Transcript:

Are You the Therapist a Grieving Client Wants to Meet?

Presenter: Jill Johnson
Recorded on September 11th, 2020

LOUIS KURTZ: Thank you for joining us today for our Grief Sensitivity Virtual Learning Institute. This is the first part of a two-part series. The focus of this institute is on supporting those individuals experiencing grief and loss during COVID-19 and beyond. We're so glad you're here today.

So today's presentation-- I want to welcome everybody again. My name is Lou Kurtz and I'm the co-director for the Great Lakes Mental Health Technology Transfer Center. I'm pleased to be your host today for this conference session. And I'm also pleased to introduce this session, which is called, "Are you the therapist a grieving client wants to meet?"

I want to thank our wonderful speaker for being here with us today. And a big thanks to all of you for joining us on a Friday. We truly hope you find today's presentation engaging and helpful in your work.

Before we move on, I need to go over a few housekeeping items just to start off. We've made every attempt to make today's presentation secure. If we need to end the presentation unexpectedly, we will follow up using your registration information.

All attendees are going to be muted and cannot share video. If you have a question for the presenters, please use the Q&A pod. If you have a comment or a link for all attendees, please use the Chat box.

The session recording and slide deck will be posted on our website. If you attend at least half of the session, you'll receive an email following the presentation on how to access your certificate of attendance.

This event is captioned. In order to view captions, click the arrow beside the CC box at the bottom of your screen and choose Show Subtitles. To change the size of the subtitles, click the arrow next to the CC box and choose Subtitle Settings, where you'll find the option of making the subtitles smaller or larger.

And if you don't already, please follow us on social media and stay in touch with us.

We just released a series of fact sheets focused on addressing various grief-related topics which you can see here. Please also check out our Responding to COVID-19 Grief, Loss, and Bereavement web page for more Mental Health Technology Transfer Center Events and resources.

We want to recognize today that participating in this and our other sessions may activate your own grief and feelings of loss. As mental health care providers, we also need to care for ourselves. Please monitor yourself and practice good self-care, including taking breaks, stretching, drinking plenty of fluids, and practicing mindfulness, or whatever helps you in staying centered and grounded. If needed, here are links to helplines and hotlines. They are also listed on the Learning Institute website.

The Mental Health Technology Transfer Center Network is funded by SAMHSA, and it focuses on technology transfer, which means the adoption and implementation of evidence-based practices for mental health across the United States and territories. We develop and disseminate resources and provide free local and regional training and technical assistance for the mental health workforce.

Here's our map displaying the 10 that make up the MHTTC Network. We have 10 regional centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a network coordinating office at Stanford University. Please visit our website and find your center so you may stay up to date on training and resources offered in your region.

This presentation was prepared for the MHTTC Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration, also known as SAMHSA. The opinions expressed in the presentation are the views of our speakers and do not reflect the official position of the Department of Health and Human Services or SAMHSA.

So once again, here is our presentation today. Again, "Are you the therapist a grieving client wants to meet?" with Jill Johnson-Young. Jill is a dynamic and engaging national and international speaker who loves teaching both professional and community groups about dementia, death, and dying, and grief and loss. She co-owns Central Counseling Services in Riverside, California, where she is also a clinical therapist and practices as a certified grief recovery facilitator.

Jill has authored three children's grief books and an adult grief workbook, with more in process. And created www.yourpaththroughgrief.com, a yearlong comprehensive grief support program. She also has a website with resources for therapists, which includes resources for therapists.

So I'm going to turn it over now to Jill. And we are very much looking forward to your presentation.

JILL A. JOHNSON-YOUNG: All right. Thanks, Lou. I'm going to do screen share and grab the presentation. And go to beginning and see if we can get Fred the dog to behave himself today.

Thank you, everyone, for being here. It has been fun to see everybody checking in from all the different places. I am currently in Southern California where the sky is orange. And the dogs can't go out. So I apologize, Fred will be coming and going as we talk today.

I call this, "Are you the therapist a grieving client wants to meet?" because I really see so many clients coming in, and they are struggling because they've already seen someone and it didn't go well. And you'll find as I do this presentation, I'm very transparent.

If you go to my website, you'll find I'm transparent. I talk about my own story there. And I have met some folks who say that they're really good grief therapists, and they don't really quite know how to connect with someone who's grieving. So that's why we're here. And I'm going to minimize the picture so I don't-- there we go. Perfect.

So as Lou said, I do all of the above. I was a medical social worker for hospice for over a decade. When I talk about knowing death and dying, I mean I know death and dying. I have attended hundreds of deaths. I also directed the social workers, and the chaplains, and the grief staff. We had all grief center.

I love doing grief work. I love seeing people do it right. I love when I'm doing presentations and people connect and go, oh, I can use this right now. I hope that that's what's going to happen today.

I've been at CCS for over a decade. And at CCS, my entire focus is dementia, death and dying, grief and loss, chronically ill folks. All this stuff, most people just go, yeah, no, I don't want to do this. And when I go to conferences and I have a table and it says, "Grief", literally about half the people there will just scooch around to get away from me. Even with their hands up so they don't have to look at the grief person.

And I don't think I look scary. I got the blue hair. I look fun, but they don't want to talk about grief. And as therapists, we need to be able to talk about death and dying, and grief and loss, because grief and loss is around us all the time. And with COVID, it's way around us right now.

I am a USF grad. If there are any Bulls in the audience, go, Bulls! And you can find me online in all the different places. I'm also active in the funeral industry, which means I see things from that side of the planet as well. Partly, that's because I'm now married to a funeral director. And partly, that's because funeral directors need to know what we can offer them as therapists

for their people that they're taking care of. And so I keep myself in that world to try and bring them into our world.

You should have seen their faces at the California State Conference when I introduced them to Psychology Today. They didn't know how to find a therapist.

So doing grief, it can be a challenge at any time. During a pandemic, it multiplies. I have not had a day in the last 3 and 1/2 weeks where I haven't had somebody come online to see me as a therapist, because I'm 100% online now, where there hasn't been a new COVID in the family, or the close friends, or a new death.

And my last client yesterday, two new family members hospitalized very suddenly, very unexpectedly, and one was heading to a respirator as we were talking. COVID has made grief harder because there's so much more. And because it's really unavoidable now. You can't talk about school without talking about COVID, which talks about grief.

And so we've got a lot more losses around us. And we really need to do better about being able to talk to our clients about loss and what they can do with it. We have to be able to meet them where they are. In grief, more than anything else, you need to know how to meet them where they are, and what things not to say. So we're going to talk about that.

I do want to remind you that in November, we'll be back here, and that will be more experiential. So I'm going to talk at you today. But I encourage you to put in questions. And the folks in the back who are amazing, who put this together, they will break in if there's a slide-specific question. So feel free to put in some questions, OK?

So we can look at deaths in categories to get an idea of where survivors are coming from. We used to have just a few categories. This is what we've got right now as I break it out. We have unexpected and expected deaths. We have expected deaths with hospice support, although even that's changed because some hospices aren't letting some of their staff go out to homes now. It's by phone.

When I talk to social workers from hospices around the world right now, they are largely doing things by telephone. And that's not the same. And we have long-term illnesses that don't have preparation or hospice support because it just seems silly to families to have a hospice come if hospice isn't going to come.

