ORIGINAL ARTICLE

The Deepest Void: Loss of Loved Ones in the Covid-19 Era

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ABSTRACT

The experience of loss, since the very beginning of civilization, proved to be an anthropological pain that it is hard to treat, especially when a beloved one passes away. In the COVID-19 era this topic has become particularly relevant for psychologists and psychiatrists because of the global impact of the pandemic and for the specific frame of the grief, due to the impossibility to see the dead for the high risk of the contagion. The aim of this paper is to investigate the *absence* that always accompanies and follows the loss of a loved person within the pandemic outbreak. In a relatively scarce number of researches on the EMDR (Eye Movement Desensitization and Reprocessing) and bereavement in the COVID-19 era, the authors sought to sketch a new conceptualization of the loss: the impossibility to cope with the hospitalized beloved in his/her last moments, and the limits imposed by law to the funerals, *hugely reflects on the making of memories of the deceased* himself/herself. Thus, when grief is processed within the EMDR therapy, this *absence* cannot properly be 'adapted'. On the contrary, the authors – a psychologist and a metaphysician - suggest that *memories of the deceased are to be built by the client/patient, before being installed*. This process asks for a relevant change in the nursing practice: a psychological, emotional, behavioral report of the last moments of the hospitalized person should be completed before death, and then delivered to the family. This paper is primarily aimed discussing the anthropological complexity of loss in the COVID-19 times.

Key words: Void, COVID-19, loss, Grief, EMDR, Systemic thinking, Perturbation, Coherence.

FACING THE ABSENCE OF THE LOVED ONE

The loss of a loved one due to the pandemic sketches different sceneries in the patient's distress and in the therapeutic process as well. Such a specific frame depends upon the relevant trait of the *absence* that characterizes two related frameworks of the phenomenon. On one side, because of the high risk of the infection, it has been forbidden to stay beside their hospitalized relatives or friends, also in the more severe passages of the disease. During the Coronavirus outbreak the family members generally acknowledge about their relative's death over phone, being the use of the phone-call the only way, for health practitioners, to deal with the patient's relatives outside the hospital.

On the other side, in case of death, the deceased affected by COVID-19 cannot be managed by his/her relatives; the coffin is generally closed very soon for avoiding non-essential contacts to minimize risk of exposure to the virus. Furthermore, the safety laws, rules, and regulations – from all over the world - generally highlight additional risks to consider when attending a funeral. For many months, funerals were allowed only to a short number of family members. Furthermore, it should be noted that all the acts of care that usually accompany the death of a beloved one are strictly forbidden in times of pandemic.

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"If the family wishes only to view the body and not touch it, they may do so, using standard precautions at all times including hand hygiene. Give the family clear instructions not to touch or kiss the body" (1).

The human touch, the very basic tool for piety and for processing the bereavement's bitterness, has become a highly relevant chance of becoming infect if we take in account that human Coronaviruses can remain infectious on surfaces for up to 9 days 7 (2). Considering that a huge number of older people died for the infection, a further exclusion is experienced also by the partners, already fragile persons, in reason of age and general health conditions. The "Infection Prevention and Control for the safe management of a dead body in the context of COVID-19" released March 2020 by the World Health Organization is clearly written that: "Adults >60 years and immunosuppressed persons should not directly interact with the body" (1). Although international guidance always focus the dignity of the dead, the strict rules for containing the contagion heavily clash against the respect for cultural and religious traditions. The need to protect the family of the deceased throughout the exposure to the risk of the contagion is, nevertheless, a huge burden in psychological terms. The *post-mortem* phase (3) is crucial in order to process mourning: it's the time of silence and meditation. The deceased's exposure in a funeral house or at home allows relatives and friends to definitely figure out that their loved one is passed away. Piety and sorrow dwell that last phase of the human being. The quality of that experience will accompany those who were close to the dead as the last, and perhaps the most touching part of the attachment experience.

