PESI – THE GRIEF SUMMIT
"TRAUMATIC GRIEF"
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>> ZACH TAYLOR: Welcome back, everybody! I hope you had a nice break. I know that I -- I accidentally let you all know we would just be 15 minutes and I had forgotten we were already in our lunch break and we would have 45 minutes. So hopefully many of you got out, I assume many of you did, and you're here with us now.

How is your day going? How are you feeling about The Grief Summit? Have you had technical issues, problems getting questions in? I know with so many people we've done incredibly positive feedback, but others might have distractions going on around you or you might have to miss certain parts of the schedule. We know that with all of you here, you are in every situation possible, and we want to thank you for sticking with us, now, half day in day number two. One half day to go and three more sessions. With that, thank you for coming back and joining us.

This session is on a really important topic, one that I think is somewhat misunderstood, and I want to reference David Kessler again who said in all trauma is grief, but not all grief has trauma. And I, for whatever reason, that popped into my brain,

which I thought was such a poignant thing to say and ties in so well with what Dr. Gentry, I believe, is about to talk about.

So where is this line between grief and trauma? Dr. Eric Gentry, I would welcome you back to the stage to talk a little bit more about this topic of traumatic grief.

>> ERIC GENTRY: So I have been told that I'm unable to start my video.

>> ZACH TAYLOR: My goodness. Maddie will momentarily. Bear with us.

>> ERIC GENTRY: There we go. Beautiful. I'm glad that Murphy waited to visit with me for the -- for this -- The Grief Summit.

>> ZACH TAYLOR: Thank you for your patience.

>> ERIC GENTRY: To demonstrate self-regulation, for sure.

>> ZACH TAYLOR: The floor is yours, and we look forward to this session, Eric.

>> ERIC GENTRY: So when I was asked to do this, I did not realize the depth of what I was getting into, to do it. And the way I've crafted this presentation is, I did -- I bet, 20 hours of research into this presentation, maybe more, for just an hour and a half. And I've dug into what is helping us get a conceptualization of traumatic grief and how is it different from regular grief. And then in the second half of the -- or annually the second triad, third of this presentation, I want to talk about existing treatments, so things that are out there. And then I want to talk a little bit at the end, and for those of you that are conscientious clinicians, for sure, you're going to want to make use of those evidence-based protocols that are out there, that have some evidence with it. Nothing has good evidence yet. It's not -- for traumatic grief, it's not a well-enough known process yet to have been developed treatments, but there are some that are emerging, and I'm going to share those with you.

And then I put together some stuff to help you interface with your clients today that you're working with that have suffered from people that have lost people during the pandemic that are suffering in their grief now, to help you to -- some tools to be able to diminish their distress and help them to move into supported grieving so it's not traumatic for them anymore. And that they are able to now -- it becomes kinetic rather than being in the stasis, and that's what the traumatic component of grief does. It turns it into something static that doesn't resolve. So with that, I'll pick off -- I said this in the last presentation, but I want to now -- if there's any way that I could be of service to any of you, I want to invite you to reach out. I know I'm opening myself up to a whole lot of contact, but as a clinician, that's what I do. I help people to help

people. So I believe there will be a way to be able to offer some assistance to any of you.

Now, with 19,000, it might be a little low before I can get back with everybody. But absolutely want to invite you, if I can be of service to you in the performance of your mission to reach out.

Okay. So let me share my screen here, if I can get the PowerPoint up. Intentional about the choice of this background. I hope you can see the metaphor of it. It kind of moves through a spectrum, and it's not a nice, straight line spectrum. There is the movement from intensity to the lessening of intensity to the resolution of re-establishing quality of life after -- and the relationship with the people that we have lost after the loss. So that's what I hope I'm going to do.

Start with some disclosures, and some front-end stuff here. This is the American Psychological Association's use statement. I won't read it to you, but it invites you to use discernment with everything that I am presenting.

On the effectiveness and limitations, the first half of a factual presentation of peer-reviewed research on traumatic grief. So there's not any kind of effectiveness, we're not into treatment in the first half of this. It's about conceptualizing what is traumatic grief. And then in the second half, we do go into treatments, and through two reviews of traumatic grief, what we've discovered is that most of the treatments are treatments that have been kind of tooled to fit to traumatic grief. It's taken the elements of traumatic stress and grief that are both active in traumatic grief and trying to amalgam a treatment that works with both of them. But there are a couple of treatments that do have some evidence that I will be presenting, and that is a Brief Eclectic Psychotherapy for Traumatic Grief, and the Dutch have worked on it, and from what I read, it's a pretty complete model. And then a treatment model for individuals and families, and then I'll present some of my work around the common ingredients, common factors for particularly working with the traumatic stress component of traumatic grief, and there is no outcome data on the effectiveness of this other than multiple meta-analysis that shows these are the active ingredients for the treatment for all trauma and stress treatments that work.

But, again, that the active ingredients approach that I'm going to present, it's not about treating the condition of traumatic grief. It's about developing some tools to be able to lessen your client's distress.

And the risks associated with this training, there's a lot, for sure. Anytime that we are working with somebody that has traumatic grief, there's three kind of things that are going on

that are very synonymous with suicide and self-harm risk, including Prolonged Complicated Bereavement Disorder, Post-traumatic stress and Major Depression Disorder. And to continue to monitor and assess in the emergence of any of those, that safety is compromised, that you're seeing increased impairment, that they are beginning to talk about self-harm or suicide, and they are engaging in self-destructive coping behaviors. Those are things we need to monitor for and be prepared to intervene, because, you know, there frequently is overwhelming amount of affect that people are navigating through while they are moving to resolution with traumatic grief.

