United Methodists
of The California-Nevada Annual Conference

# Gathering of the Orders

January 20-22, 2015

# Emotional Resilience

Supporting Materials Packet

Presenters:
Rev. Catherine Noellert, MA, MFTI 60495
William M. Buchholtz, M.D.

catenoellert@gmail.com

# The Emotional Quadrilateral

Glad Cheerful
Jazzed
Pleased Light-hearted
Sunny Joyful Delighted

## HAPPY

Content
Bright
Feeling fine In love
Blithe Can't complain
Gratified
Gleeful
Playful Up

Somber Wistful Lonely
Grieving Low
Dismal Melancholy Heartbroken
Pensive Distressed

## SAD

Gloomy
Have the blues
Troubled
Lost
Discouraged Dejected
Alone
Miserable Aching

Put-out Frustrated Hot
Bitter Furious
Cross Fiery Fuming
Sore
Sulky Wrathful
Irked Out of sorts

## ANGRY

Irritable Huffy
Displeased
Stormy Annoyed Peeved
Disgruntled
Resentful Vexed
Aggravated Indignant

Anxious Fearful Worried
Nervous
Scared Cowed Timid
Suspicious Dismayed
Terrified
Spooked Apprehensive

## AFRAID

Bothered Tense
Fretful
Ill at ease Uneasy
Perturbed Concerned
Wary Alarmed

# Positive Factors in Emotional Resilience

1. Honest with self and appropriate others about your emotional life
2. Close relationships with family and friends
3. A positive view of yourself and confidence in your strengths and abilities
4. The ability to manage strong feelings and impulses
5. Good problem-solving and communication skills
6. Feeling in control
7. Seeking help and resources
8. Seeing yourself as resilient (rather than as a victim)
9. Coping with stress in healthy ways and avoiding harmful coping strategies, such as substance abuse
10. Helping others
11. Finding positive meaning in your life despite difficult or traumatic events
12. Successfully navigating conflict

# Coping Mechanisms

Less Helpful:
* Drinking/Substance Reliance
* "Stuffing" - numbing pain with food
* Sex*
* Exercise*
* Fantasy - books, TV, movies, video games
* Shopping
* Lashing out, defensiveness, bullying
* Isolating, stone-walling, going silent
* Forming a Drama Triangle
* People pleasing
* Obsessive behaviors - perfectionism, hyper-cleanliness, etc.

More Helpful:
* Journalling
* Prayer
* Appropriate levels of exercise*
* Honest conversation with a partner/close friend
* Crying
* Counseling/psychotherapy
* Scaling back responsibilities for a set time
* Going on retreat
* Finding a support group
* Sex*
* "Care-fronting"
* Give grace
* Physically caring for self - comfortable clothes, warm and nourishing food, haircut, massage

