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What Mental Health Professionals Need to Know:

Theoretical and Clinical Considerations: Grief and Trauma

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Abstract

Since the onset of COVID-19, it is clear that mental health professionals will find themselves working with the bereaved and traumatized, thus it is imperative that mental health professionals have knowledge about the normal grief process, trauma responses, and be familiar with new developments in understanding grief, bereavement, and trauma, including non-death related losses. This paper will include an overview and discussion of currently changing developments in how we understand the grief process as well as trauma. Understanding the distinctions and similarities between the normal grief, complicated or prolonged grief, and depression is essential. Mental health professionals also must develop awareness about ways that grief and trauma are biopsychosocial processes. This paper will discuss the ways grief and trauma are rooted in interpersonal neurobiology as well as the ways that awareness of interpersonal neurobiology can impact therapeutic presence and process. Clarity around which loss or trauma is being evoked and attended to is essential. Most importantly, mental health professionals working with loss and trauma of all kinds need to develop their capacity to be present with pain and suffering and to develop active listening skills to listen well.

What Mental Health Professionals Need to Know about Grief and Trauma

Overview

We begin by discussing Elisabeth Kübler-Ross's (1969) ground breaking work with the terminally ill. Her work set the stage for advances in care for the terminally ill. Through listening to the dying and understanding what they were experiencing, her work also set the stage for professionals to work clinically with those who were bereaved (Kubler-Ross, 1969). From her series of interviews with people who were dying, Kubler-Ross developed a stage-based model of coping with dying, which focused on the psychosocial reactions. She described these stages as defense mechanisms that last for a time and then replace each other or at times exist side by side. Her work helped those who were dying and helped those around them understand what happens as a person dies. She described the stages in coping with dying as denial, anger, bargaining, depression (reactive and then preparatory), and then acceptance. While her model of coping was developed through her conversations with the dying, it has been widely applied in understanding the bereavement process and counseling the bereaved, particularly in relation to the final stage of acceptance. Regardless of what could be considered a good outcome for a bereaved person, accepting the death of a loved one is often the explicit and hoped for outcome in grief counseling. This hoped for outcome has shifted.

Kubler-Ross's views (Corr, Nabe, & Corr, 2008) have been the foundation for the ways that the public and professionals understand and approach the grief process. However, she never intended her model of coping with dying to be used as a model of grieving or coping for those who are bereaved or traumatized (Kastenbaum, 2006). Some researchers and clinicians have criticized the stages she described and emphasized that

these stages have not been empirically demonstrated. However, the real legacy that Kübler-Ross may have left us with is that listening is imperative. Her careful listening to the concerns of the dying served as a springboard to consider deeply important questions related to the experiences of those who were dying and those who were bereaved and those who experienced trauma. And, her work highlighted the importance of being an active listener.

While Kubler-Ross's views remain influential, we now have more than one model of grieving (Kastenbaum, 2006). As mentioned, the hallmark of Kubler-Ross's five-stage model is that the final stage is "acceptance." Acceptance and letting go of the deceased have become the conventionally desired outcomes for the process of grief. We now know that "accepting and letting go" is just one among the many ways that grief is resolved. However, a quick look at many mental health professionals' websites who claim to understand grief or trauma reveal that there are many who still use Kübler-Ross's model and believe that their primary focus should be on helping the bereaved or traumatized come to acceptance of the loss or the losses associated with trauma. Now, as new understandings about the grief and trauma processes are being developed and communicated in the literature, we have a more nuanced view that more accurately reflects the wide range of adaptive responses (e.g., Attig, 2000; Bonanno, 2004; Jordan & Neimeyer, 2003; Kastenbaum, 2006; Klass, 2006; Klass, Silverman, & Nickman, 1996; Monk, Houck, & Shear, 2006; Neimeyer, 2005; Shear, Frank, Houck, Reynolds, 2005; Stroebe & Shut, 1999). We also have a more nuanced view of the ways that loss and trauma becomes embodied (Menakem, 2017; Porges, 2011; Schore, 2019).

Contemporary Views of Grief

First, let's have an overview of grief by asking, what is normal grief? In normal (uncomplicated) grief there is a wide range of emotions that people consider positive and negative. Sadness is the emotion that we most commonly associate with grief. In addition, there is often a mix of intense and painful emotions that can result in the bereaved person experiencing a sense of dread, anguish, or anxiety. Often there is the question "will this wrenching pain ever stop?" There can also be confusion and guilt about feeling happy again. The emotional aspects are those we most often associate with grieving, but grief is not only an emotion. It includes all of the ways that a griever adjusts to a world irrevocably changed by loss – non-death related loss, trauma, or the death of a loved one. Grief involves an ongoing and progressive adjustment and re-evaluation of an internal self-concept, expectations of one's self and others (including the deceased), and often social role transitions. These processes are ongoing and include cognitive and affective components that shift and change in intensity over time (Worden, 2018).