So -- and exposure is a component of the treatment of traumatic grief. There is the coaching, supported process of helping people to do both imaginal and de vivo exposure, so what's happening with the trauma -- and I'll go into that later -- that it's freezing everything, that it can't move on to resolution. So as we are able to diminish the trauma expressed elements of the grief, we are able to support people on to the natural resolution, organic resolution of grief, which is the ability to remember with love instead of pain.

So that's all the front-end stuff. Going back to the late '90s, which was where the field picks up with this phenomena of traumatic grief, a couple of statistics, 16% of people who suffered loss by traumatic means met DSM IV criteria for PTSD and global, 18.6, and the international research that we have. And traumatic grief grew from the field of chronic bereavement, of complicated bereavement, all that language of the DSM-IV and 5 is that there is now a movement to make sure for the DSM-5 or the DSM-6 that traumatic grief has a seat in that diagnostic continuum with grief from bereavement disorders.

There are two significant factors that we'll be talking about in the treatment of traumatic grief, and that is the distress that is caused by the separation of a primary area attachment person. That can be with a pet, but it's mostly with close loved ones, because they were such a -- they met most of our attachment needs and suddenly they're not there anymore. But that produces a significant amount of stress. And then the more traumatic was the death, and the more violent or the more unexpected, then you add to it the traumatic components of that. So there is an interactive effect between both of those two things, and that what you hear from everybody that writes about that is that those two need to equal addressing in the treatment process, that we have to kind of talk about and help people to accommodate the attachment loss and begin to build attachment and connection in other places other than just the person they lost, and that's what the bereavement and the healing looks

like. And we have to help them to desensitize the traumatic material, the traumatic component of the grief experiences.

So those are -- you see those are two significant challenges for clinicians. So just some bullet points, traumatic grief or traumatic bereavement usually involves the unexpected, sometimes violent or horrific loss of a loved one. Where the person has an opportunity to do the end-of-life process, to prove through Kübler-Ross stage with the loved ones and the loved ones are able to do that work. You're probably not going to end up with traumatic bereavement with those folks because there wasn't any preparation, there wasn't the ability to relax into letting that person go.

When people lose intimates with sudden loss, they are at risk for chronic grief reaction. We saw that, the people who lost loved ones at 9/11, that that was a whole lot of, we were seeing people not getting better from the loss. Holly Voss wrote a lot about that, ambiguous loss, which is a component of traumatic grief.

So as I said in the story, traumatic grief is an alchemy of Persistent Complex Bereavement Disorder, PTSD, and Major Depressive Disorder. They need to be assessed for in the treatment of traumatic grief.

And I just like these two quotes. In the universe of life events, traumatic loss and traumatic stress intersect a great deal, both in the event dimensions and psychological impact of those two things. And as Zach shared before, all trauma has grief, always loss, sometimes real and sometimes ephemeral. Always loss. Not always is there trauma with loss. And that grief is a distinctive, individual social and relational experience. When we get into treatment, one thing I want to make sure that I undercover with multiple lines is that the most effective treatment is a relational engagement. There are other things that help people heal from traumatic grief, but you get their engagement, the only way that somebody that is suffering from traumatic grief is going to engage in those processes is if we are able to build, maintain, and enhance good-quality, therapeutic relationships. It is a relational process, healing from grief.

So here are these two factors, kind of parsed out. And looking at some of the -- there's overlap, you know, you can imagine these two Venn diagrams, and we've got the separation distress and the traumatic stress building this. What does separation distress look like? It's distressing, preoccupation is the wrong word, because it's just perpetual intrusion. The person is not preoccupied with it, not calling it up. It's intruding. It's a constant intrusion. There's a hole. And what fills in are all the memories of both the loss experiences

and the horror of that, but also all of the past experiences that are no longer satisfying. You know, all of those pleasant experiences that you've had with this person, you know, shortly until there starts to be some desensitization, it's not satisfying to remember the happy parts because what comes with that is more distress because they're not here anymore. And that turns into yearning, longing, and pining. It is the inability to fully accept. I'll talk about Worden's work here in a little while, that we need to accept the loss. The reality of the loss is the first stage of healing.

I mean, people who are healthy can accept that the loss happened. But what's happening internally, there's this constant wish fulfillment going on. Please, God, bring them back. Can I talk to them one more time. There's the acceptance, but it's still kind of this yearning and hoping this isn't real. And, you know, some dissociative experiences around that, which is normal, but can be fully debilitating. And that's kind of what moves to the next one, perceptual set, including visual, tactile, and auditory illusions. How many of us have lost people, especially during hypnopompic and hypnagogic, you know, the going to sleep and waking up times that we imagine that we've seen that person, you know, in the corner of the room. That suddenly they're there and that is -- that's a pretty common experience, as I have -- said people who have suffered losses. They see them out of the corner of their eye. They can smell them. They can hear their voice, as if it is present in real time.

You know, they could go get -- that would look like thought disorder symptoms. It would look like maybe schizophrenia, that they're delusional or hallucinatory, but it's -- people who hadn't had that loss, it's an acute death that now comes forward, all of this stuff. And having some of that intrusion and being able to relax into it is part of the healing process.