We have sudden deaths, the old, traditional sudden deaths that we've always had, but we also have COVID deaths which are largely sudden. And we have hospice deaths that are occurring in COVID but not from COVID, but where the family still can't be there. It's gotten complicated.

We used to have long-term deaths. Hospice was usually there. If hospice wasn't there, family was there. Even if someone was in a facility, hospice could go in. If someone was in a facility, you could go in. If someone was in a dementia or memory care unit, you could go in.

In the dementia group that I run online once a month now, it used to be in-person once a month, we've had several family members who have lost loved ones in facilities to COVID, one of whom was diagnosed with COVID while we were online in group, as a matter of fact. Those folks can't go in. Those clients, they can't go say goodbye. If they're lucky, they can do a window visit.

And then, we have the traditional unexpecteds. We have stroke. We have MI's or heart attacks, aneurysms. We have deaths due to suicide, we have more of those now.

So we have a lot of different categories. And that's a lot of different places for us to be able to jump in and be part of that client's experience and to understand that clients experience. I'm not going to say that you tell a client, oh, I get it, I completely understand. We don't because everybody's is different.

But in general, we can get with the construct was and what the experience was in large part. And we can connect with them there if we know the stuff.

So grievers, grievers are expected to do a lot of things, especially by therapists. And I watch, I I'm a lurker, I go into all the therapists groups that I can get into on Facebook. And all the grief ones I can get into, because as a double widow, I get in.

And as a grief therapist, I get in. And in the grief groups, they tell me, just be a griever, don't be a therapist. Unless they need a therapist, in which case they call me out. And in the therapist groups, I'm just a therapist.

But there's a lot of conversation that goes on about grief. And just this weekend, there was a tiff in one grief-specific therapist group, where there was somebody who said, I never advise my clients to use the word, "move on," the phrase, "move on" until well after a year. And nobody should be even thinking about making changes in their life. And especially not women.

And I thought, you know, you really don't know what you're talking about, and you are also using a little bit of privilege there. And we need to be careful about that more than ever.

So the grievers are expected to either want no outside support, I've got this, I'm strong, leave me alone. Or we send them to a support group. It's a family member of ours, we go to a support group. I'm spraying the dog for barking, yes I am. We send them to therapy, hopefully to a therapist who knows how to do grief.

But we know that on our therapist pages and on the things we can sign up for, likes Psych Today, you can check as many boxes as you want, it doesn't mean necessarily that that's a specialty. Be cautious with that. We can say, therapy and a support group. But we need to think about support groups.

And before, all of our support was in person. Clients came to me in my office. I did do some online work with clients who couldn't get to the office, but for the most part, we were in-person. Grief support groups were in-person. And now, we're not.

So I want to challenge your assumptions because your assumptions can create barriers. And you may not even recognize that you're creating a barrier. 70% of the population will not go to a support group.

So if you say to every grieving client, you should go to a support group, only 30% of your clients are going to resonate with that. The other 70 are thinking things like, I don't want to be around all the sad people, I don't want to share my stuff, I live in a town where someone's going to know somebody and share my stuff.

And I will tell you, Riverside, we have about 400,000 people here. I've been here most of my life. If I walk into the grocery store, there is a significant chance someone is going to recognize me from my mom or my sisters. If I go to a support group, someone is going to know someone who's going to know someone. That's the experience people have in support groups. And sometimes, confidentiality is not what it's supposed to be.

We have common knowledge that creates barriers, like the therapist who said, no changes for a year, I don't think it's right we should tell people how they should manage things. That's knowledge that we have shared over time that's not based in any kind of research. There's nothing in the research that says that anywhere.

There's some fascinating research that says, people who are losing a primary partner, primary intimate partner, over a long period of time with an expected death where they start to reorganize before the death, those folks are actually done with the majority of their grief in about three months. The problem is, the rest of their family is not done, and that creates a rub.

I also want to make sure that you really know death and dying. And we're not going to have time to cover all of it. But I sent in some handouts and you should be able to access them.

Those handouts actually have the dying process. And I'm going to reference that in our next group in November, so I really want you to read through it and know it by that time. If you need more information, the National Hospice and Palliative Care Organization, NHPCO, has some really excellent material on

death and dying. And they use real clinical terms instead of some of the more common terms that people use that can be traumatizing.

And I want you to think about how to set up your first session, that very first session, so they feel supported, they feel like you get them, and you'll leave them with some hope at the end of the session. I don't want them to leave they're thinking, oh, she wants me to go to a grief support group, I hate grief support groups, I'm going to disappoint her, I should find another therapist, right?

I actually-- so here's my transparency, when I was widowed the first and the second time, I met with a therapist. Because I'm a therapist, it's just what we do, right? And that first therapist said to me, I don't know how I'm supposed to help you. You're a therapist, I don't know what I can tell you that you don't know.

And we kind of stumbled around for a while. And then she said, now, if you want to wake up tomorrow and everything had changed and it was better, and you feel good again, what would have happened?

Rule number one, when you're doing grief work, don't ever use the miracle question. There's only one answer, and you don't have that power. And I finally looked at her and said, yeah, no, my wife's in a box already. That won't work.

And the second one also used the miracle question, and then very helpfully said, why didn't you get your new wife checked out physically to make sure she wouldn't get sick? A, not therapeutic, B, I was done. I got up, walked out, that was the end of it.

And that's what happens with grief clients. They have a bad interaction where they don't feel like someone gets them, and they don't come back. And they may never come back. This is your chance to make a huge difference in someone's life. And to get them from post-traumatic moments into really post-traumatic growth, it's that interaction with you that's going to make that difference. There's nothing more powerful than grief work.

So when you're going to do grief work, I want you to know who's going to go to support and who's not in general. Now, like everything else, these aren't hard and fast rules. And I'm not great with rules anyway, but this is the research.

Survivors who've had hospice come in, who have met with the hospice staff during the dying process and said, we've got these physical issues and I'm really struggling or I need help with, and they're putting their emotional needs out there, and a hospice person goes right to the physical but doesn't go to the emotional, that survivor is not going to be willing to take support from that hospice.

They will not read the emails. They will not take the phone calls. Or they'll take the phone calls, but not truly believe there's a connection because that connection was severed when that staff person didn't address their emotional needs when their loved one was still alive before the death. So you're going to want to hear what happened with hospice before you start talking about hospice grief support.

A lot of grievers also question their faith. How many of you have had someone come to see you, or a family member, or yourself, and a loved one is now dead and you are wondering, what happened? And where was God, Allah, or The Creator, or the tree outside, whatever your faith base is, it's now not so much there. It doesn't feel as good.

And people use faith to try and support people so they say things like, God wanted another angel. That's a great way to turn someone off. Or, there was a bigger plan. That included my loved one having to be dead? I don't think so.

The other issue with groups that are run in faith-based organizations are that even though some of them are national, some are local, they change personality frequently. The group is what the leader makes it. If I'm running a group, there's going to be humor and there's going to be reality. And we're going to use the word "dead" if it's a grief group.

But there are groups where they make that religious part of it such a peace that it alienates in whatever way. It just doesn't fit for that particular griever. So you're going to want to keep tabs if you're making referrals on what the groups are, and how they behave, and what their personalities are. Whether it's being in touch with all the group leaders or talking to people in grief groups online who are local, you need to know which groups are safe and which ones are not going to be.

