Grief Calls for Presence, Not Treatment: Using Attachment and IPNB to Shift Grief's Context From Pathology to Acceptance

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Not to make loss beautiful,
But to make loss the place
Where beauty starts. Where
the heart understands
For the first time
The nature of its journey.

— Gregory Orr,
in *Concerning The Book That Is the Body Of The Beloved*

Inevitably, we're all going to die. This means that we therapists will likely sit across from a patient who is grieving the loss of a loved one. From both sides of the consulting room, I have learned that the key to rebuilding life after the loss of someone dear is for grieving people to have the unwavering, fearless support of at least one important person who can bear to be with them with acceptance while they grieve. However, accurate information about working with grief from a perspective of nonjudgmental acceptance is almost impossible to find.

Interpersonal neurobiology helps us understand that "our ability to tolerate a given state—such as sadness or fear, connection or isolation—will depend on the internal and external *contexts* in which we find ourselves" (Siegel, 2012). Yet prevailing professional grief literature has a tendency to either push for prescriptive grief work or praise lack of symptoms, while pathologizing grief that falls outside some specified norm (Bonanno, 2009; McGilchrist, 2009, 2012; Worden, 2009). Unfortunately, this can create an evaluative and judgmental context for grief. This prescriptive view of grief abandons grievers to shame and isolation precisely when they need acceptance and accompaniment.

The connection and steadfastness required to truly help with grief can be challenging for therapists to offer when their professional context for grief is evaluative and diagnostic. The emotions associated with grief can be so intense that people find them frightening, confusing, or overwhelming. We need connection and nonjudgmental interpersonal help—*especially* when we are feeling afraid or in pain—to return to safety, to feel comforted, and to manage emotions that feel unbearable (Badenoch, 2011; Fosha, 2000; Porges, 2011; Schore, 2012; Siegel, 1999, 2012). This article draws on interpersonal neurobiology and attachment theory to give therapists solid footing in a reassuring, accepting, nonjudgmental context for grief that will help to hold grieving patients with the curiosity, care, and companionship that promote connection, healing, growth, and the eventual emergence of meaning.

Grief as a Disease: The Traditional Context for Grief

The model we choose to use to understand something
determines what we find.

— Iain McGilchrist,
in *The Master and his Emissary*, p. 97

Grief, like every emotional experience, occurs in a context that supports feelings of connection or isolation (Siegel, 2012). At the very least, each loss is embedded in an external context that includes culture, family history, and current social connections; and an internal context that includes temperament, physiology, and attachment experiences. However, awareness of and respect for individual differences and how they influence the experience of grief can be hard to come by in Western culture where rituals of mourning are scarce and traditional diagnostic ideas about grief abound, creating a harsh and hurtful atmosphere for grieving.

Western Culture's Left-Brained Context for Grief

Almost all of my grieving patients complain of feeling isolated by the culture's general discomfort with their very presence (Bowlby, 1980; Gilbert, 2006; Janoff-Bulman, 1992; Jordan, 2005; Ossefort-Russell, 2011). This culture-wide discomfort with loss emerges from what Iain McGilchrist (2009, 2012) observes to be Western culture's strong preference for left-brain over right-brain perspectives. In general, the left hemisphere focuses on right and wrong, narrows things down to a certainty, generalizes, and values happiness and productivity. In counterpoint, the right hemisphere is without preconception in the service of exploration, opens to possibility, remains truer to each unique embodied instance, and values meaning. Perhaps most importantly, our in-the-moment experience of connection arises in the right hemisphere (although, as with just about everything we experience, uses circuitry in both hemispheres). These differences between right and left modes are "not different ways of *thinking about* the world: they are different ways of *being in* the world" (2009, p. 31), and they profoundly affect attitudes toward difficult emotions, such as grief.

Left-brain bias in our culture is apparent in society's clear push toward and valuing of productivity, happiness, and achievement above all else; toward youth and strength over age and wisdom. There is a right way to feel (good), and a wrong way to feel (bad); there is a right way to age (with grace), and a wrong way to age (with decline). These attitudes predominate in Western life, even when nothing unusual occurs. What happens when death, trauma, or accidents come into play?