And I'll make this point a little bit later when we get into treatment. Crying is a wonderful thing. That's how we heal. But involuntary crying, it's not a good thing. And, you know, I work with folks, I've worked with a couple of clients over the past year with COVID, but my real experience with traumatic grief is working with parents. When I was in practice in Sarasota, I bet I worked with 20 parents or more that have lost children, adult children, to overdose. Terrible opioid epidemic in Florida ten years ago. Still there. But it was just starting 10 or 15 years ago. And there was a lot of overdoses. And in talking with clients about the complicated bereavement, you know, three years, four years out, they're still constrictive, still struggling. And they would say, well, I cry all the time. And I would help them to see that the crying

involuntary, they're actually in a state of constriction and suppression and it still overwhelms their constriction and suppression, and that turns into making it more fearful, more traumatic. As we help people to cry voluntarily, it becomes curative. It becomes the resolution and the diminishing of the intensity of it. But involuntary is what you see a lot in early stages of seeing a client.

Searching for the deceased. Maybe not overtly, but, again, intrapsychically, this kind of pining and hoping that they're going to see them or hear them today, in some kind of way. I mean, it's not -- it's not a conscious thing. It's more of an intrusion. They're not choosing to -- they know the person is not coming back. But as there's more and more intrusion with this, there is the hunger and looking for them in the home or in the car. And ultimately that ends up with extreme loneliness. That's the separation distress part.

Now, the way Prigerson, who is kind of the -- does most of the writing about traumatic grief and has since 2000, is -- these are some of the components of traumatic distress -- feeling unfulfilled without the person there anymore, a big part of just, you know, with trauma, what we've got is criteria B and criteria C, and that's the bipolar, biphasic nature of trauma. We have intrusion and avoidance. We have the constant intrusion over there in the same way that combat veterans have flashbacks of combat or childhood abuse survivors have the flashbacks, what they look like is involuntary remembrances paired with a lot of pain. So in the some way that combat veterans avoid loud places with people that have had recently deceased partners or family members or loved ones, there is an involuntary avoidance of places that trigger the memory. And if every place you go is causing you to be intruded upon and that causes a stress response, then what happens is a state of learned helplessness, that the distress can't get out of it so there ends up being this other side. Instead of the arousal, it's flatness and utility and hopelessness.

Believing that part of you, the self, has died, numbness and attachment Poulin, shattered attachment, loss of control, the loss of those three things. Feeling shocked, stunned, dazed, disbelief, taking on the symptoms or harmful behaviors of the deceased, picking up smoking if your partner was a smoker or your loved one was a smoker or some of those things. Ultimately it ends up with bitterness. Not everybody, but a lot.

And it's interesting, you know, I love that the research with this box down here at the bottom, I think the research from adverse childhood experiences can driving more and more of our experiences today to not just look at the psychological chronic stress but also see that it has a physiological component and

high risk of traumatic grief is associated with multiple physical health problems like high blood pressure, cancer, cardiac events, ulcerative co- -- Colitis, suicidality and global dysfunction.

We want to remove the stress so that person can move forward instead of staying in the stasis and stuckedness.

And here is the Venn Diagram, you see it's more PTSD and Persistent Complex Bereavement Disorder, but it has a component of major depression here. So there's a visual representation of what we're looking at with traumatic grief. And this is the proposed diagnostic criteria. I have this in your handout, in the back. So I won't go over that. And I've kind of talked to a lot of these already. And you're seeing as you move through these, you're seeing the weave of the separation and the lost focused symptoms and then the more traumatic focus symptoms that are woven in here. Both/and, in that. So I'll let you just read through those. I won't read the slide. And it's also in your manual. But there is -- and from my reading is that it is already -- it has already been in traumatic grief and I always get it confused, the next iteration of the ICD, I think it's 11, but it might be 12. I get those confused, but traumatic grief will be a diagnostic criteria for the next ICD. We don't know about the DSM yet. And there is, from Boelen & Smid, I have those questions, you'll need to get permission to use that from them. Either purchase or through contact with them, I'll have their citations and the manuals. These are the thoughts, the intrusive thoughts and images, strong yearning and longing. Again, the combination of those two factors that we measure, there's a Likert Scale for each one of these, one to four, but I don't have the permission to use the exact instrument. You'll have to get that on your own if you're interested in it.

Okay. Now, on to treatment. In January of 1997, this were a panel of experts that got together and discussed the need for this complicated bereavement, which now, think about the complicated grief, that it's now moving to wanting to be called traumatic grief. Don't know if there's going to be two separate things or if it will just be called traumatic grief. Same thing that we've already been through. It is the combination of separation of distress and traumatic distress. It's resistant to interpersonal psychotherapy and tri cyclic anti-depressants. We don't know about the SSRIs yet. There might be data on that. I couldn't find it. And since 2000, there have been the attempts to develop these psychotherapeutic treatments that address both of those, and I'll show you one that doesn't.

Here's what we found that does work, relationally-driven treatment. And I want to strongly recommend, if you are working with this population that you use Scott Miller's FIT, feedback-

informed treatment. It double and a halfs your outcomes. If you weren't using it before and you begin using is, doubles -- 250% better outcomes from clinicians that weren't using it that begin using it across the diagnostic spectrum. And I can't think of a group of people that it is more important that they have a treatment that is fitted to them instead of demanding that they step to a treatment manual, attuning to their relationship style and informational processing style rather than running them through a gamut of the treatment manual. Just absolutely essential that we are keeping the quality and repairing all of those micro rips, microtears of the relational fabric that happen even in good therapy. Each session, we're able to repair that so it builds the relationships. What Scott's research has season, those that don't use feedback, their quality of therapy relationship deteriorates.