And keep in mind, if someone belongs to a church, or a synagogue, or some other house of faith, they may not want to go to a grief support group there because then their stuff is in that community. And they may have some things they want to say about the person who died that doesn't go over well. Or the dying process, or what someone said to them. There's a lot more to sending someone to a group than just sending them to a group.

So you're going to need to know what's out there and what doesn't exist anymore during COVID because a lot of groups have shut down. Some people are technology friendly. Some of us transitioned into technology. Some of us struggled. [DOG BARKS] Like Fred, who is struggling right now to be quiet.

So we want to make sure that you know which groups are out there and which ones don't exist so that you don't send someone on a wild goose chase. That will damage your credibility beyond belief.

So now you have homework. I want you to find out which groups are operating in your area, and how they function, and what people think of them so that you can take that with a grain of salt and know which ones you can refer to and which ones you can't. And also, to look back at what we just covered to make sure you're not making automatic referrals. You're listening to the story before you say anything about a grief support group.

By the way, this slide is from New York City. That is part of the temporary morgue that has been broken down now. And my wife, the funeral director, served there for two weeks with the National Disaster Mortuary Team. And that is what families saw. And that's what families are thinking of in COVID when we talk about someone dying during COVID, they're thinking about refrigerator trucks to some degree.

So our prior mass loss experiences, welcome to Italy, and New York. How do mass losses differ from our regular deaths, the one I talked about at the beginning? There are lots of new consequences. Not only are they losing a loved one to death, but they've got those images, they've got the images of that morgue.

Here in California, we have some commercials out that are telling us to wear masks. But the way that they're telling us to keep masks on and keep social distance is they have a background sound in the ad on the commercials, it sounds like a bunch of respirators. And you can see feet protruding from hospital beds. And you're walking down a hospital corridor, and all you hear are respirators.

That image, while very good for saying, keep your mask on, not so great for families who are losing someone or have had someone die of COVID because that's what they are imagining. And it's not a good imagination.

We all know that when someone dies and we're not there, we fill in the blanks. Kids do this, and adults, too. They're filling it in with that and with this. So you are dealing with consequences of image and imagination, too.

They are also coping with multiple losses. Many families are like the ones I had this week, where it's not one person in the hospital, it's two, or it's three, or it's four. I know of one therapist who lost something like seven family members at the beginning on the east coast. It's not one death, it's all the deaths.

And they're all the other deaths occurring around us. We've had 191 or 2,000 now, which makes people minimize their loss because everyone else has had a loss, too. So we have that additional layer.

And then, we have all the other things, people losing housing, and jobs, and security, and having to double up with family members. And we have kids who aren't in school, or in school and then not in school, the losses just multiply,

don't they? That's all losses that we need to name so that we can help with the support and figure out what support is really needed.

Grief work is not that simple. So to look back at some other kinds of multiple losses, during AIDS, they did a couple of studies that are really significant in terms of looking at grief. What they found was both studies, at the beginning and towards the middle, was it wasn't the number of deaths that made the difference.

People could cope with multiple deaths if they addressed the death with every single one. Think of an image of the ocean and all those waves, and every death is a wave. If they could say goodbye to each one, however briefly, to be prepared to move on to the next one, they did better. If they had good support systems, if they were in a demographic that allowed them the time to be able to mark the death, even if it meant just taking a day off.

And we know a lot of our people don't have that demographic. When I worked for hospice, I had the usual three days off. Some people don't have that. But I had three days off when my wife died of Lewy body dementia. It was not a fun time during that dying process.

And I had to be back at work. And I had to share, too, and save two of those days so I could have a funeral. So I was back at work the day after she died. That's not a great spot for some people to be.

If they've got friends, if they've got people who stand by them, if they can afford a little bit of time off, and if they had some kind of spirituality to hang their hat on, I'm not saying religion, if they had something that centered them, whatever that was. Something that centered, those folks did well.

And what we also did with AIDS was we found a way to mark the losses together. As we are today with 9/11. Today's the 19th anniversary. With AIDS, we had the quilt and people could join in the grief together, even from afar.

For 9/11, of all the days for us to be doing this one, there was a group called The Surviving Sisters Club, and there was a study done on the widows of the FDNY. Now, there were lots of other groups. There was NYPD, there was the folks from DMORT and DMET, there were a lot of responder groups. This focused on just the FDNY widows.

And what they found in this group was that the ones who came together to share their grief experience and participated in some one-to-one therapy that honored their loss, those folks created their own understanding of what their grief was. They had companionship. They gathered their emotional strength together, and they shifted from post-traumatic stress disorder into post-traumatic growth because they had all of those pieces together.

So what that means for us is we need to find a way, even when people are at home and by themselves, to replicate companionship. Because that makes a difference when we're having multiple losses. That is a big trick. That's part of the reason I have Fred with me when I'm doing groups and I'm doing individual sessions because I'm petting Fred and his head is on my shoulder, and Fred gives them a sense of calm, and it helps.

We have some other groups I'm going to just briefly touch on. With people who've been in the Peace Corps, and missionaries, different aid workers who've been through things like Ebola and SARS, those folks had a different kind of loss. They lost where they were living, the people they were with-- speak of the devil, here comes Fred.

They lost their support systems where they were, but they went home to them. And those folks also had some inner resiliency. But those folks showed us that you can do multiple different kinds of losses and still come out ahead. And don't you feel calmer just looking at Fred here? Don't you want to just reach out and pet him?

Suicide is a different kind of loss. And I do want to touch on it briefly. Thank you, Lou, for putting that slide up with the suicide referral information. Suicide survivors really feel a sense of shame and guilt. What could I have done to stop it? All the stuff you know. And being stigmatized, oh, someone died. And what they say is a suicide. And then what we need to do is correct that. Someone died as a result of suicide. The language is different. The language is better now.

What we know, though, and we have a lot of research on it, is that survivors of a loss by suicide don't get support from their normal networks. Because families can blame and families can shame. And as therapists, we know that, right? That's part of the reason some of us are therapists, probably.

So we need to get them to someplace where they're not going to run into that. And what the research finds is that those folks who are survivors of a death by suicide, is they do better with a group led by someone else who's a similar survivor. Now, not a group by an untrained survivor. They need someone who knows how to do a group and has had specific training for suicide survivor groups.

But the suicide survivors who get to those groups do much better than the ones who were sent out to a community group by someone who doesn't know better. And they run into it and they're in a group surrounded by people who've lost a spouse of 50 years, and they've lost their beloved son who was 22, or their boyfriend, or their wife to suicide. They don't feel welcome in those groups. They feel stigmatized.

They also benefit from individual counseling. But it needs to be with a therapist who understands the dynamics and the language of suicide. So

please, if you have those folks, get them to those groups. Find the good groups. And when we are back in-person stuff, make sure that you make them aware of, but don't assign them to go to, the Out of the Darkness Walks, where they can go with a picture of their loved one on their t-shirt and share that experience with hundreds or thousands of other people. And do something as a give back. That's how those folks recover.

I want you to be that therapist who knows that information so that when you have someone walk in or come onto your screen, you are the one who will help them cope with their worst fears. Help them let go of the self-blame. Get them to a group if they're appropriate for it, you know of one, and they want to go.

