EMDR TREATMENT OF GRIEF AND MOURNING

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Abstract

Objective: To discuss how Eye Movement Desensitization and Reprocessing (EMDR) therapy can be utilized in the treatment of grief and mourning.

Method: Several frameworks of grief and mourning that can inform EMDR therapy are discussed. Rando's "R" processes provides a framework for understanding the psychological processes necessary for the assimilation and accommodation of loss. Attachment theory provides a framework for understanding grief and mourning given that loss can trigger the same reactions experienced as a child to loss of an attachment figure. Dual Process theory posits that healthy grief involve the oscillation between coping with emotional aspects of the loss (Loss Orientation) and coping with the daily life tasks (Restoration Orientation). Continuing Bonds theory describes how grief does not resolve from detaching from the deceased loved one, but rather in developing a new relationship, a continuing bond that endures through one's life.

Results and Conclusions: EMDR therapy, utilizing an eight phase, three pronged (past, present, future) approach can be utilized in the treatment of grief and mourning. Different theoretical frameworks inform case conceptualization and selection of memories for EMDR processing to facilitate assimilation and accommodation of the loss.

Key words: eye movement desensitization and reprocessing (EMDR), dual process theory, grief, mourning, three pronged, continuing bonds theory, loss orientation, restoration orientation

Declaration of interest: none

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The death of a loved one can be a time of unparalleled distress and the adaptation to the loss can be very challenging. Even when uncomplicated, bereavement can result in significant psychological, behavioral, social, physical, and economic consequences (Osterweis et al. 1984; Solomon and Rando 2007, 2012, 2015). It is important for the therapist to be knowledgeable about theoretical frameworks and effective treatment methodologies to alleviate pain, reduce dysfunction, work through conflicts, and promote adaptation.

EMDR therapy is a therapeutic approach that research has been shown to be effective with psychological trauma (Shapiro 1999, 2001, 2018). EMDR therapy can be utilized to treat the trauma of grief and facilitate the assimilation and accommodation of the loss (Shapiro 1997; Solomon and Rando 2007, 2012, 2015). Previous articles (Solomon and Rando 2007, 2012, 2015) have discussed processes necessary for assimilation and accommodation of loss (called "R" process [Rando 1993]), and how EMDR therapy can facilitate movement through these processes. This model provides a way to understand where a person is in their mourning process and where to intervene if the grief becomes complicated due to some compromise, distortion, or failure of one or more "R" processes.

In this article, further models pertinent to grief and mourning will be discussed that can enhance understanding of grief and mourning, how it gets complicated, and guide clinical intervention, including EMDR therapy. Attachment theory increases our understanding of complicated grief and mourning and explains individual differences. Research has shown that attachment style is an important determinant of how one grieves. The loss of a significant person in adulthood can evoke many of the same feelings and responses that accompanied separation from an attachment figure during childhood (Kosminsky and Jordan 2016). Consequently, understanding attachment theory and how attachment style results from child-caregiver interactions can guide the EMDR clinician in identification and treatment of the maladaptively stored information complicating the grief.

The Dual Process model (Stroebe and Schut 1999, 2010) conceptualizes grief as dealing with two types of stressors. One type, termed Loss Orientation (LO) involves coping with stressors that come with the emotional loss of an attachment figure (or caregiving figure in the case of parents who lose a child). The other type, termed Restoration Orientation (RO) involves dealing with the ongoing life stressors related

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to adapting to life without the deceased. Healthy grief involves the oscillation between LO and RO. Complicated grief occurs when this oscillation breaks down, and the mourner becomes stuck in the distress of loss or in avoiding the emotional pain. The clinician must not only focus on dealing with the emotional impact of the loss but also on coping with life tasks, and maintaining the balance between these two orientations.

Another important model of grief is Continuing Bonds (Klass et al. 1996). This model questions models of grief where the end result is detachment from the deceased, "closure", or "moving on". Rather than detaching from the deceased loved one, the mourner creates a new relationship, developing a continuing bond that maintains a connection with the deceased. This helps us understand the important role played by the emergence of positive memories of the deceased, which is commonly observed during EMDR therapy. These positive memories that arise perhaps facilitate the formation of an adaptive inner representation or working model that enables a heart felt sense of connection with the deceased.

All of these models complement each other and can be used to identify appropriate targets for EMDR therapy when working with loss, and will be elaborated on below.

Grief is different from mourning (Rando 1993). Grief refers to a person's reactions to the perception of loss. This includes feelings about the loss and the deprivation it causes (e.g., sorrow, depression, guilt); the mourners' protest at the loss, wish to undo it and have it not be true (e.g., anger, searching, yearning, preoccupation with the deceased); and the mourners' personal actions (e.g., crying, withdrawal, increased use of substances). *Mourning* refers to the assimilation and accommodation to the loss. Mourning encompasses not only grief, but active coping with the loss through reorienting oneself to adapt to the world without the deceased. The mourner must reorient in relation to the lost loved one, one's inner world, and one's external world (Rando 1993). Consequently, the mourner needs:

1) *To evolve from the former psychological ties that connected the mourner to the loved one to new ties appropriate to the now altered relationship.* The focus here is on the relationship to the lost person with the adaptation involving a shift from the old relationship based upon physical presence to a new one characterized by physical absence; that is, from loving in presence (when the loved one was alive) to loving in absence (with the loved one deceased) (Attig 2000).
2) *To personally adapt to the loss.* Here the focus is on the mourner and involves a revising of one's identity and assumptive world (see below) to the extent that each has been impacted by the death and its consequences.
3) *To learn to live adaptively in the new world without the deceased.* The focus here is on the external world and how the mourner will now exist within it.

Losing a loved one can violate one's assumptive world. The assumptive world is the organized whole of mental schemata containing everything a person assumes to be true about the world, the self, and others on the basis of previous experiences. They contain basic assumptions, expectations and beliefs and become virtually automatic habits of cognition and behavior (Janoff-Bulman 1989). As Neimeyer and Sands say (2015): "In the aftermath of life-altering loss, the bereaved are commonly precipitate into a search for meaning at levels that range from the practical (How did my loved one die?) through the relational (Who am I , now that I am no longer a spouse?) to the spiritual or existential (Why did God allow this to happen?)" (page 11). Guilt is also a common reaction, especially for parents who may have deep feelings of responsibility for their children, which are readily transformed into guilt after a child's traumatic death (Worden 2009). Further, Shair et al. (2007) describe four consequences of loss of the assumptive world in relation to grief and loss: a) a continuing sense of presence of the deceased (because it is too difficult to accept the loved one is not coming back), b) activation of attachment proximity seeking triggering a strong sense of yearning and longing for the deceased, c) a decrease in emotional regulation and d) activation of the attachment system which is associated with inhibition of the exploratory system, resulting in loss of interest in the world, withdrawal, and inhibition of goal-seeking.

The death of a loved one can be traumatic. The mourner is confronted with the permanent absence of someone who was a present and significant attachment figure (or recipient of caregiving in the case of parents) in their life. This permanent change in an ongoing real relationship may be too much to assimilate into a person's world view (Janoff-Bulman 1992; Shear and Shair 2005; Solomon and Rando 2007, 2012, 2015). Indeed, a major secondary loss (with the loss of the person being primary), is the loss of one's assumptive world (Rando 1993; Solomon and Rando 2007, 2012, 2015). As Colin Parkes (2011) states: "We think, 'I know where I'm going, and I know who's going with me', except when we lose someone we love, we no longer know where we are going or who is going with us" (page 4). This quote illustrates we not only lose someone we love, but potentially a significant part of our assumptive world, necessitating the need for the assimilation and accommodation of the loss.