Old bonds are going to be reinforced within a new kind of relationship with the loved one: the ceremony of farewell, in the days that precede the funeral builds memories that are expected to facilitate an adaptive response to the loss. When all these aspects – related to the connection/disconnection with the deceased – are missing, the mourner(s) cannot easily cope with the loss.

MODELS OF LOSS AND THE SYSTEMIC VIEW OF BEREAVEMENT

As Solomon and Hensley highlight, grief is "the reaction a person has to loss", to which follows the process of mourning that consists of "assimilation and accommodation to the loss and adapting to the world without the deceased" (4).

For humans, the death of a loved one gives rise to a painful condition that affects both the spiritual and the physical realm. We'll sketch some main psychological models for framing this topic, and then we'll discuss the systemic thinking perspective that seems to fit much better than linear thinking to the understanding of how bereavement works in the human experience.

Since Freud the dynamics of loss and grief have been explained through the lenses of the personal attachment, an experience that recalls the separation from a caregiver in early infancy or childhood. Precisely, Freud's Model of Bereavement brought up in 1917 (5) suggests that the process of mourning works when the loss is accepted; on the contrary, melancholia brings into surface a depressive state that escapes self-control of the individual. The first, positive condition deals with conscious mind; the second, negative feeling is related to the unconscious environment of the person. A circular instead of a linear path is the process of grief in the perspective of Swiss-born psychiatrist Kübler-Ross (6). In this theoretical frame bereavement encompasses five phases: denial, anger, bargaining, depression and acceptance. Conscious, unconscious, emotional and pathological responses to the loss are included in the 'grief circle model' and sometimes they are all experienced by the mourner before the psychological adjustment has been achieved. The third prevalent model to approach grief, and perhaps the more anthropological rooted, is the one related to Bowlby's Attachment Theory (1958), for which – at large – any loss originally depends upon the attachment/detachment process experienced by the human being since the age of early infancy. Within this frame, the loss of a loved one recalls the detachment from safety, security, warm affection of the caregiver (7, 8).

In the COVID-19 era the bitter experience of loss, which is always so deeply interwoven with self-identity (9), seemed to present a more complex profile, so that it can be considered a veritable trauma (10-11). As Gelati underlines: "Deaths that follow the infectious disease have a series of features that expose survivors to a high risk of complication and mourning, and that represents a harsh challenge for psychologists" (translation of the authors) (10).

A question arises at this point of the paper: Why is it so challenging the specific type of loss due to the pandemic? In the light of the discussion made above, and the most applied psychological models, the process of grief has to work with/on the painful memories. Whenever this content is absent, fully or partially, the efforts of the mourner (as well as of the therapist) double. What is missed is not simply the chance of making memories, but primarily to re-connect and re-build an adaptive life environment for who is affected by the loss. This

aspect, so crucial for any psychological treatment, may be better understood throughout the lenses of systemic thinking (12, 13, and 14), the interdisciplinary approach to complex phenomena, which considers living entities in terms of system and applies theoretical tool from several disciplines, mainly from physics.

A loss is an existential perturbation, or the process that derives from a shock inflicted to a living organism. When such an event occurs, it is properly the balance of the whole system to be fractured (Freud), for the deceased as well as the mourner. Not simply attachment plays a role in bereavement (Bowlby), but it is also working the circular (Kübler-Ross) suspension of a long-term unpredictability, the typical behavior of deterministic or non-deterministic chaos.

With *dissipation* - a term that systemic thinking has received from the "dissipative structures" introduced in thermodynamics by the Nobel Ilya Prigogine - a double simultaneous movement occurs, characterized by the coexistence of change and stability. This process follows to perturbation, because it originates in non-equilibrium conditions in systems where a shock (or another cause) gives rise to instability. In classical thermodynamics, the typical movement of dissipative systems is rooted in the ability to transfer a large amount of energy to the environment. It's primarily the production of entropy to guarantee the stability of such systems. The releasing energy that new configurations or 'emergent properties' develop, are expected to reach the surface. It is interesting to note that the spreading of energy in the dissipation phase recalls, for many aspects, the reinvestment of psychic energy (libido) on the world of the mourner theorized by Freud (5).

