

MOURNING AFTER THE LOSS OF A TEN YEAR OLD SON: UNFINISHED EMDR THERAPY WITH THE MOTHER - WHAT WE'VE ACHIEVED AND THE CHALLENGES FOR CONTINUATION OF THE THERAPY - A CASE REPORT

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INTRODUCTION

The loss of a child belongs to the category of traumatic loss and is identified as a high risk variable in the development of complicated mourning. Rando (1993) even points at the need to conceptualize a special model to describe parental mourning, because bereaved parents cannot, and must not, be expected to have the same bereavement experiences as other mourners. This author describes 6 „R“ processes of mourning: recognizing the loss, reacting to the separation, recollecting and re-experiencing the deceased and the relationship, relinquishing the old attachments to the deceased and the old assumptive world, and readjusting to move adaptively into the new world without forgetting the old, and reinvesting.

These processes of mourning, occurring in the three phases of grief and mourning (avoidance, confrontation and adjustments) usually lead to successful recovery after the loss. However, with mourning parents, these processes are compromised by the unique nature of the parent-child relationship. Research indicates that in situations when mourning is stacked or blocked (in either one of the mourning stages or mourning processes), EMDR therapy can allow and facilitate the process of natural healing (Shapiro & Forest 2012, Solomon & Rando 2007).

The goal of this report is to demonstrate the effects of applying EMDR in therapy with a client who has lost her child.

CASE REPORT

The client was 35 years old when she first came for therapy. She is a police officer by vocation, working in court on securing the court processes. The client has been married since 2001, with a husband who is also a police officer (manager). She and her husband had a son (an only child). The 10 year-old-boy died on January the 30th in 2014 due to leukemia, eight months into fighting the disease. The client sought treatment from the author of the article in her private practice, 40 days after the loss. She was overwhelmed with yearning and excessive grief because of the loss of her son. She also reported anxiety symptoms (panic attacks).

She was in intensive treatment from March 2014 till January 2015 (one hour sessions weekly). During 2015 and 2016, the client came for therapy on her own, based on her need to do so. EMDR was applied in fall 2014, and then the client had five EMDR therapy sessions more. In fall 2015, the client had two more EMDR sessions. The standard EMDR protocol for trauma was applied; eye movement and tapping were used for the stimulation. Overall, EMDR was integrated with gestalt therapy. Gestalt therapy was used in the initial and final treatment phases (primarily focused on the phenomenological method and dialogic relationship, clearing the ground, existential encounter and integration of the therapeutic gains) and EMDR was used in the middle phase of the treatment process.

Client history

The client's father (taxi driver) died of a heart attack when she was 28 years old. Although very strict, he loved to joke („was like a best friend to her“). The client's mother (typist) worried about her and her sister too much. Although she did not play with them, she did cook for them and she was always „there“ for them. After she lost her child, her mother was the most important source of support for the client. The three-year-old sister, who had been cured from skin cancer a few years before, was protective towards the client in their childhood. Immediately after the loss, it was very difficult for the client to stay in touch with her sister, because „she has living children“.

Before their child got sick, the client and her husband had marital problems. She even contemplated divorce. For a while, the client and her husband lived together with her husband's father and brother. She did not receive the support she had expected from him when her sister was sick; he was too critical of her. When their child got sick their relationship improved, as they directed their attention towards their care for their son and both started practicing religion (they were not religious before). The night when their child was dying, she „wore the scarf“ (the hijab, usually worn by practicing Muslim women who strictly adhere to the religion) as „a token of gratitude to God if the child stays alive, or so that God gives him goodness if he does not“. Shortly after the death of

their son they wanted another child. The client gave birth to the second child at the beginning of February 2015 and again, to the third, on the 3rd of July 2016.

Since the age of 19, the client occasionally had panic attacks (symptoms of being upset, fear of going crazy, and losing control dominated), but she was never in treatment. Her son was the most important support for her.

Initial assessment

The usual emotional, cognitive, physical and behavioral reactions to the loss of the child were present in the client. Extremely agitated, she is spasmodic due to the pain and suffering, cries a lot in sessions, and talks about the child and pain which she experiences because of his death. She is worried, and in addition to all this, disturbed by panic attacks (especially the fear of going crazy).

