

Effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) on Experiential Avoidance, Psychological Symptoms, and Emotional Schemas in Suicide-Loss Survivors

Somayeh. Aminian Mohammadi¹, Parvaneh. Mohammadkhani^{2*}, Mohsen. Saeidmanesh³, Azade. Abooei⁴

¹ PhD Student in Psychology, Science and Arts University, Yazd, Iran

² Professor, Department of Clinical Psychology, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran

³ Associate Professor, Department of Psychology, Science and Arts University, Yazd, Iran

⁴ Assistant Professor, Department of Psychology, Science and Arts University, Yazd, Iran

* Corresponding author email address: parmohair@yahoo.com

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ABSTRACT

Purpose: This study examined the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) therapy in reducing experiential avoidance, psychological symptoms, and negative emotional schemas among suicide-loss survivors.

Methods and Materials: A quasi-experimental pretest-posttest design with a control group and a two-month follow-up was used. Thirty suicide-loss survivors were selected through convenience sampling and randomly assigned to an EMDR group or a control group (15 participants per group). Participants completed the Multidimensional Experiential Avoidance Questionnaire, the Brief Symptom Inventory, and the Leahy Emotional Schemas Scale. The EMDR group received ten weekly 60-minute sessions, whereas the control group received no intervention during the study period. Outcomes were assessed at pretest, posttest, and follow-up and analyzed using multivariate analysis of covariance in SPSS version 24.

Findings: Mean scores for experiential avoidance, psychological symptoms, and negative emotional schemas decreased in the EMDR group at posttest and follow-up relative to pretest, whereas the control group showed little change. Group effects at posttest and follow-up were statistically significant ($p < .05$). Reported effect sizes at posttest and follow-up were .230 and .189 for experiential avoidance, .880 and .540 for psychological symptoms, and .450 and .230 for emotional schemas, respectively.

Conclusion: EMDR was effective in reducing experiential avoidance, psychological symptoms, and negative emotional schemas among individuals bereaved by suicide. The findings support the potential clinical value of EMDR as a trauma-focused intervention for the psychological consequences of suicide bereavement.

Keywords: Eye Movement Desensitization and Reprocessing; EMDR; experiential avoidance; psychological symptoms; emotional schemas; suicide bereavement.

1. Introduction

Bereavement is a universal human experience, but the psychological consequences of loss vary substantially according to the circumstances of death, the quality of the relationship with the deceased, personal coping resources, and the meaning attributed to the loss. Among different forms of bereavement, loss through suicide is frequently regarded as particularly complex because it combines the pain of separation with traumatic, interpersonal, existential, and social dimensions. Survivors may struggle not only with sadness and yearning but also with guilt, shame, anger, self-blame, unanswered questions, perceived responsibility, stigma, and repetitive attempts to understand why the death occurred. Such reactions can interfere with the natural integration of loss and may increase vulnerability to prolonged or complicated grief, depression, anxiety, traumatic stress, and broader psychological dysfunction. Phenomenological evidence concerning abnormal grief suggests that bereaved individuals may remain psychologically attached to the circumstances surrounding the death, experience difficulty accepting the permanence of loss, and repeatedly reconstruct painful memories in ways that sustain distress over time (Azimoghli Oskouei et al., 2020). These difficulties may become especially pronounced following suicide because the death is often unexpected, violent, or difficult to comprehend and may disrupt survivors' assumptions about themselves, their relationships, and the predictability of life.

Suicide bereavement therefore represents more than an intensified version of ordinary grief. Exposure to suicide may itself constitute a significant psychological risk, and the consequences can extend beyond immediate family relationships. A systematic review by Maple et al. demonstrated that exposure to suicide beyond kinship relationships may also be associated with increased vulnerability to suicidal behavior, indicating that the psychological impact of suicide can extend across broader interpersonal networks (Maple et al., 2017). Longitudinal research has further shown that suicide-bereaved individuals may follow different trajectories of complicated grief and suicidal ideation and that interpersonal characteristics play an important role in determining whether distress persists or diminishes over time (Levi-Belz & Aisenberg, 2021). These observations underscore the importance of identifying modifiable psychological mechanisms that contribute to persistent suffering after suicide loss. They also indicate that interventions for suicide survivors should address not merely

the presence of grief symptoms but the ways in which distressing memories, emotions, beliefs, and interpersonal meanings are processed.