Some researchers have found that there are different grief trajectories where there is not high distress (Bonanno, Wortman, Lehman, Tweed, Haring, & Sonnega, 2002) and that this is a healthy grieving process with a good outcome for the bereaved. Some bereaved individuals grieve in ways that alternate between emotional and restorative activities (Stroebe & Schut, 1999). Other bereaved individuals benefit by maintaining a continuing emotional bond with the deceased, essentially forming a new relationship with the deceased (Attig, 2000; Klass, Silverman, & Nickman, 1996; Neimeyer, 2005). Some of those who are bereaved try to make sense of the death of their loved ones by re-authoring their own life story (Neimeyer, 1999, 2005). And, for some, it is not a positive

outcome to maintain an ongoing bond with the deceased because that does not fit with their healthy adaptation (Attig, 2000; Neimeyer, 2005). This is often associated with those who have had complicated relationship with the deceased or where there was trauma (Bonanno, 2004, 2006; Porges, 2011).

Stroebe and Schut (1999) developed the dual-process of grieving. There is a loss-oriented process and a restoration-oriented process to grief. The loss-oriented focus includes experiencing many of the emotions connected to grief, especially sadness and anger. Restoration-oriented grieving is when the bereaved attempts to assimilate the loss and learns to function in a life without the deceased. The person who is bereaved is doing new things and finding new roles as the emotional and cognitive distress associated with the grief gradually becomes less intense and painful. Bereaved individuals go back and forth between the two processes.

Another new development is the idea that it can be healthy and adaptive for those who are bereaved to maintain an emotional bond with the deceased (Attig, 2000; Klass et al., 1996; Klass, 2007; Neimeyer, 2005). This represents a significant shift from the way Kubler-Ross's stage of acceptance has been widely understood and applied. That is, the healthy and acceptable outcome was thought to be acceptance and moving on by letting go of the tie with the deceased (Kubler-Ross, 1969; Kastenbaum, 2007; Worden, 2018). Now, researchers and clinicians are shifting from the view that cutting the tie is the most healthy adaptation and outcome to grief. Those who are bereaved are still often told that they should move on with their lives. When the bereaved are told to move on and let go, many experience this message as being "stop loving the person who died and move on." Many who are bereaved suffer deeply when they are encouraged to stop loving the

deceased (Attig, 1999, 2000; Tedeschi & Calhoun, 2006). Following a death, facilitating the shift of loving the living person to loving and creating an ongoing bond with the person who has died is often facilitated by rituals of mourning (Worden, 2018). These rituals have been upended in the COVID-19 pandemic, with the concern now being that facilitating this ongoing bond will now be much more complex.

Other researchers and practitioners have focused on the ways that bereaved individuals are involved in meaning-making by finding new roles and essentially re-authoring their lives by finding a "new normal." Neimeyer's view is that grievers reconstruct a new world of meaning in a world that has been challenged by loss ((Neimeyer, 1999, 2004, 2005). He observes that reconstructing meaning also may mean that bereaved individuals may redefine the relationship with the deceased rather than severing the tie or letting go. This may be one way the person makes sense of the loss. Finding new roles, re-learning how to be in the world and relationships are also ways those who are bereaved makes sense out his or her life without the deceased (Neimeyer, 1999, 2005). Shear (2008) notes that although a person is permanently changed by an important loss, it is still possible to make a life that is rich and satisfying, if always a bit sadder, but not necessarily one that involves letting go of the deceased. It is important to recognize that in this COVID-19 pandemic there have many non-death related losses as well as so many who have died (with more deaths and losses likely), that we all are permanently changed and unable to come back to where we were before these many losses and deaths and traumas of the COVID-19 pandemic.

Worden's Description of Tasks of Mourning

Many mental health professionals working with the bereaved focus on tasks that can be carried out in the process of coping with the death or loss (Rando, 1984; Worden, 2018). Worden (2018) describes the grieving process as a time of actively working through and adapting to the loss by coping. When a person becomes bereaved, adjustments start almost immediately. In the time right after the death, the bereaved person most often experiences shock and disbelief about the death. The first task for the griever is to accept the reality of the loss. This is also the time when the griever is most involved with the emotional aspects of grief, especially the sadness. The challenge at this time is to understand that the death is real, and often the first steps toward making the death real are through the funeral or mourning rituals. That these rituals have been profoundly interrupted creates a potential block or obstacle for those who are bereaved to make this necessary internal shift to understand – emotionally and cognitively – that the person was alive but now has died. As a bereaved person moves through the grief process, the next task is to work through the pain of the grief, pain that is often intensified when the death or circumstances of the death have been traumatic. This pain can include literal physical pain and sleep disturbances. The bereaved often experience intense sadness, loneliness, lack of interest in day-to-day activities, anxiety, and guilt. Many who are bereaved become reluctant to describe and experience their feelings because even in the face of this COVID-19 pandemic in our death-denying society, many have a really hard time seeing others in the pain of grief.

The next task Worden describes is that of adjusting to an environment in which the deceased is missing. For example, a widower may need to learn new skills such as

cooking or doing laundry, or managing a household. There are also internal adjustments. Often a death affects the griever's sense of self-esteem and internalized ways of identifying and defining the self. For example, for some individuals who defined themselves through their partnership or marriage, bereavement means a loss of the "we" as well as that way of that internalized representation. Often there is fear that attempts to fill the deceased's role will not work. Loss can also challenge one's spiritual or philosophical beliefs: "How could God have let this happen?" A question that has been acutely poignant during the pandemic is: "How could the leadership of this country have let this happen?"

