Dusunen Adam The Journal of Psychiatry and Neurological Sciences 2017;30:154-159
DOI: 10.5350/DAJPN2017300210

Case Report / Olgu Sunumu

Rapid Efficacy of the Eye Movement Desensitization and Reprocessing in Treatment of Persistent Complex Bereavement Disorder: Report of Two Cases

Alisan Burak Yasar[1], Dilara Usta[2], Meliha Zengin Eroglu[1], Onder Kavakci[3], Ayse Enise Abamor[4], Ecem Tavacioglu[4]

[1]Haydarpasa Numune Training and Research Hospital, Department of Psychiatry, Istanbul - Turkey
[2]Uskudar University, Department of Clinical Psychiatry, Istanbul - Turkey
[3]Cumhuriyet University, Department of Psychiatry, Sivas - Turkey
[4]Istanbul Sehir University, Istanbul - Turkey

ABSTRACT

Rapid efficacy of the eye movement desensitization and reprocessing in treatment of persistent complex bereavement disorder: report of two cases

Grief occurs following the loss of a beloved one and it is a normal experience. However, prolonged (>6 months) grief can serve as a ground for a pathological situation. According to DSM-5, persistent complex bereavement disorder (PCBD) is diagnosed if the grief period exceeds twelve months. If this grief experience accompanies a traumatic event, DSM-5 Appendix recommends including Traumatic Death Specifier. In the process of PCBD, there can be several symptoms such as decreased functionality, sleep disorders, depressed mood, guilt feelings, somatic disorders and denial of the death. Eye movement desensitization and reprocessing (EMDR) is one of the treatment methods for PCBD. In this study, two cases diagnosed with PCDB and recovered apparently with a time-limited EMDR treatment are presented.

Keywords: Eye movement desensitization reprocessing, persistent complex bereavement disorder, traumatic grief

ÖZET

Kalıcı komplike yas bozukluğu tedavisinde göz hareketleri ile duyarsızlaştırma ve yeniden işlemenin hızlı etkinliği: İki olgu

Yas tutmak bir kayıp sonucunda ortaya çıkan ve deneyimlenmesi normal olan bir süreçtir. Yas süresinin altı ayı geçmesi durumunda bu süreç patolojik bir durumun oluşmasına zemin hazırlayabilir. DSM-5'e göre Kalıcı komplike yas bozukluğu (KYB) tanısı yas tutma süresinin on iki ayı geçmesi sonucunda konulabilir. Yaşantının travmatik bir olay ile olması durumunda DSM-5 ek belirteç olarak travmatik yas belirleyicisini de kullanmayı salık vermiştir. KYB sürecinde bireylerin işlevselliğinde azalma, uyku bozuklukları, depresif ruh hali, suçluluk duyguları, somatik şikayetler ve ölen kişinin öldüğünü kabul edememe gibi semptomlar ortaya çıkabilir. Göz hareketleri ile duyarsızlaştırma ve yeniden işleme (EMDR), KYB tedavisinde uygulanabilen terapi türlerinden biridir. Bu çalışmada kısa süreli EMDR terapisiyle belirgin düzelme gösteren KYB, travmatik yas tanısı konan olgular sunulmuştur.

Anahtar kelimeler: Göz hareketleri ile duyarsızlaştırma ve yeniden işleme, karmaşık yas bozukluğu, travmatik yas

How to cite this article: Yasar AB, Usta D, Zengin-Eroglu M, Kavakci O, Abamor AE, Tavacioglu E. Rapid efficacy of the eye movement desensitization and reprocessing in treatment of persistent complex bereavement disorder: report of two cases. Dusunen Adam The Journal of Psychiatry and Neurological Sciences 2017;30:154-159. https://doi.org/10.5350/DAJPN2017300210

Address reprint requests to/ Yazışma adresi:
Alisan Burak Yasar
Haydarpasa Numune Training and Research Hospital, Department of Psychiatry, Tibbiye Caddesi, Uskudar/Istanbul, Turkey

Phone / Telefon: +90-216-542-3232/1184

E-mail address / Elektronik posta adresi: burakyasar54@hotmail.com

Date of receipt / Geliş tarihi:
July 10, 2016 / 10 Temmuz 2016

Date of the first revision letter / İlk düzeltme öneri tarihi:
August 1, 2016 / 1 Ağustos 2016

Date of acceptance / Kabul tarihi:
November 7, 2016 / 7 Kasım 2016

INTRODUCTION

Grief is a normal process that is expected to be experienced after a loss of an object. This process may become very stressful for individuals and it may present in the form of intense longing for the lost person. Person in grief may also deal with the memories of lost person constantly and behave as if he/she is still alive. Situations such as not being able to cope with the absence of the deceased person and seeing the lost person in dreams constantly may also be seen. As time passes over the loss, it is expected that these symptoms will resolve gradually. Studies have found that in 6.7% of individuals who had a loss, the grief lasts longer than one year (1).