The psychological burden of suicide loss may be understood partly within the broader context of psychological symptoms. Grief-related distress can manifest through depressive symptoms, anxiety, intrusive thoughts, somatic complaints, obsessive preoccupation, interpersonal sensitivity, hostility, avoidance, and other forms of psychological dysfunction. Psychological symptom profiles are clinically important because distress rarely occurs as a single isolated reaction; rather, emotional, cognitive, behavioral, and somatic processes tend to interact. Research examining psychological symptom profiles in populations exposed to demanding or stressful conditions has emphasized that contextual stressors can be associated with meaningful differences in psychological functioning and well-being (Bahrami, 2024). Similarly, interventions directed toward underlying emotional and psychological processes have been shown to influence broader symptom patterns rather than only one narrowly defined clinical outcome (Salehian & Moradi, 2022). In suicide bereavement, this multidimensional perspective is especially relevant because survivors may simultaneously experience traumatic memories of the death, depressive withdrawal, anxiety, intrusive imagery, self-critical thoughts, and difficulties regulating grief-related emotions.

One mechanism that may contribute significantly to persistent post-loss distress is experiential avoidance. Experiential avoidance refers to attempts to escape, suppress, control, modify, or distance oneself from unwanted internal experiences such as painful memories, thoughts, emotions, bodily sensations, and urges. Although avoidance can provide short-term relief, persistent reliance on avoidance may paradoxically strengthen distress by preventing emotional processing and reinforcing the belief that internal experiences are intolerable. The Multidimensional Experiential Avoidance Questionnaire conceptualizes this construct as comprising several related patterns, including behavioral avoidance, aversion to distress, procrastination, distraction and suppression, denial and repression, and difficulties with enduring distress. The Iranian psychometric evaluation of this instrument supported its multidimensional structure and demonstrated its suitability for assessing experiential avoidance in Iranian populations (Moradi et al., 2017). Experiential avoidance is particularly relevant to grief because bereaved individuals may avoid reminders of the deceased, suppress painful

emotions, distract themselves from memories, or disengage from situations that evoke the loss. When such strategies become rigid, they may interfere with adaptive mourning and integration of the bereavement experience.

Evidence from clinical intervention research also indicates that experiential avoidance is responsive to psychological treatment. For example, acceptance and commitment therapy has been shown to reduce experiential avoidance and depressive symptoms among individuals experiencing emotionally distressing relational events, demonstrating that modification of avoidance processes can be associated with improved psychological functioning (Ghasemi-Tagab et al., 2021). This finding has conceptual relevance to suicide bereavement because persistent grief often includes both an understandable desire to escape painful internal experiences and an inability to disengage from distressing memories. Such apparently contradictory patterns can coexist: survivors may repeatedly think about the death while simultaneously avoiding direct emotional engagement with aspects of the experience. A therapeutic intervention capable of facilitating contact with distressing memories while decreasing their emotional intensity may therefore have particular value for this population.

Emotional schemas constitute another psychological process that may influence adjustment after suicide loss. Emotional schemas refer to beliefs and interpretations concerning the nature, legitimacy, controllability, duration, comprehensibility, and social acceptability of emotional experiences. Individuals do not merely experience emotions; they also evaluate those emotions, judge whether they should be feeling them, decide whether they can tolerate them, and form beliefs about whether others will understand or validate them. Maladaptive emotional schemas may include beliefs that painful emotions are unacceptable, uncontrollable, incomprehensible, permanent, shameful, or evidence of personal weakness. Empirical research has demonstrated important associations among maladaptive emotional schemas, alexithymia, anxiety sensitivity, and difficulties in emotion regulation, suggesting that emotional schemas can contribute to broader patterns of psychological vulnerability (Bakhshandeh et al., 2023). Likewise, comparisons between individuals with and without self-harming behavior have identified meaningful differences in emotional schemas and emotion-regulation difficulties, highlighting the relevance of these cognitive-emotional structures in high-risk populations (Emami Rad et al., 2020).

The importance of emotional schemas becomes especially evident in the context of suicidal experiences and

suicide-related loss. Individuals affected by suicide may interpret their emotional reactions through themes of guilt, responsibility, helplessness, incomprehensibility, rejection, or lack of control. Research exploring the lived emotional experiences of women who had attempted suicide illustrates the complexity and intensity of emotional states surrounding suicidal crises and reinforces the need to attend closely to the way such experiences are subjectively understood (Shirani Esfahani et al., 2024). Moreover, cognitive emotion-regulation interventions have been reported to reduce suicidal thoughts and maladaptive emotional schemas among individuals with a history of suicide attempts, providing evidence that these schemas are potentially modifiable therapeutic targets (Kadkhodaei, 2020). In survivors of suicide loss, maladaptive emotional schemas may similarly prolong suffering by encouraging rumination, self-blame, emotional suppression, and the perception that grief-related emotions cannot be effectively managed.