Case conceptualization

The client's responses to the experience of child-loss were normal and expected. Since she was in therapy shortly after the loss, the client initially thought it was most important that she had a therapist who would „hold” her in phases of avoidance, and confront the loss. At the same time, the focus was on building the therapeutic relationship and stabilizing the client. Shortly after, (in June), the client got pregnant. It was expected that EMDR could support the client in the process of mourning and that there were no obstacles for its application. In preparation phase, a safe place was installed as well as a positive memory of her son (the boy's last birthday), which the client spontaneously described to the therapist during conversation. EMDR was applied when she got into the third trimester of her pregnancy.

Therapy

As the target for EMDR, the client chose the „image” of a doctor telling them that he needs to move the child to an intensive care unit as the “worst moment” related to the child's illness and death. The image is of the boy getting out of bed and asking: “Am I going? But I cannot go without my parents. Who will I be with?” The mother sees fear and helplessness in the child's eyes; she and her husband also feel fear and helplessness. She „lies” in order for the child to agree: „You are going for one night only”. Then, she kisses him for the last time. That night the child died.

The negative cognition related to the image is: “I am helpless” (because there is nothing I can do to keep him”). The positive cognition is defined as: “I did all I could. I will learn to live with this loss”.

Desensitization in the first EMDR session after initial assessment was done in three sets only. The client processed traumatic memories of the child's hospital treatment. During reprocessing, the client breathed heavily and cried a lot, experiencing extreme sorrow and pain. In the following EMDR sessions, further traumatic

scenes were processed. Reprocessing traumatic memories, (for example, lumbar puncturing, feeding the child with a syringe, the image of the child “hooked to hospital devices”, the thoughts: “I would go back to that period, everything is better than this”, the child's question: “Will I ever have one single normal day in my life?”) in which the client experienced and released pain, continued. Even during the second session, after the third set, the client reprocessed positive memories of the child (images of laughter and play, songs they used to listen to while driving to football practice). After the ninth sequence, the client reported: “I am home alone, I wake up, he is not there”, and in the next sequence has “positive” fantasies: “He is returning into my hug”, “He tells me – let me sleep, you will also come, let go of me, I will come again”, “I tell him – I know, in your mind you can always come; hug me”. During the next reprocessing sessions, besides painful memories of the child in treatment, more and more positive memories and fantasies of new contact with the deceased child which brought new positive emotions also emerged (e.g. images of a child on a swing in the next world-hereafter, telling her: “You are the most boring mother in the whole world, do not worry; I want to rest, there are lots of children here”). After the fifth session, the client wanted to stop EMDR and focus on dialog and her relationship with the therapist. It was respected because she had just entered the final trimester of her pregnancy. When she recovered after childbirth, the client continued to come for sessions during the summer of 2015. This time, topics revolved around child loss, her relationship with her husband, difficulties with being a mother to another child (for example, she felt guilty for not loving the other child enough), difficulties in “continuing” life etc. Panic symptoms disturbed her daily care for the baby, so we decided to use EMDR again. Since “float back” did not give significant content, “target” was the anxiety trigger. The “target” was feeling upset and not being able to handle it.

The negative cognition was “I will go crazy” (“I cannot, I am full of it all”), and the positive, “I can go through with it, I will be ok”. Emotions reported were pain, anger, helplessness and physically. she felt pressure in her head. Exactly one year following the last EMDR session directed to child loss, the EMDR approach towards panic resulted in a new reprocessing of the traumatic memories of the deceased child and the feeling of guilt. Reprocessing was again extremely painful and lasted four stimulation sets only. In the next EMDR therapy sessions we returned to the “old” target (child loss). Reprocessing continued in more sequences, was less painful and, besides the negatives, included positive content of contact with the child and parting with the child in fantasy. After that, the client wanted to return to dialogue with the therapist and continued working on topics which included her life and changes in her family system. At that time she was pregnant with her third child.

Changes in measures of VoC and SUDs from all seven sessions are shown in Table 1 below.