The last task is to emotionally relocate the deceased and move on in life. Often this is the most challenging task in the grieving process. Guilt over feeling happy and being afraid of betraying the deceased often arise at this time – happiness can feel like an affront to the memory. However, in the normal grieving process there is an evolution and softening of feelings, thoughts, and beliefs as the bereaved moves through the grief and moves toward again actively engaging with life. Worden believes that grief is integrated in a person's life when the bereaved no longer has a need to intensely reactivate memories of the deceased and when the griever makes room in his or her life for others (Worden, 2018). Shear (2015) describes the normative pattern in grief is that the pain and yearning "often" over time.

Does Grief Counseling Harm or Help?

In addition to new developments in ways we understand grief, controversy has arisen about what helps those who are bereaved and traumatized. As we move forward in this COVID-19 pandemic, these questions may once again arise. For example, Bonanno (2004) believes that the findings about effectiveness of grief counseling are inconclusive and suggests that there has been almost no empirical support for the effectiveness of the grief work for those experiencing normal grief. He also does not agree with the view that most bereavement theorists and clinicians have that grief is an active process that should be facilitated by clinical intervention and so he and his colleagues challenged this assumption in their 2002 prospective study (Bonanno et al., 2002). They compared pre- and post-loss measures of depression and grief and found evidence of resilience in the bereaved. That is, many who were bereaved quickly adjusted to the loss and showed little distress. The bereaved were followed up to 18 months after the loss. Forty six percent of the grievers were found to be resilient. These findings challenged the longstanding view that a lack of distress is an unhealthy denial and one that should be classified as a pathological grief reaction (Bonanno et al., 2002). These research findings suggested that only 10% of grievers were in high distress and might need any kind of intervention. The others adapt and adjust on their own. These findings raised a big question for many researchers and practitioners because of the suggestion that grief counseling was essentially useless for the normal process of grief, which went counter to what mental health practitioners and their clients experience.

The above finding was widely reported in the popular press and raised the question: Does grief counseling harm or help those who are in the normal process of grief? A number of reports in the popular press suggested that grief counseling was harmful rather than helpful (Begley, 2007; Groopman, 2006; Zaslow, 2005). This question reflected a measure of pessimism about the usefulness of grief counseling, at least for normal grief.

Larson and Hoyt (2007) and Hoyt, Del Re, and Larson (2011) found it concerning that these reports did not seem to reflect their research and clinical experiences so they decided to look at the research literature. They found – and emphasized that it is important to note – that doubt about the usefulness of grief counseling in large part resulted from a misunderstanding in the professional literature (Larson & Hoyt, 2007). Specifically, this misunderstanding began when Neimeyer cited Fortner's unpublished doctoral dissertation describing findings that suggested almost 38% of those receiving grief counseling would have fared better in a no-treatment group. However, Fortner's conclusions were faulty (Larson & Hoyt, 2007). Hoyt and his colleagues described the statistical method that Fortner used. This statistical method is intended to determine if there is a treatment-induced deterioration effect (TIDE). That is, the TIDE statistic determines the percentage of individuals who would be worse off after treatment than they would have been if they had not received treatment (or been assigned to the control group). Hoyt and his colleagues found that this statistic was inadequate and, further, had never been subject to a peer review. And, in an additional exploration of the literature, they found that these conclusions were being mistakenly cited as Neimeyer's in many subsequent studies, adding to the question of the usefulness of grief counseling (Hoyt,

Del Re, & Larson, 2011). These two factors combined with Bonanno and colleagues findings from their 2002 study suggesting that only 10% of those who are bereaved benefit from grief counseling amplified the conclusion that grief counseling was not effective and even harmful (Hoyt, Del Re, & Larson, 2011; Larson & Hoyt, 2007).

Hoyt, Del Re, and Larson (2011) carried out a meta-analysis looking at results psychotherapy outcomes of those receiving grief therapy. They looked at a wide range of standard measures and outcomes measuring well-being following a bereavement. The findings from their meta-analysis were in direct contrast to the view that grief therapy is harmful. They found that treatment was effective. That is, efficacy of treatment overall had a large effect size (near 0.8) – an unusually strong finding in social science research – and revealed that people experiencing normal grief were helped by grief counseling or therapy. They also found that bereaved individuals who sought out therapy were likely to be helped by that therapy. The bereaved who received interventions and had sustained interactions with an identified expert helper – a professional trained in providing grief counseling or therapy – had lower levels of anxiety and higher levels of well-being. In addition, Hoyt and his colleagues (2011) suggest that pessimism around the effectiveness of grief counseling may cause harm because people put off seeking out help. Gamino's (2011) research findings revealed that bereaved individuals who sought out treatment because they answered "yes" to the questions "Are you having trouble/?" and, "Would you like help?" benefited from grief therapy. It was clear that taking another look at the evidence around the effectiveness of grief counseling revealed that it is an erroneous claim that grief counseling hurts rather than helps (Hoyt, Del Re, & Larson, 2011).

