Assisting Individuals Struggling with Grief:
A Review of the Literature on Grief and its Treatment

and

Evaluating the Efficacy of Eye Movement Desensitisation Reprocessing (EMDR)
with Grieving Individuals: A Randomised Control Trial

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Statement of Originality

The topic selection, ethics application, study design and treatment protocol design for this study were completed in collaboration with my colleague Prue Cotter and supervisor Dr Christopher Lee.

Therapy and data collection with individual participants was conducted by Prue Cotter and I independently and the data was pooled. A subsequent qualitative analysis was undertaken by Prue and a quantitative analysis by myself.

As such, the following literature review and research report were written independently. This work has not previously been submitted for a degree at any tertiary educational institution.

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Literature Review

Assisting Individuals Struggling with Grief:

A Review of the Literature on Grief and its Treatment
Abstract
This review begins by placing grief that relates to the loss of someone important to us, within the context of an almost universal experience. It acknowledges the impact of grief as being costly to both the individual’s well-being and the community more broadly, as well as identifying some of the difficulties associated with affording complicated grief a diagnosis. The review examines theoretical approaches which are informative in both the understanding of grief and also its treatment. Regarding the psychotherapeutic treatment of grief it is concluded that there appears a lack of clarity and consistency in information regarding the treatment of grief in an individual setting. This arises from a number of methodological shortcomings apparent in clinical trials which subsequently limit several meta-analyses. Nevertheless, the literature does reveal clear support for the use of interventions in cases where grief is chronic or complicated in nature, in particular interventions based on a cognitive-behavioural therapy framework. Given that complicated grief is not afforded a classification within the DSM-5 to guide clinicians it is critical, for the benefit of both clinicians and those in grief, that the trialling of potentially timely and appropriate interventions are conducted in ways that attempt to overcome the limitations of those studies identified above.
Overview

The death of someone important to us is experienced almost universally over the course of a lifetime, regardless of religion, race or culture. Such a loss can trigger a myriad of physical and emotional responses which vary from one person to another but are commonly known as grief. Although grief reactions are highly individualised, a typical experience will often include sadness, episodes of crying as well as the presence of some positive emotions (Miller, 2012). As information about the death is processed these reactions lessen in intensity, such that thoughts and memories of the deceased still occur but are no longer dominant and there is a gradual increase in interest and enjoyment in people and activities that may have been lost. For approximately 10 to 20% of the population however this does not occur (Byrne & Raphael, 1994); these individuals remain ‘stuck’ in their grief and develop what is known as complicated grief – characterised by intense yearning or pining for the deceased, emotions like anger, bitterness, shock and disbelief, estrangement from others and an inability to adapt to life without their loved one (Shear & Shair, 2005). As grief is a universal and normal experience, large volumes of literature surrounding the many facets of grief and bereavement exist. This review has been limited in scope to defining grief and its impact, diagnosing grief and in particular complicated grief, theoretically understanding grief as well as exploring the psychotherapeutic approaches to its treatment. The literature will be discussed as it pertains to mental health professionals in Australia working individually with adults in a bereaved population. For a more detailed review and discussion on grief-related psychometric instruments, grief within specific populations such as children or indigenous groups, pharmacotherapy approaches and group-based psychotherapy, see a comprehensive review by Kristjanson, Lobb, Aoun, and Monterosso (2006).
Defining Grief

Numerous terms are used to describe the many and varied reactions to the death of a loved one and so it is worth examining these at the outset of this discussion. Grief, mourning and bereavement are often used interchangeably but have different connotations. Grief can be specified as the responses, both internal and external to the loss (Stroebe & Stroebe, 1987), in contrast to bereavement which is the state in which a grieving individual is considered to be. Mourning relates to the “set of practices and acts” (Malkinson, 2007, p. 3) that are influenced by socio-cultural factors. Relative to mourning and bereavement, grief is the key element involving individualised emotional responses targeted by psychological interventions and as such will be the primary term used throughout this paper. Further, grief as it relates to the death of a person will be the focus of the literature review, rather than any type of loss.

The Impact of Grief

Responses that follow such a loss may be categorically referred to as grief reactions, however they are highly individualised and can encompass not only emotional but physical, cognitive and behavioural changes. Grief, as well as complicated (also known as prolonged or chronic) grief has negative consequences not only for an individual’s physical and psychological wellbeing, but also implications for the community as a whole. A report by the Grief Recovery Institute (2003) estimated the annual cost of grief in the workplace as a result of a loved one’s death to be US$37.5 billion due to lost productivity and sick days. The report further suggested that up to one in four employees are experiencing grief at any one time; however this figure also included those grieving for the loss of family members, friends, colleagues and pets. On an individual level, complicated grief has been shown to be associated with distinct negative health outcomes, independent from depression
or other co-morbid conditions. Research has revealed that individuals suffering from complicated grief are more likely to develop physical conditions such as cirrhosis of the liver, high blood pressure, heart disease and cancer (Gallagher-Thompson, Futterman, Farberow, Thompson, & Peterson, 1993) as well as experiencing difficulty sleeping (Germain, Caroff, Buysse, & Shear, 2005; McDermott et al., 1997). Their mental health is also affected and the literature suggests that individuals with complicated grief perceive that they have more life stressors, less social support and experience a decrease in sense of well-being and poorer functioning in life roles compared than those without complicated grief (Ott, 2003).

**Vulnerability to Grief**

Current research indicates that some people are more vulnerable to these physical and psychological difficulties as a result of their grief than others and a number of risk factors have been identified. The nature of one’s attachment to the deceased plays a key role, with the loss of a child being the highest predictor, followed by the loss of a spouse (Tomarken et al., 2008). Other risk factors include dependency on the deceased as well as a history of separation anxiety. Where suicide is the cause of death, reactions of anger, abandonment and rejection often lead to becoming “stuck” in grief (Reynolds, Stack, & Houle, 2011). Conversely, protective factors that reduce the risk of developing complicated grief have been found to include acceptance of the anticipated loss prior to death and belief systems that support the idea of a just world (Bonanno, Wortman, & Nesse, 2004). These are qualities often observed in those over 85 years of age – a population observed by Newson et al (2011) to have some of the lowest levels of complicated grief. Also in older adults palliative care for widows that includes practical assistance prior to and
following the death of a loved one has been shown to contribute to resilience against these difficulties (Jordan & Neimeyer, 2003).

**Diagnosing Grief**

Affording a unique diagnosis to complicated grief confronts two issues. Firstly, it may pathologise an otherwise universal experience and suggest that to grieve following the death of someone close to us is unhealthy, indicative of some underlying mental illness or a departure from normal experience. To attach a specific time frame after which grief becomes complicated or prolonged as criteria for such a diagnosis (such as the six months cited by Prigerson et al. (2009)) asserts that everyone experiences grief in the same way, and disregards the myriad of independent factors that may influence one’s reaction to a loss. For example the relationship to the person, the nature of the death as well as whether or not it was expected can all impact our response.

The second issue associated with diagnosing complicated grief is the presumption that grief is clearly different from other mental illnesses with which it shares characteristics and symptoms, such as depression and post traumatic stress disorder (PTSD). Bonanno et al. (2007) found evidence in both longitudinal and cross-sectional studies for the incremental validity of complicated grief as a construct distinct from depression or PTSD. In other words, grief uniquely predicted social, physical and mental functioning at 4 and 18 months post-loss when depression and PTSD were controlled for. The effectiveness of psychotherapy interventions which target grief symptoms have further been found superior to those psychotherapy and pharmacotherapy interventions only targeting depressive symptoms (Bryant, 2013). Together, these findings suggest that some elements of complicated grief such as the prolonged tendency to pine or yearn for a loved one are unique to this condition and
may support a separate diagnosis for complicated grief. This notion however is disputed by other research, with O’Connor et al. (2010) using a factor analysis to highlight the overlap in symptomology between complicated grief and PTSD and suggesting that the intrusive component of PTSD in particular can largely account for complicated grief.

Despite numerous propositions for its inclusion (Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 2009) complicated grief was not recognised as a diagnosis in the recently published fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). Instead, what was previously known in the previous edition as the ‘bereavement exclusion’ – whereby major depressive disorder could not be diagnosed within the first two months of the loss of a loved one has been removed. In a bid to prevent major depressive disorder (MDD) being overlooked and ensuring it is promptly treated, notes within the manual now caution clinicians to carefully observe and differentiate between the symptoms of natural or expected grief and major depressive symptoms. One of the most contentious issues surrounding the removal of the exclusion criteria is the concern that grief could be wrongly diagnosed as MDD and subsequently attract unnecessary medications (Parker, 2013). Nevertheless, as highlighted by Kristjanson et al. (2006), recognition of grief in the DSM-5 is a separate issue to theoretical understanding of the construct and one could argue that the absence of recognition implores researchers and clinicians to seek clearer and more nuanced understandings of grief and the efficacy and appropriateness of suitable interventions. The following review explores theories relevant to those understandings.

