Utilisation of Eye Movement Desensitisation and Reprocessing in the treatment of grief and mourning

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Abstract: Eye Movement Desensitisation and Reprocessing (EMDR) can be utilised within a comprehensive framework for the treatment of grief and mourning. EMDR can process the obstacles that can complicate the grief and mourning processes. This seems to facilitate the emergence of positive memories of the deceased, which aids the formation of an adaptive inner representation. The utilisation of EMDR within six processes necessary for adaptive assimilation of the loss is described with case examples.

Keywords: EMDR, mourning, complicated grief, traumatic grief, post-traumatic stress disorder

Introduction by Colin Murray Parkes

Although all grief is traumatic, some is more traumatic than others and some people are so haunted by reliving, in their minds, horrific events associated with a death, that they strive to avoid reminders and remove themselves from any situation that will bring home the reality of the loss. They may be unable to work. This condition is termed PTSD, Post-Traumatic Stress Disorder. When it occurs following the death of a loved person, it interferes with the course of grieving (in this article referred to as 'mourning') and requires psychological treatment.

EMDR, Eye Movement Desensitisation and Reprocessing, is an effective and well-researched method of treating PTSD that is widely available from psychologists. In essence it is a way of helping people to focus their attention on particular haunting memories, or the imagination of dreadful events, by following, with their eyes, the movements of the therapist's finger or other object that is oscillated from side to side while the client repeatedly describes the painful image that torments them. With each repetition the pain grows marginally less until a satisfactory level of tolerance is reached. People do not forget the dead but they regain control of their thoughts and become free to grieve.

In this valuable paper Roger Solomon and Therese Rando review the research literature and give details of a form of integrated therapy. Using clear case studies, they show how EMDR can be integrated with bereavement support. In countries such as the UK, where well-trained bereavement support is available, collaboration between trauma psychologists and bereavement therapists is possible.

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Introduction

While loss is ubiquitous throughout all human life, there is little argument that the death of a loved one confronts human beings with particularly complicated challenges at a time of often unparalleled distress. Over two decades ago, the prestigious Institute of Medicine study documented that bereavement – even when it is uncomplicated – precipitates significant psychological, behavioural, social, physical, and economic sequelae (Osterweis, Solomon, & Green, 1984). Consequently, there are few, if any, situations that warrant greater consideration for the application of therapeutic techniques to alleviate pain, reduce dysfunction, work through conflicts, and promote adaptation. For this reason, we present this article to offer a framework for intervention in grief and mourning utilising Eye Movement Desensitisation and Reprocessing (EMDR) as a particularly potent and efficacious treatment. A general schema for grief and mourning is provided, with an overview of how EMDR can be applied within it. Numerous case examples are provided to illustrate EMDR's use.

The effectiveness of EMDR with mourning was demonstrated by Sprang (2001), who compared EMDR and Guided Mourning (GM) for treatment of complicated mourning. Results showed that out of the five psychosocial measures of distress, four (State Anxiety, Impact of Event Scale, Index of Self-Esteem, and posttraumatic stress disorder (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 behavioural measures revealed similar findings. Further, positive memories of the loved one emerged during treatment, which did not occur with GM.

Lazrove (as cited in Shapiro & Forrest, 1997) describes a three-stage model for dealing with grief, using the EMDR protocol to deal with the blocks and complications that may be present. Specifically, the first stage involves dealing with the death, the second stage addresses accepting the death, and the third stage focuses on integrating the absence of the person in the future. When there is blocking or resistance to processing, Lazrove suggests that it is helpful to have a discussion (or if there is blocked processing, a cognitive inter-weave) of 'What (in relation to the loss) do you want to let go of (eg. intrusive images, nightmares)?' and 'What do you want to keep (eg. positive memories, positive feelings)?' Shapiro and Solomon (1997) describe how EMDR can be employed with grief to facilitate processing of the trauma related to the grief and to resolve issues related to responsibility, present safety, and control. However, a broader perspective on utilising EMDR in the treatment of grief and mourning can be achieved by integrating EMDR within a comprehensive framework. Rando (1993) has delineated just such a framework for dealing with grief and mourning. It provides a useful schema for conceptualising the grief and mourning processes, assessing and intervening where the mourner is within those processes, monitoring progress, and evaluating the mourner's status.