Obviously, there's a crisis intervention component when you're working with people that have the severe of impairment, so we're always ready to shift gears out of psychotherapy into case management. I always think of looking at my clients through Maslow's pyramid, and if they're in Maslow's basement, I'm no longer a psychotherapist. I become a case manager. If they don't have good clothing and shelter, I'm helping them to get those things. If they have zero support, then we are doing that work. If they are in a suicidal crisis, then we have to kind of -- we're not -- you know, we're not doing this brief psychodynamic psychotherapy and talking about their developmental experiences and how they learned to perceive threat relationally. If they are in suicidal crisis, as we step into that, obviously.

And some brief dynamic psychotherapy, really what's -- what we're trying to extract here is not doing a psychodynamic approach necessarily, but being able to talk to people about their relational -- the way they relationally engage and how they are able to build relationships and how they are able to access and utilize support and helping them to intentionally move into doing that. And exploring some of their ACE scores, some of the developmental experiences that have perceived threats and help them move beyond those impairments that have been with them for a whole lot of their lives.

The cognitive process, I'm never going to be able to love again, to help them gradually move beyond that and help them move into situations and not avoid situations they think are painful but not dangerous so they can the in vivo with and there have been successes using EMDR, and the BEP-TG, which I'll address in a second.

The Dutch psychologists, they developed this kind of matrix, that I think is pretty nice. Levels of acuity of grief. Where

they have stage 0 that the person is having normal bereavement. They've suffered a loss. They are having low distress from that. And they have resources, then they use community support. They use their friends, their support network. And that's what the majority of the people do who have losses. If they use indigenous support and they get through it just fine. But then moving into the stage process that's really a five stage, there's two for -- stage 1 has these two, with the level of distress being the primary factors here, of -- with 1a, we're having grief, dysphoria, slight, and sadness, but mild impairment, mildly disabled, struggling at work, but they're still going. And they have pretty good resources, both SES resources and support networks. Then that is more of a self-help approach. Learning, Googling, if those people are seeing us in psychotherapy, we're helping them learn about the process. We're giving them tools. Less intervention, more tools, more coaching, to help move through that.

I'll finish up this presentation -- I had the book out. How important, I believe, that this is to helping people with grief, which is teaching and coaching post traumatic growth, once you get the autonomic nervous system calmed down, then they can begin to take on these factors of post-traumatic growth and move out of where they have been and move into where they are going.

But as the stress increases, what they suggest are online interventions, telehealth, counseling, social work, I think social work means something different in Europe than it does here.

And stages 2, 3, and 4, let me switch to those. They're a little bit magnified here. As they are beginning to experience what previously would have been called Persistent Complex Bereavement Disorder that we're now calling traumatic grief, as that distress and impairment increase from moderate to severe, then as they are losing more and more resources, we're trying psychotherapy first. That's the first run that we're going to do with this. That there's still -- even though they have impairment, they're still able to function. They're still able to do their ADLs. Then psychotherapy is indicated. CBT, the brief eclectic model and the EMDR, those are the three most endorsed treatment by these experts with traumatic grief.

As we move into serious impairment or functioning where one or more of their lives they can't because of the intensity of the symptoms, that they are not able to go to work, that they are diminished in their capacity to parent, that they're finding themselves not able to function effectively in their lives anymore. Psychotherapy first, but if psychotherapy fails, then we're looking at partial hospitalization with a psychiatric referral.

And then in the severe cases, we're looking at partial hospitalization, outpatient treatment first, and then the possibility of making sure that they're safe, which may include brief hospitalization. So that's kind of a matrix of going from less intrusive to more intrusive, and the same way with addiction, for those of you who looked at this with addiction, it's kind of the same process of less intrusive to more intensive.

So to make it make more explicit, what these folks that developed the brief eclectic model, these are what they identify as the essential elements for treatment with traumatic grief that they do not have effectively integrated the memory of the traumatic loss, and that's something that we have to help them to do. That they have a negative appraisal, that there is a -- every time there is a thought about it, it comes with negative affect and they are not able to access, you know, think about before PTSD, the inability to feel positive experiences with D7 being chronic feeling of negative affect. I might have those two reversed, D-4 is negative and D7 is the ability to feel positive, those two factors. What's happening with them, they are encountering sensory triggers out in the environment that are activating the traumatic element of traumatic grief, but a lot of folks don't know they are encountering sensory triggers. They're just having these eruptions of sensitivity and affect, and we have to help them understand, oh, this is a, you know, this is a drink that my loved one loved and when I see a commercial for it, it activates it. They may not know they have that, they found themselves shaking because someone is drinking that particular drink. That those sensory triggers, helping them to understand the sensory triggers are activating a threat response inside of their body. And the more of those they encounter, the more there is the instinctual response to avoid it and what treatment is coaching them to, as they develop the ability to be in a regulated autonomic nervous system so it's not activating and retraumatizing them, we're going to help them desensitize. And some of the cognitive work is not having that important really present anymore. There may be some elements of horrific details associated with the traumatic loss that stay repressed or disassociated. Prior experiences with loss, especially those that have not been dealt with and the person has a traumatic loss experience here in the present and it ends up being activating the practiced.

I worked with a guy once going through a divorce and we realized it wasn't the divorce that was causing his distress. It was 20 years trying to take care of his blind father who was constantly critical of him and his attempt to please his father over and over and over again where it never happened and then

his father's death and he never processed any of that, how that was all coming forward. It was less about the divorce, although that was the trigger. It was more about this previous experience.

And then the cognitive processing associated with that. I will not read through those. You can access those and see that that's what -- that's pretty much what you would expect it to be. Just good cognitive processing of that.

And let me address this. It's to help our clients be able to catch themselves when they are -- when they are going into abreactions and help them absorb is another treatment issue.

