Transcript:

Using the Lens of Ambiguous Loss to Treat COVID-19 Pandemic Fear and Anxiety

Presenter: Dr. Pauline Boss
Recorded on June 12th, 2020

PRESENTER: Hello, everyone. And welcome to our webinar this afternoon. The title of our webinar today is "Using the Lens of Ambiguous Loss to Treat COVID-19 Pandemic Fear and Anxiety. Our presenter today is Dr. Pauline Boss.

The webinar today is brought to you by the Great Lakes ATTC, MHTTC, PTTC, and SAMHSA. The Great Lakes ATTC, MHTTC, PTTC are all funded by SAMHSA. We are funded under the following cooperative agreements.

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We have a couple housekeeping details. Today's webinar will be recorded, and the recording and the slides will be available on the Great Lakes Current YouTube channel and the Great Lakes MHTTC Products page. It usually takes us about a week to get them posted.

Certificates of attendance will be sent to all attendees. We will email them to you, and it could take up to two weeks. At the end of today's webinar, you'll be directed to take a very short survey. We would really appreciate it if you could take a few minutes and complete it.

If you are having technical issues during today's webinar, please individually message Kristina Spannbauer in the Chat section. And she will be happy to assist you. If you have questions for the speaker, please put them in the Q&A section. And we will address them at the end of the webinar.

If you would like to know more about what the Great Lakes ATTC, MHTTC, and PTTC are doing, please visit us on social media. And I'm happy to introduce our speaker today, Dr. Pauline Boss.

Dr. Boss is an educator and a researcher who is widely recognized for her groundbreaking research on what is now known as the "theory of ambiguous loss." Dr. Boss is known as a pioneer in the interdisciplinary study of family

stress. For over 30 years, her work has focused on connecting family science and sociology with family therapy and psychology.

Her multidisciplinary perspective has allowed her to work as a scientist practitioner to develop theory that guides practice. The importance of her work on ambiguous loss is validated by her election to three different professional organizations, the American Psychological Society, the American Association of Marriage and Family Therapy, and the National Council on Family Relations.

Good afternoon and welcome, Dr. Boss.

PAULINE BOSS: Thank you. My pleasure to be here. I believe we begin. Is that right? OK. OK. Can you hear me OK?

PRESENTER: Yep.

PAULINE BOSS: OK. Well, we're going to begin this today with an idea about theory. And of course, I believe that theory is a useful thing for mental health professionals because you never know what kind of case is coming up next. And boy, is that true right now.

It's something we were not educated for. It's something that we've never seen before, unless, of course, you lived in the pandemic of 1918 or the polio epidemic of the '50s.

So let's start with a theoretical lens. And by the way, the theory should be broad enough to be inclusive. It should not be dictatorial. It should not give linear stages. It should just give you a framework for understanding the case that's in front of you and also I would say, today, our own selves, the self of the therapist, as well, because this is very difficult for us, as well.

So the theory is based on stress. It is not a medically based theory. It is a stress-based theory. It's systemic and inclusive across cultures. And in this case, you have a sudden unexpected stressor, COVID-19, about which we knew very little at the beginning.

And it's a sudden stressor, acute, though it's becoming chronic. And then at the same time, we have a chronic stressor of systemic racism, which has now been uncovered at this time, which is probably the good part because it was long overdue.

Ambiguous loss theory is a useful guide for therapists in interventions. The definition of ambiguous loss is simply this. It's a loss that remains unclear, not knowing the whereabouts or fate of a loved one who is missing in body or mind.

Now, that's how I began it. It was about a person that you were attached to. But today, we're going to go broader and also add other situations of loss that are ongoing and have no clear ending. They can't be clarified, cured, or fixed.

So it can be physical or psychological. But with each, there is the incongruence between absence and presence. What we're talking about more today, though, is contextual. The pathology lies in the ambiguity, the external context or the environment of the person. It does not lie in the individual or family.

So know this. When you're talking with people, do not pathologize them. What is abnormal right now is the situation we're living in. It's incredibly abnormal. So we need to be careful not to pathologize and see the person's reaction as abnormal. Right now, an abnormal reaction to an abnormal situation is quite likely. We'll say more about that.

Two types of ambiguous loss-- there's physical absence with psychological presence. Catastrophic would be people who disappear. For example, when loved ones-- often elderly in nursing homes-- were just taken to the hospital or died and taken to the mortuary without the family even seeing the body, that's a really strong physical ambiguous loss.

So it's kind of like being missing in action and not being able to be with an ill or dying parent. That's a physical ambiguous loss. More common ones are leaving home, divorce, adoption, military deployment, transitioning gender, institutional placement.