If the grief lasts at least one year, and causes functional impairments, Persistent Complex Bereavement Disorder (PCBD), in other words, pathological grief, can be diagnosed (2). PCBD may be characterized by symptoms of separation-related distress such as: intensive yearning, a lack of acceptance of the situation, anger over the loss, a sense of guilt, attempts to keep the memories alive, subsequently detaching from daily life, and overall impairment in the person's daily functioning (3).

The concept of PCBD has recently begun to take place among diagnostic and evaluation criteria. In DSM-5, PCBD is listed among the differential diagnoses in major depressive episode. It was described in "Conditions Needing Further Study" section, and in Trauma and Stressor-Related Disorder category (2).

Traumatic grief is associated with symptoms and reactions that occur after a sudden and violent death of a loved one. Traumatic grief affects the natural grief process by the fact that loss is unexpected and horrific (4). Studies indicate the importance of the development of mental disorders or somatic symptoms after the loss, such as Post Traumatic Stress Disorder (PTSD), Major Depression, Panic Disorder, Pervasive Anxiety Disorder (2). Patients with PTSD and the patients in grief are similar in context. The core indicators of traumatic grief are separation anxiety and traumatic stress symptoms (5).

The eye movement desensitization and reprocessing (EMDR) works by activating the left and right hemispheres of the brain through bidirectional eye stimuli and processing unsolved and unaccessible traumatic experience. EMDR is a treatment modality aimed at modifying negative emotions, cognition and somatic sensations related to the event. It was developed by Francine Shapiro in 1987 for the treatment of PTSD (6). It is being used more and more frequently as a different psychotherapy method (7).

EMDR is currently used in the treatment of many trauma-related mental disorders besides PTSD (8). There are case studies with successful EMDR treatment in patients with non-PTSD psychiatric disorders in our country. Semiz et al. (9) have applied 6-8 sessions of EMDR to three female patients diagnosed with Major Depression, and found that the patients showed a significant decrease in symptoms of depression and anxiety. After treatment of flight phobia with 3 sessions of EMDR, Lapsekili and Yelboga (10) reported that EMDR therapy could be considered as a treatment method for phobic anxiety even if it is not caused by traumatic experience. EMDR has been employed in PCBD and traumatic grief, and considered as an effective treatment modality in these disorders (11,12). Cognitive Behavioral Therapy (CBT) and Interpersonal Relationship Therapy (IRT) and the 16-session "Complicated Grief Treatment (CGT)" methods are also used for similar disorders (13).

EMDR speeds up the reprocessing of dysfunctional information by alleviating the cognitive blocks that occurs in pathological grief. It also facilitates the resolution of the grief process by helping to create a healthy insight and emotion (12). In PCBD cases, the EMDR helps the individual to accept the loss by recalling the positive memories and thoughts associated with the lost person, and aims to help a natural healing process. In order to achieve these outcomes, all traumatic experiences must be defined first.

Procedure: The trauma of the patients was determined; 60-90 minute sessions were held once a week. According to the EMDR protocol, for each traumatic memory, the following statements were determined and the treatment was applied.

Image: The image that comes to mind when the patient thinks about trauma.

Emotions: The emotions related with the image/picture.

Negative cognition: When the patient focuses on the image, the negative cognition arising from the memory and associated with him/herself.

Positive cognition: At the end of the treatment, while the focus is still the traumatic moment, the positive, desired cognition that the patient wants to achieve.

The validity of Cognition (VoC): The numerical value of positive cognitive validity on the picture of the traumatic moment, over a seven-point scale.

SUD (Subjective Unit of Disturbance): When the patient is focused on the traumatic moment, the numerical value on a scale of ten points of subjective feeling of the discomfort of the moment.

Bodily sensation: The location subjective discomfort in the patient's body, when he/she focuses on the designated image (11).

Clinician Administered PTSD Scale (CAPS): A scale that includes the diagnostic criteria for PTSD and assesses the severity of PTSD (14). The content was taken from the DSM IV criteria. The score range is between 0 and 136. Turkish validity and reliability evaluation was done by Aker et al. (15) in 1999.

The Beck Anxiety Inventory (BAI): It was developed by Beck et al., 1988 (16) . The Turkish validity and reliability were evaluated by Ulusoy et al., 1998 (17).