The six 'R' processes of mourning

1. Recognise 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 re-experience the deceased and the relationship
   - Review and remember realistically
   - Revive and re-experience 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

Note. From *Treatment of complicated mourning*, by TA Rando (1993). Champaign, IL: Research Press.

Rando (1993) distinguishes grief from mourning. Grief refers to the process of experiencing reactions to one's perception of loss. In contrast, mourning encompasses not only grief, but active coping with the loss through reorienting oneself to adapt to the world without the deceased. These reorientations occur in relation to the lost loved one, one's inner world, and the external world. The objectives are (Rando, 1993):

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 lost person and the adaptation to a relationship of loving in absence from loving in presence (Attig, 2000).
2. To personally adapt to the loss. The focus here is on the mourner and involves a revision of the mourner's assumptive world and identity insofar as each have been impacted by the death and its consequences.
3. To learn to live adaptively in the new world without the deceased. Here the focus is on the external world and how the mourner exists in it.

Rando (1993) has delineated the six 'R' processes of mourning (see box), which encompass what must be accomplished for a loss to be accommodated healthily, and without which complicated mourning results. As used here, complicated mourning is considered to be present whenever, taking into consideration the amount of time since the death, there is some compromise, distortion, or failure of one or more of the six 'R' processes of mourning (Rando, 1993). There are 42 sets of factors – including the circumstances of the death and the mourner's own psychology – which influence the experience of and responses to loss (Rando, in press). This renders each person's bereavement experience and their corresponding treatment needs unique. It explains why there is not just one correct way for individuals to approach these mourning processes.

The EMDR treatment approach: adaptive information processing (AIP) model

The fundamental premise of the adaptive information processing model (AIP) is that current disturbance is the result of dysfunctionally stored information (Shapiro, 2001). Processing involves the forging of new associations, with adaptive information from other memory networks able to link in to the memory network holding the dysfunctionally stored information. Hence, processing is learning. EMDR can be utilised to target distressing situations that significantly impact an individual, even if they do not meet standard criteria to be classified as traumatic. Because processing is learning, and in EMDR processing occurs in a way that is natural for the person, EMDR will not take away anything that the client needs or that is appropriate to the situation (Solomon & Shapiro, 1997). Therefore, EMDR can be used to process disturbance, including what are considered 'normal' reactions. For example, it is not unusual to be upset by recollections of a loved one in a casket, nor would it be abnormal to be angry in response to deprivation of a beloved person. With time, such images and their associated affect, along with other emotional reactions, may fade. However, EMDR can still be quite effective in facilitating the processing of these images and affects.

A major loss can indeed be distressing and there can be many moments, situations, and memories that become dysfunctionally stored. When the loss is triggered, anguish, pain, and difficulties in adaptation result. The loss can be so distressing that other memory networks with positive memories of the loved one cannot be accessed, experienced, and felt. Our experience is that with processing, positive memories with associated affect emerge. Indeed, EMDR seems to foster the natural adaptive healing and resolution patterns that are innate within human beings. For most mourners, 'good grief' seems to be the ability to remember and think about the deceased loved one with positive affect. This is what seems to get us through the painful mourning processes, and enables our adaptation.

A fundamental assessment issue for utilisation of EMDR is identification of the dysfunctionally stored information (eg. the moments, situations, and memories) that need to be processed to empower progression through the processes of mourning and the accommodation of the loss. What is targeted with EMDR is guided by a three-pronged protocol:

1. *Processing the past memories underlying the current painful circumstances*. These might include such things as the moment the client heard about the death, hospital or funeral memories, or painful past memories involving the deceased. There may be dysfunctionally stored memories that underlie the current negative response to the loss (eg. previous unresolved losses, traumas, attachment issues) that need to be identified and processed.
2. *Processing the present triggers that continue to stimulate pain and maladaptive coping*. This means addressing 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 in present and anticipated future stressful situations. Clients may first need to learn new coping skills that can then be actualised by the future template.

EMDR is not a shortcut to resolution of a trauma or movement through the processes of mourning. Clinical observations indicate that the EMDR client goes through the same mourning processes, but perhaps more efficiently because obstacles to successful integration and movement can be efficiently processed. Hence, rather than skipping parts of mourning or forcing clients through mourning processes by neutralising appropriate emotions or truncating individual growth, EMDR promotes a natural progression by processing the factors that could complicate the mourning.