And we have some of those now with college students that left campus without saying goodbye, for example, to their friends. But I'm finding that young people are very, very resilient and that they are pretty good at making the best of a bad situation. I see a lot of hope in that young resilient generation. Of course, there are exceptions.

Type two is psychological absence with physical presence. And the catastrophic would be Alzheimer's disease and other illnesses that cause dementia, brain injury, autism. Addiction is one, where the person is there but their mind is not because they're either on some kind of chemical drugs or alcohol. Depression could be another. Serious mental illness could be another.

More common psychological ambiguous loss is our homesickness. Remember this regarding so many immigrant families or people that you work with. Especially now, they must be yearning for the stability of having a parent or the family near them. And they're not. That could be a foreign student, for example.

And then there are also affairs, work, obsessions with phones. And by the way, obsessions-- we'll talk more about the anxiety of all this. But we're now

almost obsessed with cleanliness and trying to stay healthy. And so that preoccupies our mind. And if we allow it to preoccupy our mind too much, we are then psychologically absent from the people we're supposed to be close to.

Both types of ambiguous loss can occur simultaneously in one person. They can have a physical and a psychological absence at the same time. Both can occur simultaneous in one couple or family.

And it can occur-- this is new now, the third bullet. Ambiguous loss can occur within an individual. That is, you have a relationship with your own body and your own mind. And if you lose a limb, for example, that's a physical ambiguous loss for you personally. If you start losing your memory-- and often, people know they are-- that will be a psychological loss.

What ambiguous loss is not, it's not death, although that depends on your beliefs and circumstances, because some people think there's ambiguity in death, as well. We won't focus on that today. It's not a grief disorder. Please take the word "disorder" out of the picture when you're working with families and individuals today.

Yet it's akin to complicated grief. We'll talk more about that. It's not PTSD. It's not complicated grief, yet has similar symptoms. And it's not ambivalence, because ambivalence is an outcome of ambiguity. We'll take a closer look at each one.

Unlike death, ambiguous loss has no official verification, no official death certificate or information about where this person may be. Or the lost person is still here and alive, but their mind and memory are gone, like addiction or dementia.

Ambiguous loss creates a frozen grief, which I wrote in 1999 in the Harvard book and later on came to realize it's akin to complicated grief. But I need to tell you that complicated grief people-- Dr. Shear, for example, at Columbia-- do not like yet to accept ambiguous loss as similar.

So I say it's akin to a complicated grief. I'll keep pressing that case, however, because I think ambiguous loss would be a good test for complicated grief. And I think it would come out as matching the symptoms.

So pathology, again, lies-- excuse me. I went too fast. The pathology lies in the external context. Remember, Michael White talked about externalizing the symptom. I'm talking about externalizing the cause of the symptoms, externalizing the cause.

The culprit is the ambiguity, not the person or persons sitting in front of you. It is not a weak psyche. Unlike PTSD, both ambiguous loss and PTSD can lead

to depression, anxiety, et cetera, flashbacks. And boy, they will today. We'll all remember 2020.

PTSD is viewed as an individual disorder, medically defined, individually diagnosed, and treated. The goal is to return the patient to health. Ambiguous loss, on the other hand, is a relational stressor. Thus, the relational interventions are needed. And

The relationship can be with you, the therapist. But I find it even works faster if the relationships are with some people they can go home with, either family members or peers who are suffering from the same kind of stressor that they are suffering from, like grief groups, AA groups, the most effective and the first of all, the peer support groups-- Alzheimer's caregiver groups.

The therapeutic goal for ambiguous loss is not to fix it because you probably can't. So the therapeutic goal is resiliency to live with the ambiguity, because the mystery may never end, like, how did my loved one die during the epidemic? I couldn't be with them. Did they suffer? That's going to be an unanswered question probably forever.

And may I add here that racial losses that started with slavery and on down-- and we're seeing that now with Mr. Floyd and everything that has happened since then-- that's unresolved that cuts across hundreds of years, across generations.

And I think maybe because we were softened up or maybe more anxious, more alert, more aware, suddenly, this has blown up in a way that I think may have good outcomes, that we are suddenly aware of things many of us at least in the white community-- I speak for myself, many things I was not aware of before. So something good may come of all of this turmoil and illness.

I'm stuck. It's frozen. Can you unfreeze me? OK.

PRESENTER: That will involve--

PAULINE BOSS: Where are we going?

PRESENTER: Pull the screen back-- Stephanie'll pull the screen back up here. And then we will be able to transfer control back to you. So we'll get it figured out here quick.

PAULINE BOSS: OK. OK. Click to start. OK. All right.

Unlike complicated grief, ambiguous loss is chronic. And it's a normal reaction to an abnormal social situation. The source of the pathology, which is not being able to get over the grief, lies in the type of loss, which is unclear, ambiguous, not in the individual psyche. Yet because ambiguous loss is a complicated loss, it is linked to complicated grief.

