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Original article

Treatment of grief and mourning through EMDR: Conceptual considerations and clinical guidelines

Traitement du chagrin et du deuil grâce à l'EMDR : considérations conceptuelles et lignes directrices pour une pratique clinique

R.M. Solomon^{a,*}, T.A. Rando^b

^a Buffalo Center for Trauma and Loss, Buffalo, New York, United States

^b The Institute for the Study and Treatment of Loss, Warwick, Rhode Island, United States

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ABSTRACT

Introduction. – Eye Movement Desensitization and Reprocessing (EMDR) is an empirically-supported psychotherapeutic approach for treating trauma, which is also applicable to a wide range of other experientially-based clinical complaints. It is particularly useful in treating grief and mourning.

Literature findings. – EMDR is guided by the Adaptive Information Processing Model (AIP), which conceptualizes the effects of traumatic experiences in terms of dysfunctional memory networks in a physiologically-based information processing system. Numerous empirical studies have demonstrated EMDR's efficacy.

Discussion. – The death of a loved one can be very distressing, with memories and experiences associated with the loss becoming dysfunctionally stored and preventing access to adaptive information, including positive memories of the deceased. EMDR can be utilized to integrate these distressing experiences and facilitate the assimilation and accommodation of the loss and movement through the mourning processes.

Conclusion. – Applying the eight phases of EMDR to grief and mourning can yield potent clinical results in the aftermath of loss.

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R É S U M É

Introduction. – La thérapie Eye Movement Desensitization and Reprocessing (EMDR) est une approche qui a apporté de nombreuses preuves quant à sa capacité à traiter les traumatismes. De la même manière, elle se révèle intéressante sur un large éventail d'autres plaintes cliniques.

Littérature. – Cette approche s'appuie sur le modèle du traitement adaptatif de l'information, qui conceptualise les effets des expériences traumatisantes en termes de réseaux de mémoire dysfonctionnels qu'il convient de remettre en œuvre.

Discussion. – La mort d'un proche peut être une épreuve des plus pénible, avec des souvenirs et des expériences liées à la perte, qui peuvent devenir dysfonctionnels et empêcher le processus de deuil, y compris en interférant avec les souvenirs positifs de la personne décédée. Dans ce cas, l'EMDR peut être utilisée pour intégrer ces expériences douloureuses et faciliter l'assimilation et l'accommodation de la perte, donc en optimisant le processus de deuil.

Conclusion. – L'application de l'EMDR au deuil sera illustrée ici par des cas permettant de comprendre ce qui se passe pour chacune des phases du protocole EMDR en huit phases.

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1. Introduction

The death of a loved one typically confronts human beings with particularly difficult challenges at a time of often unparalleled distress. It has long been known that even when uncomplicated, bereavement can precipitate significant psychological, behavioral,

* Corresponding author. 1813 Northwood Drive, Williamsville, NY 14221, United States.

E-mail address: rogersolomon@aol.com (R.M. Solomon).

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 methodologies to alleviate pain, reduce dysfunction, work through conflicts, and promote adaptation. This article describes the rationale and clinical considerations for utilizing Eye Movement Desensitization and Reprocessing (EMDR) within an overall treatment framework for grief and mourning.

EMDR is an integrative psychotherapeutic approach comprised of eight phases and a three-prong methodology to identify and process past memories that underlie current problems, present triggers that elicit disturbance, and positive templates to be incorporated into the client's repertoire for adaptive future behaviors. Currently, EMDR is recognized and recommended as a first-line treatment for trauma in numerous international guidelines (American Psychiatric Association, 2004; Bisson & Andrew, 2007; Department of Veterans Affairs and Department of Defense, 2004; National Institute for Clinical Excellence, 2005). Over the past two decades, more than 20 randomized studies have established its efficacy with a wide range of trauma populations (Bisson & Andrew, 2007).

Each phase of EMDR therapy includes a variety of standardized procedures. However, one component of EMDR therapy that has garnered considerable attention is the use of eye movements. A meta-analysis (Davidson & Parker, 2001) found little support for this component. However, a later review of the research included in the analysis conducted by a committee of the International Society for Traumatic Stress Studies (Chemtob, Tolin, van der Kolk, Pitman, 2000) found the studies flawed because of a variety of factors. Since that time, more than 20 randomized controlled trials have demonstrated positive effects for the eye movement component (Bisson & Andrew, 2007), including decreases in emotionality and imagery vividness. These two factors alone would be expected to make treatment more tolerable for any trauma victim, including those suffering from the loss of loved one. One of these studies (Hornsvelt, Landwehr, Stein, Stomp, Smeets, & van den Hout, 2010) specifically evaluated participants recalling an aversive experience of loss. They were asked to hold in mind the image of the most distressing scene while either performing eye movements, listening to relaxing music, or not performing any dual attention task (recall only). The eye movement condition was found to be more effective than recall only, or recall with relaxation in decreasing emotionality of the most distressing scene related to loss.