Most clinicians will have some experience with clients who are experiencing normal grief and who are experiencing feelings of fatigue, feelings of anger, social withdrawal, and loss of interest in day-to-day life. These clients, who comprise about 80-90% of bereaved individuals, are most likely experiencing normal grief. Understanding how complicated grief is distinguished from normal grief, major depression, and anxiety disorders is currently being explored (Sabin, 2012). Zhang, El-Jawahiri, and Prigerson (2006) point out that while there are many overlaps in diagnostic criteria, excessive yearning for the deceased and overwhelming difficulty accepting the reality of the death all are hallmarks of complicated or prolonged grief and distinguish complicated or prolonged grief from depression and anxiety disorders or trauma responses.

Distinguishing between Grief and Depression

Clearly, understanding the process of grief and how we respond as professionals is being re-visited. Distinguishing the differences between normal grief and complicated or prolonged grief and depression is not always clear (Sabin, 2012; Shear, 2015). Clarifying the concept of complicated grief has also been a challenge because of the differences in terminology. For example, prior to 2001, the term “traumatic grief” was used but this term has now reverted to complicated or prolonged grief to distinguish it from grief reactions seen in those experiencing significant trauma from events such as 9/11 or Hurricane Katrina, and now, the COVID-19 pandemic. Complicated grief and prolonged grief are used interchangeably at this point. While there was the desire to clarify and distinguish complicated grief or prolonged grief from Posttraumatic Stress Disorder (PTSD) or depression (Bonanno, 2006), recognition of complicated or prolonged grief as a mental health disorder did not happen because the diagnosis of

complicated or prolonged grief was not added to the most recent edition of the Diagnostic and Statistical Manual, the DSM-5 (American Psychiatric Association, 2013).

In addition, during the time that the option of adding "complicated or prolonged grief" to the DSM-5, many professionals were reluctant to risk medicalizing the concept of grief and were wary of considering complicated or prolonged grief as an illness to be included in the DSM-5 because of the longstanding movement in the field of grief and bereavement to help people realize that grief is a normal process (Kastenbaum, 2007; Worden, 2018). Prigerson and Maciejewski (2005) addressed this question by asking bereaved individuals if it would disturb them to receive a diagnosis of complicated grief if they were suffering with the symptoms. Prigerson and Maciejewski found that 98.5% of the bereaved they interviewed would be interested and willing to receive help if they found themselves suffering with symptoms of complicated grief and 96.3% said they would feel better knowing they were not going crazy.

It is important to note that the editors of the newest edition of the Diagnostic and Statistical Manual (DSM-5) removed the bereavement exclusion from the diagnostic category of Major Depression (APA, 2013). This means that a person who is recently bereaved can now receive a diagnosis of Major Depression (Corywell, 2012) instead of waiting for eight weeks before making a diagnosis of depression. In the aftermath of the complex manner many died and the high number of deaths associated with COVID-19, it is essential to remember that grief can look like depression, but that it is not depression. Treatment options differ and medications often used to treat depression do not usually help those who are struggling with grief or complicated or grief. Researchers are discovering that areas of the brain activated in depression are different from those

activated in complicated grief (O'Connor, et al., 2008; Schore & Marks-Tarlowe, 2019). Given that the appropriate treatment for depression and that for complicated or prolonged grief and that for trauma are different, a diagnosis of depression may lead to inappropriate treatment that has the strong potential to interfere with the bereaved or traumatized person's coping and adapting and perhaps adding to distress rather than lowering the distress.

Hoping to highlight the importance of understanding these differences, Zisook and Shear (2009) point out that clinicians who understand the differences between grief and depression will need to clearly understand this so that they will be able to assess and provide treatment for the specific kind of pain that is presenting. Part of the professional's role is to help discern if a person who is bereaved or traumatized is also depressed – and that can be done by carefully assessing the sense of where the person's distress originates. That is, is the world is empty, as in grief? Or is the internalized self experienced as being empty, as in depression? There is an consensus that sometimes bereaved or traumatized individuals do become stuck and do suffer from a complicated or prolonged grief syndrome and that becoming stuck in grief is a risk factor for developing depression (Gamino, 2011; Hoyt, Del Re, Larson, 2011; Jordan & Neimeyer, 2003; Larson & Hoyt, 2007; Shear, 2015; Shear, et al., 2005; Zisook & Shear, 2009). It is important to remember that effective treatment of trauma, complicated or prolonged grief, and depression can be assessed subjectively. Being stuck and unable to move through the process is not considered part of the normal process of resolving grief and trauma. And, we can assess decreases in distress, improved functioning of daily living, and improved physical status – and these are all signs of improvement.