So this is in the European journal of psychotraumatology, and this is the brief eclectic model, and here is what it is. I do want to read this. I don't like reading slides, but this is a nice synopsis of what it is. (Reading). This treatment aims at elaborating and integrating memories of the traumatic loss, providing alternative avoidance strategies to control stress, modify negatively biased thinking, developing a realistic sense of safety, and revising the relationship to the loss person. Simultaneous treatment of both of these things. It's promising. I'm excited about it. Information and motivation in the first session, grief-focused exposure. They did not explicitly say that they teach autonomic nervous system regulation, and I hope they do. It doesn't say it explicitly in the article. Using writing, both journaling process and letters to the person that they lost, finding meaning and engaging and then farewell rituals in sessions 13 to 16, a 16-session process. For those working with someone with traumatic loss, I would invite you to access this article and dig into this process.

And as I said earlier, this Turkish professor of psychologist in Istanbul, she has developed with her team this family traumatic grief program that looks at working with the process as a cohesive family unit, which is exciting. I don't know if she did this in person, but Charles Figley, who I talked about in the previous session, I think his master's work was in 2002 -- no, it was before that, called "Treating Traumatized Families," and it's how to work with families with trauma, and she has taken a lot of his material from that in the construction of this eight-session model for working with traumatized families, and I invite you, if you are working with families, which I think a nice way of working with traumatic grief is systemically. Then there is a resource for you.

Okay. That's what we have on traumatic grief. Now, on this is -- I want to talk about Worden's work, but I think it's genius. I love his work. Bill Worden, he's been writing this for 30 years, gorgeously done, someone who has spent 30 years getting it right. And he separates the task of clinicians, it's

two factors, two things. We do grief counseling, but we also do grief therapy. Grief counseling is the development of an active client with a passive therapist. Grief therapy is an active client with an active therapist.

So in the first year after a significant loss, that as long as the person is not causing harm to themselves or others, what Worden recommends, whatever the person is doing, no matter how messy it is, as long as they're not causing harm to themselves or others, that is to be supported. As long as they're not causing harm to themselves or others, that we assume that person is on their most accelerated pathway to help, no matter how messy, no matter what they're doing, they're overeating, struggling, watching a lot of TV. As long as it's not impairing their functioning and causing them harm, then we support that. And those are the elements of supported therapy, which I won't go down with you right now. I would invited you to get his book and have it as a reference for you, because it's spectacular.

But as we move into prolonged or Persistent Complex Bereavement Disorder, traumatic grief, then we have to get more active. There are things that we need to do. And I'm going to talk about that here in just a second. But I do want to share with you, I think this is a really useful tool. It is an alternative to Kübler-Ross' stages, which many people have tried to retrofit to grieving and they are not appropriate. They're for navigating end-of-life, but they're not for grieving. So what Bill did was developed these four tasks to get from remembering with pain to remembering with love. How do you do that? Well, you accept the reality of the loss. And then you process the pain of the grieving. And that's the hard part, obviously. And if you think about traumatic grief, you process the pain and trauma of the grief. You know, you've got another component of that. And anybody who has ever suffered the loss of -- an anticipated loss of a loved one, you know there's a lot of pain going through that. Add to that the traumatic component, and it's a whole lot more. So this is an expansion, working with trauma and grief is an expansion of the second task. But once that's done, this is best described as the exposure work, helping people to reengage and activities of daily living that were previously truncated as a part of their distress, their grief, that's externally, going back to the same restaurant, that's internally, being able to think of happy experiences and enjoy those memories and spiritual adjustments of being able to repair any damage of the relationship with your spirit and your spiritual discipline.

And then look how cool four is. The Worden says the last task of mourning is not good-bye, it's hello. It's having resolved enough pain, worked through enough trauma, that we

desensitize enough that we can hear their voice, see their face, and they become resources. They become a compass point. They become a discernment committee. What do you think about this, mom? Would this be a good decision for me? And then I can access my mother's face and countenance and voice in real time and the relationship continues. That's what Worden says is the final task of mourning is re-engaging the relationship. And I think that's organic and real. That's a very good litmus test. For those that we want to. And if it's a contentious relationship, I would add to that, it's -- if the memory of that person stays flat instead of involuntary intrusions of a perpetrator or someone that caused you harm, but you spent a whole lot of years with them and there's still significant loss related to it.

So I've been working for the past 20 years on developing this just published a book a couple of months ago with Bob Rhoton, a 20th century, salutogenic active ingredients approach, and taking the active ingredient, embedded in every single effective treatment for trauma -- EMDR, types of processing therapy, prolonged exposure, all of the big dogs that have had success 80% of the time in practiced hands with PTSD, what is common and what are the people doing research in that treatment say why the treatment works. And to cut to the chase on that, there are four factors that share -- that are shared by every single effective treatment. There's -- for trauma, and I think this has absolute application to helping -- it may not resolve traumatic grief, but it peels away the traumatic piece so that organic, supported bereavement can happen. It unlocks it where the trauma part of it keeps it in stasis. It doesn't change as we help our clients to dissipate the energy around it, then they can change.

So these are the four factors, and let's look at that in a little bit different way. Is that they're sequential. They're hierarchical. So in using an active ingredients approach, the first thing we do is build a good therapeutic relationship. That is the number one most potent ingredient in change in all psychotherapy is whether or not we have a good therapeutic relationship that is infused with positive expectancy, which is really important in early treatment for good outcomes. And I would step one step further beyond that. My co-author is not as embracing as FIT as I am, but I would add to that, feedback-informed treatment.