The emergence of meaningful memories and the inner representation with EMDR

Therapists who use EMDR with mourners consistently observe the emergence of memories of the deceased, along with associated affect. This was also observed in the Sprang study (2001) cited above. A loss can be so distressing that it blocks access to memory networks containing positive memories of the loved one. With processing of distressing moments and memories, these memory networks become accessible. The emergence of memories plays a vital role in accommodation of loss. Memories of the deceased serve as an essential bridge between the world with and the world without the loved one (Buchsbaum, 1996), and are the building blocks of inner representations. Consequently, those memories that arise during EMDR may function to aid in the formation of an adaptive inner representation.

Having an adaptive inner representation of the loved one is essential in mourning. We do not lose attachments to loved ones that die; they are transformed (Silverman & Klass, 1996). Data suggest that rather than detach from the deceased, survivors find a way of carrying an inner representation of the deceased with them (Marwit & Klass, 1996; Silverman & Nickman, 1996). This representation is dynamic and changes with time. Fairbairn (1952) defines the inner representation 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 the meanings we give to them, is what seems to emerge with EMDR. It is the emergence of memories of the deceased that lets us know and acknowledge the meaning of the relationship with the lost loved one and that person's role in our life and identity. It enables us to carry into the future the basic security of having loved and been loved. We can go forward in a world without the deceased because we have an adaptive inner representation to take with us.

Case example

A baby was killed in the Oklahoma City bombing. The mother was not allowed to see the remains, but was told that the baby had died of a head wound. For the next two months, the only image the mother had of her child was an imagined one of her baby with a severe head wound. She had no access to other memories. Further, this negative image was easily triggered and disrupted her ability to function. Two months later, after an hour assessment, EMDR was provided. The negative vicarious image of the baby was targeted. After the first set of eye movements, a memory of the baby with her husband came to mind. With further sets of eye movements, more memories came to mind – the baby with her, family interactions, and finally the memory of handing her baby to the daycare worker and saying 'Good-bye' and 'I love you'. At that moment, she wanted to stop the EMDR because she felt a sense of peace and closure. This memory was then installed by having her keep the positive image and feelings in mind during sets of eye movements.

In this situation, the traumatic circumstances and being unable to view her baby had resulted in this mother's intrusive negative vicarious imagery and blocked access to other memories. Processing the vicarious image allowed access to other memories and a sense of closure. This enabled normal mourning to resume. Four months later, EMDR was again utilised to help the mother work through the rage she felt at the perpetrators of the explosion, with treatment continuing for another year and a half.

If, for whatever reasons, these memories and inner representations evoke distress, the processing of them is indicated. Experiencing anxiety, conflict, depression, anger, or guilt when recalling the loved one can be symptomatic of complicated mourning (Rando, 1993). History taking and utilising the floatback can enable the clinician to find memories that underlie the present distress (Shapiro, 2001). Finding adaptive resolution to conflictual or traumatic memories that make up distressing inner representations is an important element in therapy.

An important caveat: don't use too early!

It is strongly cautioned against using EMDR in the immediate aftermath of a loss when numbness, denial, or dissociation is being experienced. These psychological defences are needed to deal with what is often a horrible, overwhelming reality for the mourner. Consequently, such defences need to be respected, not processed. To process them prematurely can be an intrusion on the client that can stimulate overwhelming emotions the client cannot yet handle. Psychological first aid, support, friends, family, and 'chicken soup' are needed at this point, rather than a probing therapy. Generally speaking, EMDR can be considered when the emotional impact starts to be felt, the client has sufficient affect tolerance to deal with the emotions that may arise, and the client is sufficiently stabilized internally and externally.

Integrating EMDR into the six 'R' processes of mourning

EMDR treatment can be utilised within all of the six 'R' processes of mourning. While elaboration of the 'R' processes and case examples are beyond the scope of this brief article, some guidelines can be offered. The overall strategy is to process the dysfunctionally stored memories (both past and recent) and present triggers that interfere with the 'R' processes, and provide appropriate psychoeducation, resource development, and future templates that enable progression through the 'R' processes. Targets for each 'R' process will be discussed. However, the clinician should be alert for past distressing memories/unresolved traumas that are linked to present moments of distress (or that may arise during processing) that need to be processed, and utilise future templates as needed to facilitate coping with present and anticipated future difficult situations.

