Pakistan Journal of Positive Psychology

Print ISSN : 3078-6428 | Online ISSN : 3078-6436
Pakistan Journal of Positive Psychology

Original Article

FOSTERING RESILIENCE AND MEANING RECONSTRUCTION AFTER SUDDEN SIBLING LOSS: AN INTEGRATIVE CBT-DBT CASE STUDY OF ADAPTIVE GRIEF

Arooj Ashraf [a*], Neelam Ehsan [b], Uzma Masroor [c], & Irsa Noor Hafeez [d]

[a] Senior Lecturer/Senior Clinical Psychologist, Shifa Tameer-e-Millat University, Islamabad, Pakistan. Email: aroojashrafkhan@gmail.com
[b] Professor, Department of Clinical Psychology, Shifa Tameer-e-Millat University, Islamabad, Pakistan. Email: neelam.dcp@stmu.edu.pk.
[c] Dean, Bahria University, Islamabad, Pakistan. Email: uzmamasroor@yahoo.com
[d] Student, Department of Clinical Psychology, Shifa Tameer-e-Millat University, Islamabad, Pakistan. Email: irsanoorhafeez@gmail.com

*Correspondence to: Arooj Ashraf, Senior Lecturer/Senior Clinical Psychologist, Department of Clinical Psychology, Shifa Tameer-e-Millat University, Islamabad, Pakistan. Email: aroojashrafkhan@gmail.com. ORCID: 000-0002-8482-5741

KEYWORDS
Acute Grief, Resilience, Post-Traumatic Growth, Meaning Reconstruction, Adaptive Mourning

CITE THIS ARTICLE:
Ashraf, A., Ehsan, M., & Masroor, U., & Hafeez, I. N. (2026). Fostering resilience and meaning reconstruction after sudden sibling loss: an integrative CBT-DBT case study of adaptive grief. Pakistan Journal of Positive Psychology, 3(2), 259-266.

ABSTRACT

The concept of acute sorrow is gaining acceptance in positive psychology not merely as illness, but as the alteration of meaning that has the potential to lead to adaptive mourning and growth when proper measures are employed. Because grieving may appear similar to depression or trauma-related symptoms, diagnosis is difficult, and the processes designed to promote resilience may not be visible. Loss of a sibling, or familial role-related expectations and emotional repression that arise, does not yet have sufficient coverage in the literature on adaptive grieving. This study follows a female of age 25 who exhibited acute grief response due to her brother's sudden passing. The characteristic features of acute grief were present in this case study including sadness, emotional numbness, guilt, intrusive memories, sleeping disruption, avoidance, and impairment in functioning. Additionally, family disapproval and pressure to stay strong became obstacles in adapting to loss experiences. The integrated time-limited psychotherapy represented the combination of various approaches like cognitive-behavioral therapy, dialectic behavioral therapy and grief-centered meaning making (PM), including education on grief, teaching to cope with distress, cognitive restructuring of guilt feelings and meaning making. The client showed measurable gains in emotional expression, guilt resolution, sleep, and functioning, alongside qualitative markers of resilience: restored continuing bonds, greater emotional comfort, and an integrated relationship with faith. Standardized measures indicated reduced depressive symptoms and avoidance, supporting this strengths-oriented approach as a pathway to adaptive mourning. This case illustrates how integrating CBT and DBT within a meaning-reconstruction framework can help a bereaved individual move toward resilient, adaptive grieving after sudden sibling loss, with relevance to positive psychology's interest in growth following adversity.

I. INTRODUCTION

Emotional Grief can be perceived as a both common and unique response to experience a loss. The nature of grief differs between persons and cultures and can be expressed as somatic, behavioral, cognitive, and emotional responses. Contemporary views of grief and positive psychology think of acute grief not as pathology, but rather as