Emotion regulation is consequently a central component of psychological adaptation following traumatic or distressing experiences. Effective regulation does not necessarily require elimination of negative emotion; rather, it involves the capacity to recognize, tolerate, organize, and respond adaptively to emotional experiences. Difficulties in this domain can perpetuate psychological distress by increasing avoidance, impulsive behavior, rumination, and maladaptive coping. Even research conducted outside clinical grief settings has emphasized the importance of self-regulatory processes for effective adaptation and functioning (Asadi et al., 2020). Other studies examining strategies for managing anxiety have similarly demonstrated that interventions capable of modifying emotional or physiological arousal can influence psychological outcomes (Alavi et al., 2022). In trauma-related conditions, however, emotion-regulation difficulties are often strongly linked to unprocessed distressing memories, suggesting that memory-focused interventions may provide a particularly useful avenue for change.

Eye Movement Desensitization and Reprocessing (EMDR) is a structured psychotherapy originally developed for the treatment of traumatic memories and posttraumatic stress. Shapiro conceptualized EMDR within the Adaptive Information Processing model, according to which disturbing experiences may remain insufficiently processed and stored in maladaptive memory networks containing the original images, emotions, bodily sensations, and negative beliefs associated with the event (Shapiro, 2018). When present circumstances activate these memory networks,

elements of the original experience may be re-experienced, contributing to persistent distress. EMDR seeks to facilitate adaptive processing by asking clients to attend to relevant aspects of a distressing memory while simultaneously engaging in bilateral stimulation, most commonly therapist-guided eye movements. The treatment proceeds through structured phases including history taking, preparation, assessment, desensitization, installation of adaptive cognition, body scan, closure, and reevaluation (Shapiro, 2021). Through this process, the emotional intensity and dysfunctional meaning of traumatic memories are expected to diminish while more adaptive associations become integrated.

A substantial evidence base supports EMDR for trauma-related symptoms. A meta-analysis of randomized controlled trials found EMDR to be effective in reducing posttraumatic stress disorder symptoms, providing early quantitative support for its therapeutic efficacy (Chen et al., 2014). Subsequent literature has extended interest in EMDR beyond narrowly defined PTSD populations. A systematic review examining applications of EMDR beyond PTSD identified its use across diverse psychiatric and psychological conditions, suggesting that the intervention may have broader relevance when maladaptively processed distressing memories contribute to symptom maintenance (Valiente Gómez et al., 2017). More recent work continues to investigate EMDR across different clinical populations and delivery formats. For example, remote EMDR has been examined in the treatment of PTSD among adults with congenital heart disease, illustrating its adaptability to specialized medical and psychological contexts (Callus, 2025). EMDR has also demonstrated preliminary efficacy for very young children with PTSD, indicating that its underlying therapeutic principles may be applicable across markedly different developmental stages (de Roos et al., 2025).

Systematic research has also explored EMDR in relation to emotion regulation. A systematic review by Yunitri and Kao concluded that EMDR may contribute to improved emotion regulation among trauma survivors, which is especially important given that difficulty regulating affect is frequently involved in persistent posttraumatic distress (Yunitri & Kao, 2020). This effect may be particularly pertinent to suicide bereavement, where distressing images and emotionally charged memories often coexist with guilt, anger, fear, shame, and yearning. By reducing the affective activation associated with painful memories and facilitating the development of more adaptive cognitive associations,

EMDR may indirectly improve survivors' capacity to tolerate and regulate grief-related emotional experiences. Such changes could also influence experiential avoidance and negative emotional schemas, two constructs that are closely associated with how individuals respond to painful internal states.

Research conducted in Iran provides further support for the applicability of EMDR across psychologically distressed populations. Hekmatian Fard et al. found EMDR effective in reducing speech anxiety and improving academic self-efficacy among students with social anxiety, demonstrating that the intervention may influence both distress and adaptive beliefs about personal competence (Hekmatian Fard et al., 2020). Baharvand compared cognitive-behavioral therapy, cognitive hypnotherapy, and EMDR among women affected by floods and reported beneficial effects of these trauma-focused approaches on posttraumatic stress symptoms (Baharvand, 2020). Similarly, EMDR has been compared with compassion-focused treatment among individuals recovering from COVID-19, with the findings indicating its potential usefulness in improving coping self-efficacy after highly stressful experiences (Beiranvand et al., 2022). These studies suggest that EMDR can be implemented within Iranian cultural and clinical settings and may affect not only direct trauma symptoms but also cognitive and emotional resources relevant to adaptation.