EMDR Therapy

EMDR therapy is an eight phase, three pronged (past, present, future) approach guided by the Adaptive Information Processing (AIP) model. There is a paucity of research on EMDR and grief and mourning. Research has shown that EMDR therapy can be effective in the treatment of grief. Meysner et al. (2016), in a randomly controlled study, compared EMDR therapy with integrated CBT, and found both interventions to be equally effective. Cotter et al. (2017), presenting interview data from the same study reported both groups showed increased insight, positive shift in emotions, more of a "mental" relationship with the deceased, increase in self-confidence and increase in activity levels. However, there were some unique effects of each treatment, with those receiving CBT describing that acquiring emotional regulation skills (part of the treatment protocol) was helpful. This was not reported by the EMDR group, who were not taught the same emotional regulation skills (described as a "tool kit" for managing distress) as the CBT group. Unique to the EMDR subjects was that distressing memories were less clear and more distant. The authors note that the EMDR group reported positive shifts in emotion, self-confidence, and an increase in activity even though these changes were not targeted in therapy. The authors also reported that the CBT group reported a shift from grief to an anticipated future of hope and enjoyment. The authors attribute the difference to EMDR, though addressing future obstacles, not addressing future goals whereas the CBT group promoted active work toward building good times. Given the positive and

differential effects of each therapy, an eclectic approach for treatment of grief is recommended. Hornsveld et al. (2010), acknowledging previous studies showing eye movements reduce the emotionality of negative memories, investigated the effect of eye movement in the treatment of negative memories of loss. Recall of the negative memory plus eye movements was found to be superior to no stimulation or listening to music in reducing emotionality and ability to concentrate on the memory (which the authors point out may be related to the vividness of the negative memory). Sprang (2001) demonstrated the effectiveness of EMDR with mourning, by comparing EMDR and Guided Mourning (GM) for treatment of complicated mourning. Of the five psychosocial measures of distress, four (State Anxiety, Impact of Event Scale, Index of Self-Esteem, and PTSD) were found to be significantly altered by the type of treatment provided, with EMDR clients reporting the greatest reduction of PTSD symptoms. Data from the behavioral measures showed similar findings. Further, positive memories of the loved one emerged during EMDR treatment, which did not occur with GM.

There have also been several case studies and discussion on utilization of EMDR and grief and mourning. Murray (2012) describes three cases where EMDR was utilized to treat complicated mourning. EMDR with grief and mourning is also discussed by Lazrove as described in Shapiro and Forrest (1997), Kimiko (2010), and Solomon and Shapiro (1997).

The fundamental premise of the AIP is that present symptoms result from distressing experiences that are maladaptively stored in the brain, unable to be fully processed and integrate within the wider memory network (Shapiro 2018). Processing involves the linking in of adaptive information into the memory networks holding the maladaptive information, forging of new associations. Hence, processing is learning. EMDR can be utilized to target any distressing memory, including memories that do not meet standard criteria to be classified as traumatic (Mol et al. 2005). Small "t" trauma, those "seemingly small" (e.g., mother's angry look) memories that have a significant impact on present day functioning), and can be processed with EMDR therapy (Shapiro 2018)

With processing viewed as learning and facilitating integration, EMDR therapy proceeds in a way that is natural for the person and will not take away anything that the client needs or that is appropriate to the situation (Solomon and Shapiro 1997, Shapiro 2018). Therefore, EMDR can be used to process disturbance, including what is considered to be "normal" reactions or uncomplicated grief. For example, it is normal to be upset by intrusive imagery of the funeral or hospital scenes. However, such recollections can be very painful. EMDR therapy can process these distressing moments (e.g., when one received the news of the death, upsetting images of the loved one in the hospital), and facilitate the decrease of the pain in a way that is natural and helpful for the person. Hence, EMDR therapy seems to process the obstacles (upsetting or traumatic moments) that can complicate the grief.

EMDR therapy is not a short cut for movement through the processes of mourning or resolution of a trauma. Clinical observations indicate that the EMDR client goes through the same mourning processes as other clients, but may do so more efficiently because obstacles to successful integration and movement are removed. Hence, rather than skipping aspects of mourning or forcing clients through mourning processes by neutralizing appropriate emotions or truncating individual growth, EMDR promotes a natural progression by processing the factors that could complicate the mourning.

EMDR therapy involves eight phases (discussed further below) and is guided by a three-pronged protocol:

1. *Processing the past memories underlying the current painful circumstances.* For loss, this may involve moments of shock, denial, other dissociative symptoms, or the moment of realization. This is typically when the loved one heard the news, if not present at the death, or the worst moment if they were present (e.g., hospital scenes, accident scenes). The moment of realization may be before the death ("When I saw her at the hospital, three weeks before she died, I knew we were going to lose her") or after ("One month after he died in a car accident I went to see the car and realized there is no way anyone could have survived"). Past unresolved losses, trauma, or attachment issues can be triggered by the current loss and complicate the grief and mourning, and need to be processed.
2. *Processing the present triggers that continue to stimulate pain and maladaptive coping.* It is important to address the current situations where symptoms, "stuck points", and/or particularly painful moments are experienced.
3. *Laying down a positive future template*. This involves facilitating adaptive coping patterns and strategies in present and anticipated future stressful situations. After processing a present trigger, a future template for adaptive functioning in that situation can be incorporated. Clients may need to learn new coping skills first, which can then be actualized by the future template.

Attachment and grief

Research has shown that attachment style is an important determinant of how one grieves (Kosminski and Jordan 2016, Mikulincer and Shaver 2016). Kosminsky and Jordan (2016) assert that almost all people who seek grief therapy have had their attachment system activated by the loss. Attachment styles form early in life as a function of early child-parent bonding. Infants come into the world hardwired to attach to caregivers for physical protection and a psychological sense of safety (Bowlby 1960). The attachment system is activated in times of distress with the goal of seeking proximity to the caretaker to have a safe haven and secure base provided. When the caretaker is able to provide comfort, soothing, and meet the child's needs, the attachment system is deactivated and reset (Kosminsky and Jordan 2016), and the child becomes ready for exploration, play, and to interact with others (Bowlby 1960). This is the basis for a secure attachment. But if the child's initial distress signals (e.g., crying, etc). do not bring the caretaker into proximity or the caregiver behaves in a rejecting, angry, or impatient manner in response to the child's disturbance, secondary strategies arise to reduce the distress (Bowlby 1982, Mikulincer and Shaver 2016). These secondary strategies are either hyperactivating or deactivating. Hyperactivating strategies include an escalation of the intensity of protest. The child may cry louder and harder, become physically agitated, thrash about, and otherwise intensify their distress signals in an effort to get the caregiver's attention and care. The child may attempt to keep proximity through clinging, crying or in other ways protesting and showing distress

when imminent separation is perceived. Deactivating strategies involve suppression of behavior and affect. As a result of the failure of repeated attempts to get attention/safety from the caregiver, there is a shutting down of awareness of discomfort and signaling behavior aimed at bringing the caregiver into proximity. The child not only stops expressing discomfort, but may stop feeling it.

