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Evaluating the Efficacy of EMDR With Grieving Individuals: A Randomized Control Trial

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This study compared the effectiveness of eye movement desensitization and reprocessing (EMDR) with an integrated cognitive behavioral therapy (CBT) intervention for grief. Nineteen participants (12 females and 7 males) who identified themselves as struggling with grief were randomly allocated to treatment conditions. Each participant was wait-listed for 7 weeks and then received 7 weeks of therapy. There were no significant improvements on any measure in the wait-list period. In contrast, participants in both treatment groups improved on measures of grief ($\eta_p^2 = .47$), trauma symptoms ($\eta_p^2 = .60$), and distress ($\eta_p^2 = .34$). There was no significant improvement in participants' scores on a quality of life measure ($\eta_p^2 = .11$). Neither treatment approach produced better outcomes than the other. For those who scored in the clinical range at intake, 72% achieved clinical and reliable change on the grief measure and 82% on the trauma measure. The study had several strengths, including randomization to treatment condition, multiple therapists, formal assessment of treatment fidelity, and the pretreatment and follow-up assessments were conducted by researchers blind to treatment assignment. Overall, the findings indicate that EMDR and CBT are efficacious in assisting those struggling with grief, and that those individuals reporting higher levels of distress and lower levels of functioning may benefit the most from an intervention.

Keywords: grief; complicated grief; treatment; EMDR; CBT

T he death of a loved one is experienced by almost every person at some point in their lifetime; however, approximately 10%–20% of the population develop what is known as *complicated grief* (Byrne & Raphael, 1994). Complicated grief is identifiable by unique symptoms such as an intense yearning or pining for the deceased; strong 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). Complicated grief has been linked to increased risk of disease (Gallagher-Thompson, Futterman, Farberow, Thompson, & Peterson, 1993), depression (Byrne & Raphael, 1997), sleep difficulties (Germain, Caroff, Buysse, & Shear, 2005; McDermott et al., 1997), and a decreased sense of overall well-being and functioning (Ott, 2003).

Debate exists as to whether severe grief reactions should be characterized as posttraumatic 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. (2007) 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 *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). Prior to this publication, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000) outlined that an individual should not be diagnosed with MDD within 2 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 a diagnosis for grief, there is a large evidence base for its treatment. The results of two meta-analyses (Currier, Neimeyer, & Berman, 2008; Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011) suggest that therapeutic interventions can result in significant reductions in complicated grief symptomology, particularly when targeted individuals are experiencing high levels of distress or struggling to adapt to their loss. This is in contrast to preventive interventions which target those deemed "at risk" of developing complicated grief, which yield relatively small benefits (Currier et al., 2008). The most frequently researched approach to grief therapy is cognitive behavioral therapy (CBT).

Cognitive Behavioral Therapy

Cognitive behavioral–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 chairwork (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, & Kotoučová, 2011).

Eye Movement Desensitization and Reprocessing

The symptoms of grief share a number of similarities with PTSD, including a shattering of one's assumptions about the world, 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 desensitization and reprocessing (EMDR) is a well-established, evidence-based practice treatment for PTSD (Australian Centre for Posttraumatic Mental Health, 2013; World Health Organization, 2013). Unlike a trauma-focused CBT approach, however, EMDR does not require homework, continued exposure to a detailed account of the event from the client, nor does it directly challenge their beliefs. There is also evidence that the underlying processes in EMDR and CBT are different (World Health Organization, 2013).

The use of EMDR with bereaved individuals is not uncommon, with Luber (2009) outlining a suggested protocol and Solomon and Rando (2012) providing important insights for clinicians as illustrated by several case examples. Hornsveld et al. (2010) investigated the efficacy of eye movements in reducing the emotionality of memories relating to loss, including the loss of a loved one. Sixty participants were asked to recall a negative loss-related 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 and ability to concentrate on the memory after eye movements compared to the other two conditions, providing support for the unique eye movements used in EMDR with memories relating to loss.