a normal reaction to the loss which can be extremely painful and powerful but which can be turned into a road to meaning finding and recovery if a person gets support (Bonanno et al., 2007; Fernández-Fernández & Gómez-Díaz, 2022)). The occurrence of death in unexpected circumstances creates additional troubles for the grieving person because it does not provide a chance for anticipatory grief (Parkes, 2001; Stroebe & Schut, 1999). Shock, dismay, guilt, destructive memories, inability to integrate the loss into his/her worldview are the usual attached feelings, emotions, thoughts. The presence of these vulnerabilities may cause susceptibility towards avoidance style coping and excessive emotional burden in the early stages of grieving, but they can also act as a ground for ultimate development of meaning-making and post-traumatic development. Due to the multifactorial nature of grief responses, integrative therapeutic modalities that address simultaneously cognitive, emotional, behavioral, and meaning-related processes in clinical practice have shown an outstanding clinical utility and a great potential for building resilience instead of reducing symptoms only.

Cognitive behavioral therapy (CBT) targets maladaptive grief-related cognitions such as excessive responsibility, self-blame, counterfactual thinking, and catastrophic interpretations of loss (Beck, 1976; Duffy & Wild, 2023), helping people rethink guilt-based beliefs and regain a balanced sense of agency. Dialectical behavior therapy (DBT), originally developed for emotional vulnerability, offers evidence-based distress tolerance, emotion regulation, and mindfulness skills (Linehan, 1993) that are well suited to acute grief marked by emotional flooding and avoidance of strong emotion. Improving affect tolerance in this way can make it safer to engage with grief-related content and reduces reliance on suppression as a coping strategy. Modern grief models place meaning reconstruction at the center of adaptive mourning. Neimeyer (2011) frames grief as a disruption of one's own narratives and systems of meaning, requiring the bereaved to integrate the loss into an evolving sense of self and purpose. Meaning-making interventions — narrative reconstruction, symbolic connection, and continuing bonds — have been shown to facilitate this kind of post-loss adjustment, and align closely with positive psychology's broader interest in how adversity can, under the right conditions, generate growth (Hewson et al., 2023). Standard meaning-reconstruction work, however, presumes a client's capacity to tolerate substantial emotional exposure. Where sudden bereavement is compounded by chronic familial invalidation, that exposure can instead produce emotional flooding, cognitive disorganization, and behavioral avoidance. An integrative framework combining DBT and CBT was therefore selected a priori to build a phased, clinically safe trajectory toward resilience: the earliest sessions targeted DBT's Distress Tolerance and Mindfulness modules to expand the client's window of tolerance and establish affective stability before any direct cognitive or narrative work on the loss itself. In contexts with a strong cultural and religious foundation, grief processing is often significantly shaped by faith-based beliefs. Spiritual frameworks can be protective, offering structure, hope, and existential meaning, but when interpreted too rigidly they can also produce spiritual bypassing or emotional repression (Pargament, 1997).

Culturally responsive positive psychology practice therefore emphasizes sensitively integrating faith to support meaning-making without foreclosing emotional expression or grief engagement. The current case study demonstrates a phase-based integrative framework of CBT–DBT, supported by the grief theory, resilience research, and cultural competent practice, designed to help individuals through the mourning process after losing a sibling unexpectedly (Bolton et al., 2019). The individual in this case study is known under the initials M.S. She is a 25-year-old unmarried student from an upper-middle socioeconomic background. She comes from a nuclear family structure and is the eldest of four siblings. Sibling bonds often symbolize long-lasting emotional connections; the death of a sibling can cause family members to question previously held beliefs about security and connectedness in the system. In many collectivist cultures, such as those valued by indigenous communities, eldest daughters bear more emotional, organizational, and caregiving responsibilities after the death of a sibling. Although such expectations can inhibit feelings, lead to postponed bereavement, and increase susceptibility to long-term suffering, they can also promote post-traumatic growth and increased family cohesion if accomplished properly (Rosenblatt, 2008; Bonanno et al., 2007). The presented case adds to existing knowledge regarding support of siblings who have suffered sudden loss in an invalidating and collectivist family system. Therapy for M.S. always accounted for her problematic background marked by criticism of the father and importance of being strong. The therapist took care of establishing a trusting alliance with M.S. and did not make things sound critical, attempting to steer clear of creating similar dynamics. Instead of pressing M.S. to change her behavior or challenging her family ties, which could have also added to her issues, the therapist provided M.S. genuine empathy and acceptance.