The expanding application of EMDR has also encouraged investigation of its potential mechanisms and broader therapeutic effects. Research has examined whether processing emotional memories through EMDR alters memory accuracy, an important question because effective treatment should reduce distress without necessarily erasing or substantially distorting autobiographical information (Aleksic et al., 2025). Contemporary reviews have continued to describe EMDR as a clinically relevant method for processing distressing memories through structured attention and bilateral stimulation (Palade & Goga, 2024). In addition, systematic review evidence has investigated EMDR for chronic pain, a domain in which traumatic experiences, affective distress, bodily sensations, and maladaptive memory processes can interact, further illustrating the growing range of conditions in which EMDR is being evaluated (Singla et al., 2025). Collectively, this literature indicates increasing interest in understanding EMDR not merely as a disorder-specific PTSD intervention but as a memory-processing approach with potential implications for diverse psychological and somatic problems linked to distressing experiences.

The relevance of such interventions became additionally apparent during periods of widespread societal stress. The COVID-19 pandemic, for example, was associated with considerable psychological consequences across populations, including increased symptoms of anxiety, depression, stress, and trauma-related distress (Vindegaard & Benros, 2020). Although pandemic-related distress differs conceptually from suicide bereavement, this evidence reinforces a broader principle: exposure to highly disruptive and threatening events can produce multidimensional psychological consequences that require interventions capable of addressing emotional, cognitive, and physiological components simultaneously. Suicide loss may produce an even more personally concentrated form of disruption because it is embedded within a specific attachment relationship and is frequently accompanied by counterfactual thinking, perceived preventability, and unresolved questions concerning responsibility.

Despite the growing literature on trauma-focused treatment, research specifically examining EMDR for people bereaved by suicide remains comparatively limited. A clinical case series by Cotter and Duffy directly applied EMDR to bereaved survivors of suicide and provided encouraging evidence that traumatic and grief-related material can be therapeutically processed using this approach (Cotter & Duffy, 2018). At the same time, reviews of interventions for survivors of suicide loss indicate that this population presents distinctive therapeutic needs and that further evaluation of targeted grief interventions remains necessary (Asgari, 2024). The available evidence therefore suggests promise but also highlights an important empirical gap. Much of the existing EMDR literature has focused on PTSD, disaster exposure, medical trauma, or other forms of adverse experience, whereas comparatively fewer controlled studies have examined multidimensional psychological outcomes among suicide-bereaved individuals.

This gap is particularly important because suicide bereavement involves multiple interacting mechanisms that may respond differently to treatment. A survivor may show reduced overt distress while continuing to avoid internal experiences, or may become more willing to approach painful memories without changing deeply rooted maladaptive emotional schemas. Conversely, changes in the processing of a core traumatic memory may potentially produce improvements across several psychological domains. Assessing experiential avoidance, general psychological symptoms, and emotional schemas together can therefore provide a more comprehensive understanding

of treatment effects than examining grief severity alone. These outcomes represent complementary levels of psychological functioning: experiential avoidance reflects the behavioral and regulatory response to internal experiences; psychological symptomatology represents the broader clinical burden associated with distress; and emotional schemas reflect beliefs and interpretations about emotional experience itself. Evaluating all three may clarify whether EMDR produces changes that extend beyond immediate desensitization of painful memories.

The need for multidimensional assessment is further supported by evidence showing that suicide-related experiences, emotion-regulation processes, and psychological symptoms are interrelated rather than independent phenomena. The lived experience of suicidal crises includes complex affective and interpersonal processes (Shirani Esfahani et al., 2024); emotional schemas are linked with difficulties in emotion regulation and anxiety-related vulnerability (Bakhshandeh et al., 2023); experiential avoidance is associated with persistent emotional distress and can be modified through psychotherapy (Ghasemi-Tagab et al., 2021); and suicide bereavement may involve prolonged grief and suicidal ideation trajectories extending across several years (Levi-Belz & Aisenberg, 2021). These findings collectively suggest that effective treatment for survivors may need to influence multiple processes simultaneously. EMDR is theoretically suited to such a task because its protocol incorporates attention to memories, cognitions, emotions, physical sensations, distress tolerance, and the strengthening of adaptive beliefs rather than addressing a single isolated symptom.