The only study to date in comparing EMDR with another psychotherapy approach for grief involved 50 participants who self-selected either EMDR or a guided mourning (GM) treatment condition (Sprang, 2001). GM is a behavior-based approach using exposure principles and homework, shown to be effective with individuals who display a somewhat phobic avoidance to grief-related stimuli (Mawson, Marks,

Ramm, & Stern, 1981). Both treatments resulted in significant reductions in outcome measures such as reexperiencing, nightmares, rumination, and intrusive symptoms. Consistent with Ironson, Freund, Strauss, and Williams'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 8 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. Such an increase was not found in the GM condition. A major limitation of this study was lack of random assignment to treatment conditions. Self-selection into EMDR or GM may have affected the type of patients who received each treatment. In summary, there is preliminary evidence that EMDR may benefit people struggling with grief. However, the effect of EMDR on grief has never been tested in a randomized control trial.

This study aimed to evaluate and compare the relative effectiveness of EMDR against a more established intervention for grief, integrated CBT. It was targeted at participants who identified themselves as struggling with grief. A wait-list was used as a control condition and also to observe any changes in symptomology that may have occurred naturally over time.

Method

Design

The study used a randomized control trial design and was registered with the Australian New Zealand Clinical Trials Registry and received university ethics approval. Participants were recruited from the community and responded to information letters sent to local general practitioners (GPs) and advertisements on radio, in local newspapers, on the websites of several bereavement-related organizations, and via the university website and campus. Participants were not reimbursed or rewarded for their participation.

Individuals responded to advertisements by contacting the researchers to organize an information session and were randomly allocated to one of the two researchers. Information sessions lasted 45 minutes to 1 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 die at least 6 months ago, not presently receiving counseling or therapy for grief, and not being involved in legal matters pertaining to the death.

Once potential participants signed a consent form, they were screened for any contraindications for EMDR such as epilepsy, taking benzodiazepines, or have undergone retinal surgery (Shapiro, 2001). No one was excluded on this basis. Participants were also screened for a dissociative disorder because such clients require a more complex protocol (Shapiro, 2001). They were all administered the Dissociative Experiences Scale-II (DES-II; Zingrone & Alvarado, 2002). Two participants scored higher than 30 on this scale and were therefore administered the Dissociative Disorders Interview Schedule (Ross et al., 1989). Neither of these participants met criteria for a dissociative disorder; therefore, no participants were excluded because of high levels of dissociation. All subjects were placed on a 7-week wait-list before being contacted to schedule weekly treatment sessions and randomly allocated to treatment conditions. 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 composed of seven weekly sessions; 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 at approximately 2 weeks posttreatment. Participant flow through the study design is outlined in Figure 1.