These secondary strategies become the child's best strategy for restoring or maintaining proximity to the caregiver (Mikulincer and Shaver 2002, Kosminsky and Jordan 2016). The child appraises and learns about the caregiver's availability and the best strategy for gaining proximity as a way of coping with attachment distress. If the caretaker is perceived as comforting when available, but their presence cannot be counted on, then hyperactivating strategies have the best chance to keep the caregiver close. Hyperactivating strategies are the precursor to an anxious attachment style. On the other hand, if the caregiver is perceived as consistently not being available or able to meet needs (e.g., neglectful, critical, annoyed) then deactivating strategies (down regulating the attachment system) are the best way to avoid distress and discomfort caused by the caregiver's unavailability (Mikulincer and Shaver 2016). Deactivating strategies are the precursor of an avoidant attachment style. If the caregiver is the source of terror and safety (e.g., significant abuse and/or neglect), a disorganized attachment style, where there is both activation and deactivation strategies, develops, which can be the precursor to dissociative disorder (Liotti 1992).

Attachment theory also emphasizes the importance of caregiving. We are wired to provide caregiving to the child, that is; protection, physical well being, and comfort and support when distressed. During infancy and early childhood, parents are the main caregivers. However, adults both provide and receive care in their attachment relationships and being an effective caregiver can be as important, if not more, than being cared for in producing a sense of wellbeing (Shear et al. 2007). Consequently, the death of an attachment figure may also be experienced as a failure of caregiving. This can result in feelings of failure, self-blame, and survivor guilt, especially for parents of a child who has died. It is not uncommon for a bereaved person to rebuke him/herself for failing to prevent the death and/or to make it easier (Shear et al. 2007).

Complicated mourning occurs when the mourner attempts a) to deny, repress, or avoid aspects of the loss, its pain, and full realization of the implications of the death and/or b) to hold on to, and avoid relinquishing the lost loved one (Rando 1993). Kosminsky and Jordan (2016), provide an attachment based explanation for the chronic mourner's inability to accept that connection is impossible. The painful state experienced by the mourner in reaction to the loss can be likened who is preoccupied with reestablishing a tolerable level of proximity to a caregiver. Loss of a loved one evokes many of the same reactions that accompanied separation from an attachment figure in childhood (Kosminsky and Jordan 2016). Consequently, attachment style is a major determinant of how a person grieves and accounts for variations in the grief response (Wayment and Vierthaler 2002, Meij et al. 2007, Parkes and Prigerson 2010, Burke and Neimeyer 2013, Kosminski and Jordan 2016). Securely attached people are indeed impacted and saddened by the death of a loved one, but are likely to have an easier time adapting in comparison to those with insecure attachment styles (Mikuliner and Shaver 2008). The old adage, "time heals all wounds" applies. Individuals with insecure attachment styles may have more intense and persistent grief compared to securely attached people. Being careful not to overgeneralize and realizing there is much individuality and variability, research has shown that people with anxious/ambivalent styles are more likely to be hyperaroused and show clinging behavior, loneliness, rumination about their loved one, as well as overwhelming negative affect which can complicate the mourning process (Wayment and Vierthaler 2002, Kosminski and Jordan 2016, Mikulincer and Shaver 2016). Though the role of avoidant attachment in bereavement is less clear; studies suggest that people with an avoidant attachment style, utilizing hypoarousing strategies, have a tendency to be numb and shutdown, but when triggered may feel they are being flooded with unwelcome, distressing emotion (Meier et al. 2013). There may be an apparent lack of anxiety about the loss as a result of downplaying the need for support from others, and a belief there is little to be gained from reaching out to others (Parkes 2013). They may look like they are doing well, but may actually be experiencing internal distress. (Parkes 2013, Parkes and Priegerson 2010).

Given that attachment styles result from interactions with the caregiver, one can understand attachment styles as the result of memory networks organized around child-caregiver interactions that guide relationships and provide a foundation of emotional information about self and other. Anxious, avoidant, and disorganized attachment styles are not only determined by the major distressing experiences that become maladaptively stored (e.g., abuse or neglect) but also the ubiquitous and "seeming small" but impactful moments ("Mommy did not look at me when I was upset"). Treatment of complicated mourning, therefore, involves identification and processing of these past maladaptively stored memories that were formative in the development of one's attachment style and underlie current difficulties.

Dual Process Model

When a loved one dies, the loss is irreversible making primary strategies for seeking comfort and safety from the deceased no longer relevant. Secondary strategies, activation and deactivation, must come into play. Stroebe and Schut (1999, 2010) conceptualize a Dual Process Model (DPM) where healthy adaptation to loss involves oscillation between coping with the pain related to the loss – a Loss Orientation (LO) – and, avoiding the pain, dealing with psychological and practical issues pertaining to a future life without the deceased – a Restoration Orientation (RO). In essence, LO involves activating strategies with the loved one engaged in yearning, searching, remembering, imaginal conversations, and experiencing the presence of the loved one. RO involves deactivation strategies, turning away from the grief in order to deal with daily life tasks. In the dual process model, the process of coping occurs in an oscillatory pattern, with intervals of turning away from grief to deal with daily living as much a necessary part of the mourning process as moving toward and through the grief (Strobe and Schut 1999, 2010; Kosminsky and Jordan 2016). As Mikulincer and Shaver (2017) describe, experiencing the deep pain of the loss (activating strategies), stimulates memories of the loved one along with the realization the person is gone and not coming back. This drives the mourner to explore and appreciate the meaning and significance of the lost relationship and reorganizing their bonds to the loved one from loving in presence to loving in

absence, and integrate the loss. Deactivating strategies, where there is momentary detachment from the loved one, compartmentalizing, and turning away from grief, enables the reorganization process by allowing the person to focus on their changing roles, responsibilities and life situation. So, healthy grief involves oscillation between confrontation of the loss (LO) and periods of avoidance and respite (RO). Oscillation between LO and RO breaks down when the mourner is overly focused on either activating or deactivating strategies. The mourner using activating strategies, at some level, has the belief (or at least the hope) that if they protest long and hard enough, the loved one will return. The mourner using deactivating strategies strives to do what he/she can do to avoid being reminded of the loved one, will deny strong feelings about the loss, and suppress these thoughts if they arise. However, the painful feelings regarding the loved one, even if out of awareness still impact the mourner and can be triggered by reminders.

The DPM model illustrates the importance of taking a broad view of intervention, focusing on dealing with the emotional impact of the loss (LO), how the mourner is functioning in daily life (RO), and evaluating the oscillation between LO and RO. Some clients, overly focused in LO, may not be helped by dealing with details of the death and emotional reactions (Kosminsky and Jordan 2016). Doing emotional work too soon can deepen distress and increase rumination and depression. Rather, there may be more improvement with movement toward RO, for example, an initial focus on affect management and regulation strategies, such as Resource Development and Installation (Korn and Leeds 2002), and providing needed strategies and skills for coping with daily living tasks. Other clients stuck in RO may need initial support to gradually approach the reality of the death with its accompanying thoughts and emotions.