And someone who knows death and dying because part of the work we do in grief is correct what happened during the dying process. People come in to see us and they have been through the dying process, and they didn't understand it. Or their loved one died in the hospital and they couldn't be there. So they don't know what happened and they're filling it in.

So when someone is next to someone who's dying, if they're lucky enough to be there, and they come to see you and they say, oh, my gosh, my loved one was gasping for breath at the end, or they were gurgling, they were drowning. No, they had Cheyne-Stokes breathing and they were not drowning, they were laying prone, and there was fluid in their throat, and it was touching their vocal cords. And it makes a truly horrible, god-awful sound, but it didn't bother the person who was dying. It bothers those of us around.

And we have research that says it didn't bother those folks. They did EEG studies on dying people, of all things. We have the research. And when you can tell your client that, their shoulders will lift up and their head comes up a little bit, and suddenly they're not responsible for letting their loved one die by drowning or suffocation.

My first wife died of pulmonary fibrosis. She had 3% of her lung tissue left when she died. And she was comfortable. And I knew that, but I knew that because of my background. And I knew that because I was the one pushing the morphine. So I knew that Cheyne-Stokes were just Cheyne-Stokes. Other people don't know that.

Your ability to address dying so that they can talk about their regret for not putting in that feeding tube that would have done nothing but damage, or their regret for giving morphine because now someone has come along and very helpfully said, well, you know you caused them to die earlier because you gave them morphine.

We need you to know that information so that you can reteach it. You can change it for them. You can talk about the images in their head and that commercial that they're hearing with the sound of the respirators. And you can

reframe it with how tired we know all of our hospital staff are right now because they are doing so much for our patients with COVID so we know that they're there.

Or the patients with cancer who are in the hospital, or had an MI, or a stroke, we know that the staff are there with them. You just couldn't be there because of the new rules that were there to protect you. That lets you change their world in one session.

I have never had a session where I've been able to do this work where it hasn't made a tremendous difference for that person right then, the rest of their week, and truly for the rest of their life. And they were able to share that with other people in the family.

The domino effect when you do grief work, I've done presentations for therapists and had hospice staff there, and they had been traumatized as well by a loved one's death. And they knew this stuff. But when they were there in the moment with their loved one dying, they forgot it.

And when I went back over it, they came up to me afterwards said, wow, I just feel a sense of relief. That's what you offer to someone doing grief work. Truly, it is some of the most powerful work you will ever do.

So please read the information in the handout. Please educate yourself. Even if you've been through a death process, they are not all the same. But they are generally the same. And you need to know what their loved one was doing so that it's reality.

I know you want to kill the Gardener next door. You're not going to. We're not doing Gardener grief.

So COVID has actually made us all into Cicely Saunders, who was the founder of hospice. And if you've never done hospice, then you don't know that Cicely Saunders is the one that everyone who does hospice. Rudy Reveres, she resurrected hospice in the modern age. And everyone who works for hospice thinks about going to London to stand outside of that hospice building at St. Christopher's.

Hospice is where we're supposed to get the education. If they don't get the education, it's our turn. We need to be ready. So now, you've got find out the groups, and don't send to groups unless you know it's necessary, and the kinds of things that happen during mass losses. Now I want you to know what clients want.

When I do these groups and these education pieces, I will hop into one of my groups that I'm a member of as a graver, and I say, all right, tell me some things you wish therapists had not said to you. Tell me some things you want therapist to know. These are the things that come up repeatedly. If I put one

of those up at 8:00 in the morning, I will get 500 to 600 responses by noon in real time.

There are some strong feelings out there folks about what people need from their therapists. They want you to know that you are not supposed to assume what they need. You're not in their skin. I'm a widow. I can't assume what another widow needs. Her experience is different from mine.

They don't want you to tell them what to do. That therapist who said, oh, no, I tell my clients always, 12 months before you make a decision. That is not our place. It is not helpful. And it doesn't honor that person needing to reorganize their life and set their own boundaries which will protect them in their grief process.

They need to know what happened. They need to be able to talk through the nightmares because they don't know what happened. And they need you to listen.

An intake for grief is an intake like no other. It's listening, not talking. Until the end when you give them the re-education, it's listening. Because you're listening for all the other losses, too.

And they want you to help them forgive themselves. There is not a griever on the planet that doesn't have guilt, no matter how prepared they were. Guilt is the number one emotion. Fear is right up there with it. They're the things that grievers don't expect.

Here's what they said. And I'm going to read a couple of these. "My experience is normal." And it's not that simple. Let us lead the discussion. Sometimes I just need a safe place to cry.

They don't like the stages of grief, and I'm going to talk about those. They want you to know not to use the phrase "moving on." Don't use "get over it" either. You are never going to be a grief therapist for a client again if you say, "get over" or "move on". It's, "moving forward" and "your loved one is still with you." And those two have to be together.

So back to the title, how do we meet the grief client in the room, on the screen in the room, speak their language, not say the stupid stuff that they don't want to hear, and make the environment work. With Fred, we know what survivors do best. We know who is most at risk.

We know how previous survivors of mass losses got to where they were. You know that you're going to be listening for someone who's had a suicide loss to make sure that there's not some other thought about following. We know that if someone's got a history of depression from their intake paperwork, not from your discussion with them, that you're going to be listening for that to slide in again.

What do we do instead? We go back to five stages and we use intakes where we'd want to know their family history. All the history. Where did you go to elementary school? Were your parents divorced? And yes, that's important, but it's not important right now.

What's important is, tell me the story, tell me who died, introduce me to them. And write that name down in your notes so that you can reference that name each and every time. Never, ever forget the name. Because we can do better, and we can meet the clients and their needs.

By doing that, I want you to challenge what your perception is of what grief work is. I want you to know what you're hearing. I want you to hear the unrecognized needs that the client doesn't even know they have. And I want you to be a holistic therapist. Because basic needs matter in grief.

You can't work with a therapist on a Tuesday at 10:00 if you're wondering if you paid the power bill because your brain is fuzzy. You just can't do it. Your therapist may need to be the one who helps you put all the bills on auto pay. Because then, you don't have to worry about it.

Your therapist may need to call you to remind you more than once, and to forgive if you missed appointments because your brain is mush. Your therapist may need to suggest that even if we're back in person, online might be better because you may not be all that great at driving right now because your hand-eye reflex is really kind of lousy right now, right? We need to look at Maslow when we're doing grief. Grad school, right back, huh?

Here is my nemesis in grief work. Not anticipatory grief work, that's where this belongs. Elizabeth Kubler-Ross was amazing. She wrote the book, literally, on death and dying. She was the one who started the conversations that nobody wanted to have after we'd made death go back to hospitals and made it all nice and neat so people didn't die at home.

And what she did was describe, describe what happens during the dying process for the dying person. It's not about what happens afterward. If someone has died, it's really hard to deny that they died. You've been to the funeral. This is about the person who's dying. They don't want to think about their death. That's denial. They may be angry that they're dying sooner or in a way they don't want to. That would be reasonable.

They may be doing some bargaining. And the family may be doing bargaining, too. And there is going to be sadness because if I'm facing my death, I guarantee I'm going to be sad about it. I just had to do my advanced directives last night because I'm having some procedures done. And I know I'm going to be just fine, but it felt a little sad to be deciding who was going to decide what was going to happen to me if I couldn't be there anymore.