First process: Recognise the loss

The mourner needs to acknowledge that the death has occurred, which is contrary to the natural urge to deny death's reality and avoid confronting it. Further, the mourner has to come to some understanding of the reasons for it and get a 'cognitive grip' on what happened.

Acute grief, experienced in the beginning of mourning, is generally a form of traumatic stress reaction (Rando, 2000). Depending upon the amount of trauma perceived by the mourner in the death, there is more or less traumatic stress present. Because trauma can interfere with the mourning process (eg. intrusive symptoms can make it difficult to think about the deceased and recall memories), it is usually important to give priority to dealing with trauma-related material before working on loss-related aspects of grief and mourning (Rando, 2000).

Initially, EMDR can focus on dealing with the traumatic impact of the loss. EMDR processing can start with distressing moments that resulted in shock, denial, and/or dissociation, which can interfere with fully acknowledging the death. Hence, early targets can include the moment of hearing about the death (if the mourner was not present) or difficult moments at the scene of the death (if present); circumstances surrounding the death (eg. traumatic aspects, feelings of helplessness at the hospital, not being able to be present at the death); and negative images of the deceased (eg. hospital and/or funeral images), other unpleasant intrusive images, and vicarious imagery (eg. mourners may vicariously identify with the horror/pain experienced by their loved one). It may also be important to process moments of powerlessness, helplessness, vulnerability, and realisation of circumstance. Processing these moments helps the mourner deal with the reality of what happened and begin to grieve.

Case example

Jane's husband was killed in an auto accident. She was notified by law enforcement officials, and driven to the hospital by friends. After her husband's body was cleaned up by hospital personnel, Jane was permitted to view the body and spend some time with the deceased. The next day, Jane viewed the car and noted that there was an extensive amount of damage. Two months later, she requested help. She knew that her husband was dead, but it still felt unreal. She could not picture her husband. The only way she could remember what he looked like was by gazing at a photograph. Jane was depressed, anxious, and having difficulty concentrating. After a history taking and safe place installation, EMDR began in the third session. The initial target was the moment she had been notified of her husband's death. After several sets of eye movements, images of her husband at the hospital came to mind. She began to cry and abreact. With continued processing, she noted that he was now at peace. She recalled holding hishand, saying good-bye, and telling him that she loved him. With continued eye movements, other memories of her husband came to mind – positive moments of him laughing, of them together, and of the last conversation they had on the phone. The next image that came up was the car. Jane cried again as she saw how damaged the car was and what a horrible death her husband had experienced. With further processing, her crying subsided. She said that now the death felt more real. She also could now think of him as being at peace and was able to have memories of him, whereas before she had had difficulty visualising him. Treatment continued once a week for another three months, at which point she felt she was coping well.

The trauma of the sudden death and the images of her dead husband and his wrecked car were overwhelming to Jane, resulting in difficulty accessing positive and neutral memories. Further, the death did not feel real to her (dissociation). The negative information associated with the trauma was held in dysfunctional, excitatory form, blocking access to memories and feelings. With processing, the blocked information (eg. emotion) was able to 'associate' and integrate, and enable access to other memory networks and the emergence of an adaptive inner representation.

Second process: React to the separation

Once the reality of the death has been recognised, the mourner must react to and cope with that reality. He or she has to permit the self to experience the pain in reaction to 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. Unacknowledged and unexpressed emotions are major precipitants of complicated mourning. Over time, secondary losses associated with the death of the loved one have to be identified and mourned, such as the roles filled by the deceased, the interaction that will no longer be there, and unfulfilled hopes and expectations.

EMDR targets can include moments and situations (present triggers) where pain and distress are particularly acute ('Last Tuesday, when I was having my morning coffee, waves of sadness came over me') and situations/moments where the mourner experienced secondary losses (eg. a moment when the mourner realised the death of the son means there will be no grandchildren).