Continuing Bonds

Another important model of grief is Continuing Bonds (Klass et al. 1996). These authors questioned models of grief where the end result is detachment from the deceased, "closure", or "moving on". Grief does not resolve by detaching from the deceased loved one, but rather in creating a new relationship, developing a continuing bond that endures throughout life. The mourner maintains a psychological connection with the deceased loved one (Marwit and Klass1996).

The concept of internal working models is useful here. Through ongoing interactions with the caregiver(s) and consolidation of information on both availability and responsiveness, the child develops an internal working model (IWM) enabling the child to feel the attachment without physical proximity. Hence, the IWM provides a connection with the attachment figures when there is separation. As Bowlby (2005, 2008) describes, these inner working models have a lasting effect and influence expectations regarding relationships, including how people react when someone with whom they are deeply attached to dies. Much like the child who learns to tolerate separation from the caregiver due to the internalization of the relationship (e.g., internal working model), the mourner comes to develop a new inner model of the relationship with the deceased that enables the mourner to adapt to the permanent separation created by the death. The internalized loved one can continue to be a source of felt security, comfort, and as base for exploration into the new world and finding meaning in life.

However, healthy adaptation requires acknowledgement of the death and accommodation of inner working models to include the permanence of the loss. For some, accepting the permanence of this loss may be unbearable, too much to realize and traumatizing. The mourner may feel "stuck" in grief because he/she cannot "connect" with the loved one who is forever gone. Further, the deep pain itself can be the connection to the loved one and the mourner may fear (consciously or unconsciously) that losing the pain is akin to losing the connection. EMDR therapy, as will be elaborated below, appears to facilitate the emergence of positive, heart felt memories of the deceased that enable an adaptive inner representation.

Table 1. *The Six "R" Processes of Mourning* (Rando 1993)

1. Recognize the loss
   - Acknowledge the death
   - Understand the death
2. React to the separation
   - Experience the pain
   - Feel identify, accept, and give some form of expression to all the psychological reactions to the loss
   - Identify and mourn secondary losses
3. Recollect and reexperience the deceased and the relationship
   - Review and remember realistically
   - Revive and reexperience the feelings
4. Relinquish the old attachments to the deceased and the old assumptive world
5. Readjust to move adaptively into the new world without forgetting the old
   - Revise the assumptive world
   - Develop a new relationship with the deceased
   - Adopt new ways of being in the world
   - Form a new identity
6. Reinvest

Rando's "R" processes

Rando (1993) delineated six processes (called "R" processes since the name of each process begins with the letter "R") of mourning (see **table 1**) that are important for the healthy accommodation of a loss. If the mourner does not accomplish these processes, complicated mourning results. There are 42 sets of factors – including the mourner's own psychological make up and the circumstances of the death – which influence the experience of and responses to loss (Rando, in press), so each person's bereavement experience and the corresponding treatment needs are unique. There is not just one correct way for individuals to approach these mourning processes. The "R" processes can be useful in helping client and clinician understand where they are in the mourning processes and what has to be done to facilitate accommodation to the loss.

People do not go through the "R" processes in a linear fashion. During treatment, the "R" processes tend to segue from one to another, with the earlier "R" processes a prerequisite for the later ones. However, often a client needs to go back and again process issues and stuck points related to earlier "R" processes. Consequently,

the clinician has to continually assess client movement through the "R" processes, understanding in which process the mourner may be blocked, and processing relevant past memories, present triggers, and future templates relevant to such blocks. Attachment theory, as described earlier, can be helpful in understanding the factors causing complications and guide the clinician in identifying underlying past memories that need to be processed.

In regard to EMDR therapy, after processing past memories, the R processes can guide the clinician to identifying present triggers and situations where a client may be "stuck". Processing these triggers and stuck points, and providing future templates can help the client traverse through the R processes. It is important for the clinician to understand that if processing of a present trigger becomes blocked, or the client cannot progress through a particular R stage, past memories, as guided by attachment theory, or pertaining to previous losses or trauma, need to be identified and processed.

(1) Recognize the Loss

The mourner needs to acknowledge that the death that has occurred. This goes against the natural urge to deny death's reality and avoid confronting it. Further, the mourner has to develop some understanding of what happened, the reasons for the death and get a "cognitive grip" on what happened. Such understanding can be quite difficult where there are traumatic deaths, such as suicide, situations where no body is found (e.g., airplane crashes), or other horrific circumstances. The acute grief, which can be considered a form of traumatic stress reaction may interfere with the mourning process. The raw felt emotion that makes the loss too much to realize, can make it difficult to think about the deceased and recall memories. Therefore, it is usually important to give priority to dealing with trauma-related material (e.g., intrusive imagery) before working on loss-related aspects of grief and mourning (e.g., the sadness, anger, fear, and other emotions that go with the loss (Rando 2000; Solomon and Rando 2007, 2012).

Prior trauma or loss, as well as the difficulties resulting from attachment style difficulties, can exacerbate the trauma of the loss, and complicate the grief. Past losses, previous trauma, and problems related to attachment issues may be triggered and interfere with current functioning, and need to be processed.

(2) React to the Separation

Once the reality of the death has been recognized, the mourner must react to this new reality and start to cope with it. This involves experiencing the pain resulting from the absence of the deceased. The mourner must feel, identify, accept and give some form of expression to all the psychological reactions to the loss.

EMDR therapy can include the processing of present triggers such as moments and situations where pain and distress were particularly acute ("Last Sunday, when I watched her favorite television show waves of sadness came over me") and situations or moments where the mourner experienced secondary losses (e.g., a moment when the mourner realized the death of the daughter means there will be no grandchildren).

A person may have difficulty with this R process due to the evoking of secondary strategies of activation or deactivation of the attachment system, which can compromise the oscillation between LO and RO. Relevant past memories underlying current difficulties in experiencing or in recognizing and expressing emotion need to be identified and processed to facilitate movement through the R stages.

(3) Recollect and Reexperience the Deceased and the Relationship

In order to be able to make necessary readjustments to loss, attachment to the deceased and the old assumptive world must be altered and evolve to take into account new realities. To accomplish this the mourner needs to: (1) review and remember the deceased and the relationship realistically (including all attachment ties, such as needs, emotions, thoughts, behaviors, dreams, and expectations), and (2) revive and reexperience the feelings associated with that which is remembered. These feelings bind the mourner to the deceased through the different attachment ties and must be experienced, processed, and integrated so that they lessen in intensity and ultimately lead to adaptive information linking in (e.g., positive, heart-felt memories). Processing painful memories often involves deep pain and experiencing "raw felt emotion". When recognized and integrated, the mourner is able to form new ties that are appropriate to the loved one now being dead, along with other necessary readjustments and reinvestments that permit their eventual accommodation of the loss. EMDR therapy, as elaborated above, can help the client go through and integrate the trauma of the loss, facilitate the emergence of meaningful heartfelt memories (adaptive inner representation), and form new ties to the loved one that help with accommodation of the loss.

EMDR therapy can include the processing of painful memories or conflicts ("I feel guilty for not having been present when my father died"), specific memories related to unresolved issues (e.g., an argument that was never resolved), and present triggers where feelings of loss or distress were particularly acute ("It is really distressing to look in his closet and see his clothes").

