Individuals Grieve: AEDP as an Effective Approach for Grief as a Personal Process

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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

Let's face it. Every one of us is mortal, and every one of us will lose a loved one at some point in our lives. So it's almost inevitable that sooner or later every clinician will encounter a patient who is facing grief of one sort or another.

Unfortunately, Western culture seems to be averse to supporting the grief process in all of its difficulty. One of the main complaints I hear from my bereaved patients and that I read about in the bereavement literature is about feeling isolated by the general culture's discomfort with their very presence (Bowlby, 1980; Gilbert, 2006; Janoff-Bulman, 1992; Jordan, 2005). Having been there, I don't romanticize grief, even though I know that when grieving people are supported they can be transformed and changed for the better. Grief can be frightening, overwhelming, confusing, and debilitating, so I can intellectually understand why our culture's impulse is to avoid grief, to talk people out of it, to praise people who are "strong" (i.e., not showing emotion), to package grief into tidy stages, to expect grief to last one year, to pathologize people who have a harder than average time with grief, and so on.

The flip side of this complaint is also true. Part of grief is continuing to live after loss, finding a way to function even in bereavement. Some patients complain that if they are going about their business and making it through grief in a way that works for them but that isn't very public, people tell them that they aren't doing enough "grief work."

What a bind! Grief is one of the most intense, "feared-to-be-unbearable" emotions, in that it is "intrinsically painful and too much to bear;" and it "threatens to overwhelm [the] integrity of self" (Fosha, 2000, p. 80). Yet because of these very attributes, grief very often "elicits negative responses from the individual's emotional environment," responses which push the griever into isolation, beginning or furthering a negative spiral of unbearableness of emotion.

To counter the isolation that many grievers feel, and to provide information critical to facilitating the processing of grief to completion, I'll begin this paper by demystifying the ways that each individual grieves uniquely. Though grief is universal, each person brings his own history, and a different kind of community to the table when she loses a specific loved one in a specific way. All of these factors impact the grief process and influence therapeutic treatment.

Next, I'll illustrate through detailed case example how AEDP's focus on fostering security and providing dyadic assistance with overwhelming emotion helps grief to be borne; and how AEDP's privileging of moment-to-moment fluctuations in the unfolding experience in the therapy room (Fosha, 2010) allows for full exploration of grief in a very personalized way. By allowing for the emergence of unique patient characteristics, traumas, and emotions that influence how grief is manifested, rather than imposing an external map of grief onto the patient's experience, AEDP invites grief to open the door to a vast array of healing opportunities.

Grief Is Personal and Unique

Each patient who comes to us for help with grief is an incomparable individual with idiosyncratic ways of

tolerating and working with distressing emotions; with widely varying abilities to creatively adapt to new and painful life conditions; and with support systems all over the map in their effectiveness and presence (Janoff-Bulman, 1992). First and foremost, it is crucial that we as therapists honor these differences and hold each griever in the context of unique personality, relationship to the lost person, attachment and cultural history, and current level of grief support (Bowlby, 1980; Fraley & Shaver, 1999; Gilbert, 2006; Hagman, 2001; Janoff-Bulman, 1992; Jordan, 2005; Neimeyer, 2001b), rather than assuming that all people grieve in the same way.

To begin with, we must see beyond the myriad writings about the effort to distinguish between "normal" mourning and "disordered" or "pathological" mourning (Bowlby, 1980; Freud, 1961; Parkes, 1987), that imply that there is a specific way that grief is supposed to progress in order to be acceptable. More recently, the term being used to describe grief that is more painful or debilitating than the "normal grief reaction" is "complicated grief" (Mayo, 2010, Definition section, para 2). Though the intention of defining complicated grief is to help those who are in intense pain to get the help they need (Kersting, 2004), giving a label to a grief "condition" that people are "at risk of developing" (Harvard, 2006, Risk factors section, para 1) still places debilitating grief in the realm of something broken that needs to be fixed.

This Western obsession with diagnosing particularly intense grief often serves to fortify clinicians' defenses against their own fear in the scary realm of working with grief, given that the pathologizing position remains distant from the griever's pain, and allows crazy-looking manifestations to be labeled as other and sick. Yet this framework begins the abandonment of people who are experiencing a normal, though overwhelming and vehement, emotion (Fosha, 2000). I have yet to meet a human being who has lost a loved one who has benefited from some sort of labeling of the health or sickness of her grief process.

Western culture's fear of death and shunning of grief, showing up in this distancing way, causes many grieving people to feel terribly alone at their most vulnerable time of need. According to AEDP (Fosha, 2000), psychopathology originates in being left alone with big emotions. Whether or not someone has preexisting difficulty with big emotions, grief is enormous, and a focus on diagnostics and labels rather than on being close-in to help is certain to leave people alone with one of the biggest emotions that exists. If people didn't have difficulties with emotions before their loss, the way society treats them after a loss could cause new pathology that's not about a pathological grief response, but about being left alone with grief.

Certainly some people struggle with grief more than others. Certainly people with preexisting trauma or difficulties in handling emotions might run up against horrific breakdown when grief pounds down on them. Certainly some people shut down in grief or have trouble functioning after loss. All of these possible situations can occur, and people may seek our help with these issues, or we may recognize these issues emerging when people do come to us for help with grief. But rather than labeling the grief process itself as pathological, perhaps recognizing that in grief, just as in any other difficulty in living that people bring to our consulting rooms, the work intersects with the unique psychodynamic issues that exist in the griever's life at the point of the loss. 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 current complaint.