Without deficiency in individual, couple, or family, it leads to symptoms akin to complicated grief, which is an ongoing state of grief with problems accepting the death-- which will happen now. If you didn't see your loved one die, you may have trouble believing it-- lack of trust in others, bitterness about the loss-- sure.

Unlike ambivalence, the terms mean different things. They are not synonymous. "Ambivalence" means conflicted emotions, whereas "ambiguous loss" means a situation of unclear loss. Yet there's a linkage. The ambiguity surrounding loss leads to ambivalence regarding the missing person.

The problem is ambivalent or conflicted feelings-- such as love/hate, wishing for remains, wishing for life-- create guilt and anxiety. The goal is talk about and normalize your conflicted feelings so as not to do harmful actions. Is there ambiguity in death? My hypothesis is yes. And some deaths have more ambiguity than others.

And right now, suicide may have-- murder, death camps, genocide, lynching, death of a child or baby, miscarriage, stillbirth, abortion, and, of course, COVID-19 deaths that were not witnessed or ritualized and then unjust deaths, such as that of George Floyd and the many, many others we're hearing about now.

Examples of ambiguous loss caused by the pandemic-- well, the loss of who we have been, what we have been doing, like going out to restaurants, to a coffee shop, even to the grocery store, feeling calm about it all, being in some control over our lives, the loss of our view of the world as a safe and manageable place.

Specifically, many of us and the people we help have lost their usual agency and freedom. And some people never had much to begin with. So you need to take that into account. And some have had a lot. For example, if you do therapy with people like attorneys and engineers and so on, they're used to solving problems. So they may have more trouble at this time with the ambiguity.

They've lost control over their usual personal, family, and work lives, their in-person relationships. They've lost money and financial security, in some cases, their business, sense of safety, the ability to control how much time we spend with children and family-- too much, too little. In homeschooling, sometimes people say too much.

And then also in certain abusive relationships, that's definitely too much time together. And as we know, abuse has gone up since the at-home orders came out. And the ability to gather in large numbers-- my husband and I like to go to the theater and like to go to concerts. And that's all gone now for some time, I think.

So loss and grief, a quick history-- I'm going to go fast over this because you can study some of this on your own. In the beginning, Freud was largely correct in normalizing grief. He said, "Although mourning involves grave departures from the normal attitude toward life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment."

Unfortunately, Freud was translated into English and medicalized and medicalized. And in some cases, he certainly went along with that. But we need to know that normal grief was first mentioned by Freud.

Conflicting ideas-- in doing research for the book I'm writing now, I'm finding out that a lot of the original theorizers of loss, from Freud up to Kubler-Ross and so on, write differently in their formal writings than they write in their personal writings. Some of us academics do that.

And so the truer ideas I'm focusing on-- at least, I'm guessing that writing a letter to a friend or writing in a diary may be more authentic of the expert's feelings. So when a patient asked Freud about his beloved daughter who died from the flu, he touched a tiny locket that he wore fastened to his watch chain and said, "She is here." No closure there, right?

And other-- Freud's letters to Binswanger after Binswanger lost his son, he said something similar to that. And Kubler-Ross's last writings-- which very few people read her last two books. After suffering from strokes, she recants her five stages. So please let them go because she did, too.

Grief as repressed and delayed then-- the pathology of grief started after the Cocoanut Grove fire with Lindemann. And of course, that was a traumatic loss for the families of those young people that were killed there.

So now, we focus more on nuanced types of grief-- Doka's disenfranchised grief and many people's chronic sorrow-- Harris and Roos, for example-- Shear's complicated grief-- I mentioned her. And I like very much Bonanno's research and his writings. And he bounces from academic to personal in his book, The Other Side of Sadness. And Kissane is an Australian psychiatrist who's a family therapist.

Focus on living with grief. Let's see. It's frozen again. No, I'm sorry. OK.

OK. Here we are. So I'm going to jump over here to focus on community views of loss. And these are the top three that I wrote after we worked in New York after 9/11 and so on. And the third one is after I worked in Fukushima with the families of the missing from the tsunami. And there are some others there, as well.

Now, culture-- you need to take culture into account. Even though we all live in one region of the United States, it doesn't matter anymore. There are

differences in even a small town. Find out the people you're working with, how they view the world.

There are essentially Eastern and Western views. Of course, there are nuances here, too. Mastery over nature, which is a more Western view-- one can master anything if you try hard enough. Loss and grief are the things to get over.

Find closure. Move on. Get back to work. We can cure, fix, and solve anything. And successful people don't suffer. Now, you see these views in our country every day.