And then with a good therapeutic relationship, we step to the next task, which is helping our clients to begin to discover and then interrupt the threat response physiologically. How do you do that? Well, it's really simple. You discover the involuntary constricted muscles and you relax them. I mean,

it's really that simple. Now, that can be a multiple-year process for a lot of people. But being able to discover in real time that you were constricted muscles, why do you have constructed muscles? Because you are perceiving threat, and if you stay in symptoms, you are generating symptoms, as people can release voluntarily the involuntary constriction, then they are back to a parasympathetic dominant system, this -- they are not suffering. And then we send them out in the world to confront the things that scare them but are not dangerous. The more they do that, it is exposure paired with relaxation and we help people to desensitize the traumatic element of whether that's, you know, as I showed -- I think I showed in the -- yeah, the last session, you know, if the person is attacked by a German Shepherd and we help them to confront in a relaxed body, we help them to confront doggies, other doggies that she is now afraid of in a body that is relaxed, she is desensitizing that distress and more and more free to act in ways that she wants to around dogs, less and less in self-defense around dogs to where finally she's able to now confront, pat, be with a German Shepherd and she restores back her optimal functioning pretrauma. That is the process, the magic of reciprocal inhibition. You can't have stress and a relaxed body simultaneously. Those two things cannot coexist. But you see what we've done as a field for the past 100 years, we believe that, you know, Albert Ellis, that our thoughts determine what's happening with our feelings. Not! Not!

If you're in a threat response, it determines everything. And to finish this process up, and then to move on to some Q&As, this will be the last piece of this. This is some work that I do around helping people to first conceptualize what is healthy bereavement. And here is what healthy bereavement looks like. The person experiences a loss. And they stay in a relaxed body after they hear about that loss. When you hear about loss, your body innervates, with an I. It increases energy. That's what stress is, there's usually a period of crying, and we cry for a couple of seconds to a couple of minutes and then the tears dissipate and the energy diminishes and we go on for another few seconds or few minutes, and then we remember it again. And if we stay in a relaxed body while we are remembering the loss after experiencing the loss, we remember it, we stay in a relaxed body, the same thing happens. Energy up, crescendo, energy back down. But it is shorter in duration and it's less in intensity.

And then the next time we remember, it intrudes, we stay in a relaxed body. The same thing happens, less intensity, shorter duration. We're well on our way to remembering with love rather

than pain. That's the way that grieve works. It is the healing of the wound of loss. That's what grief is.

But what's your history? With the experience of loss? With your family of origin? With your early media experiences? With your early peer experiences? What have we learned about loss? What have we learned about the feeling of grief in our body? And just about all of us have had painful learning associated with loss, painful learning associated with grief in our body. So what happens is, as this energy wave comes forward, as this thing that is trying to heal us is happening in our body, we perceive it as a threat. So what happens, there is involuntary muscle constriction and self-defense from this thing that we believe is going to hurt us because we have painful past learning. It's trying to heal us. But in reality, we're perceiving it as a threat and we constrict and suppress. Does it stay constricted? No, thank God. Healing doesn't give up on us. It pops back up. And we are in a state of perceived threat every time we're remembering a loved one. And this is stasis. It doesn't resolve. It doesn't ever complete.

Any ideas on how we might want to heal that? Pretty simple. Pretty simple. What makes traumatic grief, traumatic grief is the instinctual avoidance of -- there is pain with grief. But avoiding it keeps it sustained. That as we relax into it, it heals. So integration is the ability to relax into and to remember in a relaxed body, just like it is with trauma. Just the same thing. It's to be able to remember. You know, and a nice way, I've done this with my clients, I say, can you think five seconds and think about your loved one right now? Five seconds, just call them up in your mind's eye. And one, two, three, four, five. What's in your body right now? And they will always report constriction. Why are you having a threat response when you remember your son? That doesn't make sense to me. What's the danger? You're not in any danger. Let's help you to relax into remembering your son. So that your healing can restart, so that you can move on through this process. To resolve it.

So we've got to help people to get in relaxed bodies and we've got to help them to get that process into language, so it gets integrated and it gets desensitized. How do you do that? Relaxed body and telling of the story. And when we help people do that -- and I would say a third piece I didn't put in here, I put it before, but going in and petting the doggies, going out in the world in all the places you've been triggered and using both imaginal, calling up the memories in a relaxed body and telling the story of that person's impact and importance to your life and being able to narrate the loss in a body that's relaxed and what we're doing that, staying in the relaxed body, we're

getting them over the hump. What they are now engaging what has been truncated for sometimes years, is they're allowing this organic process to do what it does and helps us wound the loss by completing the grieving process. And we are practicing an evidence-based way of removing the distress by pairing exposure with relaxation that has been working since 1955.

So what's that look like? Well, it looks like building a supportive relationship. That can be either with a peer or with a therapist. Getting and being able to stay in a relaxed body. Telling our story. When those three things are done, then we can move our clients into post-traumatic growth.

And what is post-traumatic growth? It's simply these five things. These are the outcome and the process for post-traumatic growth, it's the engaging in new relationships and the strengthening of old ones. It's the perception that you, as a result of having gone through what you've gone through, you are now a stronger person. It's gratitude for all that is good in your life and it is evolving your spiritual perceptions and your spiritual engagement. Those are the five pathways for post-traumatic growth, and it's not a clinical process. They say that you should not be a doctor when you're working with somebody for post-traumatic growth. You should be an expert companion. And I love that. It's a peer-to-peer process, not a doctor-to-patient process. Bada boom, bada bing. I didn't do too terrible with time.