Some people won't want to explore psychodynamic issues, and will want help to cope with grief within the emotional limitations they bring with them to the process; agreeing to leave defenses in place and facilitate coping is probably very different from most other work we do. But some people, with help, may recognize and appreciate that "the greater the crisis, the greater the opportunity," that the intensity of the crisis that grief generates provides an unmatched opportunity to break down old defenses and relate to the world in a whole new way (Fosha, 2000, p. 189). This type of work can be an extremely rewarding, though a very painful kind of work to do, especially if we keep in mind that individual idiosyncratic responses to grief are generally colored in large part by the patient's life history, the type of loss, and the support systems available to the griever.

Life History. No matter what the feeling, enormously painful emotion challenges people's ways of coping

and ways of relating. Grief, being a more overwhelming emotion than many have experienced in the past, certainly provides such a challenge, even for the most secure and functional individuals. Psychodynamic factors such as attachment history, cultural history, and trauma history play into people's ability to regulate and express their emotions (Siegel, 1999, p. 245), and so will affect how they respond to the challenge of the loss of a loved one. Note that all areas below are merely examples of possible responses to loss. None of these categories or possible outcomes is meant to be a map, and the inquiry is not exhaustive. The exploration below simply scratches the surface of the vast array of variables that interact in any given person to impact the experience of grief.

Attachment history. People who have a history of avoidant attachment may tend to suppress loss-related thoughts, and might actually benefit from doing so if they do not want to explore their defenses and get beneath them, depending on the flexibility or inflexibility of their attachment style. Prodding people who cope according to this style, and who are functioning well and are not unhappy with the outcome of their grief, to proceed with deeper "grief work" can be more harmful than helpful (Fraley & Shaver, 1999, p. 755). However, people who have an avoidant attachment history and who are met with sincere, non-intrusive caring, *might* be willing to explore the deeper realms of their experience very slowly, and end up feeling grateful that help with their grief brought them into contact with an expanded emotional repertoire.

People with a history of more preoccupied attachment respond quite differently to the suppression of grief-related thoughts, and can actually experience a strong resurgence of attachment-related thoughts and feelings if they try to suppress them. If people who have a more preoccupied style, regardless of its intensity, were encouraged to sever ties with their lost loved ones, they would suffer, possibly intensely. These grievers, especially, often need help with establishing workable internal relationships with their dead loved ones (Fraley & Shaver, 1999, p. 755). They also often need help to find ways to express the intensity of their feelings of loss in ways that do not overwhelm them (i.e., help expressing yet regulating the feelings); and they have a deep need to know they are not overwhelming the therapist.

Another grief variable that can be influenced by attachment style is anger at the deceased person (Bowlby, 1980). From time to time, people who have a more preoccupied attachment style often feel intense anger at the person who left them, and sometimes they even feel anger at God or the universe for the unfairness of the loss. At times in their history, anger at the attachment figure for leaving was possibly helpful in keeping the figure close for a while. So anger at the lost attachment figure or at a deity who they believe might have some control over things makes sense to them on an unconscious level. People with a more avoidant style often learned early on in life that anger at the attachment figure made no difference, so anger at the person who left them in death might not even emerge. It's not even that they suppress the anger. It simply doesn't exist in their conscious awareness.

People who have at least some security in their attachment style, even if they lean one way or the other toward avoidant or preoccupied in nature, at times present a paradox (Calhoun & Tedeschi, 1999, 2001; Janoff-Bulman, 1992; Neimeyer, 2001b; Ossefort, 2000). When relatively secure people who have some social support (at least a good therapist) encounter a loss that is not traumatic in nature, they are often open to using the opportunity of the grief crisis to crack open their defenses, thereby learning to live more authentically. Likewise, when people who have some security and some social support encounter grief that emerges out of an untimely or traumatic loss, a type of loss that shatters their assumptions about the way the world works, they may be willing to seize the opportunity to not only crumble their defenses but to also allow their complete worldview to shatter. Having help to hold the enormity of this double dose of disintegration of an old self allows them to reintegrate into a self that is stronger, that lives more meaningfully, more authentically, more gratefully. The paradox in these paths is that what happens with these patients before our eyes is the breakdown and rebuilding from the ground up of an entire way of being a self. The pain inherent in this process is immense and long-lasting. However, it is important to recognize that this breakdown is a healthy one that needs witnessing, regulation, pacing, and holding, not preempting as one might need to do in the case of a dangerous self disintegration.

Cultural history. Another type of history that needs to be taken into account in grieving is cultural history. Some cultures—societal, geographical, or familial—are comfortable with and even demand loud

expressions of grief; some actively inhibit expressions of grief. Some provide huge amounts of social support; some retreat from grief. Some place strict time limits around grief; some are more individualistic. Some see therapy as healthy and helpful; some see therapy as only for the sick. In any case, helping the individual discern what kinds of cultural expectations he's been brought up with, and learning where he fits into those expectations: learning which ones help him and which ones hurt him, which ones can be shed, and which ones need to be adhered to can be very helpful and healing.