And then there's this other one, which you may see less so, but certainly in the mindfulness culture. Harmony with nature-- it's a more Eastern view, also, may I say, Native American in the United States, as well. Suffering is part of life.

Thinking that suffering can be avoided is an ego wanting its own way. I love that one. It is possible to have a good life while living with suffering of loss.

More Eastern views-- the desire to stay in touch with ancestors who often perform a symbolic role. In Fukushima, for example, many of the people whose loved ones were washed away-- out of their arms, sometimes-- they say that their ancestors are watching over them. And that idea brings them much comfort.

Now, is that delusional? No, it's cultural. And as therapists, we need to be very careful what we think is an unusual or even a pathological way of coping.

More Western views would say need to be productive again. Therefore, I need to get over it. And we also show discomfort sitting

With other people who are suffering. We say we don't know what to say. But in fact, you don't need to say anything, except perhaps I'm sorry. But you need to be with them and not criticize them. So there are rituals for providing comfort for families after death. But now, they're withheld because of the COVID virus because you can't do it the way you ordinarily would have done it.

OK. I can't get it to move again. Let's see if I can go this-- it's not wanting to move. It's frozen.

PRESENTER: Let's see. Maybe try going back to the previous slide. And then see if it'll allow you to go forward again.

PAULINE BOSS: I did.

PRESENTER: Oh, OK.

PAULINE BOSS: I'm going to keep-- well, I don't know what's coming next. So I can't. Any questions right now maybe? If somebody wants to shoot a question in, we could do that.

PRESENTER: I know we did have one question that came through. It was asking if you still teach full courses or any other longer courses that are available for folks.

PAULINE BOSS: No, I don't at my age. I'm over 80. But the University of Minnesota has put my teaching of the course online for an online course for either continuing education or a certificate. And you go to www.ambiguousloss.com.

And there, you'll have the information about it. Cost is relatively low, I'm told. And that would be my actual teaching of the course. OK.

PRESENTER: Hey, we did have one other question come in. I think Stephanie's probably working on getting the screen back up and shared again so that we can move forward. And the other question was, do you or have you done any mentoring of others within the field?

PAULINE BOSS: Yes indeed. And I do consulting now. I don't do official supervision anymore, but I do mentoring and consulting. Yes.

PRESENTER: Great. Thank you. OK.

PAULINE BOSS: How are we doing?

PRESENTER: I think Stephanie must have had an issue with her connection. So please bear with us, everyone. If you'll give me one moment, I'm going to share my screen. And we're going to just pick this up, because it doesn't look like she's able to jump back online.

PAULINE BOSS: All right. There's another question from Sarah Shapiro. Is it possible to get a copy of the slides, I bet she's saying. Yes, I give you those.

Again, as I said before, given the stage in my life cycle, I want to give away this material so that you can become teachers of it yourself. First, learn it yourself. And then start doing training of your colleagues.

I welcome you to do that. Use the slides. Use the textbook with it. And the textbook that I'd like you to use with the slides is my 2006 book called Loss, Trauma, and Resilience-- Therapeutic Work with Ambiguous Loss.

In it, that book was written for professionals, for therapists. And so I want you to please-- one person in the room should have that book while you're training others using the slides. I hope that's OK and clear.

PRESENTER: Dr. Boss, we just have a couple more quick questions.

PAULINE BOSS: OK.

PRESENTER: Do you see familial estrangement as being under the umbrella of ambiguous loss?

PAULINE BOSS: I do. And those are tough cases to work with. And I've worked with quite a few. And I always say this may take five years, because it takes a while. You work with the person who's upset by the estrangement. But for the family to come back together, it takes longer.

You have to find the underlying issue. In some cases, it's a death in the family that just threw some things apart. In some other cases, it's politics or different belief systems. In another case, it was religious differences where grandparents said that if the young couple didn't baptize their baby, if they left the child with them, they would baptize it. Well, that'll cause a rift.

PRESENTER: Yes. Another question we have is, how is ambiguous loss different from guilt? And does guilt over loss make it more ambiguous?

PAULINE BOSS: The last part of your question has some truth in it. If you're stuck in guilt, you're probably not seeing the loss. You're not finding meaning and hope in the loss. You're not finding the meaning of it, aside from the fact it was my fault. So you're frozen. You're stuck there.

And one of the things I'll be saying is that in order to live with ambiguity, the ambiguity of this kind of loss or the COVID or whatever comes up, chronic or acute, you use both/and thinking. And both/and thinking actually would fit into the mindfulness category these days. It pushes against absolute thinking, which will get you nowhere.

That's why people are stuck. I'm to blame for what happened here. That's an absolute statement. And if you can change those statements to both/and-- I could have done better, and I'm not at fault for this death, something like that.