Although a brief account is given, the authors strongly underline that all the most common approach to grief/loss are strictly interconnected in a systemic point of view. Restoration too, the last phase of the grief process, entails a direct relation to the systemic dynamics: we do refer to coherence, the step in which a new balance is built. This phase supports the unitary and integrated response of the system to disturbances/perturbations, avoiding isolation or the independent organization of some parts or functions. The loss of coherence clarifies why a process of emergence may be extinguished as the consequence of an inconsistent organization.

To briefly resume: perturbation corresponds to the shock inflicted by the loss (the death / the subsequent loss); dissipation refers to the painful/hurting moments in which psychic/physical/intellectual energy spreads out the mourner (the grief); coherence marks the restoration of the balance of the whole person. Indeed, how could the healing process is interpreted, in a systemic perspective?

The self-organization of dissipative systems is at the origin of the *emergences* or *systemic properties* (or II type systemic properties), which result from the interactions within systems and between systems and environment. Thus, a process works when a new person, a new kind of connection with the deceased and even the world-of-life is going to emerge from the grief.

At this point of the paper, after having sketched the peculiar traits of the loss of a beloved one within the pandemic outbreak and having provided the readers with an overview of three psychological models for the treatment of complex grief, we can move to the EMDR treatment.

THE EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

The EMDR – Eye Movement Desensitization and Reprocessing (15, 16, 17) is an internationally well-known psychological therapy that has shown highly efficient for the treatment of Post-Traumatic Stress Disorder (PTSD) and several comorbid disorders (depressive states, depersonalization, de-realization among the others), especially when the main traumatic event has recently occurred. This approach was developed in 1987 by US psychologist Francine Shapiro by applying the Adaptive Information Process (AIP) system, whose aim consists of re-activate the brain's self-healing process, and then to reprocess the most disturbing moments connected with the critical temporal frame in which it was included. With no doubt, EMDR proved to be a valuable tool for coping with the psychological consequences of the global COVID-19 outbreak. As Fernandez wrote: "When a serious critical event - like the Coronavirus pandemic - affects the whole world, the emotional impact on individuals, first responders, medical staff and communities is profound. When the first responders are also victims of the same incident, their emotional reactions can be so intense that they can interfere with their functioning during and after the crisis" (18).

In the pandemic era, EMDR therapists could improve the efficacy of the protocols, by exchanging resources – suggestions, guidelines, tips, report on case-studies - within the international network. Several features of individual responses to fear, trauma, depressive states and resilience, sometimes new and unexpected, have been experienced (19).

The EMDR has been also applied to complex grief in the pandemic outbreak. As Solomon noted in 2018, there is "a

paucity of research on EMDR and grief and mourning" (20) and the recent literature in the field has not increased, however, some relevant contributions about this big issue should be considered (21, 22). In this paragraph a short account of the dynamics of EMDR will be given: each passage will also be discussed in relation with the loss treatment.

A process that consists of 8 phases in which the painful memories are adapted, the EMDR assumes that "psychopathology is primarily caused by memories of traumatic or adverse life experiences that have been inadequately processed and maladaptively stored in a state-specific form" (23). For a better understanding, it should be useful to sketch how the EMDR works within past, present and future time (24). At the end of each therapeutic step, it will be discussed how the phase reflects on the treatment of the COVID-19 complicated mourning.

Phase 1 History and treatment planning – Present time and past time – are sharply distinguished when the therapy begins. The client/patient meets the therapist because the disturbance is at the very heart of his/her everyday life: The 'present moment' is an incessant 'now' of pain and sufferance that makes the person unable to think of the future. Since the first session, the therapist addresses the client to his/her personal story to focus the problem. The past is evoked, not as a sequence of details but a sort of global picture in which some events are more meaningful for the patients and become the target of the following therapy. At this phase, the client does not explore the flow of time because of the awareness of the present moment. The natural attitude to the living experience still prevails.