Case example

Frank, a 49-year-old married man, came into treatment 11 months after his only child, a 23-year-old policeman, had been shot and killed. After three sessions of history taking and assessment, EMDR was administered. Over the next nine sessions, the moment he heard about the death, hospital and funeral scenes, and vicarious negative imagery involving what his son must have felt when he was shot, were targeted. Feelings of guilt over his son's felonious death were also targeted ('I could not be there for my son'). The following session he came in very sad about the fact that he will not have grandchildren. He had experienced an acute moment of distress several days earlier when he was sitting in his garden as the sun set. The image was of his looking at the sky as he realised that there would be no grandchildren, with the negative/positive cognitions being 'I cannot be fulfilled'/'There are many ways to be fulfilled – I can be fulfilled'. During this emotional session, Frank experienced deep sadness and loss over his son's death and painfully expressed that a core part of him had been killed along with his son. With further processing, memories of past fulfilling times came to mind. Along with tears were feelings of happiness and pride. The session ended with him feeling proud of his son and in touch with the fulfillment his son had given him. He described that he may never have grandchildren, but what he had with his son will always be with him, and that is of primary importance. The next session, Frank described that he felt more balanced. He was very sad about losing the possibility of having grandchildren, the children of his son, but felt balanced with the connection to his son and that he had been a good father. These thoughts were reinforced with more processing. More sadness was expressed, and more proud moments and more feelings of what Frank called 'a father's pride' were experienced. He said he may never have grand-children, but he had a wonderful, fulfilling life as a father.

It has been said that with the loss of one's parents, you lose the past; with the loss of one's spouse you lose the present, and with the loss of one's children you lose the future. Frank was grieving the loss of having grandchildren (his future) along with the loss of his son. With processing, happy and proud memories of his son emerged, resulting in Frank being more in touch with his fulfillment as a 'proud father'. Frank's identity as a father appeared to provide a balance for his secondary loss of grandchildren.

Third process: Recollect and re-experience the deceased and the relationship

In order to be able to make necessary readjustments, the mourner has to alter his or her attachments to the deceased and the old assumptive world. This only can happen after the mourner withdraws emotional investment from both. To do this, the mourner needs to: (a) review and remember the deceased and the relationship realistically (including all attachment ties, such as needs, emotions, thoughts, behaviours, dreams, and expectations), and (b) revive and re-experience the feelings associated with that which is remembered. These feelings are what binds the mourner to the deceased through the different attachment ties. These connective emotions must be felt so that they lessen in intensity and ultimately permit the ties to loosen. Recognising and processing the memories and feelings paves the way for subsequent 'R' processes in which the old ties are relinquished. This frees the mourner to make new ties appropriate to the loved one's now being dead, along with other necessary re-adjustments and reinvestments that permit his or her eventual accommodation of the loss.

EMDR's ability to enable an emergence of meaningful memories of the deceased with associated affect (the basis of an adaptive inner representation) is particularly beneficial here. EMDR targets include painful memories ('I feel guilty for how I treated him on Father's Day'), specific memories related to unresolved issues (eg. recurring arguments that never reached closure), and moments where feelings of loss are particularly acute ('It was really distressing at the park as I remembered the times we spent there'). Positive memories with associated positive affect can be targeted to enhance the feelings, thus creating resources and reinforcing an adaptive inner representation.

Case example

Betty had an argument with her husband on Mother's Day. Later that evening, contrary to her husband's desire, she did not want to make love. However, they did spend some time cuddling. The next day her husband was killed in an accident.

Betty had worked on many issues related to the loss, but eight months later was still haunted by the memory of their last night together. She felt guilty and wished that she had been physically intimate with her husband. EMDR targeted the most painful moment – when she declined to have sex. It was an emotional session, with sadness and guilt being experienced. Then, she relived the cuddling and re-experienced how good it

felt. Upon completion of the session, the memory of the sensations and feelings associated with the cuddling were predominant. Her thoughts were that even though they did not have sex, the intimacy felt good and close. The next session of EMDR reinforced this perception. This session illustrates how processing a painful memory can lead to the emergence of new perspectives that give it new meaning. EMDR results are ecological, that is, appropriate to the situation. Betty still regretted not making love that evening. However, she was able to re-experience an aspect of the situation not previously acknowledged – the pleasure and intimacy of the cuddling. Re-experiencing this aspect of the situation provided a balance to her former painful memory, enabling her to see that indeed there had been an intimate connection with her husband that night. This also illustrates what makes EMDR so potent – it can go places words do not go. Resolution for Betty did not come from a new cognitive perspective, but from re-experiencing emotions and sensations associated with the memory not previously accessible, which provided the basis for new meaning and perspective.