II. CASE REPORT

Cross Approximately three months after her brother's sudden passing in a car accident, M.S. approached for counseling services on account of multiple symptoms. M.S.'s main complaints persistent sadness, a marked lack of emotional expression combined with a distressing inability to cry, and intrusive memories of the accident. At the same time, M.S. experienced intense survivor guilt due to a quarrel with her brother days before the tragedy. She also reported a series of symptoms, including inability to sleep, physical exhaustion, and avoidance of reminders of that day. In terms of social behavior, M.S. expressed high restlessness and isolation from her friends, academic difficulties, and family conflicts. M.S. reported that her family environment was characterized by high expectations, little emotional validation, and insufficient emotional support. Due to being the oldest child in her family, she felt considerable pressure to maintain emotional fortitude while supporting other family members, which led her to suppress her own grief and avoid necessary emotional processing. She described her father as being emotionally critical, and the transition into menopause that her mother underwent added more stress to her family dynamics. Before losing her family member, M.S. went through short courses of CBT/DBT-based psychotherapy that helped her deal with her anger and interpersonal problems resulting from family issues. She had no history of psychiatric hospitalization, self-harm, or substance use. A comprehensive differential evaluation ruled out organic contributors to her fatigue, insomnia, and somatic distress. Before treatment began, her primary care physician conducted a full physical examination and laboratory workup (CBC, thyroid panel, metabolic panel), which revealed no abnormal findings.

Psychometric and Diagnostic Assessment

Assessment combined a semi-structured clinical interview, mental status evaluation, behavioral observation, and standardized psychological measures, gathered before and after intervention to track diagnostic and functional change and to identify strengths that could anchor the resilience-building work of treatment.

Table I: Pre- and Post-Intervention Measures

Measure	Baseline / Pre-Intervention	Post-Intervention	Clinical Interpretation
Patient Health Questionnaire-9 (PHQ-9)	11 (Moderate depressive symptoms)	6 (Mild symptoms)	Reduction in depressive symptoms; distress better accounted for by grief than MDD
Beck Depression Inventory–II (BDI-II; Beck et al., 1996)	26 (Moderate depressive symptoms)	12 (Minimal–mild depressive symptoms)	Clinically meaningful reduction in depressive symptom severity; residual affective distress consistent with normative grief rather than Major Depressive Disorder
Inventory of Complicated Grief (ICG)	28 (Below clinical threshold ≥30)	Not re-administered*	Indicates distressing but non-prolonged grief response
Grief Avoidance Questionnaire (GAQ)	Elevated avoidance	Reduced avoidance	Increased emotional engagement with grief-related stimuli
Rotter Incomplete Sentence Blank (RISB)	149 (Significant emotional distress)	119 (Reduced distress)	Improved emotional regulation and reduced internal conflict
Human Figure Drawing (HFD)	Emotional constriction, insecurity	Greater emotional openness	Reflects improved affect tolerance