Treatment Fidelity. To ensure fidelity to the treatment protocols and to enable therapist supervision, all sessions were videotaped. Tapes were then divided into type of treatment and whether they were early (first three sessions) or late treatment sessions (last three sessions). A member of the university clerical staff then chose four tapes at random from each group of tapes. A 3-point scale was used to rate both treatments. An approved consultant rated the eight EMDR sessions on a 15-item EMDR fidelity checklist (Leeds, 2009). Each item was scored on a 3-point scale from 0 (*no adherence*), 1 (*weak adherence*), and 2 (*good adherence*). The mean rating for each session was 1.64 (*SD* = .53). The eight CBT tapes were then rated by a therapist who had delivered CBT training in Australia approved by the Australian Psychological Society. Given that a 3-point rating scale of adherence had also been used for CBT treatments of emotional memories in a previous study (Bluett, Zoellner, & Feeny, 2014), the rater was asked to use the same scale as mentioned earlier to rate each CBT tape. Therapist adherence in the CBT tapes was high (*M* = 1.85, *SD* = .26).
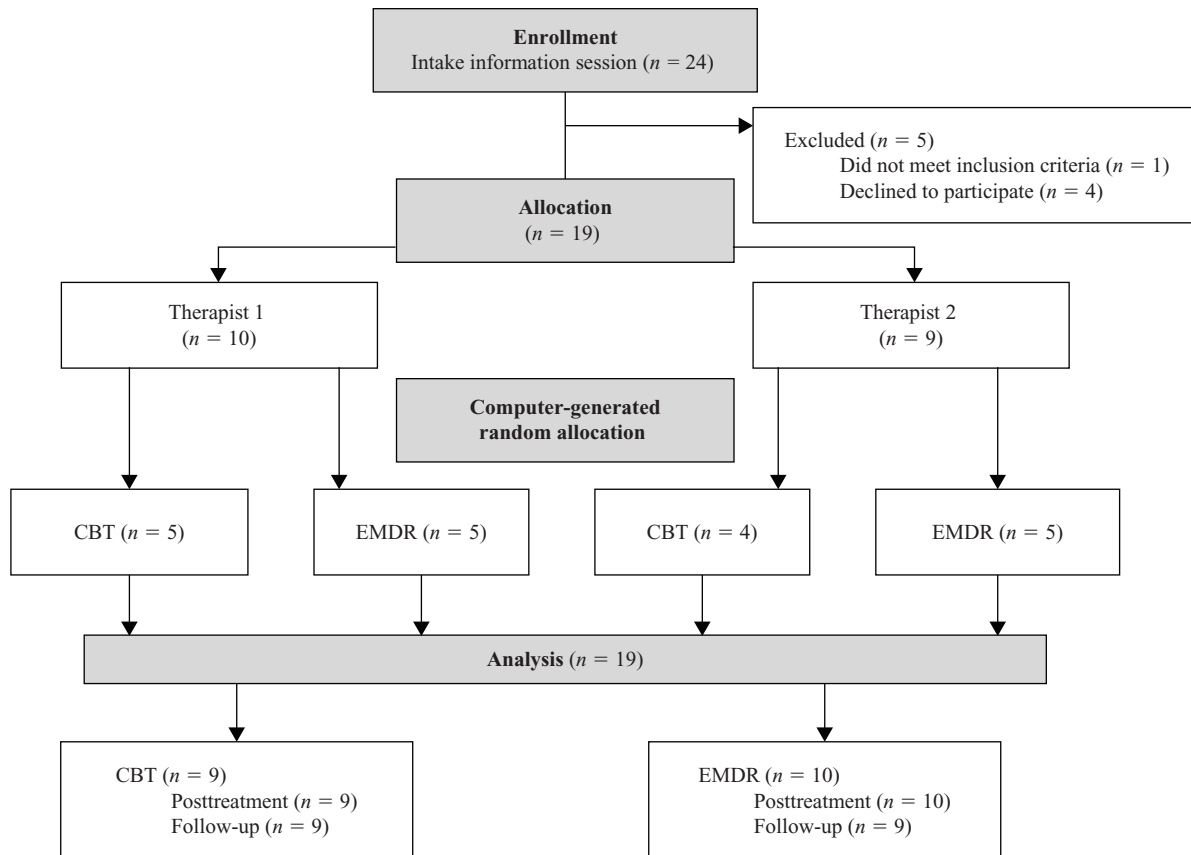
FIGURE 1. Participant flow through study design. CBT = cognitive behavioral therapy.

Participants

Nineteen participants (12 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. Participants' relationship to the deceased (illustrated in Table 1), the cause of death, and time since the death varied greatly between participants. Five participants (26.3%) 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 was used, as indicated by the participant. Time since death ranged from 6 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 counseling for their loss-related distress,

most of which were hospital-based services, general counseling, or grief support groups.