# Navigating Conflict

a few basic pointers

*Before engaging the conflict partner…*

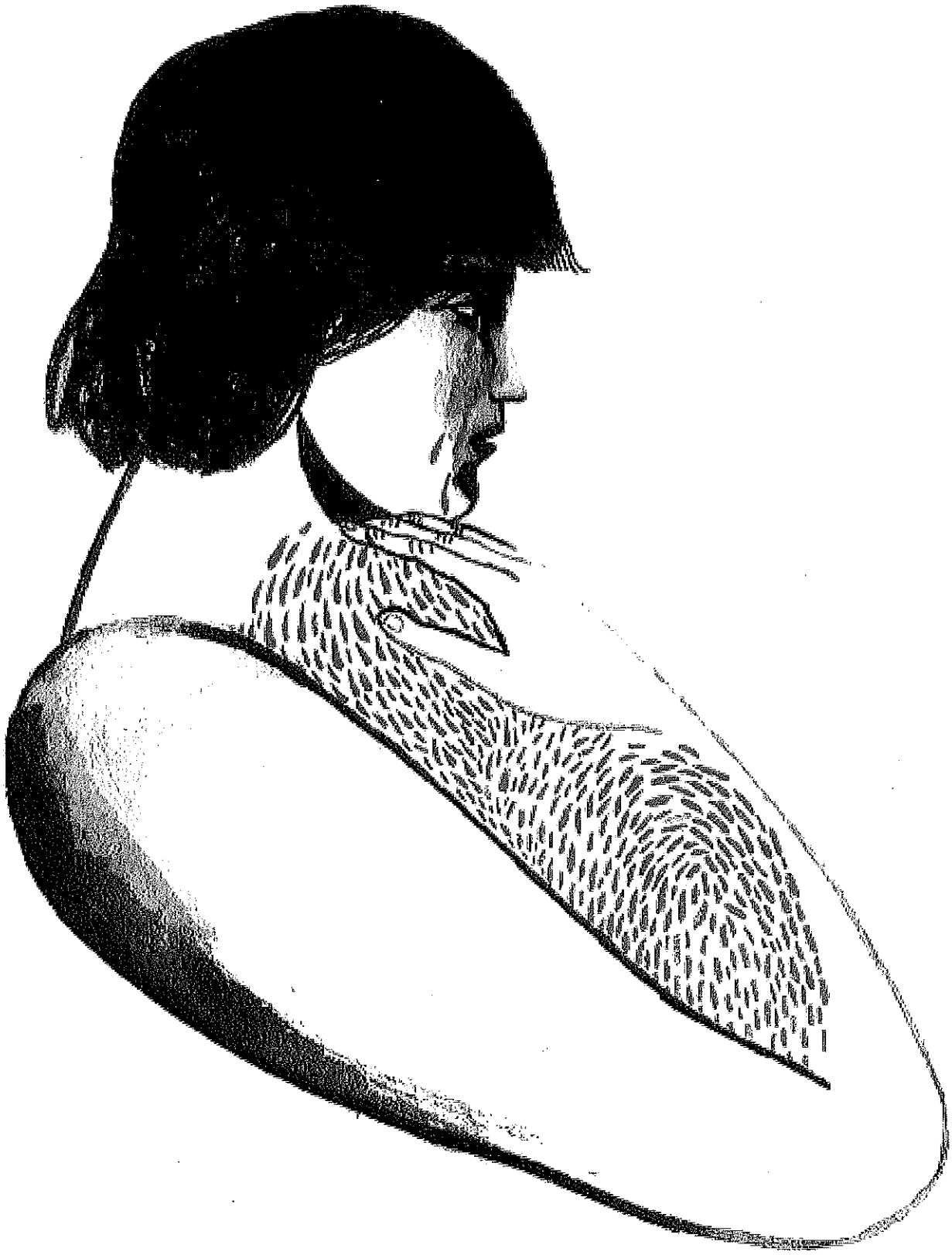
* Withdraw the projection - this person is just a person, like you.
* Identify a goal for the conversation
* Acknowledge that both of you probably have a part to play in the conflict
* Relinquish attachment to outcomes

*While engaging the conflict partner…*

* Use "I statements"
* Do not universalize - "you always; you never…"
* Speak the truth in as much love as you can muster
* Avoid sarcasm
* Acknowledge positives/give credit
* Do not concede more than you should; do not promise that which you do not want to give
* Summarize and reflect on any agreements made or progress
* Remember it's OK to leave the conversation unfinished
* Make a plan to return to the conversation if necessary

*After the conflict conversation…*

* Plan for time to take care of yourself in a calming way
* Do not go gossip about it to a mutual acquaintance/friend
* Be proud of yourself!



Credit
Arianna Vairo

# Getting Grief Right

By PATRICK O'MALLEY JANUARY 10, 2015 1:16 PM
January 10, 2015 1:16 pm

By the time Mary came to see me, six months after losing her daughter to sudden infant death syndrome, she had hired and fired two other therapists. She was trying to get her grief right.

Mary was a successful accountant, a driven person who was unaccustomed to being weighed down by sorrow. She was also well versed in the so-called stages of grief: denial, anger, bargaining, depression and acceptance. To her and so many others in our culture, that meant grief would be temporary and somewhat predictable, even with the enormity of her loss. She expected to be able to put it behind her and get on with her life.