Today with COVID, we're saying, this is terrible and we all could die, and we all could learn something from this. Boy, do I see that happening now, that we are learning something from this. We are learning how to be together differently. We are learning how to think differently about other people, other races.

We're learning new information. I'm not sure all of this would have happened if it hadn't been a terrible emergency we're living in. It's somehow opened us up in a way that is both painful and, in the end, may get us to a better place.

So both therapists and clients need to do both/and thinking, which means that we need to practice it first. So about every stressor we have, it's a good idea to make up your both/and sentence. Is this where we left off?

PRESENTER: This is.

PRESENTER: I believe this is right about where we left off. If it's all right with you, Dr. Boss, I can be in control of the screen. I had to improvise a bit because the PowerPoint was giving me some trouble opening. So if you want to let me know when to advance to the next page, I will do so.

PAULINE BOSS: OK. I'll say "OK." OK.

PRESENTER: Great.

PAULINE BOSS: OK. It's not moving. There it is.

So with religious beliefs-- by the way, I never ask anyone about their religious beliefs. What I ask is, what does this mean to you? What does this situation mean to you? Look at the bottom bullet.

Unless you're trained in theology, do not ask about religion. Ask instead, what does this situation mean to you? And then they will tell you, it's a punishment from God. I don't believe in God. I think it's something else.

They will tell you, and then you follow their lead. And what you're trying to minimize is self-blame or the desire for revenge. But overall, the diversity in beliefs is typical. OK.

The effects of ambiguous loss-- OK. Loss of a loved one-- this is what people used to say, and it still applies, I think. Loss of a loved one as she was and thus the relationship as it was-- many of our relationships are now on Zoom.

Loss of knowing the whereabouts of a loved one, status as dead or alive-- and that certainly is loved ones who have gone to the hospital or are in a nursing home. Loss of control over my life, on edge, not knowing-- loss of trust in the world as a fair and rational place. That's for sure. We're there, aren't we?

Loss of dreams for the future-- well, they may be lost. But I hope you're building new ones. And it's very important for you to help clients and patients to develop new hopes and dreams because without that, they will stay stuck. And I just ask clients for their list. We give them a sample, but then they take over and give their own information.

OK. Individual effects are depression, anxiety, hopelessness, which is difficult and could be dangerous. The brain does not like ambiguity, and we'll have to get into neuropsychology for more of that. But many people who have

ambiguous losses dream a lot because the brain tries to solve it even while you're sleeping.

Helplessness, also a dangerous state to be in-- confused identity. This is one we can work on. And the International Red Cross, which uses the ambiguous loss theory for their fieldwork around the world across cultures, focuses on that one a lot.

Who am I now that my husband was kidnapped? Who am I now that I have to teach at home? I'm a professor who teaches at home, et cetera. Increased ambivalence-- it's social ambivalence, not psychiatric, that we're talking about. We're talking about ambivalence of your relationship. And that is a social kind of ambivalence, and it's not a sickness.

Anxious attachment-- yes, you're searching for the lost person or searching for somebody you can't find and be with right now. And then there's frozen grief, which I wrote about in the 1999 Harvard book. And there's a difference between the sadness and depression that comes out of that. OK.

Sadness is mild grieving and unhappy, but it's still functioning. It's what Bonanno called "isolation." And that is a normal reaction to a loss. It's a normal grief reaction. What's the intervention for sadness? It's human connection, peer groups, social supports, and activities.

And the sadness from a loss can last a lifetime. There is no more timeline on it. And stages of grief are gone. We just know that you live with loss and grief. You don't get over it.

Sadness comes up every now and then. I think of my loved ones who have died every now and then, but it's not a preoccupation. Depression, on the other hand, is a sadness so deep, one cannot function anymore-- can't take care of yourself or others. Here, the intervention, as you might guess, is professional psychotherapy, family therapy, and perhaps medication.

OK. The point is not to pathologize grief, and it has become pathologized. I'm very much against that. The majority of people who have lost loved ones can get over it-- not get over it, can get over and live with it on their own, given community and family support. They do not need medication. And today, we're medicating a lot of people who are grieving.

The systems effects frequently are as someone guessed with their question, family alienation, rifts, and cutoffs. Rituals are canceled, instead of continued. Grandpa died, so we're not going to do this anymore. The roles are confused. The husband dies, so the wife, especially from an older generation, doesn't know what to do with the roles he performed.

Family and couple boundaries-- who's in and who's out-- become unclear. And the family decision making processes become frozen. You can use these all for individuals, as well. OK.

OK. Assessment. OK, go ahead. These are questions. I'm going to rush through them.

Let's move forward a little bit through assessment. OK. You can read these on your own. Go ahead, one more. One more.