Treatment Conditions

Integrated Cognitive Behavioral Therapy. An integrated CBT intervention was adapted from Rosner, Pfoh, et al. (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). The primary, non-CBT addition to the protocol was an imaginal dialogue between the client and the deceased, guided by the therapist and based

TABLE 1.   Relationship Between Participants and the Deceased

	Spouse	Participant's Parent	Participant's Child	Girlfriend/Boyfriend	Other Family
Proportion (n)	42.1 (8)	31.6 (6)	10.5 (2)	5.3 (1)	10.5 (2)

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TABLE 2.   Mean Questionnaire Scores at Intake, Session 1, Session 4, Session 7, and Follow-Up

	Intake		Session 1		Session 4		Session 7		Post	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
IES										
CBT	25.22	16.25	24.56	16.09	15.11	13.21	9.94	10.44	5.29	4.90
EMDR	39.60	15.67	34.80	16.90	23.90	11.10	16.32	13.36	10.96	11.20
ICG										
CBT	26.56	13.51	23.33	12.83	20.44	9.22	14.84	8.70	15.15	8.29
EMDR	31.10	13.77	28.70	8.87	25.80	10.92	18.62	13.30	15.05	13.16
DASS										
CBT	24.00	17.66	27.44	18.70	17.00	15.87	11.23	7.91	7.45	5.66
EMDR	37.20	29.00	33.60	18.19	24.30	17.37	25.53	24.02	20.68	24.59
QOLS										
CBT	78.89	16.51	75.67	14.84	77.11	14.83	82.08	11.55	79.75	11.89
EMDR	71.30	12.84	69.80	10.78	72.30	11.60	77.08	18.15	78.57	15.17

Note. IES = Impact of Event Scale; CBT = cognitive behavioral therapy; ICG = Inventory of Complicated Grief; DASS = Depression Anxiety Stress Scale; QOLS = Quality of Life Scale.

on Gestalt therapy principles (Daldrup et al., 1988). In this exercise, the client was encouraged to address unresolved issues or unmet emotional needs. Forgiveness and reconciliation between themselves and the deceased were facilitated. The therapist guided what was 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 switched roles and responded as the deceased.

EMDR. The EMDR intervention followed the standard protocol (Shapiro, 2001) beginning with a semistructured 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 desensitization, installation, body scan, and closure. Examples of further targets included periods of illness or hospitalization leading up to the death, the moment the person was advised of the death, and the funeral. 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. A future template was created in Sessions 5 and 6, focusing on important milestones such as birthdays or Christmas and strengthening the belief that the client could cope with life's difficulties without their

loved one. As in the integrated CBT condition, the seventh session did not involve any active phases of EMDR. The session was focused on concluding treatment, planning for possible future challenges such as a new relationship, establishing a special way to commemorate 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 specialized 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 beginning of the first, fourth, and seventh sessions, and approximately 2 weeks after therapy concluded. The Impact of Events Scale (IES) was completed by participants prior to each treatment session so as to provide a more sensitive indication of symptom change.

Impact of Events Scale. The IES (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 higher than 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 (Horowitz et al., 1979). The instrument was found initially to be sensitive to change, 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. The DES-II (Carlson & Putnam, 1993) consists of 28 questions which ask the respondent to indicate how often they encounter various experiences, such as "finding new things among their belongings that they don't remember buying," expressed as a percentage of the time from 0% to 100%.

Dissociative Disorders Interview Schedule. Individuals who scored higher than 30 on the DES-II ($n = 2$) were subsequently administered the Dissociative Disorders Interview Schedule (Ross et al., 1989). It is composed of 16 sections, each scored separately and corresponding to a *DSM-IV* diagnosis (i.e., multiple personality disorder, somatization disorder).

Inventory of Complicated Grief. The Inventory of Complicated Grief (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 ($\alpha = .94$) 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, 1977).

Depression Anxiety Stress Scales. The Depression Anxiety Stress Scale (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 14 items. 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. The Quality of Life Scale (QOLS; Flanagan, 1978) is a 16-item questionnaire that 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 $\alpha = .82$ to .92 and good test–retest reliability has also been demonstrated ($r = .78$–.84; Burkhardt, Anderson, Archenholtz, & Hägg, 2003; Burkhardt, Woods, Schultz, & Ziebarth, 1989).