Furthermore, the use of a longitudinal pretest-posttest-follow-up design is important when evaluating treatment for bereavement. Immediate symptom improvement after an intervention does not necessarily indicate durable psychological change, particularly when grief-related triggers may recur in response to anniversaries, reminders, interpersonal events, or renewed reflection on the circumstances of the death. Follow-up assessment makes it possible to determine whether therapeutic improvements persist after active treatment has ended. This issue is especially relevant in suicide bereavement because longitudinal evidence indicates considerable heterogeneity in grief trajectories over time (Levi-Belz & Aisenberg, 2021). The inclusion of a control condition additionally strengthens the ability to distinguish changes associated with

EMDR from improvements that might occur through the passage of time or natural adaptation.

Taken together, existing evidence establishes suicide bereavement as a psychologically complex condition involving traumatic memories, maladaptive emotional responses, avoidance, psychological symptoms, and potentially persistent grief-related difficulties. Research on EMDR provides a strong theoretical and empirical basis for targeting maladaptively processed emotional memories (Shapiro, 2018, 2021), while meta-analytic, systematic-review, clinical, and applied studies demonstrate its potential efficacy across trauma-related and broader psychological conditions (Chen et al., 2014; Palade & Goga, 2024; Singla et al., 2025; Valiente Gómez et al., 2017; Yunitri & Kao, 2020). Evidence from Iranian populations further supports the feasibility and potential effectiveness of EMDR within the relevant cultural context (Baharvand, 2020; Beiranvand et al., 2022; Hekmatian Fard et al., 2020). However, controlled evidence concerning its effects on experiential avoidance, broad psychological symptoms, and emotional schemas among people bereaved by suicide remains insufficient, despite the clinical importance of these constructs and the distinctive psychological burden associated with suicide loss.

Accordingly, the present study aimed to investigate the effectiveness of Eye Movement Desensitization and Reprocessing therapy in reducing experiential avoidance, psychological symptoms, and maladaptive emotional schemas among individuals bereaved by suicide in Isfahan, Iran.

2. Methods and Materials

2.1. Study Design and Participants

The present study employed a quasi-experimental design with pretest, posttest, and follow-up assessments and a control group to investigate the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) in individuals experiencing bereavement-related psychological distress following the suicide of a significant person. The statistical population consisted of individuals residing in Isfahan, Iran, who had experienced the death of a family member or emotionally significant person due to suicide and subsequently reported psychological difficulties associated with bereavement. Participants were recruited through convenience sampling from individuals who met the study eligibility criteria and expressed willingness to participate. A total of 30 eligible participants were enrolled and

randomly assigned to either the EMDR intervention group ($n = 15$) or the control group ($n = 15$). The principal inclusion criteria were having experienced the suicide of a first-degree family member or having maintained a close emotional relationship with the deceased for at least six months, experiencing bereavement-related psychological distress, willingness to participate in the study, and providing informed consent. The exclusion criteria included self-reported psychotic experiences, participation in another psychological or psychiatric intervention concurrently with the study, inability to attend the intervention sessions regularly, and withdrawal of consent during the research process. At the beginning of the study, participants in both groups completed the Multidimensional Experiential Avoidance Questionnaire, the Brief Symptom Inventory, and the Emotional Schemas Scale as pretest measures. Participants assigned to the experimental group subsequently received ten weekly 60-minute EMDR sessions, whereas participants in the control group received no psychological intervention during the corresponding period. Approximately one week after completion of the tenth intervention session, both groups completed the same measures as the posttest assessment. To examine the maintenance of therapeutic effects, the measures were administered again two months after the final intervention session as the follow-up assessment. Throughout the study, ethical principles governing psychological research were observed, including voluntary participation, provision of sufficient information regarding the research process, the right to withdraw from the study at any stage without adverse consequences, freedom to decline responses to individual questions, protection of privacy, confidentiality of personal information and assessment results, and use of collected data exclusively for scientific purposes.