Theories of Grief
There is no consensus as to the best available theory that explains grief; however two themes are common throughout the literature. Firstly, there is the idea that grief is, at a fundamental level, a distress response following the loss of an attachment figure; an idea based on the early work of Bowlby (1973) and reflected in his own theories of loss (Bowlby, 1980) as well as those of Elisabeth Kübler-Ross (1975). Second and more recently is the notion that grief consists of two key processes: moving through the pain of the loss and moving on with one’s life; both highlighted in the two-track (Rubin, 1999) and dual-process (Stoebe & Schut, 1999) models of bereavement. Each of these theoretical accounts of grief is somewhat limited in scope and thus in its ability to inform treatment, and an exposition of these is beyond the scope of this review. However, the grief process model (Fleming & Belanger, 2001) will be briefly discussed as it incorporates several elements of the above theories and provides a parsimonious explanation of several grief responses in such a way that treatment, where needed, may be practically informed.

Fleming and Belanger’s (2001) grief process model (see Figure 1) outlines the transition from what the authors refer to as “losing what we have” – resentfulness around the loss of someone we care about – to “having what we have lost” – confronting, embracing and emerging through the pain (as experienced by physical, emotional and cognitive responses) to arrive at a sense of gratefulness for the relationship. Acknowledging the importance of the attachment to the deceased (Bowlby, 1980), the model suggests that in order to make this transition successfully, one must “approach and befriend” their pain in order to truly confront the loss and make meaning or sense from it.
According to Fleming and Belanger (2001), an individual going through typical or uncomplicated grief (represented by line A) will encounter, embrace and work through the often unbearable pain following the loss to arrive at a place whereby they can reorganise their life around the loss or adjust their assumptions about the world, usually without the assistance of a mental health professional. By contrast, an individual with a chronic or complicated pattern of grief (B) is likely “stuck” in their pain responses to their grief and “unable to relinquish emotional attachment” to their loved one. For these individuals, the goal of treatment would involve identifying and resolving those factors that are preventing the integration of the loss. An experience of delayed grief (C) whereby an individual is aware of their loss but either suppresses or postpones grief often for reasons of fear, a lack of social support and multiple life stressors, is also illustrated. Similarly, the goal of treatment would be to identify the
reasons preventing the experiencing of pain and then going on to explore the meaning of the loss.

The significance of the literature exploring each of these models is that it provides information regarding the mechanisms that play a maintaining role in grief. The knowledge and understanding of these perpetuating factors is essential so that psychological interventions can target them and help individuals struggling with grief to adapt to their loss.

**Psychotherapeutic Treatment of Grief**

With approximately 10-20% of bereaved individuals experiencing grief of a complicated or chronic nature (Byrne & Raphael, 1994; Kristjanson et al., 2006), and several groups further identified as being vulnerable or at risk (Reynolds et al., 2011; Tomarken et al., 2008), the question of how psychotherapeutic interventions may assist in the treatment of grief becomes important. While the use of pharmacological approaches to grief is beyond the scope of this review, it is interesting to note that in a study of recently bereaved widows Johnson et al. (2009) found that more respondents with complicated grief felt receptive to psychotherapy than medication to assist with their symptoms (93.8% versus 81.3%). They further found that the majority of participants were open to these symptoms being recognised by a diagnosis, with 96.3% reporting they would be “relieved to know [they] were not going crazy” and that they “had a recognisable problem” (Johnson et al., 2009, p. 698), suggesting that concerns about the stigma of having a mental illness may be unfounded. Additionally, 100% of participants identified by the authors as suffering from complicated grief felt that a diagnosis would assist their family members in understanding what they were going through.
Together, these findings demonstrate the importance of individuals to not only be open to psychotherapy but to actively seek treatment for their grief. Consistently larger effect sizes and positive outcomes have been observed in studies where participants self-referred themselves or were referred by a general practitioner, as opposed to more aggressive recruitment or outreach approaches (Allumbaugh & Hoyt, 1999; Currier, Neimeyer, & Berman, 2008; Schut, Stroebe, & Terheggen, 2001). This section provides an overview of comprehensive meta-analyses as well as several studies examining the efficacy of cognitive-behavioural therapy and other emerging treatment approaches.

Psychotherapy approaches for those struggling with grief are commonly referred to as primary, secondary or tertiary in nature, depending on whether someone is experiencing normal or uncomplicated grief, is at risk of complicated grief or is currently experiencing complicated grief, respectively (Currier et al., 2008). A meta-analysis of fourteen randomised controlled trials of grief interventions revealed inconsistent results regarding the efficacy of preventative – that is, primary and secondary – interventions (Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). In comparison, tertiary interventions that sought to treat a target population currently suffering from complicated grief had a significant effect in reducing their symptoms. This finding was consistent with an earlier meta-analysis (Currier et al., 2008) which suggested that interventions were most efficacious when they targeted individuals with some distress or who experienced difficulty in adapting to their loss. Further, Wittouck et al. found that the positive effects of these interventions were found to increase during the follow-up periods, the length of which varied between studies, whereas Currier et al. found that control and treatment groups both showed similar levels of distress and functioning at follow-up. The latter study
suggests that tertiary interventions did not provide any significant improvement over and above the passage of time and existing resources available to control groups.

One of the limitations affecting both of these meta-analyses and problematic across much of the literature on complicated grief is the variety of measures used in studies included to assess complicated grief, making it difficult to draw accurate conclusions regarding change. Wittouck et al (2011) found that while preventative interventions often used more general measures of grief, the studies with tertiary interventions tended to assess complicated grief symptoms more specifically, using standardised quantitative measures such as the Inventory of Complicated Grief (Prigerson et al., 1995). Such targeted measurement using a well supported instrument (Kristjanson et al., 2006) – absent in Currier et al.’s (2008) analysis – lends support to their Wittouck et al.’s finding that tertiary interventions can be effective in treating complicated grief both in the short and long term. A further finding common in bereavement studies is that the mean number of female participants in all studies analysed was approximately 70% (Currier et al.; Wittouck et al.). There are several possible reasons for this, including the tendency for loss of a loved one to have a greater impact on women (Stroebe, Stroebe, & Schut, 2007) as well as females’ perception that finding help will be useful and consequent higher rates of help seeking behaviour in comparison to males (de Groot, van der Meer, & Burger, 2009). It may also simply reflect the fact that women typically outlive men and more may thus be available for such studies.

Effective interventions resulting in significant reductions of participants’ grief symptoms and improved general psychological wellbeing have been delivered in a number of modalities including group based therapy (Goodkin et al., 1999; Lieberman & Yalom, 1992; Murphy et al., 1998), internet-based therapy (Wagner, 2009) as well
as more traditional individualised therapy (Boelen, de Keijser, van den Hout, & van den Bout, 2007; Shear, Frank, Houck, & Reynolds, 2005). The majority of effective individual therapies for the bereaved are based on a cognitive-behavioural therapy (CBT) approach, with CBT shown to provide “modestly better outcomes” (Currier, 2009, p. 38) than other types of therapy. As such, it is these studies that the review will focus on now.

Cognitive behavioural therapy (CBT) approaches to grief interventions are targeted at exposing the client to the cues or situations most frequently avoided as well as challenging unhelpful thinking styles which in many instances focus on issues of blame, guilt and regret around the death. Within CBT approaches, a psychoeducation component is often included, such as the disease model of grief as displayed in Figure 2. The model illustrates a typical, albeit simplified pattern whereby a trigger reminds one of their loss, leading to the experience of emotions such as hopelessness and helplessness and other symptoms which are then dealt with by way of avoidance of cues or preoccupation with their loved one.
Figure 2. The disease model of complicated grief as proposed by Rosner, Pfoh, and Kotoucova (2011)

The usefulness of Rosner, Pfoh and Kotoucova’s contribution to the literature is that it allows the therapist, at the outset of therapy to demonstrate their knowledge in the treatment of grief, normalising the client’s experience and allowing them to personalise and enrich the schematic diagram with details from their own grief experience (Rosner, Pfoh, et al., 2011). It also provides the client with a clear understanding of how theories of bereavement are relevant to them and their treatment; avoidance behaviours or preoccupation with their loved one may keep the
pain at bay in the short term, however prevent them from fully embracing and integrating the loss as per the grief process model (Fleming & Belanger, 2001). Although based on a cognitive-behavioural therapy (CBT) framework, Rosner et al.’s (2011) treatment manual also adopts techniques from other therapies, including Gestalt therapy, relaxation and imagery work. This integrated CBT approach, as it is known, is also evident in Shear et al.’s (2005) grief treatment manual. Shear et al. (2005) randomly assigned 83 participants to the integrated cognitive-behavioural therapy treatment or interpersonal psychotherapy, a therapy in which grief, as well as role transitions and relationships with others were discussed. Improvements in complicated grief symptoms were seen in both conditions; however the CBT-based treatment demonstrated both a higher response rate (51% compared to 28% for interpersonal psychotherapy) and faster response time, with response defined as a reduction in scores on the Inventory of Complicated Grief by at least 20 points. However, the study was limited by the high number of patients also taking medication for their symptoms (45%) and a high drop-out rate (26%). It is also worth noting that 10% of participants refused to take part in key components of the complicated grief treatment.

Like Rosner et al. (2011), Shear et al. (2005) used a cognitive-behavioural therapy (CBT) framework but also used techniques from other therapies. Both manuals involved an imagined conversation – directed by the therapist – between the client and the deceased, based on Gestalt therapy principles. Here the client has the opportunity to ask questions, articulate unmet needs or unexpressed feelings towards their loved one and then change roles and respond as though they were the deceased. The inclusion of this technique across several studies suggests that it targets a key
factor preventing the integration of the loss, which may be related to unresolved issues or unanswered questions.