Fourth process: Relinquish the old attachments to the deceased and the old assumptive world

An inherent part of healthily adapting to the loss of a loved one is the mourner's relinquishing former attachments to both the deceased and the assumptive world that have been rendered obsolete by the death. If old attachments to the loved one – or to the assumptive world that are predicated upon the loved one's being alive or that involve assumptions shattered by the death – are not withdrawn, complicated mourning results. It's distinctly unhealthy for a mourner to continue to operate in a now-defunct physical or assumptive world. Untying the former ties doesn't mean that the deceased is forgotten or un-loved. Rather it means that the ties are modified to reflect the change that the loved one is now dead and cannot return the mourner's emotional investment or gratify his or her needs as before.

EMDR targets include painful and difficult moments where the attachment and the difficulty in letting go is acutely felt (eg. 'I can no longer handle being in the garden because it reminds me she is dead, and I cannot give her up'), and future templates (eg. finding positive meaning in gardening). The difficulties in relinquishing attachment may become apparent at each prong of the protocol: that is, while processing past memories, initial painful memories that reflect the realisation of the death, and more recent painful moments; and in anticipating the future without the deceased. Often, EMDR processing of such difficult moments resolves in an adaptive manner, which includes healthy revisions of the assumptive world.

Case example

Dorothy's husband was killed in an auto accident a year before she entered treatment. They had been married over 20 years. A highly competent professional, she felt incompetent and unable to take care of herself. Her history revealed that she had been very insecure while growing up with her very critical mother. Her husband had been very supportive and accepting of her, enabling a significant increase in self-esteem. The first EMDR session focused on the moment she heard the news. After the shock of this moment was processed, she started describing how her husband had provided the major encouragement in her life and helped her over-come her self-image problems. With her husband's support, she developed a strong sense of competence and self-esteem and was successful academically and professionally. With more sets of eye movements, a new awareness emerged – she had been afraid to be competent because it meant that she did not need him and would have to let him go. Hence, feeling incompetent and not able to care for herself was a way of keeping the relationship with her husband. After this realisation, she was able to appreciate the meaning of the relationship with her husband, how much she had grown with him, and how frightened she was of letting him go. With more sets and further realisation about how her insecurity was her way of coping with her fear of relinquishing, she was able to say 'I can start to take care of myself', which was installed as a positive cognition. Further sessions focused on issues related to her mother, as well as on her grief.

The loved one mirrors who one is and is an important part of one's identity. It can be difficult to give up an old identity that included the loved one and redefine who one is in the world without that person. In this example, the surviving spouse's insecurity was a manifestation of her fear of letting go of her husband, who had been the major source of encouragement and self-esteem in her life. After he died, she felt very insecure and found it hard to care for herself, even though she was functioning at a high level personally and professionally. Her insecurity was a way of continuing to need her husband and maintain her attachment to him.

This example also illustrates how past issues can again be triggered. Dorothy's insecurity also stemmed from unprocessed childhood memories. The death of her husband had stimulated these unprocessed memories from childhood (eg. a critical mother). It was these family of origin issues, combined with her unconscious desire to still need her husband and maintain her attachment, that had led to the insecurity problems which brought Dorothy for treatment.

Fifth process: Readjust to move adaptively into the new world without forgetting the old

While the mourner may have wanted to recapture the world as it once was, after the death of the loved one he or she gradually learns that this cannot happen. Slowly, the mourner ceases the attempts to bring the old world back. With release of old, now unsuitable attachments to the deceased and the former assumptive world that took place in the fourth 'R' process, the mourner is now at liberty to take steps to accommodate the loss. This involves making the necessary internal and external changes to permit the event and its consequences to fit into his or her life. Specifically, this means: (a) 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 targets for the fifth 'R' process are situations representative of difficulties adjusting to life without the deceased. These may include moments of distress and disorganisation that reflect difficulties in revising one's assumptive world ('While grocery shopping, it hit me that we were supposed to grow old together . . .'), situations that exemplify the complications in forming a new identity without the deceased ('When I went to the party by myself, I realised I don't know who I am without him'), or situations/ moments where the mourner is 'stuck' in making the transition from loving in presence to loving in absence ('At my son's birthday party, I felt that I can't be happy because she died'). In this 'R' process as with the other 'R' processes, targets may include past memories related to present difficulties (eg. 'When growing up, when Mom was sad, it wasn't okay for me to be happy') and future templates that involve appropriate revisions in the assumptive world and dealing adaptively with present triggers and anticipated difficult situations.