And then there's acceptance, that's for someone who's dying. OK, I'm dying, I get it. Let me say goodbye to everyone. This is the dying process, not the grief process.

What happens is we use this in grief because it's what we know. We know the one year rule and we know stages. And then people come in to see you, and what they will say, if you are a trustworthy grief therapist, I'm doing it wrong, I haven't been angry yet. They don't have to get angry. If they were angry about dying but they've finished that before in the anticipatory grief, they may not ever be angry when they're grieving.

They may have bargained before, they're not bargaining now. They can't say, I'm going to live a better life and you're going to bring my loved one back to life. That doesn't work.

Bargaining is when we had a beloved friend at church who was dying who was in her early 40s and should not have been dying, and the cancer took off. And she was the one every kid in church loved. So we had to go classroom by classroom and talk to all the Sunday school groups and tell them Maury was dying.

And when I got to the first and second graders, because you know, the grief therapist, they throw you into the little people, right? And I talked about, Murray's going to die, we should start talking about what we want to tell her, thanking her for everything she's been, writing her some notes or making some pictures, we're going to have a meeting with her. All the things you do with kids when you're addressing death and dying with them in a healthy way.

My little niece, who was six at the time, piped up and said, but auntie Jill, my grandma is very old. And sometimes, she's not very nice. And Murray is wonderful and she's young, could we just pray really hard and have God take grandma instead? That's bargaining. And that is bargaining where it belongs in the dying process. See? Even Fred knows better.

So those five stages, keep them out, keep them out unless you're re-educating people. Don't reference them. Listen for them. Listen for someone who's been told they need to do five stages in grief and disabuse them of that.

Some basics. This is how you're meeting your client where they are. If you've never worked with a highly-sensitive client, and I'm sure you have, look up "highly sensitive", HSPs". That's the environment that they're in.

Grievers are more than likely going to be very sensitive to lights, temperature, sound. They're not sensitive to their own needs in terms of hunger and safety so much but. The environment itself, noises make a difference. That's why dogs are so good when you're doing grief work.

Even if I'm doing grief work online, when Fred does this, and he does it on his own by the way, my clients will reach for their pets or for something on their couch or their chair, and start petting it. It's a self-soothing. And if you've got another heartbeat next to you that's slow, it slows yours down, too.

So you think about a highly-sensitive environment. You think about physical comfort. I do not dress like this when I am working with a grief client. I'm in reasonably dressy clothes, but they're comfy clothes. It's not the button down blouse that doesn't look like I can relax in it.

If the client is looking especially uncomfortable, I will go the extra mile and curl up my knee in front of me, which by the way hurts because I'm old. But I will do it because it gives them that permission to do it. In my office, I take my shoes off, they take their shoes off. They're invited to put their feet on the couch with their socks, not their shoes.

I have blankets on my couches in my office. I have blankets on my chair when I'm doing grief work because if they're talking and I pull the blanket over, they'll pull theirs over and they'll snuggle into it, and we've got a blanket fort. And there, you've got high sensitivity being met where it needs to be.

It needs to be safe. They need to know that I'm online, it's secure, I've got my headphones on, nobody else who may be in the house can hear them or see them. In my office, I put a barrier under the door. I put a sound-killing machine on, putting the sound of waves behind me. And I tell them, "what you say here stays behind that door." And I point at the door. And I do it several times in that first session, and usually about once a session after that.

It's a natural thing for me to do now. It gives them that sense that this is not like one of those groups where everyone's going to know my business. This is just mine, between the two of us. And if I want to walk in and say all the bad words, and by the way, I say them with them, about what somebody is telling me, then it's OK.

Your client needs to know that you know death and dying. You know what hospice was like in general. Sorry, Fred, I didn't mean to spray you but you're barking. They need to know that you know grief. You know death. You know what happens.

And they need you to be transparent. And I know that's a thing for some therapists. We can work with anxiety clients and never tell them whether or not we'd ever had anxiety. We can work with depressed clients and never acknowledge if we've had depression or not.

You can't work with a grief client and pretend you've never experienced grief because they know you're lying and you lose all your street cred. They need to know you know. Now, most of my clients already know my story because they've tracked me down and they've looked me up.

And if you Google my name, it comes up. And I'm not sad about that. I did it on purpose. And they get referrals from other therapists who tell them that I know this stuff and I've been there and done that.

It's not about my losses. It's about, I've walked the walk. And I'm not going to say I know your walk, but I know some of what you've walked through. And I know some of the stupid stuff you're hearing. And I'm just going to sit and hold space for you because that's what everybody needs. And I know that because I've been there.

They need someone who could normalize what they've just been through and everything they're experiencing now. The fact that grief hits them physically, emotionally, cognitively, spiritually, we're going to talk about that next time. We're going to walk through some of that.

They need to know that you get it. So when they say, I'm not sleeping, you say, of course you're not. Were you up at 2:00 AM? Because most grievers are up at 2:00 AM, and most people don't know that because we don't have books that say that. Well, mine does. It'll be out in a few months.

And we need to send them home with hope. If you go on Pinterest and you put "grief" up, you will find, I guarantee it, memes that say things like, you're going to grieve forever. Well, grief is a love with no place to go. Grief is a sadness that never ends.

And then there are some other ones that are even uglier. Things like, if you move on after the loss of your loved one, it means you didn't love them that much. And other grievers will say this. They will turn on each other, too.

So your hope piece is, I know you feel like crap right now, sometimes, use worse words than that, depending on the client, and I'm not going to make you feel different, but you're going to start feeling differently, and things are going to turn around. And when you go home this week, I want you to go outside in the sunshine and feel the sun on your face for at least 15 minutes a day so that you can reconnect with that.

I can't say that in California this week, by the way. Neither can any of you in Oregon or Washington. But when the weather clears and the fires stop, we can do that. Even if someone lives where it's cold, there's still sun, go outside. If you're in Alaska, go find when those sun lamps. Do something so that you've got that sensation.

Let them have the hope that it's going to get better. They're not going to feel like this for the rest of their life. They don't have to feel like this to have loved the person who died. They don't equate.

So that means-- meet Walter. Walter is one of our other office poodles. He's in another room right now. And he's blind, he has no eyes. He's the most

popular poodle we have. When we are actually in an office, by Friday, at the top of his head is a little brown because he gets petted.

And people come and check him out from our front desk and take him into their sessions. So he's a very busy little poodle, and he calms people down. And he puts nose-to-nose with them even though he can't see them. And kids love him. And we'll talk to them about their losses.

So they need calm. If you're online with them, and make sure they have something to drink. If I'm pretending to be healthy, I'll have the water. If it's early in the morning, it's going to be tea or coffee. If it's early afternoon, you better believe it's going to be a silver can with a red stripe.

That there's comfy seating. I am not in an office chair right now by design. Went out and bought this chair so that I could stay home and work online. Painted the wall behind me. Put up the little tchotchkies. Put up the thing on the side of me. Have banks of lights and a soft light behind me.

That's by design because it looks like I'm in calm in a calm environment. Even though the gardener is working next door and there's construction across the street, in this moment with them, they are seeing Fred on my lap or Walter, my blanket, my drink. They are seeing a safe, calm place. That's what they're looking for.