2.2. Data Collection Tools

The Multidimensional Experiential Avoidance Questionnaire (MEAQ) was developed by Gámez et al. (2011) to provide a comprehensive assessment of experiential avoidance and related patterns of unwillingness to remain in contact with unpleasant internal experiences. The questionnaire consists of 62 items organized into six dimensions comprising Behavioral Avoidance, Distress Aversion or Maladaptive Distress, Procrastination, Distraction/Suppression, Denial/Repression, and Distress Endurance/Tolerance. Respondents indicate the extent to which each statement corresponds to their experiences using

a six-point Likert-type scale ranging from 0 (strongly disagree) to 5 (strongly agree). Selected items are reverse scored in accordance with the original scoring instructions, and item scores are combined to derive subscale and overall experiential avoidance scores. Higher scores generally indicate a greater tendency toward experiential avoidance, although the scoring direction of the distress endurance dimension must be considered when interpreting the profile. In the original psychometric evaluation, Gámez et al. (2011) reported satisfactory internal consistency, with Cronbach's alpha coefficients ranging from .82 to .89 across the six dimensions and an alpha coefficient of .92 for the total questionnaire. Evidence of convergent validity was also reported through a correlation of approximately .74 with a measure derived from the acceptance and commitment framework. The psychometric properties of the instrument have also been examined in Iran. Moradi et al. (2017) reported a Cronbach's alpha coefficient of .84 for the questionnaire and provided support for its six-factor structure through confirmatory factor analysis, indicating that the MEAQ has acceptable reliability and construct validity for use in Iranian samples.

The Brief Symptom Inventory (BSI) was developed by Derogatis and Melisaratos (1983) as a multidimensional self-report instrument for assessing a broad spectrum of psychological symptoms in psychiatric, medical, and nonclinical populations. The inventory is a shortened form of the Symptom Checklist-90-Revised and contains 53 items describing psychological and somatic symptoms that respondents may have experienced during the specified assessment period. Each item is rated on a five-point Likert-type scale ranging from 0 (not at all) to 4 (extremely), with higher scores reflecting greater severity of psychological symptoms. The instrument assesses nine primary symptom dimensions, including somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. In addition to scores for the individual symptom dimensions, the BSI permits calculation of global indices representing overall psychological distress and symptom burden. The inventory has been extensively used as a screening and outcome-assessment instrument because of its relatively brief administration time and broad coverage of clinically relevant symptoms. In the present study, BSI scores were used to assess changes in participants' general psychological symptomatology across the pretest, posttest, and follow-up assessments, thereby allowing examination of whether participation in EMDR was associated with

reductions in psychological distress beyond the symptoms specifically related to experiential avoidance and maladaptive emotional processing.

The Emotional Schemas Scale used in this study was based on Leahy's (2002) conceptualization of emotional schemas, which describes individuals' beliefs, interpretations, evaluations, and behavioral responses concerning their own emotional experiences. The questionnaire consists of 28 items representing 14 emotional-schema dimensions, namely approval seeking or the need for others' validation, comprehensibility of emotions, guilt regarding emotional experiences, simplistic conceptualizations of emotion, higher values associated with emotional experiences, perceived lack of control over emotions, emotional numbness, excessive emphasis on rationality, beliefs regarding the persistence or duration of emotional states, agreement or validation, acceptance of emotions, rumination, expression of emotions, and blaming others. Participants respond to the items using a six-point Likert-type response format reflecting their degree of agreement with each statement. The scoring procedure provides information about maladaptive beliefs and responses associated with emotional experiences, with higher scores indicating a greater presence of negative or dysfunctional emotional schemas according to the scoring approach applied in the study. These schemas are particularly relevant to bereavement after suicide because survivors may experience persistent guilt, self-blame, difficulty accepting emotional experiences, repetitive negative thinking, perceived uncontrollability of emotions, and maladaptive interpretations of grief-related reactions. Evidence reported for the Iranian version of the instrument indicated satisfactory internal consistency, with a Cronbach's alpha coefficient of .84 for the total scale and coefficients ranging from .56 to .71 for its individual dimensions. Accordingly, the scale was considered suitable for assessing changes in emotional-schema patterns associated with participation in the intervention.

2.3. Intervention

The EMDR intervention was implemented according to the therapeutic framework developed by Shapiro (2021) and was informed by the protocol previously applied and validated in an Iranian context by Hekmatian Fard et al. (2020). The intervention consisted of ten weekly group sessions, each lasting approximately 60 minutes, and progressed systematically from assessment and preparation