In a nonrandomized study, Sprang (2001) demonstrated the effectiveness of EMDR therapy in the treatment of those suffering from the loss of a loved one. EMDR therapy was compared to exposure based 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. Positive treatment effects were attained more rapidly with EMDR which necessitated fewer sessions. Data from the behavioral measures showed similar findings. Both groups had significant decreases in grief intensity with no significant difference. The author concluded that the benefit of EMDR treatment lies in the expeditious reduction of trauma symptoms, which can have an availing, though indirect effect on grief. Conversely, and as would be predicted by the Adaptive Information Processing (AIP) model which guides EMDR therapy, subsequent to treatment the rate of positive memories improved at a significantly greater rate for those treated with EMDR therapy than with GM.

As predicted by the AIP model, several studies and clinical reports have shown the beneficial effects result from processing the experiences that underlie current problems, which can include the deep distress, sense of powerlessness, vulnerability, or guilt

that accompany a significant loss (Gattinara, 2009; Lazrove et al., 1998; Puk, 1991; Solomon & Shapiro, 1997; Solomon, 1995, 1998; Solomon & Kaufman, 2002; Solomon & Rando, 2007; Solomon & Shapiro, 1997). The application of EMDR therapy with grief and mourning will be explored through a case example below.

2. Adaptive Information Processing model

The AIP model, emphasizes the role of both memory networks and the physiological information processing system (Shapiro, 2001), which transfers experiences into physically encoded memories that are stored in associative memory networks. These memory networks provide an important basis for the person's interpretation of new experiences, and significantly influence his or her current perception, behavior, and feelings. Under normal circumstances, the information processing system integrates new experiences with previous ones, gleaned the information that is useful and discarding that which is not. This information, along with the appropriate emotional states, is stored in interconnected memory networks that guide the person's future actions.

However, high levels of disturbance, which can occur during even ubiquitous events (e.g., humiliations), can disrupt the system and cause the unprocessed memories to be stored in excitatory, distressing, state-specific forms (Shapiro, 1995, 2001). As a result, these experiences contain the perspectives, affects, and sensations that were encoded at the time of the disturbing event. Such experiences become dysfunctionally stored in a way that does not allow them to connect to more adaptive information, therefore preventing assimilation within more comprehensive memory networks. For instance, a person who experiences a traumatic or overwhelming incident may continue to experience the emotions, physical sensations, and frame of mind that occurred during the event, such as a sense of vulnerability and powerlessness.

Predictably, if a current situation triggers memory networks of dysfunctionally-stored information, the emotions and physical sensations inherent in the unprocessed memory automatically arise. These affects underlie the negative beliefs and perspectives that emerge and define the individual's response in the present. For instance, following the death of a loved one, a person can be "stuck" in negative beliefs and perspectives, and continue to experience the deep distress and pain that accompanies the loss.

The goals of the procedures and protocols of EMDR are to access the dysfunctionally-stored experiences and stimulate the innate information processing system in such a way that these isolated memories are linked up to and assimilated with new or currently existing functional neurological networks. Clinical observations of recovery observed in EMDR treatment sessions (for session transcripts, see Shapiro, 2001, 2002) show a rapid progression of intrapsychic connections, as emotions, sensations, insights, and memories emerge and change with each new set of bilateral stimulation (directed lateral eye movements, alternating taps or tones). In addition to a decline in trauma symptoms, clients give evidence of a comprehensive perceptual and psychological reorganization.

Physiological changes have also been evidenced by neuroimaging studies (Bossini, Fagiolini, & Castrogiovanni, 2007; Lansing, Amen, Hanks & Rudy, 2005; Levin, Lazrove, & van der Kolk, 1999; Ohtani, Matsuo, Kasai, Kato & Kato, 2009). It is posited by the AIP model that successful EMDR treatment results in the targeted memory emerging from its isolated state to become appropriately integrated with the wider comprehensive memory networks comprising the totality of the individual's life experience. Some researchers posit that the EMDR procedures link into the same processes that occur during rapid eye movement sleep, and that the memory is transferred from episodic to semantic memory (Stickgold, 2002, 2008). Data from approximately, 10 randomized trials support

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