Case example

John's wife had died of cancer two years prior to seeking treatment. He was seemingly adapting well with a successful and fulfilling career, a good social support system, and active hobbies. However, he experienced mild to moderate anxiety and depression stemming from his disillusionment that the world was not the same without his wife. To some extent, his belief in a stable, predictable world was no longer valid, and this was depressing and frightening. After three sessions of history taking, developing a safe place, and doing resource installation, the EMDR grief protocol was utilised, beginning with the worst moment when his wife died. After two more sessions targeting other painful memories and difficult moments, a recent painful moment of disillusionment was targeted. During the processing, he stated, 'The world has not changed, it is the same. It is me who has to adapt'. With further processing, the resolution (and positive cognition) evolved to 'I can adapt'.

In this case, it was difficult for John to live without his wife and the world they shared together. The world had changed. During processing, he became aware that he was struggling to keep his world the same, and came to the realisation that the world had changed. He was then able to start relinquishing his old assumptive world and adapt to the new world without his wife.

Sixth process: Reinvest

The last of the mourning processes involves the mourner's reinvesting in the new life without the loved one. The emotional energy that formerly had been directed toward the preservation and maintenance of the relationship with the loved one now must be redirected toward rewarding new investments in other people, objects, roles, hopes, beliefs, causes, ideals, goals, pursuits, and so forth. The reinvestment need not be in a duplicate of what was lost (eg. a widower does not have to marry a new wife). Rather, the sole requirement is that the emotional energy be reinvested where it can be returned to the mourner. Moving on does not mean forgetting or that the loss is no longer important. It means that the mourner can choose and is capable of loving the deceased in absence and, in the face of the new reality without that person, can adaptively go forth with a meaningful and productive life.

In EMDR, the mourner's areas of difficulty can be identified, explored, and dealt with. The caregiver assesses what new skills the client may need, whether there are past memories that interfere with present functioning, and what prevents an adaptive adjustment. EMDR targets include obstacles to moving on and the development of new resources and skills. Obstacles include fear and anxiety about engaging in new activities, pursuits, relationships, and/or resuming one's life (eg. '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'). Further, skill building, resource development and installation, and installing future templates can be important.

Case example

Ann took a year off of work following the traumatic death of her husband. She started treatment four months after her loss, during which she had received EMDR. She addressed initial moments of traumatisation (eg. when she heard about the death),

'stuck' points, and present triggers. Nevertheless, upon returning to work, she found that she could not concentrate for as long as she previously did. She got tired more easily, and could not complete her usual work-load. While she realisaed that this was normal and that she had to give herself time to build back up to her prior pace, the drop in her efficacy was anxiety provoking. Ann felt inadequate and incompetent. In further EMDR treatment, a new schedule, more realistic expectations, and stress management strategies were discussed. Then resource installation was utilised to access past moments of confidence and competence. Getting in touch with her memories felt grounding to her, and motivated her to continue to work, but at a more realistic pace. EMDR was used to target recent situations where she felt incompetent, with the processing resulting in a further appreciation of all that she had gone through, and a deeper respect for her present energy level. A future template, where she could see herself working at a reasonable pace and taking more frequent breaks, was helpful in alleviating her anxiety and deepened the permission she gave herself to work at a pace geared to her current energy level.

This example illustrates the difficulties a mourner may have adapting to life, even after the trauma of the loss and the 'stuck' points in mourning have been successfully dealt with. Processing present triggers, teaching new skills and perspectives, and future templates can be helpful in facilitating readjustment to life.

Conclusion

EMDR can be extremely helpful in intervening with grief and mourning. Processing negative memories of the loss and present triggers seems to result in positive, felt memories of the loved one. Hence, EMDR appears to facilitate the emergence of an adaptive inner representation, so essential in healthy mourning. Further, future templates and learning needed life skills and coping strategies facilitate adaptation. EMDR does not shorten or truncate the grief and mourning processes, but enables them by processing the obstacles that can impede progression. It can both promote uncomplicated mourning and help work through mourning that has already become complicated.

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