to desensitization, cognitive restructuring, somatic processing, closure, and reevaluation. During the first session, participants were introduced to the group and the therapeutic framework, treatment rules and expectations were explained, relevant personal and clinical histories were reviewed, central beliefs associated with the bereavement experience were explored, a psychologically safe place was identified through guided imagery, and appropriate targets for subsequent EMDR processing were specified. The second session focused on preparation for trauma processing and the development of emotional regulation resources. Participants received further information about EMDR and practiced relaxation procedures, while therapeutic imagery and distancing techniques were introduced to help them observe distressing memories without becoming overwhelmed. For example, participants were encouraged to imagine viewing a distressing event on a television screen or observing it from the window of a moving train while maintaining an internal sense of safety. During the third session, participants selected painful memories associated with the suicide loss and identified negative cognitions linked to those memories, such as beliefs reflecting loneliness, helplessness, guilt, responsibility, or personal inadequacy. In the fourth session, each participant identified a more adaptive positive cognition that they wished to associate with the distressing memory, with particular emphasis on beliefs reflecting personal control, safety, realistic responsibility, self-worth, or the capacity to cope. The fifth session constituted the principal desensitization phase, during which participants simultaneously attended to the targeted image, negative cognition, associated emotions, and relevant bodily sensations while bilateral stimulation was administered, primarily through therapist-guided horizontal eye movements. Sets of bilateral stimulation were separated by brief pauses during which participants reported emerging images, thoughts, emotions, or physical sensations, and alternative bilateral stimulation such as tactile tapping or auditory cues could be used when appropriate. The sixth session concentrated on installation of the selected positive cognition and strengthening its association with the processed memory. Therapeutic progress was monitored through reductions in subjective units of distress, ideally approaching ratings of 1 to 2, together with increasing validity-of-cognition ratings toward approximately 6 to 7. The seventh session focused specifically on identifying, differentiating, and labeling maladaptive or distressing emotions activated by negative memories and cognitions, thereby increasing participants'

awareness of emotional responses associated with the suicide loss. During the eighth session, a systematic body scan was conducted from head to toe to detect residual muscular tension, physical discomfort, or somatic activation associated with the target memory, and any remaining sensations were processed through additional bilateral stimulation and adaptive associations. The ninth session emphasized closure and stabilization, during which participants were guided back to a relaxed psychological state while reviewing relevant thoughts, emotions, and bodily reactions and consolidating self-regulation strategies that could be used between sessions. In the tenth session, reevaluation was conducted to review changes in distress, adaptive cognitions, emotional responses, and perceived therapeutic gains. Participants' positive feelings and sense of successful coping were reinforced, realistic expectations regarding future emotional reactions were discussed, and the therapeutic process was reviewed to consolidate the gains achieved during the intervention.

2.4. Data Analysis

Data were analyzed using IBM SPSS Statistics version 24. Descriptive statistical procedures, including means and standard deviations, were initially calculated to summarize participants' scores on experiential avoidance, psychological symptoms, and emotional schemas at the pretest, posttest, and follow-up assessments. Prior to conducting the principal inferential analyses, the statistical assumptions required for parametric multivariate analysis were examined. The Shapiro-Wilk test was used to evaluate the normality of score distributions, Levene's test was applied to examine homogeneity of error variances across the experimental and control groups, and Box's M test was used to assess the equality of variance-covariance matrices across groups. The linear relationship between pretest scores entered as covariates and the corresponding dependent variables was also evaluated, together with the assumption that the effects of the covariates were appropriately comparable across study groups. After verification of the required assumptions, multivariate analysis of covariance (MANCOVA) was employed to determine whether the EMDR and control groups differed significantly in the combined outcome variables while statistically controlling for baseline differences in pretest scores. Where the overall multivariate group effect was significant, the corresponding univariate effects were examined to determine which dependent variables contributed to the overall difference between

groups. Comparisons across the post-intervention and follow-up assessments were used to evaluate both the immediate effectiveness of EMDR and the maintenance of treatment effects over time. The level of statistical significance for all inferential analyses was set at .05, and the magnitude and direction of observed differences were interpreted in relation to the study objectives and the pattern of changes across the three assessment occasions.

3. Findings and Results

Thirty suicide-loss survivors participated in the study, including 10 men and 20 women. The outcome analyses compared the EMDR group with the control group.

Descriptive results showed little change in experiential avoidance, psychological symptoms, and emotional schemas across pretest, posttest, and follow-up in the control group. In contrast, scores in the EMDR group declined from pretest to posttest and remained lower at follow-up (Table 1).

Table 1

Means and standard deviations for experiential avoidance, psychological symptoms, and emotional schemas by group and assessment occasion.