Let's start with treatment right here. OK. Treatment and intervention-- by the way, what we just rushed through are questions you can ask in therapy with the people you're working with.

Family resilience is the path that family follows as it adapts and prospers in the face of stress. So the family definition of resilience was by Hawley and DeHaan in '96. It's also defined by Froma Walsh as "strengths forged through adversity." Well, we're seeing that now.

I like Masten's definition. She's a child development researcher here at the University of Minnesota. She calls resilience as "ordinary magic." And I have seen that in my work around the world as to how people cope. It just blows my mind because it's never what I expect.

Having grown up in Wisconsin in a rural setting, Protestant ethic, being white, what I would do really has nothing to do with the people I work with. And I like the idea that magic happens. And it surprises you.

For example, in Japan, when mothers had their babies washed away out of their arms, some of them are saying, there's a kind woman on another island who is taking care of my baby. Now, someone might call that pathological. No, it's not. It's just a beautiful way of trying to make sense out of it symbolically so you can take care of the children that are still remaining and go on with your life.

There's also a telephone booth that washed up and is still there in an odd place. And I'm told by therapists in Japan I work with that people go in there, including children, to call their loved one who was washed away. And they have a conversation with them. I see this all the time. I saw it after 9/11, and we'll see it again now. People have wonderful ways of coping, but they're a surprise.

And one of the ways that I define resilience is having a high tolerance for ambiguity. OK. Resilience is more than recovery. It's more common than we thought, and there are uncommon pathways, as I said. OK.

It's not always desirable, by the way. And that's coming up right now. While some people are very good at coping with poverty, what we really should work

for, including us as mental health professionals, is less poverty. We should not have poverty. There should be more justice for all people.

While some people are resilient and can live in the midst of it, our bigger goal should be to get rid of it. So focus on resilience may ignore symptoms. Strength-based therapy assumes agency and power. The disenfranchised need more than resilience. They need empowerment and real systemic change in our society.

I emphasize that. I wrote that some time ago. I should underline it now and highlight it. Boy, do we need that. OK.

How to increase resilience-- you name the stressor. What is it? And if it's ambiguous, call it that. You can't cope with something unless you know what it is.

You also do not use absolute thinking. You give up on the absolutes of closure. Be comfortable with unanswered questions. We'll give the Keats there in a minute. And embrace ambiguity, not closure.

Let's look at these five more closely. OK. First, you name the stressor as ambiguous loss so people can begin coping. That's psychology 101. You can't cope with something until you know what it is.

The problem is the ambiguity here. And in our culture, in our Western American culture, our can-do culture, we do not like ambiguity. Now, there are people in our cities who come from different cultures. And so they may be more comfortable with it than we are.

I learned a great deal from the Ojibwe Native Americans in northern Minnesota about that. It doesn't bother them to the degree that it bothers me with my Swiss American background. OK.

Use both/and thinking. This is probably one of the most important slides. We can calm ourselves and our clients by letting go of absolute thinking, and here are some samples.

Feel free to use some with your clients or yourself. But I usually can't get through the list. They take over before I get beyond two or three. "It's nothing to worry about" versus "we're all going to die."

Yes, it's both dangerous and manageable, like I can wear a mask. I can wash my hands. I can stay home. I can do some things.

It's both a terrible time and a time to come together for the greater good. You're seeing that now. I'm home now alone and also connected to others via technology.

We are both frightened of the virus, and there is something we can do to help. For example, stay at home. I'm trying to write a book at this time. Some other people have told me they're doing poetry, learning a new instrument, developing their physical prowess, learning to bake bread.

All kinds of things are happening. This is a terrible and dangerous time, and we can cope with it by being more flexible and resilient. OK.

More examples-- and this is sometimes with illness, addiction, dementia, et cetera. She is both gone and still here. I must find a way to both hold on and let go. He is both here and gone. That would be a missing person.

I have both the anxiety of no closure and the opportunity to move forward with new relationships and interests-- very important. I am both sad about my lost hopes and dreams and happy about some new ones. OK.

As opposed to absolute thinking-- when people say, there's nothing wrong. Nothing has changed. Dad is only forgetful because he's aging. Let him drive.

Or premature closure-- the person is alive, but extruded from the family system, saying, he's dead to me. Here again is the alienation. She no longer knows me, so I no longer visit her at the nursing home. It's not good.

So that's binary thinking. She is either alive or dead and gone, nothing in between. Binary thinking is good for an accountant, but it is not good in therapy and for people who are dealing with this kind of stress. OK.

So we have to learn to hold two opposing ideas in our mind at the same time. And F. Scott Fitzgerald has written the best line on that. "The test of a first-rate intelligence is the ability to hold two opposing ideas in the mind at the same time and still retain the ability to function." OK.