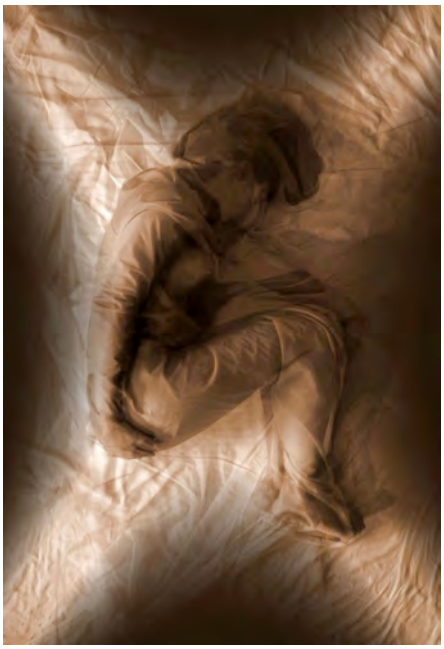
Ultimately unpredictable yet unavoidable, death, illness, and accidents profoundly trouble the left hemisphere (McGilchrist, 2009), the viewpoint that attaches vital importance to being in control, and that is highly intolerant of uncertainty. Death is uncontrollable. In response to death, grief is messy. Grief doesn't follow rules. Grief is different for each person. And grief is a more painful, confusing, and unmanageable emotion than most people have ever encountered. When overwhelming emotions come, we may unconsciously shift into a left perspective to lessen this fear and confusion, particularly in a society that gives so much support for that shift.

> Death is not usually regarded in contemporary Western culture as a teacher with whom to spend time, but rather as a looming biological and even moral failure to be denied and avoided. We do not hold a collective view of death as redemptive or liberating, but see it as an enemy to be beaten or, at best, a bad situation to be endured. (Halifax, 2008, p. 48)

Our left-brained culture largely sidesteps the painful and frightening reality of these uncertain experiences by pushing people to "get over" their grief and return to being productive, by praising people who don't have "symptoms," and by packaging grief work into definable tasks. Those who don't fit these left-brained demands are often criticized, ostracized, or diagnosed (Bowlby, 1980; Gilbert, 2006; Halifax, 2008; Ossefort, 2000; Ossefort-Russell, 2010).

The Mental Health Profession Follows Culture to the Left Hemisphere

The mental health profession's clinical context for grief is tightly tied to the culture's left-brain coattails. Because bereavement is a problem that cannot be solved, therapy with people who are grieving is considered to be a different kind of work than "regular" therapy. Even though many of today's attachment-based experiential modalities are moving away from left-brained, problem-solving styles (Badenoch, 2011; Fosha, 2000; Siegel, 2012; Schore, 2012), mainstream therapy still seems to assume an upward-moving trajectory from presenting problem to feeling better. Grief instead demands that we go down and through to get to transformation, not up and out. Hence grief is seen as something *other,* something that requires specialized knowledge.



Sadly, many therapies that claim to specialize in treating grief support the culture's judgmental grief context, actively promoting left hemispheric values of happiness, productivity, certainty, and right vs. wrong. Bereavement resiliency research identifies resilient bereaved people as "those who had no signs of depression at any point before or after the spouse's death and almost no grief at any point during bereavement" (Bonanno, 2009, p. 70); and deems the purpose of grief to be "helping us accept and accommodate losses relatively quickly so that we can continue to live productive lives" (p. 8). At the opposite end of the spectrum are those who say that grief counseling must help people achieve definable "grief tasks" with "specific goals" that "it is essential that the grieving person address. . . in order to adapt to the loss" (Worden, 2009, p. 39). In this model, grief counseling is supposed to adhere to "certain principles and procedures" (p. 89) in order to be effective.

Additionally, all the specialized grief treatments, including the more open meaning-making therapies (Neimeyer et al., 2011), emphasize right and wrong ways to grieve, with wrong ways being diagnosable pathologies. When people show "grief reactions" outside the definition of resilience, their reactions are designated as "identifiable *psychological problems*," treated "the same way we treat all other emotional *disorders*" (Bonanno, 2009, p. 104, italics added). When grief processes deviate from the task model, grief is seen as "failed" (Worden, 2009, p. 127). And grief that is outside some generalized norm is labeled as exaggerated, abnormal, complicated, excessive in duration, too strong, or prolonged (Bonanno, Neimeyer, Worden). No wonder grievers tend to feel isolated, confused, and overwhelmed! They are not only feeling distressing emotions, they are also surrounded by a society of people, including helping professionals, who are uncomfortable with their pain and who are judging whether they are grieving "normally" or not.