They also need you to be flexible in scheduling. If someone's had a really recent death, they've got a lot of stuff to do. They've got planning to do and changes to make. And they may not be able to have a regular appointment. Or they may have difficulty remembering an appointment, and you may need to do a little more to remind them, or not hold them accountable if they miss an appointment.

Grieving clients and people who are chronically ill, in my book, get a pass for missed appointments. I do talk about it with them. But if it happens, it happens. Because that's humanity, and grief is hard. And they need your full attention which can tire you out. It can exhaust you. Especially when you're online, because you are eye-to-eye the whole time. There's no looking around the room. You're eye-to-eye.

It's actually more effective for grief clients, in my experience, to be online. It also means they don't have to walk out of my office with tears coming down their face. It's safer for them.

But they need to feel like the entire time I'm with them, I'm 100% with them. So they never hear about a busy day. They don't hear about any of it. I'm taking time off in two weeks for medical stuff. All they know is I'm taking some time off, if I needed it. They don't need to worry about me.

Your first appointment, and it counts more than any other first appointment you will ever have, you're going to listen and then you're going to listen some more. You're not going to interject. You're not going to do that, uh huh, uh huh. You may use your head, but you're going to be listening and watching them because their story is what matters in the first, sometimes second and third session.

I have grief clients who've lost two family members to COVID. It has taken four sessions to get through what it was like to get through all that. They need to tell their story to someone who's not going to interrupt them, or tell them about their own loss, or compare it, or tell them they were so lucky that their person died and went to a better place. They need someone to just listen.

So if you have paperwork, and we all do, get it out to them by email, by mail, however you need to do it. Your first session is not going to be all about the paperwork. If you're online, you're going to just double check where they are, make sure they know the suicide policy and self-harm policy, and harming others policy.

And then, you're going to dive deep and let them talk. And you're going to send them out with grief does not last forever. You may miss them for the rest of your life, but you don't have to grieve. You don't have to do Queen Victoria with the black crepe for the rest of your life.

You still love them. They're dead, and you're going to take them with you when we finish what's left over. And you're going to send him home with self-care on their plan of care that makes sense.

So and Deb Hart, this one's for you. Your actions in session are their permission. So you're going to laugh. Not at inappropriate times, of course. But show them they can laugh because they're being told by the grief-world people that they're not supposed to laugh.

There are grief rules. I know you don't know that, but there are grief rules. You can't laugh, or you should laugh because you're making people uncomfortable. You should cry, but don't cry too much because it upsets people. You should be sad, but not too sad. All the rules.

They need to know they can smile again. You need to smile at them because people don't smile at them. They look at them go, oh, I'm so sorry. And all they see are [AUDIO OUT] faces. They need some smiles.

When my grief clients make a little bit of progress like getting that utility bill online, I stand up and cheer. And it makes a difference.

And make grief normal. It's a normal response to an abnormal situation. That's what it is. So they don't need to know that they have a diagnosis. There goes Fred again. They need to know that this is grief, and this is perfectly

normal in an abnormal moment. When you're working on goals with them, you're going to be working on framing it towards recovery.

And you should know what you're going to be working on toward goals with what you've listened to on the intake. If they are traumatized by that dying process, you're going to work on that.

So what are you hearing? You're hearing-- five minutes, right?

PRESENTER: Yep, we are. Sorry, Jill.

JILL A. JOHNSON-YOUNG: OK, almost there. You're going to talk about the trauma from the dying process. You're listening for misinterpretations. You're listening for things they're holding on to that didn't go the way they needed to. Because people make decisions for grieving people without permission. And you're listening for who's disappeared in their life.

You're also listening for the disenfranchised grief. Pets, out of order deaths, that's where mom dies before dad, sibling deaths, friends who die, which have a huge impact but don't get noticed, miscarriages, suicide, and people who are divorced or never married and so people say, oh, but you were married, you aren't married anymore, you love someone enough to live with someone or be married to them at some point, it's a loss, folks.

You're listening for family conflict, for sleep and nightmare issues, for fears that are coming up, for finances, and the bills being paid on time, for what stuff they've heard that's not helpful. That's in the handout.

You're listening for basic self-care. Are they eating? I ask that every time. Have they been to the doctor? Because most people who have been caregivers haven't gone to the doctor, and they have a potential for being very sick. And you're listening for them being afraid that they're going into dementia because their memory is failing, and you're normalizing that as, that's part of grief.

Your initial treatment, you're going to look at the impact of grief. Education, how to get ready for firsts, how others are responding to them, losing secondary relationships because people are uncomfortable with their new status as having had a death, and what things need to be redone, like obituaries.

You can talk about the stages, you're going to talk about reorganizing, you're going to talk about the client figuring out where they want to go with their life, not what other people are trying to tell them. And you're giving them permission to do all the things that you're doing in session with them.

You're treatment planning: realistic. You're not going to say, "Sleep eight hours." You're going to say, "Get enough sleep until you wake up and then find a way to get a nap." You're honoring what's going on with their brain.

You make it doable. Small, tiny bits. I email homework because clients can't remember it. You're going to be looking at the changes they have to make. And what you're hearing, but they're not hearing themselves say. And you're practicing with them on how to set boundaries on those people who are telling them how to grieve, and that they need to get to acceptance.

You're going to process what's leftover from the relationship that's holding them in it. That means journaling, sunshine, maybe groups, maybe not. Online support, maybe, maybe not. Giving back, the Cancer Society, the Suicide Walk, those things.

You're going to teach them how to throw that grief card down and say, you can't tell me what to do, I'm grieving. People will back off if you teach him that trick. Best ace of spades you've ever had. You're going to celebrate the changes they make.

And plan ahead for what's coming. Right now, we're heading right into the holiday season, and there are going to be people who are grieving and doing their first Thanksgiving and Christmas, you're going to help them include the people who died in those events, or Hanukkah, or Eid, any of the others.

So grief holding space using language that works looking at the things that work for them and that don't make barriers, and then acknowledging the losses by looking at ways to mark them. Whether it's people, or places, or an illness, or a new disability, help them plan the ceremonies.

You can even do one with them online. You can help them plan a funeral. Especially with COVID, encourage them to have a funeral once the pandemic is over even if they've already had something small. Because the research shows us that if we don't do something to ceremonialize a death, it makes us not finish the relationship, and it makes the recovery process longer.

It makes sense. Funerals are where we get together with people and say goodbye. And if you don't say goodbye, you're not done.

You're looking for PTSD. Especially today on 9/11. Depression, substance abuse history, suicide of course, issues that occurred with the deceased that are holding them in, and prior losses including the four footers.

In November, we're going to apply these concepts, and we're going to use that research, and we're going to talk about how to do the work together. This is how to reach me. This is who I am. And I would love to take some questions-- if there are some?

PRESENTER: Thank you. We do have some questions.

JILL A. JOHNSON-YOUNG: OK.

PRESENTER: Well the first one is, what are ways to increase impactful leading for a group leader who is not a suicide loss survivor?

JILL A. JOHNSON-YOUNG: To do an actual suicide survivors group as are not-suicide survivor? Is that what I'm hearing?

PRESENTER: Yes, that's what I'm getting from it, yes.

JILL A. JOHNSON-YOUNG: OK, that's a trick. And that's going to take going to multiple trainings and being clear with the people in the group that you're not a suicide survivor, but you've been in these trainings and you've met with people and you're there to be there with them and hold that space.