Beck Depression Inventory (BDI): A scale that assesses the level of depressive symptoms and the change in severity of depression (18). The validity and reliability studies for Turkey were carried out by Hisli (19).

The following two cases with PCBD, it was aimed to emphasize the positive effect obtained with EMDR in a short period of time (a few sessions).

CASE 1

A 22 years old, female patient, admitted to psychiatry outpatient clinic with somatic complaints such as nausea/vomiting, stomach spasms and anorexia related with anxiety complaints such as insomnia, difficulty in falling asleep, extreme stress, excitement and anxiety. She was referred to our clinic for therapy. Her complaints started at summer vacation after her exams were over, and they were continuing for three months. During the pre-session interview, she stated that she lost her sister in an accident when she was 12 years old.

Although it was 10 years after a traffic accident, it was learned that the patient went to her sister's grave only a couple of times and tried to avoid to visit her grave. Taking into consideration that she experienced a lost of a close family member and had symptoms, such as prolonged longing, intense sorrow and pain against death, being busy with the conditions of death, difficulty in remembering positive memories about the deceased, cognitive distortions related to death, avoiding things that remind her loss and feeling of loneliness, more than 12 months, we considered the patient to be PCBD. Since she was expressing intense emotions while talking about her sister, and mentioned that she could not visit her grave and stated stated that 'her sister died on her lap while vomiting', it was considered that her grief process and traumatic experience related to the accident were unsolved, and her symptoms may have been associated with these experiences. In differential diagnosis; positive aspects of the relationship, longing for missed, and distress and struggle related with the separation enabled us to move away from PTSD diagnosis in our patient. The scale scores were: BDI: 17, BAI: 13, CAPS: 70, and Peritraumatic Dissociation Scale (TSS): 38 points.

The patient was diagnosed with PCBD, traumatic grief, according to DSM-5. EMDR therapy was suggested as a rapid and effective therapy alternative in grief and trauma treatment. Informed consent was obtained from the patient.

During the first EMDR session, memory of the traumatic traffic accident was studied. According to the story; the family had to stop on the cross way on their way to home from a family visit because of a blow-out tire. Meanwhile, the patient and her father went out of the car; and another car hit their vehicle, when her mother and 8 years old sister were in it. The mother shot out of the car that overturns three times, but the sister stuck in the car. People who saw the accident took the patient's sister out of the damaged car and brought her to the patient's knee. The sister, who seemed normal in appearence, started to vomit while lying on the patient's knee. She died in the ambulance on the way to hospital. At that time; our patient was in another ambulance with her mother who was hospitalized for 3 months after the accident. She found out about her sister's death when she came home from the hospital.

During interviews, the patient stated that she felt guilty because she did not rescue her. The moment of "her sister vomiting in her lap" was chosen, as the image. Her thought stated as "I wish I had not allowed them to take her out before the ambulance arrived" selected as negative cognition. EMDR method was used.

Instead of this negative cognition, "I have done what I had to do, I have done what needs to be done" was chosen as positive cognition. The SUD value was set at "10". "Fear, anxiety, helplessness and guilt" were studied as emotions. Stomach spasms, leg jerks and headache were detected in the body evaluation. Pain in the stomach area was defined as the body sensation. Positive cognitive belief value was 4 at the beginning of the VOC session and 7 points at the end of the session.

Two sessions of EMDR therapy were performed for the traumatic memory of the patient. When asked how she felt after the first EMDR experience, she stated that there was no vomiting that she had had twice a week, the pain in the stomach area disappeared, her avoidance related with anxiety was decreased, her appetite increased, and she gained weight. The patient reported that she was talking to people about her deceased sister, and she was considering to visit her grave. At the first month of the study, the scores of scales were as follow: BDI: 12, BAI: 13 and CAPS: 32 points. Her vomiting and stomach aches disappeared.

Despite the fact that two sessions of EMDR were performed, in the follow-up interview at the second month, the patient's scale scores improved significantly (BDI: 6, BAI: 6, CAPS: 25 points) (Table 1). The SUD score was "0". In addition, her abstinence, anxiety, and somatic complaints disappeared and she was able to carry out her daily life more functionally.

CASE 2

The case; 45 years old, female, mother of two children, admitted to the clinic with a preliminary diagnosis of depressive adjustment disorder. It was found that her complaints began with the loss of her mother one and a half years ago. She had admitted to a psychiatry service with a feeling of guilt, tenderness and anxiety after her mother's death. She was blaming herself for her mother's death, because she encouraged her to have surgery. Her thought content was dominated by the thought of "I should not be happy".