Trauma history. Grief can be especially difficult for trauma survivors, especially if the death is untimely or due to a traumatic event. People with trauma histories, especially unresolved trauma histories, often have more difficulty in general holding onto their internal organization when faced with upset, and more trouble with regulating their emotions (Fosha, 2000; Janoff-Bulman, 1992). Even lower intensity emotions can seem "overwhelming, threatening to undermine boundaries, identity, and sense of control. In these cases the self will try to curtail such emotion at any cost, in an effort to preserve some sense of identity and cohesion" (Fosha, p. 82). So when people who already have a hard time with less intense emotions are presented with grief, especially traumatic grief, they can have a very, very hard time, and the types of breakdown they might experience are not the healthy breakdowns discussed above. In these cases, when people are utterly overwhelmed by emotion, we need to intervene. If we can help regulate the griever's emotions until she can get hold of her self again, her self can survive, if not thrive. But left alone, this kind of overwhelm can be devastating to the self (p. 82).

However, some trauma survivors who have already experienced extreme life events, who have had their worldview shattered in the past, and who have done the emotional work it takes to heal and to establish a cohesive and secure sense of self and world, may be in less of a position to have their assumptions about life shattered when they encounter traumatic grief. "To the extent that the survivor has reestablished a stable, nonthreatening, integrated inner world, it is conceivable that the traumatic experience may itself serve as a psychological inoculation against future breakdown" (Janoff-Bulman, 1992, p. 90). These survivors would have already come to terms with some degree of personal vulnerability, and would have made it through the emotions that led to that kind of reintegration of self. Not that people who have achieved this kind of integration are immune from suffering. Far from it. They are in a position to have the strength and the tools to feel their emotions within a secure self that knows to seek support.

Another potential paradoxical situation can emerge out of the fact that people who do *not* have a history of trauma or a history of shattered assumptions, often started off with the most positive preexisting assumptions about the world's benignity, about their lack of vulnerability (Janoff-Bulman, 1992). An encounter with an untimely or traumatic death of a loved one for a person whose worldview has always been stable in this way can generate colossal upheaval and anxiety, as her inner picture of the world goes up in flames. Recognizing that this destruction of the inner assumptions about the world is what is happening along with grief can be very helpful in sorting through and regulating emotions.

Another way traumatic history can surprise us in the face of a traumatic loss is when a person has successfully tucked away the emotions associated with her childhood trauma in her unconscious memory in order to cope with and lead a highly functional life. The experience of adult trauma can suddenly crack open the long-contained emotions; "it is like a dam breaking," and the emotions that burst forth can overwhelm her system (Neborsky, 2003, p. 284). Even if the childhood trauma was a lifetime collection of smaller traumas, and not horrific abuse, the stuffed emotions that pour out can be immense. In this case, with proper help, though the pain is intense and can last a long time, with close-in support, this emergence of ancient emotion along with grief can offer an opportunity for healing that the patient didn't even know she needed.

Types of Loss. Many aspects of the particular loss itself contribute to an individual's experience with grief. The relationship the griever had with the lost person, whether the loss was untimely or traumatic, and the life phase of the griever at the time of loss all have profound impact on how intense their grief might be, and whether their grief process is complicated by secondary trauma (Bowlby, 1980; Janoff-Bulman, 1992; Neimeyer, 2001a, 2001b; Ossefort, 2000).

Relationship with the deceased. The relationship the griever had with the lost person has more influence on the intensity and duration of an individual's grief than just about anything else. In general, the closer the relationship, the more intense the grief; and the more complicated the close relationship, the more complicated the grief. Bowlby says that almost every example of extremely intense mourning is the result of the loss of an immediate family member—"a parent (or parent substitute), spouse, child; and occasionally a sibling or a grandparent" (1980, p. 174). He also notes that the relationship that preceded exceedingly painful grief almost always tended to be "exceptionally close" (p. 176). Sometimes people also create very close relationships beyond their immediate families, with friends or pets for example, that play vital roles in the griever's attachment system, and whose loss can generate the same level of grief pain as the loss of a close family member. The intensity of the grief is related to the closeness of and attachment needs filled by the relationship, not the name of the relationship.

So not surprisingly, the most painful relationships to lose are the relationships that are closest and thus meet crucial, wired-in attachment needs that exist as long as we're alive (Bowlby, 1980; Johnson, 2008). Loss of each of these close attachment relationships leaves a hole the shape of a specific attachment role. Loss of our roles as husband, wife, mother, father, daughter, son, brother, sister entails myriad different grief responses to be dealt with. Our human vulnerability to attachment needs is never so pronounced as it is in the loss of someone we are closely attached to.

Note that though attachment relationship loss tends to create the most pain, the suffering that comes from losses of other types of relationships is still remarkable and still needs support. *All* grief is painful. It's just that attachment grief can cause hugely distressing expressions that people have a hard time understanding, so normalizing the intensity of the reaction is important.

Traumatic vs. developmentally fitting loss. The complications of grief grow more numerous and more intense when a loss is traumatic. When a loss is experienced as part of the customary progression of life, e.g., when an older person who has lived a full life dies of natural causes, grief runs a less convoluted (though still painful) course than when the loss takes place out of the expected time-line, or comes about via something other than natural causes. Loss of a child, or loss of a spouse or parent when the spouse or parent is not elderly can be hugely devastating and traumatic. Loss, even of an older person, due to causes such as accident, suicide, or homicide can also bring about horrific secondary trauma. Loss due to terminal illness in a younger person can create similar secondary trauma.

People often don't realize that the untimely loss of a child or loss of a spouse or parent or any attachment figure can be so traumatic. When someone dies in an untimely way, the loss of the relationship in the here and now and in the past is complicated by the loss of the future (Ossefort, 2000). The loss of the future never fully dissipates, as the loved one is missing at all significant events for the rest of the griever's life. Though the absence of the lost loved one is felt to a greater or lesser degree over the years and at differently significant events, the absence never fully goes away.