Table 1. Validity of Cognition (VoC) and Subjective Unit of Distress (SUDs) assessment during seven EMDR sessions

	Sessions in period from 29.9. - 18.11.2014.					Sessions on 18.11. and 2.12.2015.	
	1	2	3	4	5	1	2
VoC	2-3	2-3	3-4	4	5	3-4	5
SUDs	8	7-8	6-7	6	6	8	7

From the above Table we can see how, during the first five EMDR sessions, the level of disturbance gradually decreased and her belief in the positive cognition gradually increased. A year later, the disturbance increased and was alleviated after two EMDR sessions. Moreover, her damaged belief in her own ability to handle what she was going through was strengthened.

EPILOGUE

Meanwhile, the client gave birth to her third child. She did not seek therapy for the last year. She is focused on childcare and has started working again. She is functional in her roles.

DISCUSSION

Clinicians have a dilemma in terms of figuring out the most suitable time for psychotherapy for clients going through the process of mourning. Since no clinical model can predict with certainty the optimal recovery time for a given client, and since no clinician can fully appreciate the pain the client is experiencing, literature suggests that it is actually the client him/herself who decides on the best time for therapy (Shapiro 2001). In line with this, respecting the client's needs and rhythm in her mourning process, EMDR was applied eight months following the loss. At that time, the client was still dealing with acknowledging and understanding the death of the child, which, according to Rando (1993), characterizes the avoidance phase. The main process in this phase of mourning is recognizing the loss. However, she started the confrontation phase at the same time. The main processes of mourning in this phase are the reaction to separation, recollection and re-experiencing the deceased and the relationship with him, and relinquishing old attachments to the deceased and the old assumptive world. Everything that was accomplished during five EMDR sessions regarding these processes and phases of mourning is significant although not enough.

Firstly, the reprocessing of traumatic memories of illness and child-loss provided the client with an opportunity to discharge the pain of sorrow, which was immense. Its significance is pointed out by other authors who describe working with mourning mothers (ex. Shapiro 2001, Ruso 2012, in Shapiro and Forest 2012). Solomon (2016) states that processing allows the client to experience, express and discharge the pain. This is necessary for the eventual adaptive

shifting that results from the linking to other networks, with positive and adaptive information (e.g. a healthy accommodation).

Secondly, reprocessing difficult moments enabled the mother to approach positive memories and fantasies about her child. Earlier, she was "immersed" in memories of the pain and sufferings of the child at the hospital and the accompanying feelings of grief and helplessness. Solomon (2016) stated that the positive memories have a vital role in adjusting to the loss, because they are an essential bridge between the worlds with and without the loved one. Positive memories serve as the building blocks for developing adaptive inner representations of a loved one and are considered as conditions for healthy recovery.

One year later, the client experienced strong anxiety and pain again. Such symptom fluctuation in mourning clients is described in literature and is considered normal and expected (Arambašić 2005). In that period, the client cared for her second, newborn child, without having mourned through and relinquished the parental role with the first (deceased) child. Rando (1993) points out that simultaneously relinquishing and maintaining the same role is extremely difficult for the parents, and this significantly complicates the bereavement process. So, reprocessing resulted in relief again. The client reported feelings of guilt related to the child-loss multiple times during the therapy process, but she reprocessed the moments when she was rough towards her sick child in the penultimate EMDR session (throwing the syringe with medication on the floor and abruptly pulling the blanket from under the child). That was a significant moment in our work, because, according to Shapiro (2001), negative emotional responses to child loss are significantly related to the feelings of guilt induced by memories of the times when the client was rough or cruel towards the lost loved one. This author states that such incidents should be targeted for reprocessing. According to the scheme offered by Solomon (2016), there are many more targets for EMDR work with this client: for example, triggers of strong emotions (especially anger, guilt, yearning, despair), secondary losses, targets related to relinquishing the old relationship with the deceased son and relinquishing the old world model, as well as targets related to the adaptive moving into the new world without forgetting the old, are all potential targets. On the other hand, that what has been done so far has surely supported the client in her efforts to continue living life, moving on from loving her first child in presence, to loving him in absence.

CONCLUSION

The study supports suggestions from the literature that EMDR is not a shortcut for recovery, but that it allows and facilitates the process of mourning. The client should be encouraged to finalize the EMDR treatment so she can successfully move toward acceptance of her loss while simultaneously resolving impediments to recovery.

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