Follow-Up Interview. All participants were invited to attend a follow-up interview approximately 2 weeks ($M = 16.3$ days) after the conclusion of treatment, during which they completed the outcome measures as well as a semistructured 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

A Missing Completely at Random analysis was run to assess whether the data was missing at random or whether there was a pattern to the missing data. Results indicated that data points were missing completely at random; the expectation maximization values were not significant. Therefore, an imputation analysis was run for missing data for both those participants that completed early and for the participants where assessment results were not available following treatment.

A paired samples t test was conducted to determine whether participants' scores on outcome measures differed significantly between intake interview and Session 1 of treatment, in other words, to determine whether their distress improved naturally over the course of time without intervention. The means and standard deviations for these times are presented in Table 2. 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 7 weeks later.

Repeated measures analyses of variance (ANOVAs) were conducted to compare the effects of intervention (EMDR vs. integrated CBT) on outcome measures over the duration of therapy (as measured at intake, Session 1, Session 4, Session 7, and at follow-up). The means and standard deviations for each time and each condition are presented in Table 2. Mauchly's

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test indicated that the assumption of sphericity had been violated for the ICG, $\chi^2(5) = 17.30$, $p = .045$, and QOLS, $\chi^2(5) = 28.18$, $p = .001$, but not the other two outcome measures. Therefore, Roy's largest root was used for multivariate effects and Greenhouse-Geisser corrections for univariate tests for the ICG and QOLS.

A significant main effect for time was found, such that participants' scores from intake to follow-up, across both interventions, reduced on measures of negative symptomology, $F(4, 68) = 28.93$, $p < .001$, partial $\eta^2 = .63$. Univariate analysis for each measure indicated a significant time effect for IES: $F(4, 68) = 25.54$, $p < .001$, partial $\eta^2 = .60$; ICG: $F(2.87, 48.74) = 15.07$, $p = < .001$, partial $\eta^2 = .47$; and the DASS: $F(4, 68) = 8.91$, $p = < .001$, partial $\eta^2 = .34$. Across both conditions, there was no significant difference in participants' scores on the QOLS, $F(2.02, 34.41) = 1.97$, $p = .155$, partial $\eta^2 = .11$.

There was no significant time and condition interaction, $F(4, 68) = 2.30$, $p = .067$, partial $\eta^2 = .12$.

Participants With High Levels of Distress

This 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 as having complicated grief, the data of those participants who scored in the severe or clinical range on the IES, ICG, and Depression subscale of the DASS was compared with those who scored below cutoff levels on these measures.

The reliable change index and requirements for clinical change were calculated using norm data for the ICG (Prigerson et al., 1995), the IES (Fischer & Corcoran, 1994), and the Depression subscale of the 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 nonclinical means toward the "normal sample" mean (Jacobson & Truax, 1991). The results of these calculations are shown in Table 3.

Discussion

We used a randomized control trial design to compare the efficacy of an integrated CBT intervention and EMDR for individuals who identified themselves as struggling with grief. As was expected, participants'

TABLE 3. Comparison of Reliable and Clinically Significant Change Between Participants With Lower and Higher Scores on Outcome Measures

Measure	Low Distress Scores*		High Distress Scores	
	n	Achieved Clinically Significant Change (%)	n	Achieved Clinically Significant Change (%)
ICG				
Both	7	3 (42.3)	12	8 (66.7)
CBT	3	0 (0)	7	4 (57.1)
EMDR	4	3 (75)	5	4 (80)
IES				
Both	5	1 (20)	14	12 (85.7)
CBT	3	1 (33.3)	7	5 (71.4)
EMDR	2	0 (0)	7	7 (100)
DASS-Depression				
Both	15	4 (26.7)	4	2 (50)
CBT	7	2 (28.6)	3	2 (66.7)
EMDR	8	2 (25)	1	0 (0)

*As discussed in the measures section low distress scores was defined as below 25 on the ICG, 26 on the IES, and 21 on the DASS. High distress scores were above these values. ICG = Inventory of Complicated Grief; CBT = cognitive behavioral therapy; IES = Impact of Event Scale; DASS = Depression Anxiety Stress Scale.