Traumatic losses almost always involve the secondary difficulty of a shattered worldview (Janoff-Bulman, 1992). This kind of shattering adds immensely to the enormity of the emotions that go along with grief. In addition to losing a loved one, suddenly the entire world lacks meaning, nothing makes any sense, nothing is safe, and nothing is expectable.

When there isn't a perpetrator to blame for an unnatural or untimely death, such as a death due to accident or early disease, grievers are most apt to "turn to questions of meaning and the rules governing the universe. . . .[They] are confronted with a less-than-benign universe" (Janoff-Bulman, 1992, pp. 81-82), a sense of shaken vulnerability, anger, and fear. And these feelings are piled onto the grief they are already experiencing. This kind of shattering can be hugely unnerving and massively painful, and can take years of work to rebuild and transform.

Grievers who have lost a loved one to human-induced means may suddenly find themselves confronting "the existence of evil and questioning the trustworthiness of people. They experience humiliation and powerlessness and question their own role in the loss" (p. 78). They have experienced "interpersonal betrayal" (p. 82). When a person's loved one is also the death-inducer, as in the case of suicide, the

interpersonal betrayal is all the more poignant.

Life phase of the griever. Loss can be excessively painful as well if it occurs during a sensitive life phase of the bereaved (Ossefort, 2000). That is, when a treasured loved one on whom a person depends for security dies during an important life transition, the security of the griever is threatened. One of the extremely important needs an attachment figure fills is to provide a secure base from which we can launch into exploration of new life experiences (Bowlby, 1980). If the secure base we're depending on and leaning into (in the background, with certainty) dies as we're enthusiastically or cautiously moving into a new experience of life, such as a new school grade, leaving home for college, getting married, having a baby, moving to a new city, etc., a debilitating despondency can pervade and accompany grief.

Social Support. Whether we look at grief from a physiological, emotional, or cognitive perspective, one of the most important factors, if not *the* most important factor, in a grieving person's experience of grief is the helpfulness or unhelpfulness of the social support they receive (Bowlby, 1980; Calhoun & Tedeschi, 1999; Fosha, 2000; Hagman, 2001; Lewis et al., 2000; Neimeyer, 2001a, 2001b). Author after author and griever after griever confirms that when grievers are able to share their feelings in their own way and in their own time with people who are able to be helpful and comforting and understanding of the acceptance or rejection of their help, then they emerge from grief with more strength and confidence.

Bowlby (1980) says that those grievers with a "good outcome" almost always reported receiving help and comfort from immediate others, and few unhelpful interactions as they begin to express their feelings about the loss (pp. 193, 200). He goes on to say that the principal criterion for predicting an "unfavourable outcome" was a report by the griever of "unhelpful interventions by relatives and others and of needs that had gone unmet" (p. 195).

Not surprisingly, culture exerts a large impact on how supported people generally feel in response to their grief. Bowlby (p. 190) confirms, given that "beliefs and practices vary in many ways from culture to culture and religion to religion," that it makes sense that these beliefs and practices would "have an influence on the course of mourning," either promoting healthy mourning or contributing to difficulties with it. In my experience with my own grief and that of my friends, family, and patients, Western culture, with its fear of suffering and death, is overall a culture that contributes to *difficulty* with grief.

Fosha (2000) talks about how a person learns to "exclude all aspects of his experience that his caregiver cannot tolerate, hoping to preclude her turning away from and becoming unavailable to him" (pp. 39-40). Lewis et al. confirm that a caregiver's turning away is one of the most painful experiences there is. "Limbic regulation makes expulsion from the company of others the cruelest punishment human beings can devise. . . . Limbic regulation mandates interdependence for social mammals of all ages" (2000, p. 87). The Western attitude about death results in the culture being a caregiver that cannot tolerate the experience of grief, and so the culture hands down the "cruelest punishment" of turning away from, being unavailable to, and expelling these emotions from society.

Bowlby does say that strong evidence shows that "families, friends, and others" who *can* stay present, provide comfort, turn toward and not away can "play a leading part in assisting the mourning process" (p. 191), *even when the culture cannot.* This fact is the reason that our presence as therapists can be so crucial to grievers. Not only that, it's important to see that the social support our patients bring with them in their lives plays a big part in how their grief shows up in the room with us.

Do our patients have people in their lives who understand them, whom they can talk to about the loss if they want to talk, but who also understand and don't pressure them if they don't want to talk? If not, their need for the therapist will most likely be more intense; or their desire to push away the grief feelings might be the most prominent need they want to address. It's also important to realize that it's not just people who have a lack of social support in general in their lives who face a lack of support during grief. People with a full cadre of support for their lives in general often feel quite abandoned during times of grief if the people who have always been there for them suddenly don't want to hear about their suffering because of their own fears.

Does the *style* of support our patients have, whether it's religion, family, friends, other social groups, fit

with the needs of the patient? Some people take great comfort in their religious beliefs. Others begin to question everything they have ever believed, and resent that their religion is trying to tell them how to feel. These issues can very much add to or subtract from the intensity of the feelings of grief for a particular person.

By seeing how our grieving patients come into our consulting rooms not only full of feelings of grief, but also as individuals who bring their own unique histories, types of loss, and availability and experience of social support, the picture of working with grief expands. Grief, while sharing some universal qualities among all humans, looks different for everyone. These differences are to be expected, and are not necessarily pathological. Seen against the backdrop of a particular patient's cluster of life experiences, the craziest looking grief expressions can begin to make sense. Of course, horrific feelings that make sense still need tending and intervention. But when they make sense to us, we can be less afraid, and we can more easily find ways to comfort and regulate those very difficult feelings.