The literature indicates that cognitive-behavioural therapy (CBT) is helpful; however the use of eclectic or integrated treatments limits our understanding as to why. In an attempt to address this, Boelen and colleagues (2007) compared results from two groups of cognitive-behavioural therapy (CBT) for grief – one in which exposure therapy was delivered first and another in which cognitive restructuring was delivered first – with a supportive counselling approach. Both CBT conditions showed significant improvement on a measure of complicated grief in comparison to supportive counselling at mid and post treatment points. Within the CBT conditions, exposure therapy followed by cognitive restructuring was found to have slightly more positive effects on grief symptomology than the reverse; however this difference was not significant. The authors suggest that this merely highlights the importance of avoidance behaviours in the maintenance of complicated grief, rather than suggesting that negative thinking about a loss is not important (Boelen et al., 2007).

Nevertheless, the results of the study provide support for the use of CBT approaches in assisting those struggling with grief, over and above purely counselling approaches.

The use of psychotherapy approaches for individuals other than those based on cognitive-behavioural therapy (CBT) in the treatment of grief is not well represented in the literature. One alternative approach, an energy-based therapeutic touch – likened by the American Cancer Society to the practice of Reiki (2011) – has reportedly provided relief from grief symptoms (Kempson, 2001; Robinson, 1995) but is strongly criticised by studies that demonstrate flaws in its fundamental components (e.g. Rosa, Rosa, Sarner, & Barrett, 1998). Emerging research does however appear to provide support for two approaches with an established empirical basis in treating
other mental health illnesses; behavioural activation, supported as an effective treatment for depression (Cuijpers, van Straten, & Warmerdam, 2007) and eye movement desensitisation reprocessing (EMDR), recognised as effective for post-traumatic stress disorder (PTSD) (Ironson, Freund, Strauss, & Williams, 2002; Rothbaum, Astin, & Marsteller, 2005). Given the existence of some similarities among symptoms of complicated grief, depression and PTSD (Kaltman & Bonanno, 2003) the research surrounding behavioural activation and EMDR interventions for grief will be briefly outlined.

Behavioural activation is targeted at addressing the mechanisms of avoidance and preoccupation that maintain complicated grief, as outlined in the disease model of grief (see Figure 2, Rosner, Pfoh, et al., 2011). Papa, Sewell, Garrison-Diehn, and Rummel (2013) investigated the efficacy of this approach with a group of bereaved individuals. Results indicated that behavioural activation achieved significant reductions in symptoms of complicated grief, PTSD and depression, including the finding that clinical change (see Jacobson & Truax, 1991) resulted in 95% of participants deemed recovered or improved on measures of complicated grief. It is important to note that the small sample size (N=25) limited the reliability of effect sizes as well as the authors’ ability to examine anything other than large effect sizes. Despite this limitation, together with the findings of Boelen et al. (2007) this study provides support for interventions that directly target the maintaining factors of avoidance and preoccupation identified in theoretical accounts of grief (Fleming & Belanger, 2001; Rosner, Pfoh, et al., 2011).

The symptoms of avoidance and intrusion in PTSD are similar to avoidance of triggers, and intrusive thoughts of the deceased often present in complicated grief and as such, O’Connor et al. (2010) suggested that the treatments effective for PTSD could
also be used with complicated grief. One therapy recommended by numerous organisations (Australian Centre for Posttraumatic Mental Health, 2013; National Institute for Clinical Excellence, 2005; World Health Organisation, 2013) for the treatment of PTSD is eye movement desensitisation reprocessing (EMDR). Based on adaptive information processing models, EMDR is aimed at reprocessing distressing memories, desensitising the stimuli that trigger present distress and encouraging more adaptive attitudes, skills and behaviours (Shapiro, 2002). In EMDR, the client must simultaneously focus on a distressing memory and visually track the therapist’s finger in a precisely prescribed manner as it moves bilaterally across their field of vision (Albright & Thyer, 2010). It is believed that this dual-attention allows the memory to be re-processed and the distressing components relieved (Schubert & Lee, 2009), however the precise mechanisms remain unclear.

Sprang (2001) compared the treatment outcomes of 50 individuals who had lost a family member in a traumatic manner who received either EMDR or guided mourning – a grief counselling approach underpinned by behavioural principles (Mawson, Marks, Ramm, & Stern, 1981). Both approaches resulted in significant reductions in symptoms including re-experiencing, nightmares, rumination and intrusive-symptoms; however EMDR participants experienced significant reductions to almost zero-levels after approximately 8 sessions, whereas guided mourning participants achieved these reductions at close to 13 sessions. Perhaps most relevant to the unblocking of cognitive mechanisms hindering adaption to one’s loss as per the grief process model (Fleming & Belanger, 2001), guided mourning participants did not experience a significant increase in positive recall from pre-post treatment or pre-test to follow-up, whereas the EMDR group achieved significant increases between both intervals. Results from Sprang’s study suggest that EMDR was a more efficient
method of treatment in which patients experienced a more rapid reduction in traumatic stress symptoms. Two crucial methodological shortcomings in this research were a lack of any control group and that participants self-selected into treatment conditions.

**Conclusions and Recommendations**

**How should grief be recognised in a clinical setting?**

Despite several propositions for inclusion and continued debate regarding the issue (Lichtenthal et al., 2004; Prigerson et al., 2009), complicated grief is not afforded a classification within the DSM-5 (American Psychiatric Association, 2013). However as Kristjanson et al. (2006) highlight, an absence of recognition in DSM-5 should not preclude the recognition and screening of complicated grief symptoms. The importance of recognising grief in clinical settings is fundamental to a clinician’s tool-kit; clinicians must be aware of the risk factors and health outcomes associated with grief and how to recognise an individual whose grief is chronic or complicated in nature and that adversely affects their social and occupational functioning. Increased knowledge about grief and its symptoms is particularly important given the removal of the ‘bereavement exclusion’ from the DSM-5 and the task of differentiating between major depressive disorder and grief, as well as post traumatic stress disorder and grief. Despite the large volume of literature available regarding grief and bereavement, there is a lack of clarity and consistency in information regarding its treatment in an individual, rather than group-therapy setting.

**Should grief be treated?**

There is little empirical support for preventative grief interventions; that is, providing treatment to those suffering from uncomplicated or normal grief (Currier et al., 2008; Wittouck et al., 2011). The literature suggests that help can be helpful, but
its application should focus on clients’ idiosyncratic needs and not a therapists desire to relive possible or current distress (Currier, 2009); a view supported by Government review bodies in Australia that recommend treatment for grief should be needs-based rather than risk-based (Kristjanson et al., 2006). Treatment of complicated grief in both research and clinical settings should thus adopt the stance of intervening only where grief is truly complicated or chronic and refrain from doing so unnecessarily in what should otherwise be considered a natural and healthy process. Findings from studies that demonstrate better outcomes for individuals who self-refer for treatment rather than those who are aggressively recruited (Allumbaugh & Hoyt, 1999; Currier et al., 2008; Schut et al., 2001) suggest a need to provide accurate and comprehensive information and education regarding the best available treatment approaches.

**Which treatments are most appropriate?**

The literature is less clear when it comes to evaluating which treatment approaches for grief are most effective. Studies of interventions available to date are fraught with limitations that include inconsistent use of measurement tools and definitions (Currier et al., 2008; Wittouck et al., 2011), small and heterogeneous samples (Boelen et al., 2007) as well as an over-reliance on self-reported data; something further research should be cognisant of and endeavour to avoid. Nevertheless, studies to date show clear support for the use of cognitive-behavioural therapy-based interventions (Boelen et al.; Rosner, Pfoh, et al., 2011; Shear et al., 2005) The core components of cognitive restructuring and particularly exposure therapy (Boelen et al.) appear to deal with the core theoretical elements of complicated grief including approaching and tolerating pain, identifying and exploring and resolving those issues that have prevented the integration of the loss (Fleming & Belanger, 2001). More research is needed to examine to potential efficacy
of EMDR as a treatment for grief, and should be conducted in ways that attempt to overcome the limitations of those studies identified above.
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Research Report

Evaluating the Efficacy of Eye Movement Desensitisation Reprocessing (EMDR)

with Grieving Individuals: A Randomised Control Trial
For submission in Clinical Psychology and Psychotherapy

The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text*. Figures should be uploaded as separate figure files*.

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Abstract
Background: Eye movement desensitisation reprocessing (EMDR) has been shown to be effective in treating post traumatic stress disorder (PTSD). Based on similarities in symptoms of PTSD and complicated grief, as well as limited research to date, this approach may be effective in treating grief and its associated distress.

Aim: This study evaluated and compared the effectiveness of EMDR with an integrated cognitive-behavioural therapy (CBT) intervention using a randomised control trial design.

Method: Participants (N=19) who identified themselves as struggling with grief were randomly allocated to treatment conditions and following a seven week wait-list received seven weeks of therapy.