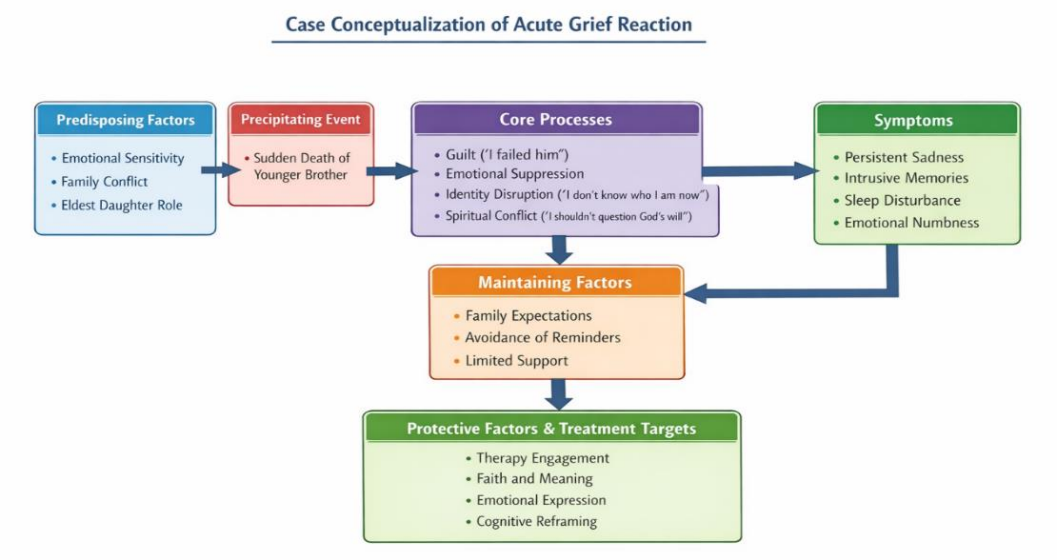
**Note.* The Inventory of Complicated Grief (ICG) was deliberately omitted at post-intervention because therapeutic contact concluded approximately five months' post-loss. Because diagnostic frameworks (e.g., DSM-5-TR) require a minimum 12-month post-bereavement duration to evaluate prolonged grief formally, re-administering the ICG at five months would have yielded premature data. Treatment outcomes were instead tracked using the PHQ-9, BDI-II, and RISB to evaluate immediate symptomatic relief and functional recovery.

The diagnosis was confirmed through structured clinical interview and psychometrics according to the DSM-5-TR guidelines (American Psychiatric Association, 2022). Thus, Major Depressive Disorder (MDD) was excluded, due to stable self-esteem, presence of situational mood reactivity, and the reason for distress being related to grief and not constant hopelessness and any intent for suicide. In addition, Posttraumatic Stress Disorder (PTSD) was ruled out because of the absence of enduring somatic hyperarousal and general schemas of threat or avoidance of trauma. Lastly, the diagnosis of Prolonged Grief Disorder (PGD) could not be applied, as it would require at least one-year evidence of disorders after death, which was absent in this case. Therefore, the accurate diagnosis was Other Specified Depressive Disorder: Depressive Episode with Insufficient Symptoms (311/F32.A) combined with Z63.4 (Uncomplicated Bereavement) meaning that the patient was suffering from acute grief process complicated with environmental challenges and lack of validation from the members of their family instead of having primary depressive disorder.

III. CASE FORMULATION

The client's grief reaction was conceptualized using a biopsychosocial “four Ps” model, with explicit attention to the protective and resilience-relevant factors alongside the clinical ones. Predisposing factors included a strong emotional bond with the deceased, a family-oriented cultural background that values emotional control, and personal emotional sensitivity. The precipitating factor was the sudden, unprepared death of her sibling, which immediately repositioned the client as an emotional stabilizer within the family. Perpetuating factors were cognitive and behavioral: guilt, emotional control, and avoidance of grief reminders. The client held a strong belief that expressing emotion would disrupt family functioning, and so consciously suppressed her feelings while over-involving herself in family duties. Protective factors — the resources this treatment sought to amplify — included the client's own insight into her emotional difficulties, generally positive family relationships, and a faith-based meaning system that, once engaged rather than avoided, offered a durable contextual framework for recovery. Treatment therefore focused on reducing maintaining factors while deliberately strengthening these protective processes to enable adaptive grief integration.

Figure I: Case Conceptualization Model



Viewed through an integration of cognitive-behavioral, dialectical, and existential perspectives, the client's grief response reflected the interaction of low distress tolerance, maladaptive beliefs about sadness (e.g., “If I allow myself to fall apart, my family won't be able to cope”), and cultural beliefs about emotional suppression. Beliefs such as “to move forward means I didn't love my sibling enough” contributed to guilt and emotional avoidance, and to self-monitoring in which the client actively managed her emotional experience (Vaillant, 1992). She described a fear of emotional overwhelm: “when I feel sad it seems as though I will be consumed completely with

sadness," reflecting difficulty with emotion regulation. DBT-informed strategies helped the client build distress tolerance, label her emotions, and stay present (Linehan, 1993). Psychodynamically informed observation suggested suppression and intellectualization as her primary defenses — adaptive shortly after the loss, but ultimately keeping her disconnected from her own grief. The therapist deftly reconstructed these defenses into previously effective strategies which do not fit her current emotional needs anymore. The client mentioned the ambivalence between faith and suffering: "Yes, I know that GOD has a plan for everything, but I do not understand why I have gone through this" while trying to give the context to her life story and integrate faith. The focus of the work has been to support the client to keep faith and grief together and realize that faith embraces experience of emotions rather than eludes it. This formulation constituted a phased intervention plan aimed at helping her get through the loss emotionally, change her way of thinking about it, and re-write it as an integral part of her life story (Pargament, 1997; Worden, 2009).