AEDP Elicits Personal Aspects of Grieving

The following case example illustrates how AEDP's undoing of aloneness, going beyond mirroring by actively offering help to the patient, processing emotion to completion, and exploration of receptive affective experiences (Fosha, 2003) all serve to facilitate the grieving of a patient who is struggling mightily against her intense feelings. And importantly, the privileging of moment-to-moment fluctuations in the unfolding experience between therapist and patient invites the uniqueness of *this* dyad, "each moment, to declare itself" (Fosha, 2010, Introduction section, para 2), and so allows for the emergence and healing of unique psychodynamic issues that this *particular* patient brings to the experience of her loss. The patient's identity has been disguised by omission and alteration of non-crucial information.

This perspective on working with grief is quite different from concluding that this patient's difficulty with a round of grief seven years after her daughter's death is complicated grief that needs closed-ended, scope-limited symptom management coaching (Kersting, 2004) or desensitization treatment (Harvard, 2006) to lessen her protracted feelings of loss. Instead, AEDP's focus on somatically rooted affective and relational phenomena that guide the clinical work moment to moment (Fosha, 2010) opens the door to healing not only this patient's grief, but also to attending to a deep and traumatic loneliness she has felt around big emotions for most of her life. The transformational cascade set in motion by *this* work is open-ended, expansive, and generative.

The Patient

The patient is a business executive whose only child died of a terminal illness at age 15, seven years prior to treatment. Prior to her daughter's contracting her illness, the patient's first husband suddenly left her for his high school sweetheart with whom he reunited during a high school reunion. During the aftermath of her divorce, and during her child's illness and subsequent death, the patient started a private business in her home state. The constancy of the business and its cadre of employees provided a stable base for her during the many tumultuous times she faced. After her daughter's death, the patient had felt permitted to cry a bit and to grieve for a few months, because that type of emotional expression was culturally allowed in her family. Following those few months, however, she engaged her normal coping routines of throwing herself into high functioning and high achievement in her work.

The patient remarried two years before her daughter's death, and about three years before coming to therapy, she and her husband moved to Texas for her husband's job. Following the move, she worked from home in Texas, while traveling at least twice a month to her home state to continue the business she had founded. Upon entrance into therapy, she was facing an opportunity to sell her business and relocate permanently to Texas. Leaving behind the secure base of her business, while feeling abandoned by her husband's preoccupation with his new job at this transitional time in her life, shook her to the core and startled her by resurrecting deep feelings of grief for her daughter. She came to therapy struggling with depression, overwhelm, and regular tearfulness, all quite uncharacteristic of her past experiences.

"A Glimmer, A Foundation"

We begin this session with the patient feeling tearful and overwhelmed by her feelings of depression that she just doesn't understand. She tells me about her fears of losing her identity if she leaves her business; we explore how much security and joy she felt in her work in the midst of turmoil in her life; she tells me about her sense of pride and accomplishment and *control when nothing else was controllable* that she gained from her work; she speaks of the aloneness she feels when her husband works all the time while she is frantic over her potential loss of her business, even though it will be a relief not to travel. All of this, then:

(*The patient closes her eyes, and is tearful and in distress*)

Patient: I've been working so hard to figure out *what is wrong with me!*

Therapist: What do you mean?

Pt: Why do I feel so *bad?!* And so *down?* And, you know, why has the joy gone out of me? …And I don't feel secure…Almost nowhere I feel secure right now. (*Tears up)*

Th: (*Feeling it with her)* I know. I know.

Pt: I don't feel secure at home.

Th: (*Whispered)* I know.

Pt: My relevance, naturally over three years [of working from long-distance], is diminished at work…

Th: (*Quietly, caring deeply)(***Normalizing the enormity of what she's feeling***)* So you ask why you feel so down, and it makes sense to me. It makes *sense* to me. That's a *big* statement you just made.

Pt: Do all people *need* security?

Th: Unequivocally—yes. (**Indulging her intellectual question in order to encourage self-acceptance of her own pain***)*

After this assurance that I think her distress makes sense, the patient enters into a push/pull exploration of the fear she feels about leaving her business, about the loneliness she feels while her husband is unable to be there for her in her time of distress, and a recollection of how much she leaned on the people at work when her daughter died, all the while moving back and forth from feeling into intellectualization. Finally she expresses that she feels utterly *weak* for being so emotional.

(The patient is once again tearful, sitting back, clearly in overwhelming distress)

Pt: It's terrible to be fragile, you know? Because…it's just terrible to have depression.

Th: (*Whispering, a question)* Yeah?

Pt: I'd rather have the flu…I'd rather have…[Sadness] is not seen as being sick. It's just seen as being *weak.*

Th: That's a big part of it, isn't it? (**Acknowledging that it's the judgment of her sadness as weak that's the problem, not the sadness itself***)*

Pt: (*Nods, tears up a bit. Then stops herself short)*

Th: (*Kindly)* Yeah. Ah… It's so hard to stay down there in those feelings, isn't it?

Pt: I *know* I'm not a weak person.

Th: *I* know you're not a weak person. You're nothing close to a weak person.

Pt: (*Intellectualizing)* And I *really* empathize with other people who struggle too.