I have a treat for you today. One of my very best friends that I have known for 32 years that has been an integral part of my life experienced some traumatic loss recently and we've been fishing this week and I've been talking about his willingness to do this. I'm going to ask him to come on, share his narrative of what he went through and to talk a little bit about what has helped him to -- his life to not be destroyed by traumatic grief. And what he did to stay afloat through that.

Ladies and gentlemen, my very good friend, Joe Moore. Joe, can you unmute and join us? Hopefully it will work.

>> JOE: I'm trying.

>> ERIC GENTRY: There should be a camera where it says stop video. You just need to click that one. There you are. You got it.

>> JOE: Hey. Can you hear me?

>> ERIC GENTRY: I can, perfectly.

>> JOE: Great, because I'm not on headphones, so I'll put them down. Well, my experience is, my wife contracted COVID last September. I was actually away when it happened. And she knew, but we were conversing on my way home from where I was, and she didn't -- she didn't tell me until I got home. And she's pretty quickly became evidently sick and such as her way

was to deny such thing and keep working, and she works in our field, and her -- her version, her dedication to her clients, which, you know, allowed her to get sicker. And so she waited too long to get treatment and when she did, first place we went to was the place she had a test pending and the guy discharged her and she was very obviously sick with COVID and within 24 hours she was in another hospital. And they admitted her and she never left.

So -- and within a week, she was vented and we never really connected again. So she died November 1st. And I was really lucky to already be in a process with Eric in the beginning of this Forward-Facing, and I don't mean this to be a commercial, but we were talking about perceived threat and how to live with it and we'd already talked about it some personally. And so we're within that group and the first week of it, I think, when she was hospitalized, and I -- I went ahead with the weekly meetings, because they were very helpful. And also -- I mean, after an extensive peer network, so they were very helpful. And sometimes against my will, which, you know, I mean, there are times in my life when I would have considered that intrusive. But I didn't then. They really went out of their way to be supportive. And I've learned to accept that.

>> ERIC GENTRY: Joe, would it be okay if I asked you something?

>> JOE: Sure.

>> ERIC GENTRY: I've been connecting with you through this whole process, and one of the things I had to deal with with my perceived threat was about your life kind of -- I was afraid it would fall apart, and I've watched that it hasn't. That you've been able to continue to stay engaged in the activities of your life and you're still fully functioning. And I guess I would love to hear from you, what did -- what types of things, in addition to the support of the people that you have as the extensive network do you have, what other tools have you used to be able to walk through this process?

>> JOE: Well, really, I mean, some of it was just out of necessity, which I'm oddly grateful for, was -- she was in -- before she went to the hospital, she was in our bedroom all the time quarantining while working and -- so I didn't really want to go in there after she died. But I had to. Because there were things of ours in that room that I had to get. So I had to go in there. And I wouldn't have, had I -- had I not needed things in there. So I got this exposure, that I didn't really want. But it took that -- I guess aura of fear away.

So, you know, I had that. I had my dog. I really -- what I want to share is that I'm not really -- what one might look of sadness is. It's really gratitude. Because I didn't

intentionally build this life. And I've heard this -- it's just how I live. But everything I needed to live through this was already in place.

>> ERIC GENTRY: Thank you, Joe. You know what, I spent the last week with you, and I experienced you having genuine joy over the past week. Is that -- did I perceive that accurately?

>> JOE: Yeah. Certainly.

>> ERIC GENTRY: Mm-hmm.

>> JOE: And -- I mean, with the exception of the bedroom, you know, I didn't intentionally avoid anything and -- I mean, particularly one of the things was that we finished it together. And I had told my mother-in-law last fall, I don't know if I would ever do that again. And I realized in saying that that I had to. So I did. And I have not avoided the places that we did it together. And that will never be a bad place for me.

>> ERIC GENTRY: Not expected that what came, came. Thank you for that. And ladies and gentlemen, that's what healing from traumatic grief looks like. There it is. Right in front of you. In real time. Beautifully articulated. And Joe, I just really appreciate your courage for being willing to do that. It was beautiful.

Well, we have about ten minutes left. And I want to invite -- are you okay to hang around, Joe?

>> JOE: Yeah.

>> ERIC GENTRY: If somebody has a question for you, would you be available to answer?

>> JOE: Yes.

>> ERIC GENTRY: So we're available for the next ten minutes, any of the material I presented or Joe presented, and happy to address those. Zach, do you have anything for us?

>> ZACH TAYLOR: Hi Joe.

>> JOE: Hi.

>> ZACH TAYLOR: I just want to say, I'm eye-balling it. 200 or so people have written in just thanking Joe. And you've got thousands of people, I know, upholding you in their hearts. So thank you, Joe.

And I think there's some people who just want to make sure you're okay sharing this in this forum.

>> JOE: Yes.

>> ERIC GENTRY: I can promise you, I've run him through multiple filters of him before I would even have allowed this to happen. This would not have happened. And I remember he said, these are not tears of sadness. These are tears of gratitude.

>> JOE: Thank you.

>> ERIC GENTRY: And you are okay, Joe?

>> JOE: Yes.

>> ZACH TAYLOR: Okay. Well, it's hard to go back to the, you know, the clinical, the treatment, you know, questions at this moment.

>> ERIC GENTRY: Which is really important.

>> ZACH TAYLOR: Yeah. And now the questions are a little buried, and there's still love coming in for Joe. Faster than I can read. Thank you, everyone. It's wonderful.

>> ERIC GENTRY: Let me interrupt you for a second. My hope is, all of the clinical stuff, you saw it narrated in Joe's narrative of both of those pieces that he was able to use indigenous support to play through, but that was what he was able to very beautifully articulate both the separation and the traumatic components that came from that.