The poet John Keats also wrote about that. He described negative capability, which is precisely the skill needed to discover new hope with ambiguity. OK.

I'm rushing a little bit here. Enjoy the paradox. Really, that's what we're talking about, being able to embrace paradoxical thinking. The absent can be present. The present can be absent.

So have fun with ambiguity. My mentor, my professor, was Carl Whitaker. Many of you are too young to remember him, but Google him. He was a psychiatrist, family therapist, a pioneer in family therapy, and believed in spontaneity.

He would say himself he was a little crazy. He was certainly nontraditional. And when he died, his grandchildren talked about one of the things he did with them that they loved so much. And that was he would take them one at a time in the car to get lost.

And they just loved it. And I tried it with my grandchildren, and they were young at the time. They loved it, too. But now, they're in college. And they still want to do it.

My husband and I do it sometimes still. With no agenda, just go somewhere. Meander. But here are some others.

Go fishing. Fishermen never know if they're going to catch something or not. They are wonderful at dealing with ambiguity. Walk a new trail. Go sailing.

Play a new sport. Enjoy improvisation in the theater. Yes, improvisation is dealing with ambiguity. OK.

Treatment and intervention-- OK. There are six guidelines, and they are in a circle. So please see that they are in a circle. They are not linear. You do not with a certain client have to deal with all of them.

There is no order in which to use them, except to say that finding meaning and discovering hope, the sixth one, are tied together. So the circle is complete. The ultimate goal is to find meaning and hope. OK.

Finding meaning is this. Give the problem a name. Talk with others. Use both/and thinking. Find a spirituality, whether it's religious or meditation type, forgiving yourself for others, continuing but adapting family rituals.

Rituals help give meaning. What hinders? Seeking revenge, retribution, family secrets, isolation, and closure. OK.

Adjusting mastery means those of us from a master-oriented culture, which certainly therapists for the most part are high in control, recognizing the world is not always fair, decreasing self-blame, externalizing the blame or the cause, mastering our internal selves if we can't master what's going on outside, and believing that bad things can happen to good people and that some problems have no solution.

So we just have to live with unanswered questions. These are very good for us as therapists, as well. They're tough, by the way. I've only spent 40 years trying to learn this.

Today with COVID and racism, if you feel helpless, do something you can control. You have to balance it. Cook, bake, exercise, dance, et cetera. You see that.

And what hinders is believing that you have failed if you remain sad about a loss. OK. And I think let's go beyond this one. OK.

Reconstructing identity-- what helps? Finding a psychological family helps if you aren't near to your own family, redefining who's in and who's out of your

intimate circle, who plays what roles. Yesterday, I read somewhere it's called a "forged family" or "chosen family."

Who am I now? What community or group do I belong to? What is my purpose in life? What hinders this is your resistance to change, that you want the same people you always had. It might not happen right now in a case like COVID. OK.

Normalizing ambivalence-- we'll have mixed emotions about what's happening to us. We should talk with professionals or a peer group. In our case, maybe in a peer group-- Carl Whitaker always recommended that therapists have a cuddle group of three to four other professionals, not your supervisor and not the people you supervise.

They should be equal footing who meet perhaps once a month in each other's offices and talk about these kinds of things that you may have about a client or about your own life and to talk about our conflicted feelings because they are normal. OK.

Revising attachment-- now, attachment comes out of Bowlby and all of the child development, human development people. Recognizing that your lost loved one is both here and gone at the same time-- I hadn't read about that in graduate school, but it's true.

Finding new human connections, not expecting closure-- loved ones remain part of the fabric of our lives, even after they die. It's OK. You do not have to get rid of all the photographs and not talk about them anymore. In fact, it's easier if you have a connection that is just altered, but not a closed door.

What hinders? Holding on without also developing new attachments. That's the secret. OK. We have to develop new friends, as well.

New hope-- finally becoming more comfortable with ambiguity, which is a kind of spirituality. And for those of you who are religious, that is called "faith," I am told, by the religious set of people that I've worked with. And they did cross-- they were fundamentalist, Catholic, Jewish, and Protestant groups I've talked with.

We laugh at absurdity. We really do have some things to laugh about now, for example, a lot of people not having haircuts or one of these kinds of things.

Redefining justice, imagining new options, feeling you have some control, even if the ambiguity persists and things don't go your way-- I have to tell you that my way of coping has been to continue writing, because I can shape that sentence the way I want it. And right now, that's about all I control.

I'm also a caregiver. So it's not just the situation outside, the riots and also the COVID, but inside. And so the bit of control I still manage is being able to continue writing. So I hope you find your way. OK.

Self-care about working-- I'm wondering if I'm going to stop here and ask. Should we move to questions, or should I go through this? It's not very long.