Th: I know you do. Let's stay with your feelings. It's so hard to stay down there, isn't it? (**Acknowledging, but bypassing her defense***)*

Pt: Yeah, it is. (*Hands on her belly)*

Th: It's really hard. (**Acknowledging the difficulty, yet holding the focus on her body***)* What's happening in there [in her belly] while you're in it right now?

Pt: I have that gut-wrenching thing again.

Th: Oh…In your gut, huh? Yeah.

Pt: Just *tightening*…

Th: Yeah. That's the place where you have all those old messages about being weak. **(We've talked about this before)**

Pt: (*Nods)*

Th: Do you think *I* think you're weak? **(Bringing her awareness to *this* relationship, *this* moment, rather than her past experiences of being seen as weak for her feelings)**

Pt: (*Shakes head)*

Th: What's *that* like? To be here showing me this and knowing that I don't think it's weak? **(Holding the focus on the here and now)**

Pt: It's a glimmer. (*Huge sigh)*

This interaction between us frees her from judging herself as "weak," and so the old grief over her daughter—brought into the present by the threat of the loss of the secure base that has held her in place since the death—surges forward. She says that she feels lost, not knowing who she is since her daughter died, and she tears up. Her tears are richer, slower, deeper than the tearfulness earlier in the session. They are a manifestation of her core feelings of grief.

Th: Do you feel like I get it? **(Again, holding her focus on metaprocessing the here and now)**

Pt: (*Quietly)* Yeah.

Th: You sure?

Pt: (*With feeling)* Oh yeah.

Th: What's that like?

Pt: (*Pause, eyes closed)* It's…(*Pause, eyes open, looks straight at me)* It starts to form some foundation for me. (*Body relaxes)*

Th: Yeah?

(*Pause)*

Pt: To the extent that anybody can ever be in somebody else's deepest pain. (*Pause. Feeling, then starting to tense again)* There's so much rationalizing you could do in your head.

Th: Right.

Pt: **(Intellectualizing, matter-of-fact, soft defense)** People lose children.

Th: **(Therapist has self-disclosed with tears, and so is metaprocessing here to slip past the soft intellectualizing defense)** So what's it like to see me crying with you about everything you've lost, even though we know people lose children?

(*Pause)*

Pt: (*Tearing up, body relaxing again)* It matters that somebody cares that I lost *my* child.

Th: It does, doesn't it?

Pt: (*Nods)* Yeah.

Th: It wasn't just *children.*

Pt: No.

Th: It was *your* child.

Pt: (*Closes eyes and shakes head, crying)* She was *my* child, and she was special to *me*.

Th: (*Reassuring, kind)* That's right. That's right. And it *matters* that somebody gets that, huh?

Pt: Yeah. My first husband served as an anchor for me in a lot of ways.

Th: Mhm.

Pt: And then my daughter also served as an anchor.

Th: Mhm. Right. **(Patient seems to be soothed in the connection with the therapist)**

Pt: **(Then, she pops up into intellectualizing again)** Does everybody need an anchor? I seem to be… somewhat *anchorless.* (*Chuckles)*

Th: I know. And that's why it's so hard right now. I think everybody *does* need an anchor. **(Again, acknowledging and then bypassing the defense, coming back into the relationship in the room)** And…to the extend that I can help you feel a little anchored, it's a privilege for me. If there's any way I can provide you a little foundation, a little anchoring, I want to do that.

Pt: (*Tentatively)* I've been afraid of anchors anymore.

Th: Ah. Afraid to really let yourself sink down in and have it.

Pt: Yeah.

Th: 'Cause it might go away, huh?

Pt: It *did* go away.

Th: Mhm. So is it hard to really let yourself have the connection here?

Pt: I think it's hard for me to have a full connec–yeah, it's hard for me to have a *full* connection anywhere.

Th: Yes.

Pt: I'm too afraid.

Th: Yeah.

Pt: There are a couple places…My niece…My one set of good friends. I think that they would probably

hang with me. I think…But who wants to hang with a crazy person too long? **(Defense resurgence)**

Th: **(Matter-of-fact dismissal of the defense)** There's that pejorative part, huh?

Pt: Yeah.

Th: You're not crazy. You're not crazy.

Pt: (*Chuckles. Sounds very superficial)* **(Speaking from defense)** You remember the old Mary Tyler Moor show?

Th: Uh huh.

Pt: (*Still laughing, surface laugh)* Ted says to Mary, "Don't be such a gloomy Gus." And that obviously resonated with me, and I used to laugh about it…"Don't be such a gloomy Gus. Who wants to spend time with a gloomy Gus?"

Th: (*Quiet, kind, serious, not laughing)* That's a really toxic message…You know who *I* want to spend time with?…Who you *really* are…What's *really* going on inside of you. What's at the core of your heart. To me it doesn't matter if it's happy, or it's sad, or despairing, or anything in between. If it's *real*, and we're here together, then there is something *very* powerful in being connected with that.

Pt: (*Tears up, deepens once again)* That means a lot to me.

Th: (*Gently)* Can you take that in?

Pt: Yeah. (*Deep, deep breath)*

The patient deepens into her body and seems to be taking me in. …This place of softness and taking-in of connection is a huge shift for this patient.

