your loved one doesn't happen overnight. Continue reaching out with offers to listen and help.

What to Say

- "I've been worried about you. Can we talk? If not, who are you comfortable talking to?"
- "I see you're going through something. How can I best support you?"
- "I care about you and am here to listen. Do you want to talk about what's been going on?"
- "I've noticed you haven't seemed like yourself lately. How can I help?"

For more resources, visit www.SAMHSA.gov/families.

If you or someone you know needs help, call **1-800-662-HELP (4357)** for free and confidential information and treatment referral.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. 1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov

SAMHSA
Substance Abuse and Mental Health Services Administration

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Eating Disorders

Eating disorders (EDs) differ from other types of disorders. In some ways, they are similar to substance use and other behavioral disorders, but they have their own characteristics and challenges. We will discuss some here, but if you would like more information, we recommend the National Eating Disorder Association (NEDA) and its NEDA Parent Toolkit.

All eating disorders affect the body significantly. Monitoring physical symptoms and medical risks are essential, as an ED is the most lethal type of mental illness. In addition to safety risks that occur with other types of mental illnesses like self-harm, suicidal ideation and substance use, ED behaviors generally cause harm to the body, leading to health concerns like malnutrition, cardiac and/or gastrointestinal complications, growth issues, and more that not only put a patient at risk but also can interfere with the effectiveness of any treatment someone may be getting. In most cases, these issues need to be addressed first for any therapy or other treatment to be effective. If your child has an ED, please make sure you are working with a qualified medical professional and treatment providers who are trained in eating disorders.

(4) Starting the conversation Guide | SAMHSA

Body - גוף

Navigating Kashrut

Treatment can be chaotic and difficult to navigate, especially when it comes to finding kosher food. Anyone staying in a hospital or other treatment center who keeps kosher should contact the chaplain or patient services as soon as possible to learn if they have any kosher options available.

Eating nonkosher food or eating on a fast day can be mentally and spiritually distressing. Many Jews find religious practice grounding at times when the rest of their lives are chaotic, and for someone in a situation where their health requires violating their normative kashrut practice, losing that can feel awful. But sometimes observing a law means "breaking" the law. Hasidic tradition tells a story of two brothers, Rabbi Elimelech of Lizensk and Rabbi Zushe of Anipoli, who were once stuck in a room that was unsanitary and therefore unfit for prayer and couldn't recite evening services for the first time in their lives. Losing this path to connection with God distressed Rabbi Elimelech so much that he began to cry, but his brother told him there was no reason to cry.

Don't you know the same God who commanded you to pray also commanded you not to pray when the room is unfit for prayer? By not praying in this room, you have achieved a connection with God. True, it is not the connection you had sought. Yet, if you truly want the divine connection, you would be happy God has afforded you the opportunity to obey Their law at this time, no matter what it is!(5)

(5) The Joy of a Mitzvah, Rabbi Yossy Gordon, The Joy of a Mitzvah - Chabad.org