** The client/patient presents himself/herself as the mourner of a complex grief, affected by the unresolved trauma due to the loss of a beloved one.*

Phase 2 Preparation – After having established an alliance with the clinician, the patient is invited to learn some techniques to control the emotional disturbance: They may be useful both during the session and in everyday life. These practices – from the eye movement to breathing – are basically exercises of self-awareness and self-consciousness: they play the same role of attention, primarily because they focus on the non-conscious implications of an event. Life-flow cognition does not deal with the natural attitude; it is something more complex and related to the inner subjective experience. This is a preparation phase also for leaving the natural attitude to the world of life and assuming a new point of view.

** What emerges from the confrontation with the therapist is the sense of disbelief that comes from the incapacity to face with the death of a relative/friend. It's the time in which the patient becomes aware of how harmful has been the lack of physical proximity with the beloved one in his/her final moments. At this point the pain of loss includes the lack of the inner representation of the deceased. After the shock of the loss, now the mourner makes the experience of the deepest void.*

Phase 3 Assessment – The patient, at this point of the treatment, experiments a deep cognition of the 'now' time and can realize how temporality is related to his/her living experience. Consciousness of the 'now' moment has nothing to do with other punctual experiences of the present time, in which now is a point, a fragment in one's life. At this step, the therapist asks the clients how he/she feels. Negative cognition ("I'm unlovable") are scored, by the patient, using the 1-to-7 Validity of Cognition scale.

Reprocessing – Each target is processed when the disturbing past is compared to the safe present. If the patient was "in danger" before, then he/she is "safe now." This awareness of the continuity of the floating life experience is a fundamental achievement to re-connect disturbing memories and events.

** The memory network is going to be activated. As Solomon and Hensley note, the therapist invites the patient to identify "(a) the worst image; (b) negative cognition (i.e., irrational belief about the self); (c) positive cognition (i.e., the preferred belief about the self); and (d) emotions and sensations" (4).*

Phase 4 Desensitization – "In Phases 4 through 6, the memory is desensitized, cognitive reprocessing occurs, and the somatic distress is relieved" (Solomon & Hensley, 4). The complete resolution of the target reveals, on a temporal perspective, a further step in the phenomenological experience of the time. Precisely, the patient learns to get back to the past and to come back to the present. Eye movements participate in making faster and more vivid a number of memories related to the target. On a chronological point of view, the relationship between past and present in this phase is more advanced if compared with Phase 3. It is not the difference of the temporal states to be experimented, nor the floating of them. What the therapist notices are the experience of the retention, the presence of the past that can be continually modified by the mind. It is important to precise that this modification does not mean 'to change' past memories but to refresh them with new and unexpected details provided by the act of memorizing. In other terms, on temporal side, retention gets the (recent) past in the present, on a cognitive side; trauma memory opens up in the flow of consciousness.

** At this moment the patients can work with the last memories of the beloved one by integrating them with the information provided by the hospital or directly by the nursing team that took care of the deceased.*

Phase 5 Installation – A positive belief replaces, at this point of the therapy, the negative one. The goal of the treatment has been reached. On a temporal side, the patient experiments the relationship between the present and future.[29] At first glance, it would seem that the now moment plays the main role because the installation of positive belief highlights the present time ("I'm now in control") and the therapist makes an objective evaluation of it with the validity of the cognition scale. The control of the situation, nevertheless, is oriented to forthcoming life experience; it is oriented to the future.

Phase 6 Body scan – Body sensations associated with the negative beliefs of the patient – anxiety, fear, etc. – disappear when the positive belief has been reached and installed. This attentive act is mainly emotionally involved than cognitive implicated. On a temporal point of view, the patient experiments the floating of his/her existence: The now moment is not focused, it is part of a process or, more properly, of a re-processed human condition in which the well-being – an emotional state – prevails on the temporal-being.