Intervention

An organized framework was developed for this integrative therapy. The intervention takes place in the form of ten distinct sessions. The sessions help to change the feelings of the participant from being suppressed in an emotional state to a more efficient and flexible mournful stage.

Phase 1: Stabilization and Psychoeducation (Sessions 1–2)

The initial stage centered on re-establishing therapeutic rapport and creating emotional containment. Psychoeducation was delivered to the client about normal expectations of grief, how grief can be differentiated from mood disorders, and its non-linear trajectory (Worden, 2009). Grounding and distress tolerance skills from DBT were explained to enable the client to cope with distressing emotions.

Phase 2: Emotional Regulation and Grief Engagement (Sessions 3–4)

This stage concentrated on promoting emotional tolerance and minimizing avoidance. The client was guided to recognize and articulate her feelings, particularly guilt and sadness, and to gradually narrate the events related to her brother's death so that she could become emotionally connected, yet feel secure. A grief diary recorded her feelings, triggers, and coping methods utilized in-between the sessions.

Phase 3: Cognitive Reframing and Guilt Processing (Sessions 5–6)

Maladaptive grief-related thoughts were tackled using CBT-based cognitive restructuring (Duffy & Wild, 2023). The client's self-blame regarding her brother's death was tackled through Socratic questioning and coming up with different viewpoints, such as switching around the concept of responsibility and bitterness. The use of DBT emotional regulation techniques was crucial for coping with the pain during the process.

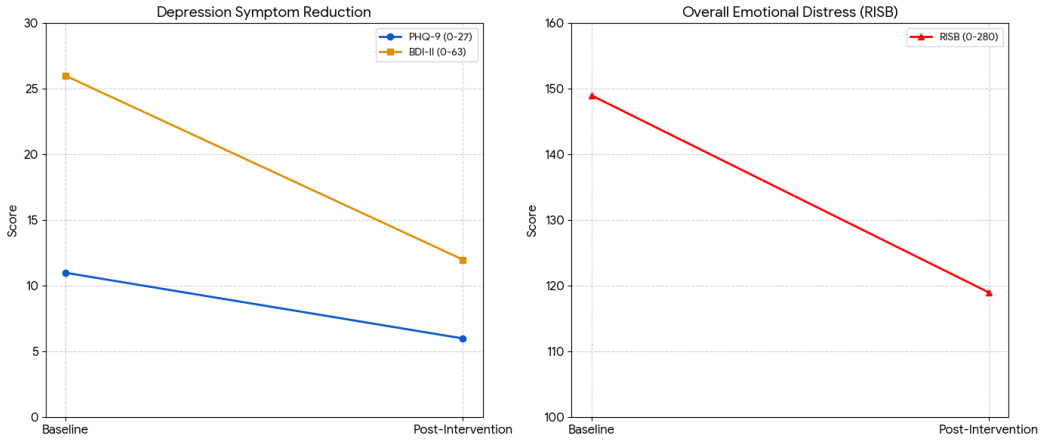
Phase 4: Meaning Reconstruction and Integration (Sessions 7–10)

This phase concentrated on helping the client accept the loss of her brother into her sense of self and regain a sense of meaning. The work moved through the transitional roles of the family system, the continuing bonds, and the symbolic connection with her brother and then looked further into relapse prevention, individual normalization of grief experience, and ethical termination.