In addition to clarifying if the person who is grieving is also depressed, the emotional and empathic presence of the grief counselor is particularly important for the emotional work with grief and trauma. For example, Kosminsky and Jordan (2016), Gamino (2008), Manzella (2008), Neimeyer (2008), Shear (2008, 2015), and Worden (2018) raise the issue of the importance of the relationship between a person who is traumatized or bereaved and the mental health professional. They address what is needed to work with the bereaved, including the importance of finding ways to enhance the professional's empathic capacity and ability to listen and be present for an immense amount of pain in the story – especially if a person is experiencing complicated or prolonged grief or trauma since part of the for treatment for complicated or prolonged grief or trauma is to reduce distress by first intensifying the story through re-telling and re-imaging the death and pain of the loss – intensifying the story makes the unspeakable speakable and reduces distress (Ossefort-Russel, 2018; Shear, 2015). And, it's important to remember that grief relates to separation distress (yearning and pining) and trauma reflects trauma distress (hypervigilance, flashbacks, difficulty regulating emotions, and intrusive thoughts).

Complicated or Prolonged Grief

In normal grief, the pain of grieving gradually becomes less intense and the bereaved person makes adaptations and changes. This seems to happen for about 80% of grievers. For the other 10 to 20%, the grieving process never seems to resolve (Monk et al., 2006). Monk and his colleagues (2006) found that in complicated grief, sadness and loneliness become persistent. Many researchers have found that ongoing adjustment is inhibited by the inability to accept the death, having persistent and intensely painful

emotions, as well as disturbing and often vivid memories or thoughts about the death (Monk et al., 2006; Shear et al, 2005; Zhang et al., 2006). Other symptoms of complicated or prolonged grief include the inability to accept the death or having a sense of disbelief about the death that does not change over time. While disbelief usually occurs early in the grieving process, in complicated or prolonged grief or embodied trauma or a traumatic death, the feeling of bitterness, anger, and guilt related to the death of the person who died often remain fresh and raw. That months or years after the death, the grief feels as fresh and raw as it did right after the death, is a hallmark of complicated grief (Monk et al., 2006; Neimeyer, 2005; Shear, 2015; Shear et al., 2005).

Another aspect of complicated or prolonged grief is that often the bereaved may come to fear strong emotions and be afraid that if they are triggered, they will never stop. Often people with complicated or prolonged grief will avoid talking about the person who died or looking at reminders such as photographs. Sometimes those with complicated or prolonged grief see that others are uncomfortable with their "emotional displays," so the bereaved then stop talking about the deceased person and end up feeling estranged and isolated from family and friends (Shear, 2008). It is possible that given the profound interruption of natural supports and the complex constellation of losses associated with the COVID-19 pandemic, that those who are bereaved might be at risk for developing complicated or prolonged grief.

Understanding ways to effectively treat complicated or prolonged grief and trauma is ongoing and has been under investigation for over 10 years (Dana, 2019; Neimeyer, 2005; Porges, 2011; Shear et al., 2005; Shear, 2015; Zhang et al., 2006). The first randomized controlled trial of a therapeutic intervention specifically designed for

complicated grief was carried out by Shear and her colleagues in 2005 (Shear et al., 2005). The complicated grief therapy (CGT) protocol specified 16 sessions. Early sessions focused on both psychoeducation about normal and complicated grief and identification of personal life goals. Subsequent sessions included both of these topics and also included some elements of trauma therapy, such as intensifying the retelling of the story of the death and imaginal exposure. Shear described the difficulty that those with complicated grief had in telling the story. For many of the participants, the pain of the grief had become unbearable and unspeakable (Shear et al., 2005). In this study, participants in the control condition (n = 46 vs. n = 49 experimental) received the same number of sessions of standard interpersonal therapy (IPT). Shear and her colleagues (2005) cite their colleagues' findings that IPT and tricyclic antidepressants are effective treatments for depression following bereavement, but not for complicated grief. Shear and her colleagues (2005, 2008, 2015) do not imply that depression is an expected outcome of normal or uncomplicated bereavement, but remind us that grief is often mistaken for depression. Wortman and Silver (2008) also found that complicated grief is often confused with depression. Antidepressants or IPT did not work for complicated grief so these researchers developed the CGT protocol. Shear and her colleague's (2005) findings were significant. More participants showed treatment response to CGT (51%) than to IPT (28%) and the time to response was significantly faster with CGT. The results of this study suggest that this intervention was effective for those with complicated grief. Ongoing studies investigating this clinical approach have suggested that this intervention protocol is effective (Shear, 2015).

Worden (2018) suggests that treatment for complicated or prolonged grief should focus on reviving memories of the person who died. This is similar to Shear and her colleagues' (2005; 2015) approach of intensifying and re-telling the story of the death. Worden's approach is to build on positive memories so that the bereaved will be able to bear the more difficult or mixed feelings such as disappointment or guilt. Shear and her colleagues (2005, 2015) pointed out that the effectiveness of treatment depended on the therapist being able to tolerate listening to deeply painful experiences as well as helping the client intensify and amplify these feelings so that they would become unstuck. That 10% of the clients were not willing to continue because of their intense pain, suggests that clinicians need to find ways to support the expression of these deeply painful memories (Shear et al., 2005; Shear, 2015). The same challenge of being able to hold pain exists for those working with traumatized clients (Ossefort-Russel, 2018; Schore, 2019).