Phase 7 Closure.

Phase 8 Reevaluation – Closure is a phase that belongs both to the single session and the end of the treatment. It basically refers to the capacity, for the patient, to be in control. Self-calming techniques may be useful to reach this goal. Reevaluation marks the end of the relationship between patient and therapist after the clinician has checked the success of EMDR. Temporally speaking, these phases restore the natural attitude of the living experience. Not now, nor the past are separated in the patient's perspective. Connection has been established; life flows again.

** In Phases 5 to 8 the worst memories are targeted and new, more positive ones are installed. The patient could identify the unresolved losses of the past and unresolved aspects of the relationship with the deceased. The possibility to cope with the unknown final moments of the deceased, through the witnesses of the final caregivers allows the mourner to enlarge his/her intimate distress to other subjects, not feeling the only one to keep on the burden of the loss itself. Reevaluation of the whole experience, then, brings about a change in the trauma of the loss, giving rise to a process of veritable resilience. A criticism could be moved: "the final memories of the beloved one are not originally experienced by the mourner because they are basically borrowed from the nursing team". It's correct. However, healing is a process. As seen before, any process entails a systemic dynamic that involves the whole environment. Not the BORROWED MEMORIES provide the mourner with the final healing. Each solution to the present loss is due to the result of the multiple interactions of sub-systems (mourner, therapist, memories, and nurses). Thus, this cooperation is not only valuable but also recommended for the allowing the mourner to feel better.*

CONCLUSION

The loss experimented, on global scale, during the COVID-19 pandemic is a peculiar kind of multifaceted trauma, linked to the attachment system (25), characterized by at least four essential traits: 1) in the majorities of the cases it was impossible to be hand by hand with a loved one who is dying; 2) in several cases, especially within the lock-down restrictions, the loss was accompanied by the impossibility to mourn someone's death in-person with friends and family; 3) it is generally required a long time to accept the loss, and to recover from the trauma; 4) all these conditions make the grief much more complicated and prolonged. At the very heart of the grief complicated by COVID-19 lies a double absence that increases the experience of existential void (26): the loss of a beloved person; the loss of the emotions and memories that generally go along the death of a relative/friend.

In reason of the peculiar bad features related to the pandemic, the loss of a beloved one may be really hard to process and become a veritable traumatic experience for the mourner, whose 'natural' abilities to go through mourning are not enough. The EMDR therapy, this investigation argued, is a natural healing process (4) that allows "clients to mourn with a greater sense of inner peace" (15).

From a philosophical perspective – as the authors underlined for the first time – such a treatment is 'natural' because it depends upon a number of systemic dynamics (perturbation, dissipation, coherence, and emergence) in which memories are the main component. Although only briefly sketched, this paper was addressed to underline a limit of the EMDR therapy when the mourning is complicated by COVID-19, namely the absence of the experience of the last moments of the deceased, and even of the possibility to see his/her corpse for sanitary reasons.

The authors suggest EMDR international network to provide a specific *enlarged protocol* to be filled by the healthcare

practitioners and the nursing staff in the case a patient affected by COVID-19 is going to die. It could be a multiple-choices form for specific question primarily related to: 1) behaviours of the patient before he/she died; 2) the possibility that the patient was aware about what was happening; 3) the capacity of the patient to relate with the doctors/nurses; 4) the last words pronounced; 4) when and how the patient expires; 5) the psychological distress of the patient; 6) the physical, psychological, medical, pharmaceutical efforts to reduce the patient's suffering. Once the form has been completed, it should be given to the family of the deceased as a set of memories that can fill the heavy burden of the absence. A direct confrontation – if it is possible in presence or through Zoom or a videocall – is warmly suggested.

These new memories, to be included and adapted in the mourner mind, are expected to be the veritable source for the spreading of the positive psychic energy: such an energy, generated by external stimuli (the nursing/healthcare practitioners report) is finally absorbed by the individual process of mourning, giving rise to the adaptation of experience of grief.

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