She moved to another city, by the belief of a change would be helpful. She said that this change led problems with her husband and she blamed herself because of this. She also described herself as a bad daughter.

For her mother's surgery, she organized everything to the finest detail, and her mother came out healthy from surgery. When she entrusted her mother to another family member, the mother lost her life after suffering a heart attack. The patient started to experience major problems in her work and family life due to the disrupted adaptation with her mother's death. The patient was considered to have the diagnosis of PCBD, traumatic grief; according to DSM-5, because of the symptoms caused by the death of a close relative, the intense longing that lasts for more than 12 months after death, intense sadness and emotional pain towards death, being busy with the dead, being busy with death conditions, difficulty in accepting death, anger towards the loss, self-blame for death, avoiding things that remind the loss (eg. moving the house), distrust to anyone since the moment of death, loneliness and finding life meaningless (2).

Her outcomes from the clinical scales were as

Table 1: Scores of clinical scales for case 1

	Assessment	1st month	2nd month	1st year
Beck Depression Inventory	17	12	6	2
Beck Anxiety Inventory	13	13	6	5
Clinician Administered Posttraumatic Stress Disorder Scale	70	32	25	7
Subjective Unit of Disturbance	10	4	0	0
Peritraumatic Dissociation Scale	38			

Table 2: Scores of clinical scales for case 2

	First assessment	2nd month
Beck Depression Inventory	15	0
Beck Anxiety Inventory	14	4
Clinician Administered Posttraumatic Stress Disorder Scale	51	23
Subjective Unit of Disturbance	7	2

follow: BDI: 15, BAI: 14, CAPS 51 points. Since the patient was breastfeeding, sertraline 25mg/day and alprazolam 0.5mg/day were started. The patient did not benefit from the treatment after three weeks. Because of breastfeeding, the dose of the regimen could not be increased, and it was decided to treat her with psychotherapy. EMDR therapy was suggested to the patient. Informed consent was obtained. "The moment she saw her mother in the coffin" was chosen as the image. Negative cognition was "I am guilty". "I can be happy" was positive cognition. The SUD score was 7. One session of EMDR therapy was applied.

During follow-up interviews one week and two months after the initial session, the patient stated that she did not blame herself and felt better compared to the past. The SUD score was 2. There was a significant decrease on clinical scale scores after two months (BDI: 0, BAI: 4, CAPS: 23 points) (Table 2). The patient's quality of life and social relations improved, and she was able to visit her mother's grave. She continues follow-up in outpatient clinic.

DISCUSSION

As the psychiatric treatment, EMDR therapy was applied to Case-1 for two sessions and Case-2 for a single session. During the follow-up visits, the patients expressed that their traumatic experiences and prolonged grief processes, which they described as disturbing and anxiougen before the treatment, were not felt as disturbing as before. They were less worried, and had less physical complaints. They expressed that their evasions related to their lost, like not wanting to visit grave, were diminished. They had more positive memories and positive dreams about their lost. They stated increase in their functionality and alleviation of their complaints in a short time.

A difference was observed when the scores of clinical scales before and after therapy were compared. The CBT is widely used in the treatment of PCBD, but with the standard protocol, after an average of 20 sessions in approximately six months, the response can be obtained (20).

Guided Mourning (GM) therapy is another treatment option used in the treatment of PCBD. The protocol of GM treatment is quite similar to the Exposed Exposure Therapy. In his study, Sprang (12) observed the effects of GM and EMDR treatments on patients diagnosed with PCBD. In this study, it has been shown that EMDR therapy is more effective than GM treatment and greatly reduces the severity of PTSD symptoms. Furthermore, while the average time for GM treatment is approximately twenty sessions similar to the CBT, the time to achieve positive results with EMDR treatment is much shorter (12).

In order to better recognize complex mourning and traumatic mourning cases and direct them to rapid and effective treatments, these cases should be investigated by further research. To have wider samples in future studies will increase both the generalizability and the validity-reliability of the study.

With the short-term application of EMDR therapy, functionality in patient with PCBD can be greatly improved. In addition, it has been observed that EMDR therapy is beneficial in reducing the anxiety symptoms, interpersonal problems, physical complaints, and in improving mood. The fact that the EMDR provides a large-scale improvement on the PCBD symptoms in a short period of time, it may be considered as an alternative to the CBT, the Fractured Exposure Therapy, and the GM. It should be kept in mind that, it can be used in patients who can not take medication or it can be used in addition to medication.