It is clear that it is important that the mental health professional be as comfortable as possible and feels at ease listening to stories of death and loss and trauma (Neimeyer, 2012; Schore, 2019; Shear, 2008). This is sometimes the most challenging aspect of working with people who are bereaved or traumatized. The difficulty of listening to stories of death and loss and trauma can become a big problem when the clinician's loss or trauma is triggered. Most of us have lost loved ones or have experienced other non-death related losses, we have our own grief story, and have been with in the "same boat" with our clients through this COVID-19 pandemic. There is always a possibility of activating or re-activating painful emotional reactions. We need to be aware of this so

that when we are with clients, we can address the loss and trauma of our clients, not our own.

Attachment

This leads in to a topic that is at the heart of bereavement: attachment. There has been a growing recognition that attachment styles deeply influence the way that individuals grieve and process trauma (Kosminsky & Jordan, 2016; Shear & Shair, 2005, Worden, 2018). As many researchers and clinicians have been highlighting, a mother and a baby are a dyad and from before the baby is born, and certainly after the baby is born, an affective connection is formed that is at the heart of how human beings love (Beebe & Lachmann, 2014). Throughout the lifespan, these early beginnings shape the ways that not only love is experienced, but the ways that separations are endured. When a loved one dies, the bereaved person experiences significant disruptions in life, including disruptions in the usual attuned and synchronized affective communication between himself or herself or themselves and the person who died, communications that were anxious or secure (Schore & Marks-Tarlowe, 2019).

So let's briefly consider the traditional definitions of attachment styles. First, is secure attachment. This attachment style evolves when, in addition to providing physical protection and a psychological sense of safety, parents are responsive and attuned and loving. Attuned care promotes attachment security – a secure attachment style that helps a child feel safe and curious and eager to learn while also being able to tolerate emotional distress (and be more able to self soothe), often for the rest of their lives. There is a balance of independence and dependence.

An anxious attachment style develops when there is a lack of attuned care and inconsistent parental caregiving. An infant and adult with an anxious attachment style are each less likely to be able to tolerate separation. There can be subtle and not so subtle ways that a person seeks continual proximity because of the person's difficulty and impaired capacity to be independent or to feel safe. The impact on grief is that an anxious attachment style interrupts the capacity to form internal representations that reflect a sense of safety. It is important to note that experiences perceived to be dangerous during the COVID-19 pandemic are likely to be intensified and may often include distressing intrusive thoughts. Internalized fears and worries and expectations, along with real difficulty tolerating emotions in grief, raise the risk of developing significant complicated or prolonged grief or a coexisting depression or anxiety because during this COVID-19 pandemic, close physical proximity is not possible.

The avoidant attachment style develops because of uncertainty around what to expect from maternal or primary caregivers – love one day, distance or hostility the next day. A person who has developed an avoidant attachment style moves away from people – essentially seeking distance and in that distance, safety. The impact on grief is that a person who is bereaved (and who has an avoidant attachment style) is more likely to be isolated and not able to name or understand their own emotional responses. Being too afraid to understand or name inner experiences, clearly exacerbates the adverse effects of loneliness and isolation, both factors that heighten the risk of emotional distress or developing depression or anxiety.

In the Disorganized attachment style there can be an emotional and cognitive "shut down" and this "shut down" results in becoming stuck in painful emotions that become unspeakable. Access to emotional life becomes limited. Emotions and thoughts are often confusing and frightening.

An important development in the theoretical development of attachment theory that is the concept of earned security (Kosminsky & Jordan, 2016). This concept reflects research findings that revealing that an attachment style is not "fixed" or static in life – and that an attachment style can be changed or modified, often in relation to intentional reparative work to address loss or trauma in life. In earned security, there is often profound growth and shifts in attachment style, moving from the less adaptive anxious insecure attachment styles to one that is more adaptive. Often this can happen from addressing early challenges (in childhood or other losses or trauma) while moving through the grief process. When working with families who have experienced the death of a child or other loved one, I have often been told, "I would never have made this choice for my loved one to die. If she could be alive and well with us now, I would trade all of this growth for her, but this loss has helped me grow." Moving through grief can help individuals develop a mature narrative that includes more cognitive and emotional flexibility – and one that includes the perspective and understanding that loss is a sad part of life.

Kosminsky and Jordan (2016) emphasize that mental health professionals benefit from being aware of their own attachment styles because the clinician's attachment style may consciously and unconsciously influence the ways that the clinician listens and responds to bereaved individuals.

Interpersonal Neurobiology: Attuned Presence

Ways to understand the empathic presence of the clinician can also be considered through the lens of interpersonal neurobiology. Essentially, empathic presence and communication is rooted in right brain to right brain communication, communication that is affectively based (from the limbic portion of the brain) and that fosters a clinician's attuned presence (Schore & Marks-Tarlow, 2018). Looking at the therapeutic encounter and holding through the lens of interpersonal neurobiology, therapeutic holding reflects an affectively attuned, right brain-to-right brain therapeutic approach that facilitates safety and mirrors the dyadic relationship between a mother and her baby. The affective (emotional) centers of a healthy baby's right brain are fully formed at birth and are shaped as the baby and the mother engage and the affective connection and attachment between the mother and the baby form. Schore and Marks-Tarlow (2018) note that the area of brain that is activated in quiet love is amygdala. The bond between mother and baby moves from quiet to excited to mutual love, which involves the periaqueductal gray area and the anterior cingulate cortex in the limbic portion of the right brain. These areas are activated in mutual love and separation distress – the same areas activated in love and separation distress and grief (Kosminsky & Jordan, 2016; Schore & Marks-Tarlow, 2018; Schore, 2019).