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scores on outcome measures did not change significantly from their initial intake interview to their first therapy session 7 weeks later, suggesting that their scores on these measures were unlikely to improve with time alone. This finding is likely caused by 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 6–14 months (Horowitz, Bonanno, & Holen, 1993; Prigerson et al., 2009). In addition, most entered the study still symptomatic after having had some prior treatment. Thus, recovery simply by being on a wait-list was unlikely to occur.

As expected, participants in both treatment conditions experienced a significant reduction in scores on measures of negative symptomology (IES, ICG, DASS) following 7 weeks of grief therapy. These improvements were clinically significant. Given we did not use stringent inclusion criteria regarding participants' degree of distress, any individual who felt they may benefit from therapy was offered treatment. Calculations based on individual participant data 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 nonclinical range posttreatment. For the DASS, 50% of those who had severe scores on the Depression subscale achieved reliable and clinical change on that subscale. For the ICG, of those who met criteria for complicated grief, 66.7% demonstrated reliable and clinical change on their scores at the conclusion of therapy. For those who recorded pretreatment scores below cutoff levels, the proportion of participants who achieved reliable and clinically significant change on outcome measures was more modest: 20% for the IES, 26.7% for the DASS-Depression, and 42.4% for the ICG. Together, these findings support the conclusions of Currier et al. (2008) and Wittouck et al. (2011) that interventions can be effective in reducing grief and will be of most benefit to those who report higher levels of distress and lower levels of functioning.

Although no significant differences between EMDR and integrated CBT were found, both interventions resulted in an improvement in negative symptomology across the treatment period. These results support the findings of Sprang (2001) regarding the comparative efficacy of EMDR in relieving bereaved individuals of their distress. Sprang's study compared EMDR with GM and found that both interventions resulted in symptom relief, with EMDR participants experiencing a more rapid improvement. Although this study did not measure the rate of symptom change, its results do indicate that EMDR may

be as effective as other, more established interventions for grief.

In line with the literature, the integrated CBT intervention resulted in symptom improvement for participants in this study. As with several other studies (Boelen, de Keijser, van den Hout, & van den Bout, 2007; Rosner, Pfoh, et al., 2011; Shear, Frank, Houck, & Reynolds, 2005), participants' scores on a measure of complicated grief and a measure of quality of life improved from pre- to posttreatment. There were, however, considerable differences in the nature and length of the integrated CBT intervention for this study with those protocols used in previous research, with Shear et al. (2005) delivering 16 sessions and including retelling of the death, and Rosner, Pfoh, et al. (2011) delivering nine, double weekly sessions in a group format. The length of intervention (7 weeks) in our study more closely reflects the range of Medicare-funded treatments available in Australia.

This study had several methodological strengths which lend support to the validity of its findings. First, 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, Pfoh, 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, videotaped 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 born 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 this study include the relatively small number of participants ($N = 19$), unlike other studies comparing grief interventions with at least 50 participants (e.g., Rosner, Lumbeck, & Geissner, 2011; Shear et al., 2005; Sprang, 2001). The interventions in this study were delivered by two master's-level students. Despite having received specialist training in both CBT and EMDR for the study,

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they were relatively inexperienced. The therapists in Rosner, Lumbeck, et al. (2011), Shear et al. (2005), and Sprang's (2001) studies had an average of 4–5 years' experience in their therapy approaches. However, significant results in this 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 participant's ratings of emotionality and ability to concentrate on loss-related 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. This 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 bereavement memories.

Conclusion

This study provides further support for the use of EMDR with individuals struggling with grief. It also appears that EMDR may be as effective as an integrated CBT approach for this population. Most participants who met criteria for complicated grief (85.7%) benefitted from treatment using criteria of reliable and clinically significant change. This finding is in line with the findings of previous meta-analyses 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, further research is needed to determine its long-term efficacy for grief.

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