Grief is an Intense Emotion: An Updated Context for Grief

Your grief for what you've lost lifts a mirror
up to where you're bravely working.

— Rumi,
in *The Essential Rumi*, translated by Coleman Barks

When we therapists view grief in this pathologizing context, patients can immediately sense that, even with us, their intense feelings are not welcome. Interpersonal neurobiology reveals that mirror neurons and resonance circuits cause us to mutually influence each other's neural firing and autonomic activation. The awareness of safety or danger enters through the viscera in the belly, below consciousness. Stephen Porges (2011) uses the word "neuroception" to distinguish this process from conscious perception. The viscera senses the intentionality of expression, gesture, and tone of voice of another, and responds with a sense of safety or threat (Porges, 2009, 2011). Consequently, if we view our patients' emotional experience as pathological, even implicitly, we increase their shame, decrease their feelings of safety, and exacerbate difficulties with distressing emotions by judging, rather than accepting, their already overwhelming experience (Badenoch, 2011, 2012; Schore, 2012; Siegel, 1999, 2012).

Imagine what a different neuroception would be evoked if therapists maintained awareness that grief, like death, is natural, organic, and unique to each person.

That's why the first step we need to take in truly helping grieving patients is to update and soften the context in which we hold grief in our minds and hearts. Imagine what a different neuroception would be evoked if therapists maintained awareness that grief, like death, is natural, organic, and unique to each person. Beginning to see death and grief as "part of a web of interconnections" (McGilchrist, 2012, Location 204) is an initial move toward a more useful grief perspective that relies on the right brain abilities to be open to and curious about uncertainties, to be true to each embodied instance of experience, and to be tender toward suffering (McGilchrist, 2012). Three facets of grief as a natural part of our human experience can strengthen this compassionate context: grief's inherent enormity, each individual's unique tolerance for strong emotions, and an attachment/interpersonal neurobiological view of what an adaptive response to overwhelming emotion might look like.

Grief's Inherent Enormity

Most people I encounter are astonished by grief's intensity and duration, and by the profound ways loss impacts functioning. Attachment theory and interpersonal neurobiology can help to explain why grief is so intense, and how such a big emotion can overwhelm us, which can begin to provide reassurance that this feared-to-be-unbearable anguish and out-of-the ordinary behavior is within the realm of what we'd expect to see, rather than something that should alarm us.

Why grief is intense: The anguish of attachment loss.

We enter the world with a vital need for attachment security from the "cradle to the grave" (Bowlby,1980; Fosha, 2000; Johnson, 2008; Karen, 1998; Lewis et al., 2000; Schore, 2012; Siegel, 1999). Our emotions, physiology, sense of well-being, and contact with our inner and outer worlds all depend in large part on the relationships we have with the people closest to us. While this necessity for attachment is hardwired into our

embodied neural system for survival, that same wiring leaves us vulnerable to devastating distress when we lose the very beings who regulate us and give our lives a sense of security and meaning.

The very fact that human adults "cannot be stable on their own—not should or shouldn't be, but *can't* be" (Lewis et al., 2000, p. 86), leads to profound emotional and physiological expressions of pain when someone we are deeply attached to is ripped away by death. We "spiral down into a somatic disarray" (p. 83), with ongoing interruption of connection causing "physiologic rhythms [to] decline into the painful unruliness of despair" (p. 85).

> There is a tendency to underestimate how intensely distressing and disabling loss usually is and for how long the distress, and often the disablement, commonly lasts. Conversely, there is a tendency to suppose that a normal healthy person can and should get over a bereavement not only fairly rapidly but also completely. (Bowlby, 1980, pp. 7-8)

Given that our attachments are so vital to us that the permanent loss of those whom we love affects us even at the deepest bodily level, it's not surprising that grief and the many emotions that accompany it are shockingly intense. Susan Johnson (2008) echoes Bowlby, saying that, "Losing connection with our loved one jeopardizes our sense of security. . . and leads to 'primal panic'" (p. 30). "To feel suddenly emotionally cut off from a partner, disconnected, is terrifying. . . [The] longing for emotional connection with our attachment figures is *the* emotional priority, overshadowing even the drive for food or sex" (p. 47). She is referring to a disconnection in the attachment relationship that comes from a "simple" emotional breach! Add the element of death, where the loss of attachment connection is *permanent*, where no amount of work or seeking or reaching out or understanding will restore the person to life, and feelings that are already described as "panic" and "terror" are magnified.