Results: Participants in both conditions showed improvement post-treatment, with significant reductions on Impact of Events Scale and the Inventory of Complicated Grief in the EMDR condition and a significant improvement in quality of life in the integrated-CBT condition. At follow-up, assessment conducted by an independent researcher revealed a significant reduction in mean scores on Impact of Events Scale and Inventory of Complicated Grief for both conditions, however for the CBT group only improvement on the Impact of Events Scale remained significant after a Bonferroni correction was applied. Results from individuals who scored highly on measures of distress prior to treatment also support current literature which indicates that primary interventions targeting those with complicated grief are effective.

Conclusion: The findings provide preliminary support for the use of EMDR with grieving individuals.

Keywords: Complicated grief, EMDR, CBT, psychotherapy interventions.
Key Practitioner Message:

- The present trial demonstrated that EMDR is as effective as an integrated-CBT approach for individuals struggling with grief.
- EMDR may provide a more symptom-specific approach to treating grief.
- Both integrated-CBT and EMDR are most useful when grief is considered complicated or a client is experiencing high levels of distress.
- Further research is needed to determine the long-term efficacy of EMDR for grief.
Introduction

The death of a loved one is experienced by almost every person at some point in their lifetime, yet the grief that follows affects each individual differently. Known as grief reactions, the responses to such a loss can be emotional, physical, cognitive and behavioural, and for most people will gradually reduce in intensity over time. Approximately 10-20% of the population however will develop what is known as complicated grief, and instead of the intensity decreasing over time they will remain “stuck” in the grieving process (Byrne & Raphael, 1994), placing them at a higher risk of disease (Gallagher-Thompson et al., 1993), depression and depressive symptoms (Byrne & Raphael, 1997), sleep difficulties (Germain et al., 2005; McDermott et al., 1997) and a decreased sense of overall well being and functioning (Ott, 2003). Symptoms unique to complicated grief have been reported to include an intense yearning or pining for the deceased, emotions such as anger, bitterness, shock and disbelief, estrangement from others and an inability to adapt to life without their loved one (Prigerson et al., 2009; Shear & Shair, 2005).

Debate exists as to whether severe grief reactions should be characterised as post-traumatic stress disorder (PTSD), major depressive disorder (MDD), or whether symptoms of complicated grief are best accounted for by a distinct diagnosis (Bonanno et al., 2007; O'Connor et al., 2010; Prigerson et al., 2009). Research suggests that similarities do exist between complicated grief and PTSD, with one study using factor analysis to illustrate the overlap in symptomology and suggesting that the intrusion component of PTSD can largely account for grief symptoms (O'Connor et al., 2010); a link found to be particularly strong in cases where the death was unexpected (Sanders, 1993) or violent in nature (Kaltman & Bonanno, 2003). With respect to depression, the literature reveals conflicting findings. Bonanno et al.
found that symptoms of grief predicted functioning up to 18 months post loss over and above depression, whereas Zisook and Kendler (2007) maintained that the two share more similarities than differences. The relationship between grief reactions and depression has been the focus of much controversy and culminated in the removal of what was termed the *bereavement exclusion* from the DSM-5 (American Psychiatric Association, 2013). Prior to this publication, the DSM-IV-TR (American Psychiatric Association, 2004) outlined that an individual should not be diagnosed with MDD within two months of the death of a loved one. With respect to treatment implications, Bryant (2013) investigated different psychotherapy approaches and found that those targeting specific grief symptoms – such as yearning for the deceased – were superior to those targeting only depressive symptoms. In light of this research, it is timely and important that further studies are conducted to determine which approaches are most effective in the treatment of grief and its symptoms.

**Psychotherapy Interventions**

Despite disagreement in the literature regarding the diagnosis of grief, an evidence base for treatment does exist. The results of two meta-analyses (Currier et al., 2008; Wittouck et al., 2011) suggest that therapeutic interventions can result in significant reductions in complicated grief symptomology, particularly when targeted individuals are experiencing significant distress or struggling to adapt to their loss. This is in contrast to preventative interventions which target those deemed “at risk” of developing complicated grief, which yield relatively small benefits (Currier et al.). Wittouck et al.’s meta-analysis found that the benefits of effective interventions increased during follow-up periods, however this differs from Currier et al.’s finding that the small effect size of bereavement interventions was no longer present at follow-up, the mean length of which was 36 weeks post treatment. The most
frequently researched approach to grief therapy is cognitive behavioural therapy (CBT).

**Cognitive-behavioural therapy.**

Cognitive-behavioural based therapies have been shown to have a positive impact on those struggling with grief (Currier, 2009) and involve guiding the client’s exposure to avoided people, places or triggers, as well as identifying and challenging dysfunctional thoughts about the deceased and their loss. Integrated CBT approaches have also included the use of imaginal dialogues with the deceased, which has its roots in Gestalt therapy-based chair-work (Daldrup, Beutler, Engle, & Greenberg, 1988). This technique involves the therapist guiding a conversation between the client and deceased in which the client is able to express any unmet emotional needs as well as ask questions, before switching roles as responding as the deceased, allowing for reconciliation, forgiveness and closure (Rosner, Pfoh, et al., 2011, p. 8002).

This Gestalt therapy-based technique was included in a manualised, integrated-CBT intervention for grief by Rosner, Pfoh and Kotoucova (2011), which formed the basis of an intervention condition for a group of 50 inpatients with co-morbid complicated grief (in addition to anxiety, somatoform and eating disorders). When compared to a control group of 22 inpatients who received treatment as usual, the nine sessions of integrated CBT produced large effect sizes for complicated grief symptoms in the treatment group as measured by the Inventory of Complicated Grief (Rosner, Lumbeck, & Geissner, 2011). Interestingly, no difference between the groups was found for overall psychological distress or depressive symptoms, a finding the researchers attributed to the specificity of the grief intervention.

A further integrated approach which combined CBT techniques with some aspects of interpersonal therapy was compared to traditional interpersonal therapy,
each delivered in a group format (Shear et al., 2005). The authors found that while both groups improved on measures of complicated grief symptomology, there was a greater and more rapid response rate in the CBT based approach.

**Eye movement desensitisation reprocessing.**

The symptoms of grief share a number of similarities with post traumatic stress disorder (PTSD), including a shattering of one’s assumptions about the world, separation anxiety and traumatic distress (Fleming & Belanger, 2001; O'Connor et al., 2010). Therefore it has been suggested that treatment approaches that target reducing symptoms of PTSD may also be effective for individuals struggling with complicated grief (O'Connor et al., 2010).

Eye movement densensitisation reprocessing (EMDR) is an integrative psychotherapy approach recommended as an evidence based practice by a number of organisations (Australian Centre for Posttraumatic Mental Health, 2013; National Institute for Clinical Excellence, 2005; World Health Organisation, 2013) for treatment of PTSD. EMDR targets distressing memories, stimuli associated with a trigger of distress and then encourages more adaptive attitudes, skills and behaviours (Shapiro, 2002). Unlike a trauma-focused CBT approach however, EMDR does not require homework, exposure or a detailed account of the event from the client, nor does it directly challenge their beliefs (World Health Organisation, 2013).

EMDR has been found to achieve rapid improvement for clients’ distress, with Ironson et al. (2002) finding a significantly faster reduction in PTSD and depressive symptoms as well as a lower dropout rate when compared to prolonged exposure for trauma. Furthermore, following treatment EMDR clients tend to report a traumatic event as being observed from a detached perspective, a phenomenon otherwise known as psychological distancing and found by Lee, Taylor and Drummond (2006) to be
linked to greater symptom improvement. The current literature suggests that eye movements play a key role in the efficacy of EMDR for relief of trauma symptoms (Lee & Cuijpers, 2013), however the precise mechanisms remain unclear.

A limited number of studies have explored the use of EMDR and its elemental components with grieving individuals, each demonstrating promising results. Hornsveld et al (2010) investigated the efficacy of eye movements in reducing the emotionality of memories related to the death of a loved one. Sixty participants were asked to recall a negative bereavement-memory before and after one of three conditions – eye movement, relaxation music, or a control with recall-only. The results demonstrated a significantly greater reduction in emotionality after eye movements compared to the other two conditions, providing support for the use of this EMDR component in individuals with grief.

The only study to date in comparing EMDR with another psychotherapy approach for grief involved 50 participants self selecting into either an EMDR or guided mourning (GM) treatment condition (Sprang, 2001). GM is a behaviourally based approach using exposure principles and homework, shown to be effective with individuals who display a somewhat phobic avoidance to grief-related stimuli (Mawson et al., 1981). Both treatments resulted in significant reductions in outcome measures such as re-experiencing, nightmares, rumination and intrusive symptoms. Consistent with Ironson et al.’s (2002) findings in a PTSD population, however, EMDR participants experienced their improvements at a much faster rate than those in the GM condition; symptom reduction to almost zero levels took approximately eight sessions in EMDR and 13 sessions in GM. Participants in the EMDR condition also reported a significant increase in the number of positive memories of their loved ones recalled, a finding not replicated in the GM condition. This study was primarily
limited by the lack of random assignment to treatment conditions, as participants self-selected into EMDR or GM.

In summary, there is preliminary evidence that EMDR may benefit people struggling with grief. However, to date the only study to compare EMDR with another psychotherapy (Sprang, 2001) did not employ randomised allocation to conditions.

**Current Study**

The current study was aimed at evaluating and comparing the effectiveness of two interventions – integrated CBT and EMDR – targeted at participants who identified themselves as struggling with grief, using a randomised control trial design. A wait-list was used as a control condition but also to observe any changes in symptomology that may have occurred naturally over time.