But make sure they know that you've had training and that you're not going to provide judgment. And you're not going to ask them what they didn't do or how they didn't notice that someone was suicidal. Because that's what they're looking for.

PRESENTER: Excellent, thank you. The next question is, I want to self-educate with death and grief to be a better support, what are some resources or books that you can recommend?

JILL A. JOHNSON-YOUNG: I would go to-- in terms of educating yourself about death, I would go first of all to NHPCO, National Hospice and Palliative Care Organization. I like the last lecture by Randy Potts-- Poltz. I like the original Kubler-Ross book because that really was just talking about the dying process. And I also like just going into groups where people are talking about their loss experience and the death experience.

I would recommend going to some hospice trainings and finding a training program that we'll talk about, in-depth, the dying process. Because you really need to know it. You need to know what happens a month out, three weeks out, the day before, the things that can go wrong, you need to know that stuff so you can help people who are struggling with it.

I think the grief process, I would recommend The Grief Recovery Handbook. And then I also have a guided workbook that could be helpful sometimes. I'm not trying to sell my own stuff, but it's the process I use.

PRESENTER: And I just want to take a quick second to draw people's attention to the evaluation information. As we're taking questions, please take a minute to go, either use the link or you can put your phone up to the QR code so that you can fill out an evaluation for this amazing presentation.

JILL A. JOHNSON-YOUNG: Thank you for the comments, guys.

PRESENTER: Sure. Do you believe in CBT for grief as a therapeutic modality for grief?

JILL A. JOHNSON-YOUNG: To some extent because people have their own thoughts in their head about what grief is supposed to be and they tell themselves that they're doing it wrong. So for that sense, I do. And I also use it to help them counter what they are hearing from other people who are trying to take over their grief process.

There's a whole lot of trying to protect the griever that goes on which violates the boundaries the griever needs to be building so they can rebuild their life themselves. And they need to know how to navigate that. And CBT is really good with that.

PRESENTER: Great, great. How do you introduce personal lived experience to the client? What kind of words do you use?

JILL A. JOHNSON-YOUNG: To some extent, I'm in a better place for that because I am so public. But what I used to do back in the day was when they would talk about grief and they-- grievers will call and say, are you good with grief, I would say, I've been widowed twice. And it's not about my loss, but I have walked that. And I've also worked for hospice so I've been with lots of families during the dying process. I understand it.

I don't understand what you've been through because yours is unique. And it was your loved one. But I have walked the walk and I'm here for you. And then I shut up and let them talk.

PRESENTER: Excellent. Do you offer additional training for psychotherapists to expand their knowledge for working with clients experiencing grief?

JILL A. JOHNSON-YOUNG: As a matter of fact I do. If you go to my website, which is jilljohnsonyoung.com, who knew social workers could be a .com. It's a weird feeling, I've got to tell you. There are some trainings on there that are coming up pretty quick.

PRESENTER: Excellent. You may have mentioned this, but is your dog therapy trained? Any recommendations for the type of dog that would be best? And if you know any financial or other resources to obtain a therapy dog?

JILL A. JOHNSON-YOUNG: Our dogs that we take to the office, Fred is not one of them because Fred is too much puppy. That's why he's up and down a lot, because he's only about four. And he's the kind of dog who breaks into our swimming pool to do laps, so he's not a good office dog.

The dogs we bring to the office, like Walter, have not been through specific training. But they are all poodles or poodle breeds because they don't shed and they have no allergens. You need to have a dog that's not going to set off allergies for people.

And you need to have more on your website so people know that they're there so they're not caught off guard. And if you're in a group practice, they need to have their page so people can find them. Our dogs have their own page on our CCS website.

And they're all seniors. We adopt senior poodles so that A, they get a home, and B, they go to work with us. Better for them, and clients do well with senior dogs because they're calm, and they just sit and pet. And poodles tend to be very intelligent and intuitive. So, yeah, It's yay for senior dog rescues is right, Loretta.

So when Fuzzy was alive, Fuzzy died at 17 last year, when Fuzzy was alive, she sat on my couch. In her really older years, she sat on a heating pad on a blanket on her little fuzzy throne. And when someone was crying, she would get up without prompting and walk across the couch and sort of throw herself against the client. She had bad legs. And would just settle, and the client would just automatically start doing this.

There are people who do training for therapy dogs. You can find them online. We have a local trainer here in Southern California who does that training. And if you jump on my website, there are some pet loss things on there that have some trainers on them. Or you can email me and I'll hook you up.

PRESENTER: Great, thank you. How do you maintain hope as someone who's experienced grief and loss on a regular basis in your professional life in addition to your personal life? To put it differently, what are some recommendations for self-care for therapists in grief work?

JILL A. JOHNSON-YOUNG: What I do every time I finish a session is I make sure I finish on time and I go outside and I do get the sunshine because we know that vitamin D changes our brain. I make sure that I have a journal of success. So when I have moments where I've done really good work, I can write it down and I can look at that on the hard days.

Because I do have some hard days. I have clients I'm preparing for deaths, and preparing for deaths of their children right now. Those are hard days. Bar none, those are hard days. So I look back and go, OK, there's a reason I'm doing this, there really is.

And I exercise. I swim. I take my vitamins. If I'm tired, I drink a lot of coffee. Today, I've had way too much coffee. And before I start the day, I put on some really happy, peppy music which has nothing to do with death and dying. So if you see me present in person, you will hear me playing, What

Doesn't Kill You Makes You Stronger as I walk up to the stage usually, because it gets people's attention and it's got a bounce to it. It's all the take care of.

I worked through the deaths of both of my wives. And it's doable, you just have to keep the boundaries, and you have to take care of yourself. And you have to have a good support team.

PRESENTER: Thank you. A question is, I know you mentioned it's very important to just listen, but what if our client is being quiet and does not want to talk. How do you approach that?

JILL A. JOHNSON-YOUNG: I use it therapeutically. You're being super quiet today, can you help me understand what's going on in your head? And I do that therapeutic head tilt, right? The teach us in MSW school, therapeutic heal tilt.

Can you tell me what's going on in your head? What you were dreaming about this week. Just tell me about your week a little bit and let's get where you are right now. Usually, it opens them up.

And then I also offer, if the session is too much today, we can reschedule to a day you're feeling more like you can be here. Because sometimes, people can't. At the end of every session, I check in. Did this feels safe? Did this feel comfortable? Is there something we could do differently next time?

And when I send them homework, I make sure the homework fit what they were doing and that it didn't overwhelm them.

PRESENTER: Excellent. How do you include people who died into the holidays? You talked about that earlier.

JILL A. JOHNSON-YOUNG: We talk about how to include them in Thanksgiving. Most families do something at Thanksgiving where they go around the table and share something they are thankful for. I'm sure someone's positioned in that family to talk about being thankful for the life of the person who died and for being able to be present for their death. And to do it in a positive way.

When it comes to Christmas, the month before Christmas, in our office, when we're in office, and I'll do it online this year, there's Christmas ornaments, or little menorahs, and/or little blankets, and we make memory somethings. So we put the picture on it we. Write a happy memory, a funny memory, tends to be more towards the humorous.

I talk about the ornaments I have on my tree. Because with all the pets and people we've had die in our lives, our Christmas tree is about 50% memorial. But it's fun memorial. I have a picture on there in a frame of my first wife that

she absolutely hated. That is her picture on the tree because I know she would've laughed and she would've hated it at the same time. We prepare people for it.