Seen through an attachment lens, then, the intensity of grief is a natural, biological phenomenon. Add to this lens an exploration of *how* our emotional systems respond to these enormous, feared to be unbearable emotions, and we deepen our understanding of the ways that grief can cause people to suffer, particularly when there is no societal context for holding that grief.

How intense emotion overwhelms: The window of tolerance.

When we lose an attachment figure, not only can bewildering, unanticipated emotions such as terror, helplessness, and despair crash in, but the overwhelming magnitude and unfamiliarity of the feelings themselves can stimulate an additional layer of fear and turmoil. Feelings that are so intrinsically painful can be "feared to be unbearable, . . . so big that they break through protective devices, . . . leaving us feeling helpless to avoid or stop [them] and powerless to get away from [them]" (Fosha, 2000, p. 80-81). In addition, these feelings can be the most intense, long-lasting emotions ever experienced in conscious awareness.

Interpersonal neurobiology (Badenoch, 2011, 2012; Ogden, et al 2006; Ogden, 2010; Porges, 2009, 2011; Siegel, 1999, 2012; Schore, 2012) explains the universality of emotions breaking through protective devices in terms of a "window of tolerance," which is a range in which various intensities of feeling can be experienced without disrupting our ability to think, feel, and behave effectively and also leave our ability to connect with others intact.

> Within the boundaries of the window of tolerance, the mind continues to function well. Outside these boundaries, function becomes impaired. . . . The width of the window of tolerance within a given individual may vary, depending upon the state of mind at a given time, the particular emotional valence, and the social context in which the emotion is being generated. (Siegel, 1999, p. 254).

From this view, any emotion that pushes people beyond their window of tolerance can cause difficulty with thinking, feeling, behaving, and connecting. Given that grief can generate distressing emotions and circumstantial disruptions that are intense in magnitude and painfulness, and that these emotions often encounter very little social acceptance, it makes sense that even people with wide windows of tolerance can be pushed outside their range into difficulties of all sorts.

Grief symptoms of extreme distress, such as insomnia, pounding heart, disorganized thoughts, crazy dreams, fear, anxious searching, and intrusive thoughts and memories can be seen as symptoms that emerge when people are pushed out of the top of the window of tolerance into a hyperarousal zone. The other extreme of grief symptoms, collapsing into numbness, extreme tiredness, shock, memory problems, dizziness, and appetite problems emerge when people are pushed outside the bottom of the window of tolerance into the hypoarousal zone. Seeing grief's symptoms as those that naturally emerge when overwhelming emotions exceed a person's window of tolerance, then, provides a reasonable, nonpathologizing, accepting container for holding our patients' grief.

Walking with people through grief when it is so debilitating and when it goes on and on can feel frightening, hopeless, or daunting to us therapists, too, leading us to want to turn to the left brain to label varieties of intensity and duration of grief as pathological. However, attachment and the window of tolerance give us a context for grief that helps us to understand not only grief's intensity and long duration, but also the difficulties with functioning that arise. Knowing that all these experiences can make sense in light of what it really means to lose an attachment figure can calm our own nervous systems, allowing us to be present, holding, curious, and calming.

Individual Varieties of Emotion Tolerance

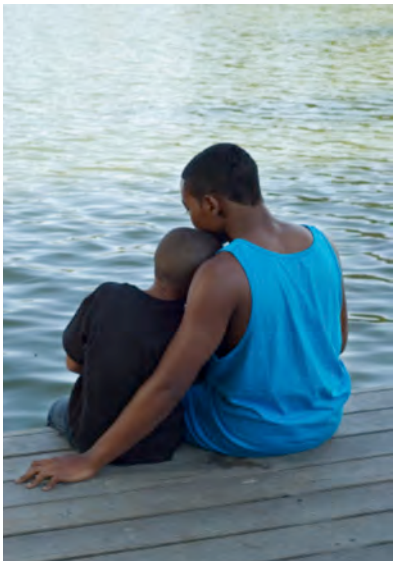
It should go without saying that everyone responds to loss in unique ways, and that all losses provide their own particular experience. However, this idea is crucial to integrating the right brain into grief's context, and often gets lost in generalized left-brained prescriptions for working with grief. Culture and clinicians evaluate grief responses, but these reactions are not generally *chosen*. Unconscious visceral experience and the emotional meaning of events, informed by current realities, implicit embodied learning from the past, and current level of support are what determine the width of a window of tolerance at any given moment, i.e. how easy or overwhelming an experience feels to an individual. People are affected *differentially* by events. We cannot tell from the outside what an individual's response to loss *should* be (Ecker et al., 2012; Porges, 2011).