Based on research outlined above, it was hypothesised that:

1. There would be no significant improvement in symptomology for participants over the seven week wait-list period, that is, from intake session to first therapy session;

2. Measures of negative symptomology – grief, impact of event, depression, anxiety and stress – would decrease significantly in both the integrated EMDR and CBT conditions, while measures of quality of life would increase significantly in both the EMDR and CBT conditions;

3. This improvement would be significantly greater in the EMDR condition than in the CBT condition;
Method

Design

The study utilised a randomised control trial design, and was registered with the Australian New Zealand Clinical Trials Registry (see Appendix A for registration approval). It received ethics approval from the Murdoch University Human Research Ethics Committee. Participants were recruited from the community, and responded to information letters sent to local GPs, advertisements on radio, in local newspapers, on the websites of several bereavement-related organisations, and via Murdoch University’s website and campus (see Appendix B). Participants were not reimbursed or rewarded in any way for their participation, however were provided with a university parking permit so as not to incur costs.

*One participant dropped out after four sessions; their data was included in analysis, with post-treatment data taken from session four outcome measures.

Figure 1. Participant flow through study design.
Individuals interested in participating responded to advertisements by contacting the researchers via a dedicated mobile phone number to organise an initial intake session, and were randomly allocated to one of the two researchers by tossing a coin. Individual intake sessions lasted 45 minutes to one hour, during which each treatment condition was explained in detail and some basic demographic information was collected. Inclusion criteria were a minimum age of 18 years, having someone important to you die at least six months ago, not presently receiving counselling or therapy for grief and not being involved in legal matters pertaining to the death.

Once potential participants signed a consent form (Appendix C) they then completed questionnaires to screen for contraindications to EMDR. EMDR may be contraindicated for individuals who suffer epilepsy, are currently taking benzodiazepines or have undergone retinal surgery (Shapiro, 2001) and so anyone who met these criteria was also excluded. Similarly, people who have a tendency to dissociate require a more complex protocol (Shapiro) not possible to deliver in this research context. To screen for dissociative disorders the Dissociative Experiences Scale-II (Zingrone & Alvarado, 2002) was completed during the intake interview and any participant who scored above 30 was further administered the Dissociative Disorders Interview Schedule (Ross et al., 1989). No participants met criteria for a dissociative disorder. All subjects were placed on a seven week wait-list, before being contacted to schedule weekly treatment sessions. Data collected at the beginning and end of the wait-list acted as a control condition.

Allocation to treatment condition – EMDR or integrated CBT – was achieved by a computer generated random number table, administered by the project supervisor. Each treatment condition was comprised of seven weekly sessions held at the Murdoch University Psychology Clinic; the first six sessions were 90 minutes in
duration whereas the final session was shorter at 45 minutes. Follow-up data was collected by an independent researcher. To ensure fidelity to treatment protocol and to enable therapist supervision, all session were videotaped. Video recordings were stored in a locked cabinet in the Murdoch University Psychology faculty and de-identified using participant numbers.

Participants

Twenty participants (13 females and 7 males), aged between 22 and 75 years ($M=45.6$, $SD=15.52$) volunteered to participate in the study and 18 completed treatment. Their relationship to the deceased (illustrated in Table 1), the cause of death and time since the death varied greatly between participants. 26.3% of participants ($n=5$) had suffered multiple losses, with one participant experiencing the death of three immediate family members and one close friend. For those participants with multiple losses, the most recent or distressing bereavement, as indicated by the participant was used in demographic data. Time since death ranged from six months to 24 years ($M=5.5$ years, $SD=7.9$ years). No participants had previously received EMDR or CBT, however 78.9% of participants ($n=15$) had received some form of counselling for their loss-related distress, most of which were hospital based services, general counselling or grief support groups.

Table 1. Relationship between participants and the deceased

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Proportion ($n$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>42.1 (8)</td>
</tr>
<tr>
<td>Participant’s parent</td>
<td>31.6 (6)</td>
</tr>
<tr>
<td>Participant’s child</td>
<td>10.5 (2)</td>
</tr>
<tr>
<td>Girlfriend/boyfriend</td>
<td>5.3 (1)</td>
</tr>
<tr>
<td>Other family</td>
<td>10.5 (2)</td>
</tr>
</tbody>
</table>
Treatment Conditions

Integrated – CBT.

An integrated CBT intervention was adapted from Rosner, Pfoh and Kotoucova’s (2011) manual and over seven sessions addressed the areas of psychoeducation, cognitive restructuring, exposure, reconciliation and integration (see Table 2 for session by session outline). As with traditional CBT approaches, each session included a review of the previous week’s content and homework, an educational component, skills practice and the setting of a homework task for the next week (Beck, 2011).

Table 2. Session by session outline of integrated-CBT intervention

<table>
<thead>
<tr>
<th>Theme</th>
<th>Session number</th>
<th>Session content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoeducation</td>
<td>1</td>
<td>Psychoeducation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Progressive muscle relaxation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Semi-structured clinical interview</td>
</tr>
<tr>
<td>Cognitive restructuring</td>
<td>2</td>
<td>Identifying cognitive distortions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The thought-feeling link</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Cognitive disputation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily thought record</td>
</tr>
<tr>
<td>Exposure</td>
<td>4</td>
<td>Exposure task</td>
</tr>
<tr>
<td>Reconciliation and</td>
<td>5</td>
<td>Walk to the grave – Gestalt therapy exercise</td>
</tr>
<tr>
<td>integration</td>
<td>6</td>
<td>Review walk to the grave</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Planning for the future</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Concluding</td>
</tr>
</tbody>
</table>

The primary, non-CBT addition to the protocol was an imaginal dialogue between the client and the deceased, guided by the therapist and based on Gestalt therapy principles (Daldrup et al., 1988). In this exercise, the client is able to address
unresolved issues or unmet emotional needs and forgiveness, and reconciliation between themselves and the deceased is facilitated. The therapist guides what is otherwise free dialogue with prompts of, “I always wanted to ask you”, “I always wanted to tell you” and “this is how your death impacted my life”, before the client switches roles and responds as the deceased.

EMDR.

The EMDR intervention followed the standard protocol (Shapiro, 2001) beginning with a semi-structured interview during the first session. The actual event of the death was treated as the initial target memory for each client and from there associated memories relating to their loved ones and their grief were subsequently reprocessed, moving through the phases of desensitisation, installation, body scan and closure. Although memory content differed from one client to the next, common target memories included intrusive images, nightmare images, present triggers and earlier incidents relating to issues of personal responsibility, mortality or previous unresolved losses. As in the integrated-CBT condition, the seventh session did not involve any active phases of EMDR and was focused on concluding treatment, planning for possible future challenges such as anniversaries and addressing the end of the therapeutic relationship.

Therapists.

The interventions were delivered by two Masters of Applied Clinical Psychology students who had completed specialised training in both CBT and EMDR. They were supervised by a specialist clinical psychologist who was also an accredited trainer with the EMDR International Association. CBT training was accredited by the Australian Psychological Society.
Measures

To quantitatively assess participants’ levels of distress and difficulties associated with their grief, several measures were administered during intake and at the conclusion of the first, fourth and seventh sessions, and approximately two weeks after therapy concluded. The Impact of Events Scale was completed by participants prior to each treatment session so as to provide a more sensitive indication of symptom change.

Impact of Events Scale (IES). The IES (M. Horowitz, Wilner, & Alvarez, 1979) is a 15 item scale measuring subjective distress in response to a specific event, with scales specifically designed to assess symptoms of intrusion and avoidance. Higher scores indicate a greater impact and scores above 26 are deemed to be indicative of moderate or severe distress. Test-retest reliability is \( r = .89 \) for the intrusion subscale, \( r = .79 \) for the avoidance subscale and \( r = .87 \) for the whole scale (M. Horowitz et al., 1979). The instrument was found initially to be sensitive to change and a subsequent study by Fischer and Corcoran (1994) found it to be effective in detecting significant changes in subscale scores for an outpatient sample receiving treatment for bereavement.

Dissociative Experiences Scale – II (DES-II). The DES-II (Carlson & Putnam, 1993) consists of 28 questions which ask the respondent to indicate how often they encounter a variety of experiences, such as “finding new things amongst their belongings that they don’t remember buying”, expressed as a percentage of the time from 0-100%.

Dissociative Disorders Interview Schedule. Individuals who scored above 30 on the DES-II \( (n = 2) \) were subsequently administered the Dissociative Disorders Interview Schedule (Ross et al., 1989). It is comprised of 16 sections, each scored
separately and corresponding to a DSM-IV diagnosis (ie. Multiple personality disorder, somatisation disorder).

**Inventory of Complicated Grief (ICG).** The ICG (Prigerson et al., 1995) is a 19 item measure designed to measure symptoms of grief such as “longing for the person who died” which are considered to be distinct from depression and anxiety. Scores above 25 are considered to be reflective of greater distress and social and occupational impairment. High internal consistency (α = .94) and test-retest reliability (r = .80) have been reported, in addition to good concurrent validity with other grief-specific measures including the Texas Revised Inventory of Grief (r = .87) (Faschingbauer, Devaul, & Zisook, 1978).