Contribution Categories	Name of Author
Follow up of the case	A.B.Y., M.Z.E., D.U., E.T., O.K.
Literature review	D.U., O.K., E.T., A.B.Y.
Manuscript writing	O.K., A.E.A., A.B.Y., M.Z.E.
Manuscript review and revision	A.E.A., E.T., M.Z.E., D.U.

Conflict of Interest: Authors declared no conflict of interest.

Financial Disclosure: Authors declared no financial support.

REFERENCES

1. Robinaugh DJ. Examining Cognitive Impairments in Bereaved Adults With and Without Complicated Grief. Doctoral dissertation, Harvard University, Graduate School of Arts & Sciences, Boston, 2015.

2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5®), Fifth Edition. American Psychiatric Publication: Washington DC, 2013.

3. Li J, Prigerson HG. Assessment and associated features of prolonged grief disorder among Chinese bereaved individuals. Compr Psychiatry 2016; 66:9-16. **[CrossRef]**

4. Sezgin U, Yuksel S, Topcu Z, Discigil AG. When is traumatic grief diagnosed? When should the treatment begin? Turkish Journal of Clinical Psychiatry 2004; 7:167-175. (Turkish)

5. Celik FGH, Hocaoglu Ç. After landslide in Rize 'Traumatic grief': three case studies. Turkish Journal of Clinical Psychiatry 2015; 18:130-136. (Turkish)

6. Shapiro F. Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. J Trauma Stress [Internet] 1989[cited 2015 Apr 20]; 2:199-223. **[CrossRef]**

7. Kavakci O, Dogan O, Kugu N. EMDR (eye movement desensitization and reprocessing): a different option in psychotherapy. Dusunen Adam: The Journal of Psychiatry and Neurological Sciences 2010; 23:195-205. **[CrossRef]**

8. Kavakci O, Semiz M, Kaptanoglu E, Ozer Z. EMDR treatment of fibromyalgia, a study of seven cases. Anadolu Psikiyatri Derg 2012; 13:75-81. (Turkish)

9. Lapsekili N, Yelboga Z, Treatment of flight phobia (aviophobia) through the eye movement desensitization and reprocessing (EMDR) method: a case report. Dusunen Adam: The Journal of Psychiatry and Neurological Sciences 2014; 27:168-172. **[CrossRef]**

10. Semiz M, Atik S, Erdem M, Treatment augmentation effects of EMDR intervention after traumatic experiences in patients with major depression: a case series. Dusunen Adam: The Journal of Psychiatry and Neurological Sciences 2016; 29:91-95. **[CrossRef]**

11. Solomon RM, Rando TA. Utilization of EMDR in the treatment of grief and mourning. Journal of EMDR Practice and Research 2007; 1:109-117. **[CrossRef]**

12. Sprang G. The use of eye movement desensitization and reprocessing (EMDR) in the treatment of traumatic stress and complicated mourning: Psychological and behavioral outcomes. Res Soc Work Pract 2001; 11:300-320. **[CrossRef]**

13. Ozer U, Yildirim EA. Complicated grief and its treatment. Dusunen Adam: The Journal of Psychiatry and Neurological Sciences 2015; 28:281-282. **[CrossRef]**

14. Blake DD, Weathers FW, Nagy LM, Kaloupek DG, Gusman FD, Charney DS, Keane TM. The development of a clinician administered PTSD Scale. J Trauma Stress 1995; 8:75-90. **[CrossRef]**

15. Aker AT, Ozeren M, Basoglu M, Kaptanoglu C, Erol A, Buran B. Clinician Administered Post Traumatic Stress Disorder Scale (CAPS) reliability and validity study. Turk Psikiyatri Derg 1999; 10:286-293. (Turkish)

16. Beck AT, Epstein N, Brown G, Steer RA. An inventory for measuring clinical anxiety: psychometric properties. Journal of Consulting and Clinical Psychology 1998; 56:893-897. **[CrossRef]**

17. Ulusoy M, Şahin N, Erkman H. Turkish Version of The Beck Anxiety Inventory: psychometric Properties. Journal of Cognitive Psychotherapy An International Quarterly 1998; 12:28-35.

18. Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. Arch Gen Psychiatry 1961; 4:561-571. **[CrossRef]**

19. Hisli N. A study on the validity of Beck Depression Inventory. Turkish Journal of Psychology 1987; 6:118-122. (Turkish)

20. Rosner R, Bartl H, Pfoh G, Kotoučová M, Hagl M. Efficacy of an integrative CBT for prolonged grief disorder: a long-term follow-up. J Affect Disord 2015; 183:106-112. **[CrossRef]**