Understanding the neurobiological underpinnings of love and interpersonal neurobiology can help us create a more fully embodied understanding of the therapeutic process. How? If we understand that the ways that the mother (or primary caregiver) and the baby formed an affective bond to form mutual love and attachment are grounded in

conscious and unconscious processes related to neurobiological attunement, we (clinicians), too, can understand the deep need to listen and provide care that mirrors the love that develops between mother and baby, love and care that is based in right brain-to-right brain affective connections. This love then activates an affectively based therapeutic alliance as we provide bereavement care. And, just as an infant, from the start of life, thrives on mutual love, those who are bereaved or traumatized can also thrive through an intentionally and affectively grounded therapeutic relationship, one that from the first point of contact is attuned to each client's internal states so the clinician is able to flexibly modify and synchronize responses – and essentially mirror mutual love. The therapeutic alliance creates resonance with the original infant-mother attachment; love that is rooted in right brain-to-right brain unconscious processes – and this can be reparative as the clinician becomes a transitional figure (Kosminsky & Jordan, 2016). Schore and Marks-Tarlow (2018) write that "effective psychotherapeutic treatment…facilitates changes in the complexity of the right hemispheric unconscious system" (p. 42). The clinician's attuned presence and right brain to right brain communication with the bereaved are at the root of therapeutic holding that facilitates change when working with those who are bereaved (Kandel, 2006; Kosminsky & Jordan, 2016, Neimeyer, 2012; O'Conner et al., 2008, Schore & Marks Tarlow, 2018).

Being aware that the therapeutic holding is grounded in love and that the neurobiological underpinning of love is the right brain to right brain connection can enhance our awareness of how to create an effective therapeutic alliance. That is, love or what is more usually called the therapeutic alliance, essentially facilitates resonance between two people and is grounded in "communicating brains [that] align their neural

activities" with each other (Schore, 2019, p. 2) and is at the heart of how change happens. Intriguingly, Kandel (2006) found that through psychotherapy, synaptic communication between axons and dendrites actually increased and improved because new synaptic connections were formed and so the brain functioned more efficiently – facilitating moving through grief and trauma as well as moving from being overwhelmed to being able to be more emotionally regulated and embodied.

Interpersonal Neurobiology: The Polyvagal System

Another aspect of interpersonal neurobiology to consider is the polyvagal system. The polyvagal system includes the 10th cranial nerve, the vagus nerve (the wanderer), the longest nerve in the body. The polyvagal system has three components: The ventral vagal complex that regulates social engagement, which reflects a relaxed and safe state, "rest and digest;" the sympathetic nervous system, "fight or flight;" and the dorsal vagal complex, which is the unmyelinated primitive pathway that regulates the shut down or "drop dead" response, the survival response of last resort (Ossefort-Russel, 2018; Porges, 2011). The polyvagal system is like a personal surveillance system asking: "Is this situation safe?" and is a major part of the affect regulation system that stems from the early forming, autonomic, non-conscious neurobiological processes in the limbic portion of the brain that is at the heart of emotional co-regulation (Porges, 2011; Schore, 2019).

This therapeutic alignment and neurobiological underpinnings can explain the effects of the ways we or those who are bereaved become afraid or engaged. Do we collapse or want to run away? This might suggest that the clinician's sympathetic nervous system (the fight or flight response) or the dorsal vagus of the 10th cranial nerve (collapse or freeze) is activated, reflecting an autonomic state seeking safety through some kind of

escape or fight or as a last resort, a complete collapse (Dana, 2018; Ossefort-Russel, 2018; Porges, 2011). Or, a clinician might experience a relaxed and attentive sense of inner safety and spaciousness, even in the face of a client's excruciating pain, suggesting that the clinician's autonomic response is supporting social engagement and safety while being present, reflecting that the ventral vagus of the 10th cranial nerve is "on line" and facilitating interpersonal connection and safety (Kosminsky & Jordan, 2016; Ossefort-Russel, 2018; Porges, 2011; Schore, 2019).