(4) Relinquish the Old Attachments to the Deceased and the Old Assumptive World

Healthy adaptation to the loss of a loved one requires relinquishing former attachments to both the deceased and the assumptive world which have been rendered obsolete by the death. Complicated mourning develops if old attachments to the loved one and the assumptive world, still based on the loved one being alive, do not evolve. It is maladaptive for a mourner to continue to operate in a now unrealistic assumptive world. It must be emphasized that relinquishing former ties does not mean that the deceased is forgotten or unloved. Rather it means that the ties are modified and transformed to assimilate and accommodate the new reality that the loved one is dead and cannot return the mourner's emotional investment or gratify his or her needs as before.

EMDR therapy can include the processing of painful and distressing moments involving the mourner feeling the attachment but having difficulty in letting go of the old assumptive world (e.g., "I can no longer work in our garden because it reminds me she is dead, and I cannot give her up") and future templates (e.g., working in the garden with fond remembrance and positive meaning).

The processing of painful memories and present triggers results in the emergence of positive, heart-felt memories which seems to result in adaptive changes to the representation of the loved one and the assumptive world. After processing difficulties having to do with

relinquishing the old world the mourner seems to naturally segue into the fifth R process.

(5) Readjust to Move Adaptively Into the New World Without Forgetting the Old

Although the mourner may want to keep the world as it was before the death of the loved one, gradually it is learned that this cannot happen. With time, the mourner ceases the attempts to bring the old world back and becomes able to take steps to accommodate the loss. Internal and external changes evolve that enable the death and its consequences to fit into his or her life. Specifically, this means: (1) revising the assumptive world, (b) developing a new relationship with the deceased, (c) adopting new ways of being in the world, and (d) forming a new identity.

EMDR therapy relevant to the fifth "R" process include situations or moments that represent the distress of adjusting to life without the deceased. These may include moments of distress that reflect difficulties in revising one's assumptive world ("While playing cards with friends, it hit me I am supposed to be with my wife"), situations or moments where the mourner is "stuck" in making the transition from loving in presence to loving in absence ("At my daughter's graduation, I felt that I should not be happy because my wife died"), or situations or moments that exemplify the complications in forming a new identity without the deceased ("When I went to the party by myself, I realized I don't know who I am without him").

(6) Reinvest

This last process involves the mourner's reinvesting in a new life without the loved one, putting energy into other people, activities, ambitions, roles, hopes, causes, pursuits, and so forth. The reinvestment need does not have to replace or duplicate what was lost (e.g., a widow does not have to remarry). Rather, the sole requirement is that emotional energy be reinvested in a fulfilling manner. Moving on is not forgetting and does not mean that the loss is no longer important. It means that the mourner can love in absence and, in the new world without that person, can adaptively go forth with a meaningful and productive life.

There is still pain, but it can be meaningful. As the father of a 27-year-old man who suicided said, "Pain is the other unavoidable side of love in a world haunted by illnesses and death such as ours. This is why, I think, no parent would really wish not to feel any pain, even when many years or a whole life has elapsed, after the loss of a beloved child. Indeed, it seems to me that such a pain after such a loss increases the experience of love and its meaning – our only human goodness – in our lives".

EMDR therapy can process obstacles to "re-engagement," such as moments where the mourner experienced fear and anxiety about pursuing new activities, relationships, and/or resuming one's life (e.g., "I met someone I want to date, but I feel I'm cheating on my deceased husband" or "I want to go back to college, but I'm afraid"). Skill building, resource development and installation, and installing future templates can be helpful.

The EMDR therapy treatment approach

How soon does one utilize EMDR for memory processing? The circumstances surrounding a death can be traumatic. EMDR therapy protocols have been developed for the processing of recent traumatic events (Shapiro 1995, 2001, 2018; Jarero and Artigas 2011; Shapiro and Laub 2013). For example, a woman witnessed her husband commit suicide with a gun. Three days later, an EMDR therapist successfully reduced the intrusive imagery enabling her to start coping more adaptively. When to begin processing of the loss is guided by client response. For example, basic criteria (to a "good enough" level) for EMDR memory processing readiness include ability to stay present with the emotions (e.g., maintain dual awareness with one foot in the past and one foot in the present), the ability to self soothe/lower arousal, the ability to articulate and reflect on the impact of the loss, and there is sufficiently stable external environment (Shapiro 1999, 2001, 2018; Solomon and Rando 2007, 2012, 2015). Especially when there is complicated or chronic grief, with affect dysregulation impacting the clinical picture, the old adage "slower is faster," can be sage advice with the clinician taking the time to help clients understand, articulate, and express, the emotional impact and meaning of the loss before doing EMDR therapy (Solomon and Rando 2007, 2012, 2015). It is strongly cautioned against using EMDR therapy in the aftermath of a loss when numbness, denial, or dissociative symptoms are being experienced. These psychological defenses indicate there is an overwhelming, horrible reality to cope with that is "too much" for the mourner; which needs to be respected. To process memories prematurely can be an intrusion on the client that can stimulate overwhelming emotions the client is not ready to deal with. Psychological first aid, support from friends and family, and "tender loving care" are needed at this point (Solomon 2008, Young 2016)

The Emergence of Meaningful Memories and Continuing Bonds with EMDR

The pain of realization that the loved one is truly dead and the connection is forever gone can be overpowering for a client. The mourner can be "stuck" in the pain of loss, finding the loss of connection unbearable, unable to go through the processes necessary for assimilation and accommodation. Access to memory networks containing positive memories of the loved one are blocked. EMDR processing seems to allow the client to experience, express and discharge the pain which is necessary for the eventual linking in of other networks with positive, adaptive information (e.g., healthy accommodation). When using EMDR with mourners, it is common to observe the emergence of memories of the deceased, along with associated affect (Solomon and Rando 2007, 2012, 2015). This was also observed in the Sprang study (2001) cited above. These positive, heart felt memories provide a sense of connection to the loved one. As Continuing Bonds theory (Klass et al. 1996) points out healthy adaptation occurs when mourners can internalize a representation of the deceased into their inner working model so that psychological proximity can substitute for the previous physical proximity. That is, the mourner moves from loving in presence to loving in absence (Attig 2000). In this context, the memories that arise during EMDR are the building blocks of an adaptive inner representation.

Fairbairn (1952), highlighting the importance of memories, defines an inner representation (in relation to the deceased loved one) as: (a) those aspects of the self that are identified with the deceased, (b) characteristics

or thematic memories of the deceased, and (c) emotional states connected with those memories. This inner representation, experienced through memories and their meaning to us, is what seems to emerge with EMDR. It is the heart-felt memories of the loved one that allow us to know and acknowledge the meaning of the relationship with the deceased and the person's role in our life and identity. The inner representation enables us to carry the connection with the loved one into the future. The client seems to go from "I can't connect" with its consequent deep pain to a sense of connection ("I can connect") with the emergence of heart felt memories. The adaptive inner representation allows the deceased to continue to serve as an attachment figure and to be an important source of felt security in times of distress.