Memories

Two weeks later, the next session after she traveled back to her home state again following the above session, the patient is tearful and distressed once more. The distress had lifted for a time after the previous session, but returned upon her coming back to Texas. We do several rounds of work where I gently, actively, relentlessly bypass her defenses against her grief for her daughter that the potential leaving of her business in her home state taps into. She drops down into core grief and sadness for some critical moments, crying deeply, before moving back into defenses. When she has finally been able to bear to stay in the grief for some deep sobs, she leans back, takes some deep breaths, and her unconscious "unlocks" (Fosha, 2010). Memories suddenly surface, memories that help us deeply understand why she is so afraid of feeling the vulnerability of her grief and sorrow:

- A memory of being in Kindergarten and hearing her parents arguing. They argued so loudly that her brother ran away into the night. She went to their door and lay on the floor outside their door begging them not to get divorced. (They did, when she was 12.) She remembered then deciding that she wouldn't cause any problems, and would take care of herself so that they could work things out.

- Many memories of being told by her father to keep the secret of his numerous affairs.

- A memory of her mother having a "nervous breakdown" when she was in the fifth grade, where she was "sad and less tolerant than usual, and I never knew when I came home from school whether it would be a good day when my mom would be 'regular,' or a bad day when she would be sad. I heard my brother say that she went to a psychiatrist, and I didn't even understand what that was, but I knew it was something we weren't supposed to talk about. All I knew was that I wanted to fix that, too. So I took care of myself. And I never wanted to be crazy like her."

Th: Whew! There was a huge amount of feeling and fear and overwhelming situations you were alone with when you were just a girl! …And that reverberates now, doesn't it?

Pt: (*Tearing up)* Feelings are scary. Feelings bring conflict, and conflict brings pain.

Th: (*Gently)* **(Normalizing her experience as not crazy)** So no wonder your grief does that to you, makes you fight it.

Pt: (*Pleading)* So what do I do about that?

Th: Stay here with me.

Pt: I'm just crawling. **("Putting self down for being weak" defense again)**

Th: **(Turning the defense inside out)** Yes. You're crawling. You're crawling through something very hard. And you don't stop. You keep crawling. You never give up. (*Tears up. Pause)* What's it like to see me tearing up with you?

Pt: (*Tears)* It creates a safer place.

Th: What makes it feel safer?

Pt: Letting my emotions out in other places is something I do really sparingly and only when I feel like it's really going to be safe. I don't want people to think, "She's *so* depressed, that I just can't stand to be near her."

Th: And that's what you're afraid of, that you'll be left alone?

Pt: (*Nods and wipes eyes)*

Th: So what makes this place feel safer?

Pt: (*Nodding again*) I'm pretty sure you're not going to leave me by myself.

Th: Me too. (*Pause)* And it sounds like that's important.

Pt: (*Tears up*) It is. It's *hugely* important.

By not assuming the patient's return to such distress and grieving about her daughter is some sort of disordered state, by not desensitizing her to her complicated grief and instead getting past her defenses *into* her grief, we found our way to deeply rooted pain from the distant past that has kept her from feeling her authentic feelings and that has prevented her from having deep connections with precious others for her whole life.

"Chocolate Cake"

A week later, the patient returns for another session. As the session begins, the sun shines around her face, and she looks kind of angelic. Her face is sad, but much less pained. Her defenses are softer, not hard to bypass, and she has self-awareness about her own defenses. We begin at a much slower pace. She talks about missing her daughter.

Th: What's happening in your body right now?

Pt: There's a tightness in my chest.

Th: A tightness in your chest.

Pt: (*With much self-awareness)* It's holding back a whole lot of sadness.

Th: **(Helping her to stay with her body and the sadness)** Can you just focus on that tightness for a moment? Not trying to change it, but just seeing what it has to say?

Pt: I'm afraid.

Th: You've never had a safe place to let the sadness pour out.

Pt: (*Shakes head*) There isn't a safe place. (And starts to leave the now by speaking about the unsafety in her life)

Th: (*Immediately interrupts)* What about here?

Pt: (*Slows down)* Here is a safe place.

Th: **(Bring focus back to now, back to her body)** So…what happens in this chest area?

Pt: It lets go a little bit. (*Pause*) It's not…*perfectly* safe.

Th: No it's not…

Pt: There's no place that's perfectly safe.

Th: What's the imperfect piece?

Pt: The imperfect piece is that I'm not supposed to show that much weakness. I'm supposed to be strong…These feelings chase people away. **(Old fear)**

Th: **(Focus on now)** Do you think it's gonna chase *me* away?

Pt: (*Shakes head*) No. (*Pause*) But I don't want it to chase away people who are meaningful to me. (*Pause, tears up*) It wouldn't chase my cousins away. It would just make them sad… **(This is a first for her, unconscious unlocks so she can see some exceptions to chasing away others with her emotions)**

Th: Just breathe into that place in your chest [that stops your emotion]. Don't try to push past where it gets caught. Just notice what happens.

Pt: It's something that keeps me from experiencing a full emotion. (*Pushes down with her hands)*

Th: What's happening with your hands?

Pt: It's holding it down… You don't *go* there. . . . Stop *here*.

Th: Wow. What do your arms want to do right now…if they could just move on their own?

Pt: They still wanna hold tight!

Th: They're really invested in holding it down, aren't they?

Pt: Yeah.

Th: **(Compromising, allowing defense to protect and yet asking it to let her have some leeway)** Would one hand be willing to go over your heart while the other one keeps pushing down? And it may not. You don't have to force yourself. **(She's practiced at forcing herself. Trying to stay with the softness that is present in the room)** Just see what you notice.

Pt: I feel almost immobilized. . . I *am* immobilized. (*Then, paradoxically, pulls her right hand up over her heart*)

Th: What happens when you do that?