IV. DISCUSSION

The intervention has led to a marked improvement in terms of depressive symptoms, emotional regulation, and functionality in daily life. PHQ-9 score declined from 11 (Moderate) in the baseline to 6 (Mild) after the intervention (a reduction of 45.4%). BDI-II score also came down by 53.8% from 26 to 12 (Moderate to Minimal). Although there is some degree of lingering grief after the intervention, there was considerable improvement in the client's distress showing symptoms that were more characteristic of usual bereavement rather than clinical depression.

Figure II: Line Graphs Showing the Reduction in Depressive Symptoms (PHQ-9, BDI-II) and Overall Emotional Distress (RISB) Over 10 Sessions



The Rotter Incomplete Sentence Blank reflected a parallel progress in emotional stability: 20.1% decrease in internal conflict (149 to 116), indicating M.S.'s transition from emotional numbness to openness and active engagement with grief. Qualitative feedback confirmed these conclusions: improvement in sleep quality, reduced intrusive memories, and ability to manage family responsibilities without emotional shutdown. Taken together, the findings highlight how a combination of CBT and DBT in phase structure can enhance adaptive mourning rather than mere symptom reduction.

Implications for Positive Psychology and Adaptive Mourning

The focal theme of this matter is a key aspect of the interaction between positive psychology and adversity, which asserts that resilience and recovery are not about escaping suffering but rather about being able to stay with it and heal by finding new meaning, connection, and purpose. For example, M.S.'s recovery is not about not grieving anymore; it is about grieving in a new way — with adaptive sadness instead of being overwhelmed, with the ability to maintain connections instead of avoiding, as well as with the confidence that allows her to cope with, not ignore, her pain. This capacity to combine obligations towards the family with independent emotional processing illustrates the essence of posttraumatic growth already discussed by resilience researchers, who see it as the successful outcome of facing tragic loss (Bonanno et al., 2007; Fernández-Fernández & Gómez-Díaz, 2022). The interaction of two factors — the role of personal defense mechanisms as well as of prevailing cultural norms in an emotionally invalidating family system — was crucial in complicating the situation. M.S. — being the oldest daughter of a South Asian family that highly values collectivism — was meant to fill the role of the one providing emotional support to her parents and younger siblings, which was implied by her cultural background. At the same time, being in this role imposed pressure on her not to allow any form of emotional expression, which is why she resorted to employing suppression and intellectualization as defense mechanisms.

Moreover, because of her father's emotionally critical stance, her emotional state got invalidated all the time, which made her fear that being openly sad would result in family disintegration. Not to mention that the initial spiritual model that M.S. interpreted as implying absolute relinquishment of control made her feel constrained in expressing anger or sadness at the same time. While the family belonged to an upper middle class category and should have access to generally available psychological service due to their financial capabilities, in this case it was more the relationship and cultural dimension which have played a role in the access to mental therapy. These facts strongly influenced the case of M.S. who regarded visiting a therapist as a sign of his/her incapability to overcome the grief only through faith. In addition to prejudice against any assistance with the trauma she experienced external social factors such as being the eldest among siblings as well as being culturally expected to cope with trauma independently demanded considerable time to elapse from the moment of experiencing trauma and starting seeking assistance. After the intervention of ten sessions based on different phases, this success was continued by means of some informal support system. M.S. managed to preserve the success six months after she

completed the intervention; there was complete evidence of stability in the variable she started with and no signs of delayed grief problems or psychological regressions.

In terms of quality, her sleep habits were normal, and she was able to reach her memories related to her brother without experiencing intrusive trauma or an overwhelming sense of guilt. She had managed to incorporate her beliefs in such a way that she was able to use faith for the containment of her feelings instead of the avoidance of them, which has allowed her to strike a balance between her family obligations and the processing of her grief. This case has broader implications for supporting acute grief in collectivistic environments offering minimal validation to the bereaved. Traditional exposure-based or insight-oriented grief therapies may produce emotional flooding if introduced too early, particularly for clients who were highly sensitive or emotionally inhibited before the loss (Shear, 2015). Sequentially integrating dialectical techniques ahead of cognitive and narrative work therefore appears necessary in such presentations: expanding the client's window of tolerance first creates the safety needed for cognitive restructuring — particularly of guilt — and narrative meaning reconstruction to occur without retraumatization (Hewson et al., 2023). This phased map gives clinicians and, by extension, positive psychology practitioners, an evidence-informed route to facilitate adaptive mourning through the resolution of maladaptive suppression rather than its avoidance.