>> ZACH TAYLOR: Yeah. Mm-hmm. Some of the questions coming in, Eric -- and Joe, welcome your response too -- are that they're finding clients that have a hard time, who are in traumatic grief, having a hard time expressing any kind of emotion whatsoever. Clients who are so distressed they can't cry, they can't feel very easily. I know you touched on this. Could you say any more about your clients are so distressed that they have a hard time feeling or expressing anything?

>> ERIC GENTRY: My guess is about 40% or so of the audience will be familiar with Steven Porges therapy, and what is going on, the newest defense system we have to manage our human beings have is relational engagement. But when a person can't use relational engagement to deal with the perceived threats, it shifts to the parasympathetic nervous system, when a person can't get back to a perceived state of safety, they are constantly in that state of agitation, then what was is the most ancient process of managing a threat comes on, and that is shutdown. And it's dissociation. And that's what you're describing. That's what it happening with a lot of our clients is that they're in a place where they can't ever get to where the distress associated with the loss is not present. So there's just no escaping it because it is a constantly state of autonomic arousal and what the body does is shut us down. And that means not being able to feel. That means numbness. So there's two processes. In shorthand, the two ways out of there are both relaxation and moderate engagement in activity. Walking, aerobic activity, talking to people, social engagement. People, as Joe said, I didn't want to. And at previous times I would have called that intrusion, but I'm grateful that people called me because it forced me to engage. That's kind of what it looks like, climbing out of that dorsovagal complex, the skills of relaxation and being able to re-engage and activate ourselves intentionally rather than it being an involuntary

threat response. That's a little long-winded, but that's the challenge.

>> JOE: I can tell you my children would text me to see how I was, and, you know, at the very start I was brief, maybe even terse at times, when it was an effort to plug that off, and they were persistent.

So eventually I just had to accept that. And see them, not just text, but go there. And the same with my friends, you know. They constantly, how are you, how are you doing, and the more I allowed myself to be responsive, the more I was able to feel. And I think that for those folks who are in that state of numbness and not feeling is that you do have to gradually engage.

>> ERIC GENTRY: Yeah. I want to say one more thing about what's happened here today. If any time during Joe's sharing you found your body constricted, mine's constricted right now, Eric. What's the danger? There's nothing here that's been dangerous. But you see our learning process of how scared we get when people share what you just saw shared. There's nothing dangerous. It was beautiful. There was nothing wrong with that. But how we have been conditioned to be so afraid of people's expression of that, that we constrict and how difficult that is for anybody that's walking through that process to be able to share with anybody about it because of how much threat we perceive in it. Nothing dangerous at all about it. But because of our painful past learning, all of us, most of you watching it will have found at least one time when you were listening to Joe, your body tightening up. Why? He's just talking about his experience. There's nothing dangerous here. He's not diminished. Nothing is wrong. But man, we perceive that grief stuff as dangerous. And I hope that's important to you as you witnessed in your reactions to Joe.

>> ZACH TAYLOR: Yeah, you left all kinds of -- you left us with all kinds of bread crumbs that we can follow, especially clinicians on the call, to look at the different treatment models and all the interventions that you've kind of touched on. And I think if there's one thing I walk away with, real feeling that constriction in my body as a gateway to unlocking my own grief, so thank you for that, Eric, and Joe as well. Thank you for being here.

There was just a couple of loose ends I wanted to tie up. There were just so many of these questions in the chat. They wanted to know, it was Scott Miller's feedback-informed Treatment that you mentioned. I think a lot of people missed that. Scott Miller.

>> ERIC GENTRY: Scott D. Miller.

>> ZACH TAYLOR: Scott D. Miller, and people wanted to get a little more info about the book you held up about post traumatic loss. Lawrence and Tedeschi, post-traumatic growth and clinical practice. Here's what it looks like. And Eric, this is a tough session. How can you help us relax that constriction, maybe, as we get off of this session? What would you recommend that we do to maybe help ourselves and help ourselves this afternoon or in the next 15 minutes?

>> ERIC GENTRY: Three things, continue to pay attention to your body the rest of the day, if you have constricted muscles, release them. Connect with someone and share your experience about watching this so it's narrated and it gets behind you and you're doing that in a supported relationship. And three, do something aerobic. Discharge some of the energy you built up while listening to this. So a quick walk, a trip to the gym, a treadmill or anything, do something 20 or 30 minutes that you get your heart rate up and those three things will stand you in good stead. Remember, nothing happened here that was in any way dangerous. There was nothing dangerous. But good God, how much do we perceive that it's threatening.

>> ZACH TAYLOR: Joe, let me ask you, what do you do to release the tension in your muscles, in your mind?

>> JOE: Well, the same things. I would think, just deep breathing and relaxation and like that, you know, so head down, head -- where I really hold it and Eric has taught me -- he didn't have to, I knew it, because I get back spasms behind it -- is that lower back and hips is like -- I just really bunched up. It is right now, understandably, but I am, you know, when we're through, that's exactly what I'm going to do is just breathe deeply, let it out, and let it go all the way down to my toes, essentially. Kick my legs out straight and just lean back and let it go. Let the tension go.

>> ZACH TAYLOR: All right.

>> JOE: And I think we're taking a walk too. I am. I don't know whether he is or not.

>> ZACH TAYLOR: What wonderful -- Joe, great way to end us there, Joe. Thank you all for being here. I hope you take good care of yourselves and those who want to continue along this journey, we have two more session on grief counseling and treatment, upcoming. We'll see you in a little bit. Thank you, Eric. Thank you, Joe. Bye-bye.

(End of session at 2:02 p.m.)