**Depression Anxiety and Stress Scale (DASS).** The DASS (Lovibond & Lovibond, 1995) is a 42 item self report scale, measuring a respondent’s levels of depression, anxiety and stress across three scales, each comprising of 14 items. Total scores are indicative of higher levels of distress and normative data on Australian samples include non-clinical and clinical ranges for each subscale. Very good to excellent internal consistency has been established for the depression, anxiety and stress subscales at r = .91, r = .84 and r = .90, respectively (Antony, Bieling, Cox, Enns, & Swinson, 1998).

**Quality of Life Scale (QOLS).** The QOLS (Flanagan, 1978) is a 16 item questionnaire which asks respondents to indicate to what extent they are satisfied with various elements of their life, with higher scores indicating a greater perceived quality of life. The scale’s construct validity has been well established; internal consistency is generally high, with Cronbach’s alpha ranging from α = .82 to .92 and good test-retest reliability has also been demonstrated (r = .78 to .84) (Burkhardt, Anderson, Archenholtz, & Hagg, 2003; Burkhardt, Woods, Schultz, & Ziebarth, 1989).
Follow-up interview. All participants were invited to attend a follow-up interview approximately two weeks ($M=16.3$ days) after the conclusion of treatment, during which they completed the outcome measures as well as a semi-structured interview conducted by a research assistant who was not otherwise associated with the project. Results of the qualitative element of the study are reported elsewhere and as such are not detailed in this report.

Results

The study was designed such that scores on outcome measures could be compared between conditions across intake, pre-treatment, mid-treatment, post-treatment and follow-up using a multivariate analysis of variance (MANOVA). However, a number of assumptions for this analysis were violated.

An inspection of skewness and kurtosis values, in addition to histograms for each of the post-treatment (session 7) outcome variables indicated that the assumption of normality of variances was violated. Significant Shapiro-Wilk tests for both conditions of the ICG, DASS and QOLS, as outlined in Table 3, indicate that the variance of scores on these measures was significantly non-normal. The assumption of homogeneity of variance was also violated for DASS scores, with Levene’s test significant $F(1,15)=8.94, p=.009$, indicating that variances of scores on this measures were significantly different. Further, Box’s test of equality of covariance matrices was significant, Box’s $M(10,1033.85)=27.25, F=1.91, p=.040$. See Appendix D for SPSS output.
Table 3. Shapiro-Wilk tests of normality for post-treatment outcome variables

<table>
<thead>
<tr>
<th>Scale</th>
<th>Condition</th>
<th>Shapiro-Wilk Statistic</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IES</td>
<td>CBT</td>
<td>.79</td>
<td>8</td>
<td>.024</td>
</tr>
<tr>
<td></td>
<td>EMDR</td>
<td>.82</td>
<td>9</td>
<td>.035</td>
</tr>
<tr>
<td>ICG</td>
<td>CBT</td>
<td>.88</td>
<td>8</td>
<td>.175</td>
</tr>
<tr>
<td></td>
<td>EMDR</td>
<td>.89</td>
<td>9</td>
<td>.196</td>
</tr>
<tr>
<td>DASS</td>
<td>CBT</td>
<td>.86</td>
<td>8</td>
<td>.114</td>
</tr>
<tr>
<td></td>
<td>EMDR</td>
<td>.84</td>
<td>9</td>
<td>.057</td>
</tr>
<tr>
<td>QOLS</td>
<td>CBT</td>
<td>.96</td>
<td>8</td>
<td>.818</td>
</tr>
<tr>
<td></td>
<td>EMDR</td>
<td>.93</td>
<td>9</td>
<td>.471</td>
</tr>
</tbody>
</table>

df = degrees of freedom. Sig.=significance. IES=Impact of Events Scale. ICG=Inventory of Complicated Grief. DASS=Depression Anxiety and Stress Scales. QOLS=Quality of Life Scales. CBT=Integrated CBT intervention. EMDR=Eye movement desensitisation reprocessing intervention.

Due to the violations of these assumptions and the small sample size, paired samples t-tests were used to investigate the study’s hypotheses.

1. There would be no significant improvement in symptomology for participants over the wait-list period

A paired samples t-test was conducted to determine whether participants’ scores on outcome measures differed significantly between intake interview and session one of therapy, in other words, to determine whether their distress improved naturally over the course of time without intervention. Across all participants, there was no significant difference between scores on the total IES $t(18)=.99, p>.05$, ICG $t(18)=1.31, p>.05$, DASS $t(18)=.07, p>.05$, or QOLS $t(18)=1.32, p>.05$, between intake session and the commencement of therapy seven weeks later.

2. Both groups will have significant reductions in negative symptomology and an increase in quality of life after therapy.

In order to determine whether participants in both conditions achieved reductions in negative symptomology and an increase in quality of life, paired
samples t-tests were conducted comparing scores at pre and post treatment. The results of these t-tests, in addition to their effect sizes, are illustrated below in Table 4. Scores on the IES, ICG and DASS were significantly lower post-treatment. Similarly, scores on the QOLS were significantly higher following both interventions, however the significance of this effect was not maintained after a Bonferroni correction was applied to adjust for multiple analyses.

Table 4. Results of paired samples t-test comparing outcome measures at session 1 and session 7 across both treatment conditions.

<table>
<thead>
<tr>
<th>Measure</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>IES</td>
<td>5.95</td>
<td>16</td>
<td>.000**</td>
<td>.54</td>
</tr>
<tr>
<td>ICG</td>
<td>4.04</td>
<td>16</td>
<td>.001**</td>
<td>.36</td>
</tr>
<tr>
<td>DASS</td>
<td>3.02</td>
<td>16</td>
<td>.008**</td>
<td>.37</td>
</tr>
<tr>
<td>QOLS</td>
<td>-2.50</td>
<td>16</td>
<td>.024*</td>
<td>.12</td>
</tr>
</tbody>
</table>

*Significant at α=.05
**Significant at α=.0125
±Effect size, as measured by Cohen’s d, has been calculated using the original standard deviation for each outcome measure, as argued for by Dunlop, Cortina, Vaslow and Burke (1996) in designs with significant correlations between paired samples of measures.
IES=Impact of Events Scale. ICG=Inventory of Complicated Grief. DASS= Depression Anxiety and Stress Scales. QOLS=Quality of Life Scales.

2. These changes will be greater in the EMDR condition than in the integrated – CBT condition

To compare the effects of each type of therapy on outcome measures over the duration of therapy, paired samples t-tests were conducted separately on data from participants in each treatment condition. These results are summarised in Table 5.
Table 5. Means ($M$), standard deviations ($SD$) and paired samples t-test results for outcome measures in each intervention condition at pre-treatment, post-treatment and follow-up.

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
<th>Follow-up</th>
<th>Pre-post</th>
<th>Post-follow-up</th>
<th>t</th>
<th>p</th>
<th>ES±</th>
<th>t</th>
<th>p</th>
<th>ES±</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of Events Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>24.25</td>
<td>17.17</td>
<td>9.13</td>
<td>10.86</td>
<td>6.13</td>
<td>6.77</td>
<td>2.93</td>
<td>.022*</td>
<td>.88</td>
<td>3.49</td>
<td>.010**</td>
</tr>
<tr>
<td>EMDR</td>
<td>34.00</td>
<td>17.73</td>
<td>17.44</td>
<td>13.66</td>
<td>13.11</td>
<td>11.80</td>
<td>5.20</td>
<td>.001**</td>
<td>1.12</td>
<td>6.55</td>
<td>.000**</td>
</tr>
<tr>
<td>Inventory of Complicated Grief</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMDR</td>
<td>29.22</td>
<td>9.24</td>
<td>19.00</td>
<td>14.05</td>
<td>16.22</td>
<td>14.65</td>
<td>4.25</td>
<td>.002**</td>
<td>1.23</td>
<td>4.71</td>
<td>.002**</td>
</tr>
<tr>
<td>Depression Anxiety and Stress Scales</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>25.50</td>
<td>18.99</td>
<td>10.38</td>
<td>7.80</td>
<td>7.75</td>
<td>6.48</td>
<td>2.63</td>
<td>.034*</td>
<td>.80</td>
<td>3.13</td>
<td>.017*</td>
</tr>
<tr>
<td>EMDR</td>
<td>33.89</td>
<td>19.26</td>
<td>26.22</td>
<td>25.37</td>
<td>23.22</td>
<td>26.84</td>
<td>2.05</td>
<td>.071</td>
<td>-</td>
<td>2.25</td>
<td>.055</td>
</tr>
<tr>
<td>Quality of Life Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>73.63</td>
<td>14.45</td>
<td>83.00</td>
<td>11.99</td>
<td>79.75</td>
<td>17.08</td>
<td>-3.35</td>
<td>.012**</td>
<td>.65</td>
<td>-1.25</td>
<td>.252</td>
</tr>
<tr>
<td>EMDR</td>
<td>69.89</td>
<td>11.43</td>
<td>77.33</td>
<td>19.24</td>
<td>75.11</td>
<td>18.17</td>
<td>-1.36</td>
<td>.206</td>
<td>-</td>
<td>-1.943</td>
<td>.373</td>
</tr>
</tbody>
</table>

*Significant at $\alpha=.05$
**Significant at $\alpha=.0125$ (Bonferroni correction)
±Effect size, as measured by Cohen’s $d$, has been calculated using the original standard deviation for each outcome measure, as argued for by Dunlop, Cortina, Vaslow and Burke (1996) in designs with significant correlations between paired samples of measures.
In the EMDR condition, participants’ scores on the IES improved significantly from pre to post treatment. The effect sizes found indicate that the difference between the means change between IES scores from pre-post treatment and pre-treatment to follow-up were 1.12 and .61 standard deviations, respectively. Similarly, scores on the ICG improved significantly from pre to post treatment and follow-up, with effect sizes indicating these changes represented 1.23 and .45 standard deviations, respectively.