> Case Example: A 44-year-old woman came into treatment three years after the death of her father. She still suffered from negative images of him at the hospital. He had suffered, was in pain, and she felt helpless. A major goal for her was to be able to think of her father and have positive images of him. During the processing, she got in touch with past memories of her father when he was healthy. She also remembered her father did not like their dog when she was growing up, and the father had joked about his upcoming death, "Spot (the dog) is up in heaven right now going, 'Oh no". Memories came up of all the things she did to help her father (e.g., work with hospital staff to make him more comfortable, hold his hand, read to him). At the end of the session, she realized she had helped her father as much as she could, and their last interactions were meaningful. After installation of the positive cognition ("I helped him") she was asked to think of her father, since the goal of the session was to have positive images of him. Images of her father smiling and of happy moments with him emerged. These images and positive feelings associated with them were reinforced with eye movements.

This case illustrates how processing painful moments can result in the emergence of positive, heart felt memories. It is suggested that at the end of a processing session, the client can be asked to think of the deceased and describe what memories come up. If positive, these memories with heart felt emotion can be reinforced with bilateral stimulation. This serves as an additional installation to enhance the adaptive inner representation. If negative, painful, or neutral images arise, it can, in the author's experience, be an indication that the client would benefit from further processing. It must be emphasized that the emergence of positive heart felt emotions does not mean the client is through grieving. Rather, it appears to balance out the pain, enabling the client to continue to go through the mourning process, providing relief and a sense of connection and positive meaning (Neimeyer 2006, 2015).

However, memories that arise can evoke distress. This is especially true in cases of complex trauma involving abuse and neglect. Experiencing anxiety, ambivalence, depression, anger, or guilt when recalling the deceased can be symptomatic of complicated mourning (Solomon and Rando 2015). In these cases, treatment needs to address both the complex trauma issues as well as grief.

Case Conceptualization and Treatment Planning

Acute grief can be likened to acute trauma (Rando 2000; Shear et al. 2007; Solomon and Rando 2007, 2012, 2015). Following the three-pronged approach of past, present future, as described above, memory processing can begin at the initial moment(s) of shock, denial, dissociative symptoms, or realization of the loss, (e.g., getting the news). However, one can modify this depending on whether past trauma or losses may be influencing the current clinical picture. For example, a husband was killed in a car crash which also triggered memories of her father's death. The father had committed suicide, and had told her he was thinking about it several days before he did so. There is a choice of going with the present trauma of her husband's death (for example, when she got the news) or the past trauma and loss regarding her father (e.g., when her father told he was suicidal). Common practice seems to be to first target what is most painful and intrusive, giving priority to what is most present and felt by the client, and then the other identified memories that arise during processing (Solomon and Rando 2007, 2012, 2015). However, the choice of initial memory processing has to be tempered with client readiness and what can be tolerated. If the client is suffering from complicated grief then it is important to first identify and process not only past memories related to loss or trauma, but also memories as informed by attachment theory. The loss of a significant person in adulthood can evoke many of the same feelings and responses that accompanied separation from an attachment figure during childhood (Kosminsky and Jordan 2016). Consequently, past maladaptively stored memories that were formative in the development of one's attachment style and underlie current difficulties need to be identified and processed. Research has shown that EMDR therapy of early traumatic memories or unresolved losses moves patients toward a more secure attachment status (Wesselmann et al. 2012, Verardo and Zaccagnino 2016).

Case example: Six years after her mother died of cancer, a 47 year old woman was still feeling guilty and depressed over her mother's death. She felt she should have taken better care of her and could have been more supportive. Her worst memory was when the doctor told her at a check up that further treatment would not help. On the way home from the appointment, they stopped at a restaurant and talked casually. The client felt she could have talked more openly with her mother, and encouraged her mother to talk more openly to her. The client, with an anxious attachment, described a history of growing up with an alcoholic father who was critical, and a mother who tried to be supportive but was often overwhelmed by the father's behavior. The processing of this worst memory became stuck, and when asked to follow the negative feelings she was experiencing back in time (called the "affect scan" procedure – Shapiro 2001, 2018) a memory came to mind where her father was being very critical and her mother was very upset at watching this. The child was not only distressed about what the father said, but also felt guilty that her mother was so upset. Over the next three sessions, this memory and other past memories (e.g., moments where she felt alone, experienced helplessness) were processed. There was a generalization effect from processing the past memories, and her worst memory (at the restaurant with her mother) spontaneously integrated.

EMDR therapy involves an eight phase protocol that will be elaborated below.

PHASE 1 History Taking

The history phase of EMDR includes identifying experiences that underlie present difficulties. In the context of grief, this involves identification of the upsetting moments, situations, and memories (maladaptively stored information) that need to be processed to empower progression through the phases of mourning and the accommodation of the loss. Further, it is important to identify personal issues, premorbid problems, coping skills and ability, and previous trauma and losses that may need to be dealt with at some point during treatment. Although impactful and intrusive moments of distress related to the loss are often initial targets, it is sometimes more important to first process past memories related to other losses, traumas, or present problems that intrude, preoccupy the client or may otherwise block EMDR processing. Many people who seek treatment after a major loss have other personal issues that have been triggered and may need to be dealt with first. For example, as described above, one's attachment style has a significant impact on how one grieves and can interfere with the integration of the loss.

Not uncommonly, a client will come in with depression or anxiety symptoms that they do not recognize as linked with an earlier loss. Or, a previous loss that the client has thought they had accepted may be an unrecognized cause of present dysfunction. For example, one man came into treatment to deal with his increasing anxiety after an automobile accident. The fear and helplessness experienced during the accident was connected to the death of his brother when he was eight years old. Once this was processed, his fear significantly abated.

Some important areas to assess are described below (adapted from Rando 1993, and Kosminsky and Jordan 2016). History gathering is not only important in getting to know the client and the context of the loss, but it begins the building of a therapeutic alliance that provides a safe base. Some areas of initial investigation include:

- Circumstances of the death, including the events that led up to and

followed it

- Nature of the loss and the meaning to the client/ personal impact
- Cognitive, emotional, physiological and behavioral reactions to the death
- What has changed in the client and in life since the death
- Reactions to reminders
- Assessment of client's functioning, both objectively and how the client feels he/she has been doing with the loss and will be able to deal with it in the future
- Coping skills and strategies, and daily life functioning (evaluate balance between a Loss Orientation and Restoration Orientation)
- Reactions of others in the client's life and degree of support received

(and is still receiving)

- History of prior losses and how they have impacted the client before this loss and now
- Emotional difficulties the client has experienced prior to this loss and how these issues are impacting the client now
- Trauma history
- History of relationships with close attachment figures
- High risk factors (e.g., suddenness and lack of anticipation of the death, violence, human caused event, suffering of the loved one prior to the death, unnaturalness, preventability, intent of responsible agents, randomness, multiple deaths, untimeliness, loss of a child)

As elaborated above, it is particularly important to assess the attachment history with the deceased since a loss can be compounded and complicated by unresolved attachment issues and conflicts (Kosminsky and Jordan 2016). For example, one woman never felt accepted by her mother. When the mother died, the realization that she would never get the acceptance she always wanted resulted in a *secondary loss* that complicated the grief. Hence, along with the trauma of the loss, earlier memories pertinent to the lack of acceptance throughout her life needed to be dealt with.

Phase 2 Preparation

The preparation phase of EMDR involves establishing a therapeutic alliance, providing education regarding symptoms and reactions (including the grief and mourning processes), discussing EMDR treatment and its effects, and developing stabilization, depending on the needs of the client.