Clinical Applications

Listening well, accurate neuroception and interoception, and sensitively processing the prosody (the music) of the words we hear, all of these are techniques that "sit atop the right brain implicit skills" (Schore, 2012, p. 39). Schore and Marks-Tarlow (2018) write that "neuroscience now indicates that intuition, creativity, and insight are all right, and not left, brain functions (p. 46)." Researchers and clinicians are recognizing the critical importance of engaging in an attuned process of therapeutic holding (Beebe & Lachman, 2014; Kosminsky & Jordan, 2016; Schore, 2019). As clinicians working with those who are bereaved and traumatized we can learn to intuitively and creatively work with our own awareness of our autonomic state – are we are feeling safe or not? – and use this awareness to enhance wordless empathy, intuition, and an expanded clinical presence. That is, being aware of our own autonomic state can lead to an enhanced capacity to receive and express nonverbal affective communication (Dana, 2018; Porges, 2011; Schore, 2019) that can help a bereaved person find meaning and move through grief and trauma. Accurately responding to verbal and nonverbal responses as well as creating an empathically based therapeutic alliance is at the heart of effectively helping

those with whom we work clinically regain their equilibrium and wellbeing (Kosminsky & Jordan, 2016; Neimeyer, 2012; Ossefort-Russel, 2018; Porges, 2011; Schore, 2012, 2019).

Neimeyer (2008, 2012) describes using one's felt sense and intuition as a guide to understanding the griever's situation. To follow the client in this way – and following the affect trail – we mental health professionals need to have personal clarity about our attachment style, our autonomic state, and our own losses and trauma. With personal clarity, the clinician can more easily follow the client's lead and use the intuitive understanding of the client's situation to help the client move through grief and trauma and regain their lives. Exploring our own losses or trauma – our own life story – is essential (Manzella, 2008; Neimeyer, 2008, 2012; Worden, 2018). This exploration is necessary so the clinician's losses or traumas do not become the focus of attention and become obstacles to being present with clients who are grieving. Being clear about whose loss is whose helps professionals to be as clear as possible and to focus on responding to the pain and states of those with whom we work, not our own. It is our responsibility to resist the urge to try to fix a bereaved person or traumatized person trying to minimize pain. We let the person with whom we are working clinically tell the story of his or her or their life and grief and trauma. We let them lead.

When a person comes to us: listen to the story. Assume nothing. There are many myths and societal expectations and often oppressive societal "rules" surrounding how grief and trauma works. While being bereaved or traumatized does not always result in a diagnosis of a depression or other mental disorder, being bereaved or traumatized is often a deeply confusing time and involves shifts in internal identity representations and

possibly guilt or ambivalence toward the deceased as well as anger around the circumstances of the death, all of which can be a confusing if normative part of the process. Confounding this difficulty is that many who are newly bereaved are influenced because we are a death-denying society and many believe the societal myth that grief and trauma involves only sadness rather than including guilt or ambivalence and anger (Shear, 2015; Worden, 2018). Especially during the COVID-19 pandemic, many newly bereaved or traumatized people have been terrified to tell anyone about these thoughts or to discuss their rage or ambivalence or boredom because they are afraid they will be considered inadequate or that they are not "processing" the death or losses or trauma in the right way. Often those who are bereaved or traumatized are truly relieved when they realize that they are not alone in having these intensely distressing emotional experiences and find that naming these experiences can be an important first step in bringing about real change and recognizing that it might be possible to embrace life again. How is this possible? We can allow ourselves to love and be loved by those with whom we work.

It is important to note that it has been conventionally assumed that speaking about grief and trauma immediately following the trauma or loss is beneficial. However, Groopman (2004) notes that it is not always beneficial for those who are bereaved or victims of trauma and loss to immediately review the events by participating in critical incident debriefing. Further, in contrast to the commonly held assumption that speaking about loss and trauma is helpful, Seery, Silver, Holman, Ence, and Chu (2008) found that people who made the choice not to speak about their losses from trauma related to 9/11 immediately following that event, fared better than those who made the choice to speak. It is important to note that these researchers also found that those who did benefit from

speaking were those who had a very high level of distress following the event and wanted to speak about these events (Seery, Silver, Holman, et al 2008). The only way a mental health professional can know whether or not to encourage bereaved or traumatized individuals to speak about these events is by asking. And, then, listening for the "yes" or the "no."

One of the most essential tasks for those who will be counseling the bereaved or traumatized is to develop and foster active listening skills. Active listening includes paying attention with our eyes and our bodies – the felt sense of the body (Gendlin, 1978) – while also "turning off the analyzer" in our minds (Manzella, 2008). Analyzing as we listen takes us away from the situation that is being described (Manzella, 2008; Neimeyer, 2012). Active listening includes not assuming that we know what clients are going to say or where they are going in their story (Neimeyer, 2012; Schore, 2019). Having personal clarity and not assuming we know who will benefit from interventions is crucial so the clinician will not be imposing his or her agenda on clients. Not all those who are bereaved or traumatized need an intervention. Yet, there are those who are suffering and want to feel better and need our help. Even if they have tremendous fear and anxiety, they want relief from that pain. The key to facilitating this relief is using ourselves – including awareness of the affectively based right brain to right brain communication that guides and leads our knowledge-based left brain, which is the scaffolding for listening well. Listening well can help those who are bereaved or traumatized know that even following the death of a loved one, that bereaved person can be cherished, loved, and soothed and, therefore, *the bereaved or traumatized person* can cherish, love, and soothe. And, through experiencing the affective connections in the

therapeutic context, grounded in clinicians' listening well (and implicit love for those with whom we are working with clinically), those who are bereaved or traumatized can move beyond just enduring life to the possibility of once again finding meaning as well as a lifelong love of life.

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