Pt: (*Pause, upgaze*) I feel…less vulnerable…but sadder.

Th: Wow. Less vulnerable, but sadder.

Pt: (*Slowly melts into sobs of deep, undefended grief for long moments*)

Th: Oh…Oh…yeah, yeah…so much. **(Letting her know she's not alone. These tears are so deep and rich, needing lots of room rather than soothing)**

Pt: (*Stops crying slowly and names <u>on her own</u>:*) And then I want to come back out again because it's too scary.

I give her permission here to choose to use her hand to push down if she gets scared so that she has a sense of control, of being able to have choiceful regulation of how much sadness she lets herself feel. I encourage her to experiment with this. The patient says she can feel more of her sadness, even as she feels more in control and less afraid. She suddenly sees that the *fear* of deep feeling, rather than sadness itself, is what "immobilizes her during the day" and makes her feel stuck. She practices putting her hand on her heart again, feels another round of grief, and another round. She feels sad, but "peaceful" and "more okay."

Briefly, she returns to thoughts, and I can sense that there is more feeling left to be expressed.

Th: What is that part-of-you-that-needs-to-control afraid would happen if you just let yourself sob right now?

Pt: I think that it wouldn't make any difference, that nothing would be different if I sobbed.

Th: (*Gently)* How do you know?

Pt: Gosh. It's been so long since I've done that. (*Sobs, covering her face with her hand)* I haven't cried like that since my girl died. …And I think *that's* the only time I ever cried like that. …Because it's ok to cry when your child dies…(*Still crying*) It doesn't feel as okay to cry when… **(Begins to pull out of sadness)**

Th: **(Keeps her there, tenderly)** When your child's been dead for a long while? And a lot of other things are making you sad?

Pt: (*More crying, puts her head in her hand, closes her eyes)*

Th: Yeah…There you go…So much…I'm right here…

Pt: (*Upgaze*) And my brain just keeps trying to reconcile all these things…Because I watch my friends and those around me…Their kids get older…They have grandkids…(*Closes her eyes again, cries deeply again)* (**Note: This is anything but disordered grief. It's grief that comes around again and again and again when someone loses a young person**)

Th: (*Resonating deeply)* Your child doesn't just die once really…She's still dead…It still hurts.

Pt: (*Sobs deepen. Breath deep, ragged)*

Th: This feels clean and pure and real.

Pt: (*Looks at me and nods. More deep sobs*) I don't get to have the life that I wanted. I wanted to be a mother. I liked being a mother…But I have to have a different life, and I want a different life. And I want that life to be happy. It's so hard…People don't understand…

Th: …That the hole doesn't go away.

Pt: Yeah.

A little later:

Pt: When I get that cried out, I feel a certain sense of renewal…But I can't do this at work. **(Nothing that**

feels bad is ever the last step, (Fosha, 2010))

Th: What if you use this place, here with me, as a space to fall apart when you need to, as a container that you know is here, so you can hold it together during the week without sacrificing yourself?

Pt: (*Smiles, a real smile)* For some weird reason, that made me think of chocolate cake… Yeah—you become the place of the chocolate cake. (*Pause)* Strange, but true.

Th: So coming here and getting a chance to really cry is like chocolate cake.

Pt: (*BIG nod*)

Th: That's pretty profound…You must really need to cry…if it's like chocolate cake to get to come here.

Pt: (*Another BIG nod; another round of deep, deep crying)*

And a bit later:

Pt: I feel less alone. I feel more optimistic. But I'm skeptical. (*Pause)* I've been thinking I'm gonna lose it.

Th: (*Emphatically)* You're *not* crazy.

Pt: (*Sincerely, like a child*) I'm not?

Th: You're not crazy. You're just sad.

Pt: (*Nods, sobs some more)*

Th: You're sad for *you*, aren't you? **(Mourning the self)**

Pt: (*Nods)*

Th: It *really* affected you when I said you're not crazy, didn't it?

Pt: (*Lots of nodding*) I have just felt so out of control, so unhappy. It has felt *crazy* to me…But if I'm not crazy, I can get through this.

Th: You're *not* crazy. And I wouldn't say it if I didn't believe it. Do you *know* that?

Pt: (*Again, like a child, sincere, not defensive)* Have you seen crazy? Do you know what it is?

Th: I have. I do know what it is, and this isn't it. **(Giving her the reassurance she needs)**

Pt: (*More deep, wracking sobs*) That makes me feel *sooo* much better.

Th: Thank you for trusting me.

Pt: Thank you for being here…I have to know each week that there's some place I can go.

Th: I'm here.

The patient sends me an email after this session. She says, "I just wanted to thank you for today's session and the work that you are doing with me. I am deeply grateful for the sense of hopefulness, however cloudy it may seem, which I receive when I'm with you."

And so it goes. The societal void we fill as therapists willing to engage moment-to-moment with grief and defenses against it—and not shut it down when it gets hard or intense or complicated—is a huge one. The community need is great, given how averse our culture is to this process. The rewards for both therapist and patient in tending to the unique aspects and manifestations of grief for each and every person are, in a word, profound.

We take the next step across the span that bridges the broken heart

because there is little else that honors our relationship with a lost loved one or ourselves.

It takes courage to trust the process of surrendering to our sorrow.

It is so painful to open that fist of resistance cramped about the heart.

We peel back the pain, one finger at a time, but slowly our openness returns.

It is the pain that ends pain.

It is the mercy that expands into loving kindness.

— Stephen Levine, *Unattended Sorrow*, p. 63

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