A loss can be devastating and interfere with present functioning. Consequently, the grieving client should be assessed for EMDR treatment readiness and appropriate stabilization strategies implemented. The balance (oscillation) between LO and RO should be evaluated. If the client is overly focused in a LO, provide interventions that help with RO, such affect regulation and daily life coping strategies. A client overly focused on RO needs a safe, collaborative relationship to explore the emotional impact of the loss (LO). Indeed, especially with grief when the mourner has lost an attachment figure or caretaking figure (as when a parent loses a child), the therapeutic relationship provides a sense of felt security and a safe base for exploration both in the outer world to adapt to life without the deceased, and the inner world to stay present and process the deep pain.

In initial sessions for the newly bereaved, psychosocial education on common reactions and coping strategies may be useful as acute grief can be quite frightening and clients do not necessarily understand their reactions or why they are experiencing them. Often the newly bereaved need reassurance that their distressing feelings and reactions are normal reactions to an intense situation.

Phases 3-8: EMDR therapy memory processing

The following case will illustrate EMDR standard protocol for processing negative memories. This case has been presented before (Shapiro and Solomon 2017, Solomon and Rando 2012) and is adapted for this article.

"Jane" had come to counseling to address her anxiety, depression, and suicidal thoughts after the death of her son, "Sam," who was killed in an automobile accident two years earlier. Despite the counseling, Jane was still having difficulty accepting the reality of her son's death. She reported that every time she thought of Sam, she was overwhelmed with grief.

Phase 3: Assessment

The assessment introduces the reprocessing phases of EMDR. In this phase the specific elements of the targeted memory are called to mind. The disturbing experience is accessed, and the client identifies the worst image, negative belief and emotion associated with the recall of that experience, and the location of the associated bodily sensations. The negative belief is the negative self-referencing appraisal that arises when the disturbing experience is brought to mind. This can be something like: “It’s all my fault”, “I am not good enough”, “I am vulnerable”, “I am powerless”. A preferred, positive cognition (a positive, adaptive belief such as: “I did the best I could”, “I am good enough”, “I am safe now”, “I have some control”) is also elicited that identifies the client’s desired outcome. Baseline measures utilized are the Validity of Cognition ([VoC] Shapiro 1989) scale, with clients rating how true the positive cognition feels to them on a 1 to 7 scale, where 1 = totally false and 7 = totally true, and a Subjective Units of Disturbance ([SUD] (Wolpe 1969, Shapiro 1989) scale, which uses a 0–10 scale, where 0 = calm/neutral and 10 = the worst it could be.

Case example: The EMDR therapy session focused on a moment when Jane had been thinking of her son (while she was driving the previous week) and again realized he was dead, and was very upset. The image was of driving and thinking of her son, with a negative cognition of, “I can’t go on living,” a positive cognition of, “I can go on” (VoC of 3), the emotion was one of deep sadness, and a SUD level of 9 that was felt “in her gut”.

Phase 4: Desensitization

In the desensitization phase, the first of the three active reprocessing phases, the client focuses on the image, negative belief, and physical sensations associated with the disturbing memory, while simultaneously engaging in sets of bilateral stimulation. The goal of this phase is to address the maladaptive aspects of the memories and allow their full integration within adaptive memory networks. The bilateral stimulation seems to stimulate a chain of associations which is conceptualized as the linking in of adaptive information. Spontaneous shifts in cognition, emotion, and physical sensation demonstrate the in-session treatment effects. Further, clinical observations indicate that EMDR can facilitate the processing of the “raw felt emotion” (Solomon and Rando 2007) often experienced by mourners that prevent realization of the loss.

Case example: Initial sets of eye movements were accompanied by strong emotions. For example, Jane said: “I just had a realization – that it’s like being robbed a second time. When I look at his face, or think about his beautiful smiling face… instead of being able to experience that love and the person that is Sam… it’s just horrible, it’s not even allowing me to enjoy that”. The intense emotions lasted for about 16 minutes. The following is an excerpt of the transcript of the session: after about 16 minutes of processing, involving intense emotions, the therapist asks Jane to go back to the target memory.

Therapist: What do you get now when you go back to the memory of when you were thinking of Sam?
Jane: I feel sad, but I also feel a little bit of happiness.
Therapist: Go with that. (The therapist proceeded with a set of eye movements).
Jane: A thought just came to me that I don’t have to expend so much energy fighting the fact that Sam is dead.
Therapist: Go with that. (The therapist proceeded with a set of eye movements).
Jane: Maybe I could possibly come back to trusting the universe a little.
Therapist: And now when you think of that moment we started with, what comes up?
Jane: It doesn’t feel so emotionally charged.
Therapist: (after another set of eye movements with her feeling no change) How disturbing is the memory 0 to10, with10 being the absolute worst it could be and 0 being calm?
Jane: I would say like, a 1 or 2 or something in that range.
Therapist: Okay. Just notice that. (The therapist proceeded with a set of eye movements).
Jane: I feel pretty good and peaceful at this moment in time.
Therapist: Okay. Just notice that. (The therapist proceeded with a set of eye movements).
Jane: This is the first time I can think about Sam’s image and his beautiful, smiling face without hurting so bad.
Therapist: Good, so when you go back to the memory we started with, what do you get?
Jane: I think of Sam and its bittersweet—like a feeling of warmth and love and sadness mixed together.
Therapist: Go with that. (The therapist proceeded with a set of eye movements).
Jane: It’s like, I’ll be able to live through it, not that I’m not going to still be sad but I won’t be stuck.
Therapist: Go with that. (The therapist proceeded with a set of eye movements).
Jane: I’m not feeling sorrow. I can learn to live with this.
Therapist: Go with that. (The therapist proceeded with a set of eye movements).
Jane: I know that Sam would want that and I would be honoring his life.
Therapist: Go with that. (The therapist proceeded with a set of eye movements).
Jane: I feel more accepting – I can‘t say that I accept his death. But that I‘m feeling more willing to move through the process because I want to honor him.
Therapist: Go with that. (The therapist proceeded with a set of eye movements)
Jane: I feel like, it‘s safer to allow this to come to mind now.
Therapist: Go with that (The therapist proceeded with a set of eye movements)
Jane: And it‘s not so threatening and scary. It‘s going to be okay.

At this point, the SUD was a “2”, which was thought to be appropriate to the situation.

She also wanted to stop because she felt she was in a good place.

In this phase of EMDR, the raw felt emotion was processed, enabling her to think of her son positively: “This is the first time I can think about Sam’s image and his beautiful, smiling face without hurting so bad”, illustrating the change in her inner representation of her son. She was no longer “devastated”, and could have hope for the future. The SUD got down to a “2”, which was deemed appropriate for the situation. Usually, the goal of this phase is to achieve a SUD of “0”, that is, no distress. However, we are not unemotional beings and EMDR clinical experience and observations indicate that EMDR will not take away appropriate emotion or anything a person needs (Shapiro 1999, 2001, 2018).

Phase 5: Installation

With processing, the negative images and emotions decrease and positive images and emotions increase. Given the consistently emergent adaptive, positive perspective that arises through processing, EMDR therapy can be conceptualized as a paradigm for enabling resilience and coherence (Solomon and Shapiro 2012). The Installation phase enhances this naturally occurring shift toward resilience and adaptive resolution by pairing the positive cognition with the negative memory and continuing the processing with additional bilateral stimulation. The VoC scale is used to measure treatment effects.