To look at her, she already had done so. The mask she wore for the world was carefully constructed and effective. She seemed to epitomize what many people would call "doing really well," meaning someone who had experienced a loss but looked as if she was finished grieving. Within a few days of the death of her daughter she was back at work and seemed to function largely as before.

The truth of her life was something else. Six months after her baby's death she remained in deep despair. She was exhausted from acting better than she felt around co-workers, friends and family. As is so often the case, she had diagnosed her condition as being "stuck" in grief, believing that a stubborn depression was preventing her from achieving acceptance and closure.

Was she in denial, she wondered. She also wondered if she was appropriately angry. The bottom line was that she knew she was depressed — a psychiatrist had prescribed an antidepressant — and that is what she wanted me to treat.

Earlier in my practice, I would have zeroed in on that depression. Was there a family history? Had she been depressed before? Was the medicine helping? What were her specific symptoms? Knowing the answers might suggest why she was stuck. Or I would have reviewed the stages of grief, as she had, looking for one in which the work remained incomplete.

But I had begun to operate differently by the time Mary showed up, which was 10 years after my own loss. My firstborn child had also died before he was a year old. It was why Mary had chosen me.

In our first session I put Mary's depression aside. I asked her to tell me the story of her baby rather than describe the symptoms of her grief. Though she was resistant, she eventually started to talk.

Like most other things in Mary's life, the baby, whom she named Stephanie, was planned. Mary was delighted with her pregnancy and had wonderful dreams for her daughter. After a routine delivery, Mary stayed home with Stephanie for the first three months. Returning to work had been difficult, but Mary was comfortable with the child-care arrangement, and managed to balance motherhood with her busy professional schedule.

Then Mary told me about the Saturday when she went to check on her napping daughter and found that Stephanie wasn't breathing. She began C.P.R. as her husband called 911. There were moments of surreal focus as she and her husband tried to save their baby. Then this woman, so accustomed to being in control, had to surrender her daughter to an emergency crew. Her husband drove as they followed the ambulance to the hospital.

She described the waiting room in great detail, down to the color of the furniture. When the hospital chaplain walked in with the doctor she knew her baby was gone. She and her husband were taken into a room where they held the baby for the last time.

At this point in her story Mary finally began to weep, intensely so. She seemed surprised by the waves of emotion that washed over her. It was the first time since the death that the sadness had poured forth in that way. She said she had never told the story of her daughter from conception to death in one sitting.

"What is wrong with me?" she asked as she cried. "It has been almost seven months."

Very gently, using simple, nonclinical words, I suggested to Mary that there was nothing wrong with her. She was not depressed or stuck or wrong. She was just very sad, consumed by sorrow, but not because she was grieving incorrectly. The depth of her sadness was simply a measure of the love she had for her daughter.

A transformation occurred when she heard this. She continued to weep but the muscles in her face relaxed. I watched as months of pent-up emotions were released. She had spent most of her energy trying to figure out why she was behind in her grieving. She had buried her feelings and vowed to be strong because that's how a person was supposed to be.

Now, in my office, stages, self-diagnoses and societal expectations didn't matter. She was free to surrender to her sorrow. As she did, the deep bond with her little girl

was rekindled. Her loss was now part of her story, one to claim and cherish, not a painful event to try to put in the past.

I had gone through the same process after the loss of my son. I was in my second year of practice when he died, and I subsequently had many grieving patients referred to me. The problem in those early days was that my grief training was not helping either my patients or me. When I was trained, in the late 1970s, the stages of grief were the standard by which a grieving person's progress was assessed.

THAT model is still deeply and rigidly embedded in our cultural consciousness and psychological language. It inspires much self-diagnosis and self-criticism among the aggrieved. This is compounded by the often subtle and well-meaning judgment of the surrounding community. A person is to grieve for only so long and with so much intensity.