PRESENTER: I think that you could go through it, since we got questions already. And also, I'll remind everyone that any questions we don't get to, we'll follow up with via email after.

PAULINE BOSS: All right. So here's the deal. This is hard stuff for ourselves as therapists. We are trained to heal. Medical doctors and nurses have the same problem.

We are trained to heal. And all of a sudden, we have a situation we can't fix. So what we have to do first before we can help others cope with ambiguity and live with ambiguity is to increase our own tolerance for ambiguity and lack of closure. So we work to increase this because it's our source of resilience.

OK. OK. I thought I took that off. Hold on.

AUTOMATED VOICE: Call from--

[PHONE RINGING]

PAULINE BOSS: I can't. I'm sorry. We'll just have to go on. The warning signs when you're in trouble regarding all this ambiguity and not being able to fix things--

STUART: Hello. This is Stuart. I thought I'd call and say hi.

PAULINE BOSS: Stuart, please, I'm in the middle of a webinar. Hang up. OK. Sorry.

You'll feel tired, exhausted, but you can't sleep. You're hyper-alert, depressed, anxious. By the way, I looked up the anxiety list in a very good book on anxiety disorders.

Everything on the list that shows you have obsessive-compulsive disorder, like washing your hands too much, washing the groceries when they come in-- I'm even wiping off the mail right now-- makes us very high on the list of an anxiety disorder. But it's not our problem. It's the problem outside. The COVID is the problem, not our own anxiety disorder.

Psychological-- you feel angry and hopeless. I'm sure people go off every now and then. And relational-- blaming, shaming, having conflict, abusing alcohol,

which we find has gone up now, drugs. Abusing others, mates, that has gone up.

So if it's us, the mental health professional, we need to get into therapy or get some help right away on this. Any good therapist has been in therapy at one point in time. It doesn't mean that you have bad mental health. It means that you need help at the moment. OK.

How to stay resilient-- practice having fun with ambiguity. Take an improvisation course. Try a new game. Take a new path.

Set firm boundaries for work. Take times for rest and recreation. Talk with colleagues and friends. Have a social life. And of course, that's tough right now. OK.

Acknowledge your own ambiguous losses. This one is important. You've all got them. And you all have clear-cut losses, such as the death of your parents if you're older.

Loss is inevitable in our lives. It doesn't mean you failed, but it means you need to deal with it. And you need to talk with others about it. If you feel overwhelmed, helpless, or hopeless because you're not so effective in therapy right now, which I saw after 9/11 in New York with very, very senior therapists, seek professional therapy or supervision.

But I would add here peer-- peer support is very important. So get into your cuddle group and help each other. With large-scale disasters, debrief, perhaps, because you need to talk with each other about this. Professional secrets lead to more trauma and stress. OK.

Oh, we made it. So today, naming the problem "ambiguous loss" helps people understand that the stressor is not only the virus, but also the many ambiguous losses that came from it.

And of course, it's also coming now from trying to make it better for people who have suffered before, black Americans especially and brown Americans, who apparently we are just now-- perhaps the COVID pandemic has uncovered things that all of us should have known before and did not.

Thank you. Are there any questions, or are we out of time?

PRESENTER: Well, we are pretty close to out of time. But we do have a couple questions. And I just also want to let people know that we will take all of these questions. And we will send them to Dr. Boss, and she can answer them in writing. And we will make sure that we get them on the website.

Just a couple really quick ones-- as an educator, what are things that I can set up in a school to help students during ambiguous times, without knowing if school will be in session?

PAULINE BOSS: Do we know what age?

PRESENTER: We don't.

PAULINE BOSS: Well, all I know from my experience is from eighth grade up, they understand the theory of ambiguous loss and that you would simplify what I gave you today. But the both/and questions I would share with children, with maybe fifth grade on up, and certainly adults, high schoolers, and college students.

So what you would do is pick and choose the slides I gave you and/or the information I gave you and use it with them. You will be shocked by how quickly young people catch on to the idea of both/and thinking and that it's ambiguity that's the problem and that you need to know what the problem is before you cope with it.

They want to be normalized. They want to know that the feelings they have don't mean you have to send them to see a psychiatrist. That's what we do, by the way. That's what many parents do. So the kid is not sick. The situation is sick, and that's what you have to tell them.

PRESENTER: That sounds like a fantastic note to end on. Again, I want to thank you very, very much. This was an amazing presentation. People have loved it.

And again, I just want to remind people that we will have all of the questions that you submitted answered. And again, thank everyone for their time. We thank you for your patience, and have a fantastic afternoon.

PAULINE BOSS: Yes. Thank you all.

PRESENTER: Thank you, everyone.