These differential visceral responses are informed by a multitude of factors. Each grieving patient is an incomparable individual with idiosyncratic ways of tolerating and adapting to distressing emotions, with widely varying abilities to creatively adapt to new and painful life conditions, and with very different support systems (Janoff-Bulman, 1992). Windows of tolerance are also determined and influenced by temperament, experiential history, and present physiological and emotional conditions and states of mind (Siegel, 1999, 2012). These differences influence windows of tolerance for emotions in general and for intense emotions especially, so it is crucial to honor these differences and respectfully meet them as they are. We need to be curious about how an individual's experience of grief might be affected *at least* by personality, relationship to the lost person, attachment and cultural history, and current level of grief support (Bowlby, 1980; Gilbert, 2006; Hagman, 2001; Janoff-Bulman, 1992; Jordan, 2005; Neimeyer, 2001).

Certainly some people struggle with grief more than others, and some show more distressing symptoms than others. However, in no other problem that people bring to our offices would we assume that the patient's past or current relationships would have no bearing on their suffering. Viewing grief struggles within a context of *uniqueness* opens us to exploration of how grief, just as any other life difficulty, intersects with personal psychodynamic and social issues.

An Adaptive View of Emotion Tolerance and Response

When emotional wounds from psychodynamic histories add to or exacerbate grief and narrow windows of tolerance, it is helpful to remember that the attachment system is hardwired to make the best adaptation possible to our early childhood environments. These best efforts to ensure emotional survival and restore feelings of safety become embedded into instinctual, implicit responses to emotional situations (Badenoch, 2012; Fosha, 2000; Siegel, 1999).



> The brain is working as evolution apparently shaped it to do when, decades after the formation of such emotional knowledge, this tacit knowledge is triggered in response to current perceptual cues and launches behaviors and emotions according to the original adaptive learning. Such faithful retriggering is, in fact, proper functioning of the brain's emotional learning centers, not a faulty condition of disorder or dysregulation. (Ecker et al., p. 8)

This "faithful retriggering" view applied to difficult responses to grief means that when we see our patients struggling with grief and its sequelae, we can be curious about what kinds of historical attachment adaptations might be emerging under the present day threat of being swamped by big emotions. If we greet overwhelming symptoms or apparent lack of suffering with diagnoses or evaluation, we become part of the wider cultural problem of abandoning grievers in a prescribed, rigid, left-brained wasteland, where fear magnifies and shame grows. If we can instead hold the view of our patients as adaptively responding to intense emotions based on internal and external experiences in the past and present, we have an unparalleled opportunity to create safety that can not only help people heal and grow through loss, but can also heal old implicit wounds that stunt or amplify grief.

Conclusion: Summary of a Compassionate Context for Grief

Our updated, safety-engendering context for grief, then, includes:

- respect for how intense and long-lasting the normal pain of losing an attachment figure commonly is;
- knowledge that grief's intense emotions naturally push people beyond their windows of tolerance, which causes understandable difficulties with thinking, feeling, functioning, and connecting;
- understanding that each person's response to grief is unique, arising out of countless personal factors—social and internal, past and present;
- recognition that when old emotional wounds affect responses to grief, these responses represent normal functioning of the brain's emotional learning, not pathology; and
- the emergence of these wounds presents an opportunity for multiple layers of healing.

Within this updated context, we can move away from the pathologizing attitude of predetermining how people *should* respond to grief, and instead welcome grieving people as individuals responding to specific losses of unique loved ones in singular ways.

I hope this right-brain context for the emotions of grief offers some assurance, solid footing, and encouragement for therapists who are generous enough to do real work with grief. When we therapists are willing to do the work on ourselves that will carve out the capacity to be fully present with and accepting of the level of suffering that loss creates, the help we provide can be appreciated more than anything we've ever offered before. The societal void we fill is a huge one; the community need is great; and the rewards for both therapist and patient are profound.

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