In the CBT condition, participants’ scores on the IES were significantly reduced from pre to post treatment, as were scores on the DASS. Conversely, CBT participants experienced a significant increase in mean quality of life scores. However, when a Bonferroni correction was used to reduce the likelihood of Type I error due to multiple analyses being conducted (four measures), and a more stringent alpha of 0.0125 (.05/4) was used only the change in mean scores on the QOLS remained significant. The effect size for this comparison indicated that participants’ scores improved 0.65 standard deviations across the intervention period. At follow-up, when data was collected by an independent researcher, a significant improvement in IES scores was observed in the CBT condition. Unlike the EMDR condition however, there was no significant improvement in ICG scores after a Bonferroni correction was applied.

**Participants with High Levels of Distress**

The present study did not require a minimum score on outcome measures for inclusion in the study and as a result participants’ scores captured a broad range of grieving experiences, from very low to very high levels of distress. For a clearer picture of how the interventions assisted those who would be considered struggling with complicated grief, the data of those participants who scored in the severe or
clinical range on the IES, ICG and DASS was explored to determine whether these individuals achieved reliable and significant change at post-treatment.

The reliable change index and requirements for clinical change were calculated using norm data for the ICG (Prigerson et al., 1995), and subscales for the IES (Fischer & Corcoran, 1994) and DASS (Lovibond & Lovibond, 1995). Where applicable, clinical change was calculated using either criterion A - in which participant’s score moved more than two standard deviations from the clinical mean, or criterion C – in which the participant’s score has moved past the midway point between the clinical and non-clinical means towards the ‘normal sample’ mean (Jacobson & Truax, 1991). The results of these calculations are shown in Table 6.

**Table 6.** Reliable and clinical change data for participants with extreme pre-treatment scores on outcome measures.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Subscales</th>
<th>Cut-off score</th>
<th>Number of participants who scored above cut-off</th>
<th>Number of participants with reliable and clinically significant change (% of those scoring above cut-off)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IES</td>
<td>Total*</td>
<td>26</td>
<td>14</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td></td>
<td>One or both of**</td>
<td></td>
<td></td>
<td>8 (57.1)</td>
</tr>
<tr>
<td></td>
<td>Avoidance</td>
<td></td>
<td></td>
<td>8 (57.1)</td>
</tr>
<tr>
<td></td>
<td>Intrusion</td>
<td></td>
<td></td>
<td>8 (72.7)</td>
</tr>
<tr>
<td>ICG</td>
<td></td>
<td>25</td>
<td>11</td>
<td>8 (72.7)</td>
</tr>
<tr>
<td>DASS</td>
<td>One or more of</td>
<td></td>
<td></td>
<td>4 (66.7)</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>21</td>
<td>5</td>
<td>3 (60.0)</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>15</td>
<td>1</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>Stress</td>
<td>26</td>
<td>1</td>
<td>1 (100)</td>
</tr>
</tbody>
</table>

*Norms not available for total IES, cut-off score for moderate to severe range
** Cut-off scores not available for IES subscales
Discussion

The present study used a randomised control trial design to compare the efficacy of an integrated – cognitive behavioural therapy (CBT) and EMDR intervention for individuals struggling with grief. As was expected, participants’ scores on outcome measures did not change significantly from their initial intake interview to their first therapy session seven weeks later. This finding is likely due to the large variance in time since death, with a mean length of 5.5 years; the most dramatic changes in grief symptomology are typically found within the first six to 14 months (M. J. Horowitz, Bonanno, & Holen, 1993; Prigerson et al., 2009).

It was also expected that participants in both the CBT and EMDR conditions would have a significant reduction in scores on measures of negative symptomology (IES, ICG, DASS) and a significant increase in quality of life scores. With respect to negative symptom measures, participants’ scores across both treatment conditions were significantly lower following seven weeks of grief therapy, with a medium effect size for the IES and small to medium effect sizes for the ICG and DASS scores. This supports the findings of Currier et al. (2008) and Wittouck et al. (2011) that interventions can be effective in reducing grief and its associated distress.

Participants’ scores on the Quality of Life Scale (QOLS; Flanagan, 1978) did improve, however were only significant at $\alpha=.05$, rather than the more conservative level of $\alpha=.0125$ set to control for the multiple analyses conducted. It is worth noting that the QOLS is a subjective measure and some of the aspects measured (e.g. fitness, leisure, child rearing) may not be expected to improve as a result of such a short, issue-specific treatment protocol.

With respect to differences between the interventions, it was further anticipated that changes on outcome measures would be greater in the EMDR condition than in
the CBT condition. After a Bonferroni correction, there remained a significant improvement post-treatment on measures of impact of event and grief symptomology in the EMDR group, but for CBT only an improvement in quality of life was observed. What occurred at follow-up, again with a Bonferroni correction, was that participants in both treatment groups showed improvement across a variety of measures. This data, collected by an independent researcher approximately two weeks after the conclusion of therapy, shows that both treatments resulted improvements on the IES, but only the EMDR group achieved significant reductions on the ICG.

These findings regarding the efficacy of EMDR both support and extend the findings of Sprang (2001). Sprang’s comparison of EMDR with guided mourning (GM) for grief revealed a significantly higher rate of improvement on scores on the IES, as well as measures of anxiety, self-esteem and PTSD in the EMDR group; whereas no difference between the interventions was seen on a measure of grief – the Texas Revised Inventory of Grief – although both improved significantly. Supporting these findings, the current study showed medium to very large effect sizes in the reduction of IES scores at follow-up and post-treatment in the EMDR condition, demonstrating the efficacy of this intervention in alleviating symptoms of avoidance and intrusion. Unlike Sprang’s study however, the current results indicate that a difference between interventions on a measure of grief, with EMDR resulting in medium to very large effect sizes on the ICG - something not evident in the integrated-CBT group. Together, these findings suggest that not only did EMDR lead to a considerable degree of improvement on measures of distress, but that this therapy targeted grief symptoms specifically and that these changes remained at follow-up.

In the CBT condition, participants’ scores on the IES, DASS and QOLS changed from pre-treatment to post-treatment, but only the change in QOLS scores
remained significant after a Bonferroni correction. Similarly, scores on the IES, ICG and DASS all reduced from pre-treatment to follow-up, however only IES scores remained significant at the more conservative alpha level. It is worth noting that the smaller number of participants who completed treatment in the integrated-CBT condition ($n=8$ compared to $n=10$ in EMDR) may have influenced results, such that a larger sample may have detected significant differences at the corrected alpha level. The significant change in scores relating to quality of life at post-treatment do, however, provide some support for the results of Shear et al. (2005), whose study revealed a greater response rate on a measure of work and social adjustment in the integrated CBT and interpersonal therapy (IPT) intervention than the traditional IPT approach. This trend may reflect the generalisation of skills learnt in CBT, such as greater awareness and control of thoughts, feelings and behaviours that may be applied to other areas of one’s life.

The reduction in IES scores in the integrated-CBT group, significant at $\alpha=.05$ from pre-treatment to post-treatment, and significant at $\alpha=.0125$ at follow-up, suggests a trajectory of improvement after the conclusion of therapy and supports Wittouck et al.’s (2011) findings that the benefits of grief interventions can increase during follow-up periods. It is important to note however that the mean time between conclusion of therapy and follow-up interview in the present study was only 16 days. A further follow-up interview at three months post therapy is planned and this will provide additional, more meaningful data regarding the long-term efficacy of both interventions.

Interestingly, in the present study’s integrated-CBT condition, participants’ scores on the ICG did not reduce significantly at either post-treatment or follow-up. This is in contrast to Rosner, Lumbeck, et al. (2011) and Shear et al. (2005), both of
whom found that an integrated-CBT intervention produced significantly greater reductions on ICG scores than a treatment as usual and an interpersonal therapy (IPT) intervention, respectively. Possible reasons for the discrepancy between these studies and the present study could be the number and severity of grief of the participants, or the type of interventions delivered. Both former studies had large numbers of participants in their integrated-CBT approaches (Rosner et al. \(n=49\) and Shear et al. \(n=50\)), and only included those who met criteria for complicated grief as measured by ICG scores and a clinical interview. The current study had only eight participants complete the integrated-CBT intervention and no inclusion criteria regarding ICG scores, although of these six did score above the recommended cut-off of 25 (Prigerson et al., 2009). Further, there were considerable differences in the nature and length of interventions, with Shear et al. delivering 16 sessions and including re-telling of the death, and Rosner et al. delivering nine, double weekly sessions in a group format. However, the longer treatment periods in these studies are outside of the range of Medicare funded treatments in Australia.