To be sure, some people who come to see me exhibit serious, diagnosable symptoms that require treatment. Many, however, seek help only because they and the people around them believe that time is up on their grief. The truth is that grief is as unique as a fingerprint, conforms to no timetable or societal expectation.

Based on my own and my patients' experiences, I now like to say that the story of loss has three "chapters." Chapter 1 has to do with attachment: the strength of the bond with the person who has been lost. Understanding the relationship between degree of attachment and intensity of grief brings great relief for most patients. I often tell them that the size of their grief corresponds to the depth of their love.

Chapter 2 is the death event itself. This is often the moment when the person experiencing the loss begins to question his sanity, particularly when the death is premature and traumatic. Mary had prided herself on her ability to stay in control in difficult times. The profound emotional chaos of her baby's death made her feel crazy. As soon as she was able, she resisted the craziness and shut down the natural pain and suffering.

Chapter 3 is the long road that begins after the last casserole dish is picked up — when the outside world stops grieving with you. Mary wanted to reassure her family, friends and herself that she was on the fast track to closure. This was exhausting. What she really needed was to let herself sink into her sadness, accept it.

When I suggested a support group, Mary rejected the idea. But I insisted. She later described the relief she felt in the presence of other bereaved parents, in a place where no acting was required. It was a place where people understood that they didn't really want to achieve closure after all. To do so would be to lose a piece of a sacred bond.

"All sorrows can be borne if you put them in a story or tell a story about them," said the writer Isak Dinesen. When loss is a story, there is no right or wrong way to grieve. There is no pressure to move on. There is no shame in intensity or duration. Sadness, regret, confusion, yearning and all the experiences of grief become part of the narrative of love for the one who died.

Patrick O'Malley is a psychotherapist in Fort Worth.

This is an essay from Couch, a series about psychotherapy at nytimes.com/opinionator. Some details have been altered to protect patient privacy.

## *Worden's Tasks of Grief*

William Worden created a theory called "Tasks of Grief" which are the experiences that we go through after the death of someone we care about. Though it may be logical for a person to go through these tasks in the following order, it is also very normal to be in the midst of a few of them at once. These are not "stages" we go through like climbing steps; they are more like a project list at work - you might be wholly invested in just one project on one day and be working on several another day.

1. To accept the reality of the Loss: this means knowing that the deceased person is no longer alive and won't be part of our everyday lives.

2. To experience the pain of Grief: this means that we may experience a variety of intense feelings and begin to work through them as part of the grieving process (eg: we can't avoid these feelings forever- at some point we need to face our grief).

3. To adjust to the new environment where the deceased person is missing: this is the part where we struggle with all of the changes that happen as a result of the person being gone- including all of the practical parts of daily living (eg: more responsibilities at home if it is a parent who died) and all of the effects their loss has upon our sense of who we are and how we see the world
(eg: suddenly feeling like "Life is not fair" or being frustrated with friends who "don't understand us anymore").

4. To reinvest energy in life, loosen ties to the deceased and forge a new type of relationship with them based on memory, spirit and love: This means that we begin to acknowledge the value of the relationship we had with the person who died and everything we may have learned or loved or respected or disagreed with about them. We recognize that we don't need to 'forget' them and that it is okay to care and connect with other people and continue to live our lives even though we miss them.

# Grief Misbeliefs

1. It should end relatively quickly.
2. Feeling grief means something is wrong with you.
3. "Normal" existence means feeling happy.
4. Replacing what is lost will help.
5. Grieve alone.
6. Time will heal the pain of loss.
7. It is appropriate (and even commendable) to ignore your own pain of loss in favor of being strong for others.
8. Keep busy.

# Common Responses from Others to Grief

1. Intellectualize it:
   "This too shall pass"
   "She lived a full life"
   "Be grateful you still have _____."
   "It could have been worse."

2. Changing the subject.
3. Not really listening/hearing.
4. Trying to fix.
5. Displaying obvious discomfort, which implicitly asks us to take care of them.
6. Replacing feelings with faith.

# Loss History Graph: Personal