Case example: The positive cognition that emerged for the mother was, "I can learn to live with this and honor his life". On a 1 to 7 scale, with one being totally false and 7 being totally true, the VoC was a 6. The "6" was thought to be ecologically appropriate to the situation since no matter how positive she felt, there was still sadness. This also shows how EMDR therapy is a paradigm of resilience with the mother feeling her son as an inspiration to go on, honoring his life.

Phase 6: Body Scan

While holding the memory and positive cognition in mind, clients are asked to scan their body and identify residual disturbing physical sensations, which are then processed to complete resolution. Processing is considered complete when all negative somatic responses are eliminated. Not uncommonly, the body sensations that arise during the Body Scan are connected to earlier, maladaptively stored memories or other aspects of the target situation, which then are processed. However, it is common for positive affective responses that are associated with strength and confidence to emerge and strengthen during this phase.

Case example: The client was able to think of the target memory and the positive cognition with her body feeling much lighter and calm, though she experienced some sadness. Another set of bilateral stimulation resulted in her continuing to feel calm, but sadness was still experienced and because it was deemed to be appropriate to the situation, this phase of treatment was considered complete.

Phase 7: Closure

At the end of the session, it may be important to provide interventions to return the client to equilibrium (e.g. a safe place exercise or other stabilization and grounding strategies [Shapiro 2012]). In addition, the client is advised that processing may continue between sessions, and that it is helpful to keep a log of any disturbance that arises so that this can be addressed at a subsequent session. The client is also reminded to use the self-care techniques that were taught in the preparation phase of EMDR.

Case example: The previous session was discussed and the mother was asked for her impressions about the session and what she noticed was different. Among the topics discussed was her becoming aware of a fear of letting go of her pain because she thought it might lead to losing contact with her son. Indeed, it is not uncommon for emotional pain to be the connection to the deceased so there may be resistance to letting go. What she now realized was that without all the emotional pain she could feel the connection to her son more and enjoy her memories of him and honor him. She reflected on the session saying, "It was difficult to go there but I do all the time anyway... and now I can go through it with new feelings that I haven't experienced before. What was good was being able to move through it. I feel some sort of resolution". She also felt a sense of accomplishment, and that there is something to be gained from moving through it. "It's growth and some freedom".

She was informed that after the session, processing continues and that other feelings, thoughts, and memories related to her son may come up, and that she could use her safe place and other grounding exercises as needed.

Phase 8: Reevaluation

At the next session, clients are assessed regarding their current psychological state, whether the therapeutic effects of the previous session were maintained, and other material (e.g. dreams, flashbacks, other memories, distressing moments) that may have emerged since the last session. The result of this assessment guides the direction of further treatment.

Case example: At the next session, two weeks later, the mother reported being able to think of her son with positive affect and "enjoy my memories of him and feel him in my heart... I feel connected to him now".

This case example illustrates how a traumatic loss complicated the mourning processes. The mother could not think of her son without significant distress. She felt stuck and distressed that she could not connect to him or move on with her life. EMDR therapy helped her to process the raw felt emotion, evolve an adaptive inner representation, feel connected to him, and continue to move through the mourning processes with a sense of resilience.

Overall therapeutic framework

EMDR therapy needs to be incorporated into a comprehensive treatment framework. As stated earlier, almost all people who seek grief therapy have had their attachment system activated by the loss (Kosminsky and Jordan 2016). Attachment behaviors rooted in infancy and childhood can complicate grief and movement through the "R" processes of assimilation and accommodation. Fostering a trusting therapeutic relationship is essential to provide a safe base to explore the inner world of reactions (a loss orientation), and to explore the new world without the deceased (a restoration orientation). EMDR therapy can be incorporated with therapeutic frameworks specific to attachment style (e.g. see Wallin 2007, Brown and Elliot 2016, Kosminsky and Jordan 2016). Clients with disorganized style may need therapeutic frameworks appropriate for complex trauma and dissociation, providing treatment of loss within a Phase Oriented Treatment approach (Van der Hart et al. 2010, 2013, 2014).

For clients suffering from traumatic loss, it is important to address trauma symptoms to prevent further complications (Solomon and Rando 2012). However, if the trauma of the loss may be triggering significant past issues then past memories may need to be dealt with first. It is common to go back and forth between grief issues and past developmental issues as guided by the client's symptom picture.

It is also important to provide appropriate treatment interventions for the specific factors associated with the death. For example, the issues surrounding death of a child are different than issues surrounding death of a spouse. Suicide of a loved one brings unique issues

that need special consideration (Rando, in press). It is important to address the specialized issues and needs specific to the type of loss.

Many interventions can be beneficial. As Cotter et al. (2017) noted in their study comparing EMDR therapy and CBT, each method had some unique effects so an eclectic approach is recommended. Other interventions (e.g. bereavement rituals, memorials, or writing a letter to say good-bye can augment EMDR therapy, etc). can provide the client with a comprehensive and well rounded treatment framework.

Conclusion

EMDR can be extremely helpful in the treatment of grief and mourning. However, having a theoretical framework to understand how grief gets complicated is needed to inform EMDR case conceptualization. Rando's framework describes the processes a mourner needs to go through for healthy accommodation of the loss. Attachment theory helps us understand the complications that can arise in going through these processes. Given that the loss of a loved one can arouse many of the same reactions that accompanied separation from an attachment figure in childhood, attachment style is a major determinant of how a person grieves and accounts for variations in the grief response. Understanding attachment style as memory networks that result from child-caregiver interactions, the clinician can target relevant attachment memories (from the obvious significant memories to the "seemingly small" but impactful moments) underlying current difficulties. Continuing Bonds theory helps us understand that the connection to the loved one does not go away, but transforms to enable the shift from loving in presence to loving in absence. This helps the clinician understand the importance of the positive memories that arise during EMDR. These memories aid in the formation of an adaptive inner representation of the loved one that brings to heart the meaning of the relationship and enables adaptation to the new world. The Dual Process Model informs us that healthy grief is the oscillation between coping with the emotional loss and coping with daily living tasks. Helping clients maintain the balance and oscillation, and not just focusing on grief work, is important for healthy adaptation.

EMDR therapy's three pronged approach (past, present, future) can help the client: a) process the trauma of a loss, b) treat the attachment based memories underlying complicated grief (as well as present triggers and providing future templates) c) develop a meaningful continuing bond with the loved one through an adaptive inner representation composed of heart-felt memories, d) maintain a healthy oscillation between LO and RO, and e) facilitate movement through the processes necessary for the assimilation and accommodation of the loss.

Given the importance of attachment on grief, it cannot be emphasized enough the importance of the therapeutic relationship as the vehicle for safety, integration, adaptation, and change. Being knowledgeable about attachment based psychotherapy frameworks, and having a variety of techniques and interventions specific to grief and mourning, can provide a comprehensive treatment approach.

Lastly, more research is needed on EMDR and treatment of grief and mourning. EMDR as a treatment of disturbing memories is well founded in research. But further specific research on the application to grief and mourning is needed as well as more RCT's comparing EMDR therapy and other interventions.

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