Given the present study did not have stringent inclusion criteria regarding participants’ degree of distress, any individual that felt they may benefit from therapy was offered treatment. Calculations based on individual participant data however revealed that, of those who met criteria for moderate to severe impact of distress on the IES, 85.7% moved from a clinical to a non-clinical range post-treatment, on one or more subscales of the measure. This indicates that interventions were able to promote meaningful change in these areas and provides support for the idea expressed by O’Connor et al. (2010) that complicated grief and PTSD share a number of common features and can often be treated using similar therapeutic approaches. For the DASS, 66.7% of those who had severe scores on one or more subscales achieved reliable and
clinical change on that subscale. The DASS was included as an outcome measure in the present study because literature suggests that in addition to symptoms unique to grief – and captured by the ICG – individuals struggling with the loss of a loved one often suffer from additional psychological distress (Ott, 2003). At pre-treatment, 31.6% of participants scored in the severe range for at least one subscale, adding support to research that posits additional mental health complications/risks for those struggling with grief (Stroebe et al., 2007). For the ICG, of those who met criteria for complicated grief 72.7% demonstrated reliable and clinical change on their scores at the conclusion of therapy. Together, these results support the findings of both Currier et al. (2008) and Wittouck et al.’s (2011) meta-analyses, which indicate that interventions targeting those identified as struggling with complicated grief are indeed effective at reducing their distress, in comparison to interventions targeting only those at risk.

The current study had a number of methodological strengths which lend support to the validity of its findings. Firstly, participants were randomly allocated to treatments, which were subsequently delivered by multiple therapists. The treatments delivered followed manuals (Shapiro, 2001 for EMDR and adapted from Rosner et al., 2011 for integrated-CBT) and were replicable by future researchers. The exclusion criteria further meant that confounding conditions were controlled for insofar as participants were not receiving concurrent psychotherapy elsewhere for the duration of the wait-list and therapy periods. The measures used had demonstrated reliability and validity, and follow-up assessment was conducted by an independent researcher who was trained and skilled in the administration of measures used in the study. Finally, video-taped sessions enabled treatment fidelity to be checked through regular supervision. Together, these elements of the study’s methodology score 6.5 out of 10
on Maxfield and Hyer’s (2002) revised Gold-standard scale for PTSD research. This scale was borne out of research studying the relationship between research methodology and outcome of studies using EMDR for PTSD, and the research indicates a significant relationship between scores on the scale and effect sizes found.

Limitations of the present study include the number of participants (N=19) being smaller than the 32 participants needed for paired samples t-tests to detect a medium effect size of 0.6 (Faul, Erdfelder, Lang, & Buchner, 2007). Unlike other studies comparing grief interventions (e.g. Rosner, Lumbeck, et al., 2011; Shear et al., 2005; Sprang, 2001) the current study did not require participants to meet any inclusion criteria regarding scores on measures of complicated grief symptomology or psychological distress. Future research comparing EMDR and integrated-CBT approaches would benefit from using more stringent inclusion criteria, in line with Wittouck et al. (2011) and Currier et al.’s (2008) finding that the most effective interventions target those struggling with complicated grief. The interventions in the present study were delivered by two Masters level students. Despite having received further specialist training in both CBT and EMDR for the study, interventions in Rosner et al., Shear et al., and Sprang’s studies had an average of four to five years of experience in their therapy approaches. However, significant results in the current study indicate that with specific training, even clinicians in their formative years can make a meaningful difference in the lives of those struggling with grief.

In their study on the efficacy of eye movements for grief-related memories, Hornsveld et al. (2010) assessed for the emotionality of these memories. Similarly, Sprang’s (2001) study employing EMDR specifically measured the frequency of positive memories recalled of the deceased throughout therapy, in addition to psychometric outcome measures. The present study did not examine the nature or
frequency of grief related memories. Given these form the targets for EMDR, future research would benefit from including some measurement of memories of a loved one.

**Conclusion**

The present study provides preliminary support for the use of EMDR with individuals struggling with grief. It also demonstrated that EMDR is as effective as an integrated-CBT approach for this population. EMDR appeared particularly effective on the symptom-specific measure of grief, relative to the integrated-CBT condition.

The majority of those participants who met criteria for complicated grief (86%), benefitted from treatment using criteria of reliable and clinically significant change. This finding is in line with the findings of previous meta-analyses (Currier et al., 2008; Wittouck et al., 2011) which indicate that those who are severely distressed are most likely to benefit from interventions, highlighting the importance of a comprehensive clinical assessment for individuals presenting with grief.

This study, together with the burgeoning body of existing literature regarding grief tells us that grief reactions and their associated psychosocial distress are both real and detrimental to a person’s overall functioning. With respect to EMDR as a treatment approach, further research is needed to determine its long-term efficacy for grief. Given that bereavement is an almost universal experience and will continue to affect individuals regardless of their age and background, and now DSM-5 has been published, perhaps the psychotherapy community would benefit from shifting its focus from diagnostic issues to robust research dedicated to investigating how best to help these individuals.
References


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Appendices

Appendix A

Registration Confirmation from ANZCTR

Dear Christopher Lee,

Re: Assisting individuals struggling with grief.

Thank you for submitting the above trial for inclusion in the Australian New Zealand Clinical Trials Registry (ANZCTR).

Your trial has now been successfully registered and allocated the ACTRN:

ACTRN12613000173796

Web address of your trial:


Date submitted: 8/02/2013 8:24:54 PM

Date registered: 12/02/2013 3:06:58 PM

Registered by: Christopher Lee

If you have already obtained Ethics approval for your trial, could you please send the ANZCTR a copy of at least one Ethics Committee approval letter? A copy of the letter can be sent to info@actr.org.au (by email) OR (61 2) 9565 1863, attention to ANZCTR (by fax).

Please be reminded that the quality and accuracy of the trial information submitted for registration is the responsibility of the trial's Primary Sponsor or their representative (the Registrant).

The ANZCTR allows you to update trial data, but please note that the original data
lodged at the time of trial registration and the tracked history of any changes made will remain publicly available.

The ANZCTR is recognised as an ICMJE acceptable registry (http://www.icmje.org/faq.pdf) and a Primary Registry in the WHO registry network (http://www.who.int/ictrp/network/primary/en/index.html).

If you have any enquiries please send a message to info@actr.org.au or telephone +61 2 9562 5333.

Kind regards,

ANZCTR Staff

T: +61 2 9562 5333
F: +61 2 9565 1863
E: info@actr.org.au
W: www.ANZCTR.org.au
Research Advertisement

Project Title: Assisting individuals struggling with grief

Description: We wish to understand what are the most effective ways of helping people cope with grief. We aim to compare two different psychological treatment approaches to assess which might most help others who experience grief. We also want to know how people experience each of these therapies.

If you are willing to contribute your experience, we will first need to talk with you and ask you to complete a few short questionnaires. In the first instance, you need to be over 18 years of age and have lost someone who you care about at least six months ago. We will be asking you to talk about and share your experience and memories of that person.

If, on the basis of the above, you are suitable for inclusion in the study you will be asked to individually participate in six sessions after a 6-week wait. Irrespective of the treatment you receive you will be asked to talk about your memories and at various intervals throughout the process you will be asked to complete a number of brief questionnaires.

We understand that talking about our grief is not easy and can lead to the experience some distress. Be assured that the researchers involved in this study will be sensitive to any distress and can offer relaxation techniques should these be required. Of course, you will be free to withdraw from the study at any time.

If you have any questions regarding the study, please feel free to contact either Larissa or Prue, whose contact details are below. This study and advertisement have Ethics approval, number: 2012/022 and has been registered with the Australian and New Zealand Clinical Trial Registry: ACTRN12613000173796.

Investigators: Larissa Morozow
31710142@student.murdoch.edu.au

Prue Cotter
31789247@student.murdoch.edu.au

Phone: 0478 195 997

Supervisor: Dr Christopher Lee
Appendix C

Consent Form

The efficacy of EMDR in the treatment of grief:
A randomized control trial.

1. I confirm that I meet the criteria for participation in this study:

☐ I am over the age of 18 years.
☐ I have normal or corrected to normal hearing and vision.
☐ I have no retinal damage or a history of serious eye disease.
☐ I do not have epilepsy
☐ Somebody who was important to me passed away at least 6 months ago
☐ I am not involved in any legal proceedings relating to this person’s death (other than will/estate settlements)

2. I agree voluntarily to take part in this study.

3. I have read the Information Sheet provided and been given a full explanation of the purpose of this study, of the procedures involved and of what is expected of me. The researcher has answered all my questions and has explained the risks associated with my participation in this study.

4. I understand I am free to withdraw from the study at any time without needing to give any reason.

5. I understand I will not be identified in any publication arising out of this study.

6. I understand that my name and identity will be stored separately from the data, and these are accessible only to the investigators. All data provided by me will be analysed anonymously using code numbers.

7. I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.

8. ☐ I consent for my treatment sessions to be videotaped.
☐ I am not willing for my treatment sessions to be videotaped.

9. ☐ I wish to receive feedback about the results and findings from this study. These will be available from February 2014 and can be sent to you via e-mail. Email address: ___________________________
☐ I do not wish to receive feedback about the results and findings.

Signature of Participant: ___________________________ Date: ……/……/…….
(Name)

Signature of Investigator: ___________________________ Date: ……/……/…….
(Name)
Appendix D

SPSS output

Only pertinent output is included here. For full SPSS output, see enclosed CD.