V. CONCLUSION

This case highlights the value, for clinicians in training and in practice, of prioritizing affective stabilization before intensive grief work, and of treating resilience-building as an explicit goal alongside symptom reduction. Patients who have experienced severe emotional suppression often struggle to engage with their grief precisely because of how deep that sadness runs; when feelings cannot yet be expressed directly, clinicians can work collaboratively with patients to identify culturally appropriate avenues of support that don't force a premature confrontation. In societies that value collectivism, the perception of the responsibility of the eldest daughter in a family is one of unquestioned, accepted burden. In this context, a clinician should help the patient find alternative ways to provide help and not contribute to the definition of the separation anxiousness and shame involved in caring for the family. Furthermore, it is essential for the clinician to work with the patient to deal with the guilt associated with the belief systems or existential loss, and also to help them build the means to take care of their own needs while still expressing their grief. The case being discussed illustrates how the concept of positive psychology can be applied to complicated grief or traumatic loss and still result in positive outcomes.

Disclosure Statement
No potential conflict of interest was reported by the authors.

Funding
The author received no funding from any organizations.

VI.REFERENCES

American Psychiatric Association. (2022). DSM-5-TR: Diagnostic and statistical manual of mental disorders (5th ed., text rev.). Author.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. International Universities Press.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). Manual for the Beck Depression Inventory–II. Psychological Corporation.

Bolton, J. M., Au, W., Chateau, D., Walld, R., Leslie, W. D., Enns, J., ... Sareen, J. (2019). Bereavement after sibling death: A population-based longitudinal case-control study. World Psychiatry, 18(3), 338–345.

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., ... Nesse, R. M. (2007). Resilience to loss and chronic grief: A prospective study from preloss to 18 months postloss. Journal of Personality and Social Psychology, 83(5), 1150–1164.

Duffy, M., & Wild, J. (2023). Living with loss: A cognitive approach to prolonged grief disorder—Incorporating complicated, enduring and traumatic grief. *Behavioural and Cognitive Psychotherapy, 51*(6), 645–658. https://doi.org/10.1017/S1352465822000674

Fernández-Fernández, J. A., & Gómez-Díaz, M. (2022). *Resilience and grief facing the loss of a loved one: A systematic review*. *Revista de Psicopatología y Psicología Clínica, 27*(1), 43–57. https://doi.org/10.5944/rppc.27762

Hewson, H., Galbraith, N., Jones, C., & Heath, G. (2023). The impact of continuing bonds following bereavement: A systematic review. *Death Studies*. Advance online publication. https://doi.org/10.1080/07481187.2023.2223593

Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. Guilford Press.

Neimeyer, R. A. (2011). Reconstructing meaning in bereavement. Routledge.

Pargament, K. I. (1997). Psychology of religion and coping. Guilford Press.

Parkes, C. M. (2001). A historical overview of the scientific study of bereavement. In M. S. Stroebe et al. (Eds.), Handbook of bereavement research (pp. 25–45). American Psychological Association.

Rosenblatt, P. C. (2008). Grief across cultures: A review and research agenda. In Handbook of bereavement research and practice (pp. 207–222). American Psychological Association.

Shear, M. K. (2015). Complicated grief. The New England Journal of Medicine, 372(2), 153–160.

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. Death Studies, 23(3), 197–224.

Vaillant, G. E. (1992). Ego mechanisms of defense. American Psychiatric Press.

Wakefield, J. C. (2012). Should prolonged grief be reclassified as a mental disorder in DSM-5? World Psychiatry, 11(2), 81–82.

Wild, J., Duffy, M., & Ehlers, A. (2023). Moving forward with the loss of a loved one: Treating PTSD following traumatic bereavement with cognitive therapy. *The Cognitive Behaviour Therapist, 16*, e12. https://doi.org/10.1017/S1754470X23000041

Worden, J. W. (2009). Grief counseling and grief therapy: A handbook for the mental health practitioner (4th ed.). Springer Publishing Company.