I also refer them to a Facebook group run by the woman who does Life As a Morticians Wife. If you go to Life As a morticians Wife on Facebook, she has a second one about holidays. It's for people who are preparing for holidays who've had a death. She and I have become good friends. She's really good with helping people with grief because her husband is a mortician.

PRESENTER: Excellent.

JILL A. JOHNSON-YOUNG: Mm-hmm.

PRESENTER: I have one, I am a teacher that is distance-learning with fourth graders on the Navajo Nation. Many have lost family members to COVID. What would be a good initial acknowledgment of that?

JILL A. JOHNSON-YOUNG: I would ask them who they're missing. And I would make sure that I'm careful with making sure I'm using Navajo belief systems because they are very different from some of the rest of the belief systems that we have in this country.

I would make sure that I would ask them if they've been able to have any kind of recognition ceremony. And then ask them if that's something they might need. Should we plan on something so we can do a circle together? In the Navajo Nation, there are circle ceremonies. And we can't light candles because we have fires.

But something where she can do that, she or he, can do something to help the kids recognize who's lost loved ones and to bring them into the present. And I'd make sure that I was remembering those names or those titles and referencing them. So if that child gets an award, you say, I bet your grandpa would be so proud of you and is watching over you. It makes all the difference. You've got to remember the names.

If you watch the movie Coco best message for kids for grief ever. And if you have a down day with your kids on the reservation, I would put Coco on. It's an investment. It's a different culture, but it talks about, as long as you say their names, they stay alive.

PRESENTER: Great, thank you.

JILL A. JOHNSON-YOUNG: Mm-hmm.

PRESENTER: We have a couple more. I am a licensed social worker and a medical social worker, and I've been through a lot of loss. I have found that talking and supporting others with loss, it has helped me heal as well. How do

you recommend beginning with coaching online? I just have no clue where to begin.

JILL A. JOHNSON-YOUNG: Coaching people yourself online or being coached online? I'm curious.

PRESENTER: I don't know.

JILL A. JOHNSON-YOUNG: You don't know, OK.

PRESENTER: It sounds like being a coach online. But I'm not sure.

JILL A. JOHNSON-YOUNG: I do a lot of coaching online, I do a lot of teaching online. I got to where I am now by digging in and doing a lot of work. I did a lot of small presentations for community groups, got to know the flavor of the community. Dug in deep and learned what therapist needed to be able to cope.

Because therapists are scared of grief and loss, and scared of death and dying. Just frankly, they don't teach in grad school. And a lot of people are not comfortable with it. General population, but therapist, too. And so, I made sure that I was hearing what people needed.

And then I speak to that. I write blogs. I have the books. You join the groups online that have the Facebook Groups online that are therapists who do grief. And if you want to do that, look up Debi Jenkins Frankle, D-E-B-I, Jenkins Frankle, she has a therapists who do grief online group.

PRESENTER: Thank you.

JILL A. JOHNSON-YOUNG: Mm-hmm.

PRESENTER: Have you worked with disaster survivors that have lost loved ones in disasters? Or any special recommendations for working within this scenario.

JILL A. JOHNSON-YOUNG: I have worked with people who have been mass disaster survivors, and I've worked with people who have been survivors of Las Vegas, and San Bernardino, and the San Fernando Valley shootings. So all of the above. And my wife has also spent 10 months in Louisiana during Katrina with the Disaster Mortuary Team.

With mass disasters, you spend a lot of time just listening, and you acknowledge how terrible it really was, and you let them talk about the fear. All the fear, all the stuff they didn't expect. What happened that you never saw coming. Not, how much did you respond, but what didn't you see coming, and what happened to your life, and where are you now, and what are you not settled with.

And with Las Vegas survivors, it was working on the sounds of the gunfire and the fact that someone next to them that they were there at the concert with was shot in front of them. Or having to find people at hospitals and notify family. We just started there and dug in deep.

And then you finally get to the, "What's left "unfinished? If you had to abandon Puerto Rico, what didn't you get to say goodbye to? What's still there that's still in your heart that you need to say goodbye to or finish? Who do you need to reach out to connect? What things aren't done? Because it's the things that aren't done that keep us grieving. I hope that helps.

PRESENTER: OK, unfortunately we have just time for one more question. And this one is a long one, so I'm not sure if we'll get through it, you'll be able to get through it. But--

JILL A. JOHNSON-YOUNG: They can email me too, but OK.

PRESENTER: Potentially, they can email you.

JILL A. JOHNSON-YOUNG: Yeah.

PRESENTER: I'm a substance use disorder counselor, but sometimes wear a grief counseling cap. How do I approach a dear friend that is in grief over the loss of her husband for three years? She's dysfunctional to the point of not living in her home alone, at times lived out of her car, and spent many nights with her sisters, isolating from family if she feels they don't understand. She's now living with a brother who has a mental disorder. And that is very challenging, and she's just distraught.

JILL A. JOHNSON-YOUNG: She's kind of a mess. Yeah, those are the folks who are not finished with that relationship. And so when I reach out to someone like that, usually they reach out to me, what I say is, we really need to dig in to what happened to the death of your loved one. And I use the "D" word all the time.

And we need to talk about what's left over so that we can get you into a place where you can inhabit your own space again. And you get to decide the rules. You can decide how you do it. But we got to get you into a safe space where you can let your head do the work and let your heart heal. And I appeal to them from that part.

I've been known to just send the workbook to people, too. Never a blank journal, because grievers don't like blank pages. But we got to get you to a space that's safe and nurturing because you can't say goodbye while you're still holding on. And something in that relationship is holding you in it.

You don't have to stay in grief to prove that you loved someone. You can finish the grief and still have loved them.

PRESENTER: Thank you.

JILL A. JOHNSON-YOUNG: Yeah.

PRESENTER: Our last question is, when does your new book come out? And what is the topic?

JILL A. JOHNSON-YOUNG: The new major book that's coming out is called The Rebellious Widow: Reclaiming Life And Love After A Loss. And it has some of my story. But mostly, it's actually task stuff for people who have been widowed. And it is written largely for widows because widowers are treated differently than widows are. But it talks about all the stuff we talked about here and we're going to talk about next time.

And then I also have a workbook coming out that will have a certification with it. So it will have, how to do an eight week solution-focused grief program online and in-person, and how to do a weekend retreat, Friday, Saturday, Sunday for grief with grieving clients that is also solution-focused. Because as you probably can tell from the way I've lived my life and the work that I've talked about here, I really think grief is a place where you do the work. And recovery is where you take your life and turn it into what you want it to be.

PRESENTER: Those are excellent words to leave this session on. Lou, I'm going to turn it back over to you for the next couple of minutes.

LOUIS KURTZ: OK, sure. Thank you very much, Jill. That was wonderful. I want to remind everybody that Jill will be back in November, so look for the email. We're excited about her return.

The next session will be up, the next and final session in about five minutes. And we're going to hear about listening and loving conversation with youth leaders about grief and healing.

JILL A. JOHNSON-YOUNG: Yay.

LOUIS KURTZ: Thank you all for joining us. And have a good day and a good weekend. Thank you, Jill.

JILL A. JOHNSON-YOUNG: Thank you.