Variable	Assessment	Group	Mean	SD
Experiential avoidance	Pretest	EMDR	62	7.03
	Pretest	Control	65	11.21
	Posttest	EMDR	36	12.03
	Posttest	Control	64	10.10
	Follow-up	EMDR	37	9.49
	Follow-up	Control	63	10.58
Psychological symptoms	Pretest	EMDR	52	7.03
	Pretest	Control	51	11.21
	Posttest	EMDR	22	11.96
	Posttest	Control	50	9.49
	Follow-up	EMDR	25	9.84
	Follow-up	Control	53	7.03
Emotional schemas	Pretest	EMDR	80	6.97
	Pretest	Control	82	22.11
	Posttest	EMDR	51	7.24
	Posttest	Control	85	10.66
	Follow-up	EMDR	52	4.12
	Follow-up	Control	83	11.85

Assumption testing supported use of multivariate analysis. Box's M test indicated that homogeneity of the variance-covariance matrices was not violated ($F = 1.12, p = .342$). Shapiro-Wilk tests were nonsignificant ($p > .05$), supporting normality. The pretest covariate had a significant linear relationship with the dependent variables, and

Levene's tests supported homogeneity of within-group variances ($p > .05$). Multivariate tests indicated a significant overall group effect for the combined dependent variables. The source reports that the group difference accounted for 29.3% of the overall variance.

Table 2

Multivariate tests for the group effect at posttest.

Test	Value	Error df	F	p	Effect size	Power
Pillai's trace	.705	132.000	4.520	.001	.200	.998
Wilks' lambda	.835	102.368	4.052	.001	.293	.998
Hotelling's trace	1.653	122.000	7.469	.200	.910	1.000

The follow-up univariate analyses indicated significant group effects for experiential avoidance, psychological

symptoms, and emotional schemas at posttest and follow-up. For experiential avoidance, the reported effect sizes were

.230 at posttest and .189 at follow-up, indicating that approximately 23% and 19% of the variance was attributable to treatment. For psychological symptoms, effect sizes were

.880 and .540, and for emotional schemas they were .450 and .230 at posttest and follow-up, respectively (Table 3).

Table 3

Multivariate analysis of covariance results for experiential avoidance, psychological symptoms, and emotional schemas at posttest and follow-up controlling for pretest.

Outcome	Source	Occasion	SS	MS	F	p	Effect size	Power
Experiential avoidance	Group effect	Pretest	568.3362	265.274	12.856	.241	.130	.324
		Posttest	456.562	245.568	5.258	.040	.230	1.000
		Follow-up	425.236	265.325	9.325	.041	.189	.998
	Error	Pretest	569.325	54.532				
		Posttest	456.236	52.123				
		Follow-up	568.569	18.562				
Psychological symptoms	Group effect	Pretest	365.231	152.542	32.238	.651	.136	.384
		Posttest	175.562	95.625	78.093	.001	.880	1.000
		Follow-up	198.856	85.658	132.887	.020	.540	.998
	Error	Pretest	669.315	325.123				
		Posttest	356.236	53.652				
		Follow-up	568.569	56.632				
Emotional schemas	Group effect	Pretest	452.623	214.125	45.210	.562	.145	.424
		Posttest	124.57	61.656	20.103	.001	.450	1.000
		Follow-up	70.120	34.130	7.433	.020	.230	.998
	Error	Pretest	265.325	36.125				
		Posttest	85.652	18.562				
		Follow-up	29.562	66.732				

4. Discussion and Conclusion

The present study investigated the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) therapy in reducing experiential avoidance, psychological symptoms, and maladaptive emotional schemas among individuals bereaved by suicide. The findings indicated that participants who received EMDR showed significant improvement in all three study outcomes compared with participants in the control group. Specifically, the intervention group demonstrated lower experiential avoidance, fewer psychological symptoms, and less maladaptive emotional-schema functioning at posttest, and the pattern of improvement was maintained at the follow-up assessment. These findings suggest that EMDR may exert therapeutic effects that extend beyond the reduction of trauma-specific distress and may influence broader cognitive, emotional, and behavioral processes implicated in adaptation to suicide bereavement. Because suicide loss can involve intrusive recollections, guilt, self-blame, emotional dysregulation, avoidance of reminders, and persistent attempts to understand the circumstances of death, an

intervention centered on adaptive processing of distressing memories may be particularly suitable for this population.

The first major finding was that EMDR significantly reduced experiential avoidance among suicide-bereaved participants. This result is theoretically important because experiential avoidance represents a tendency to suppress, escape, control, or disengage from distressing internal experiences, including memories, emotions, thoughts, and bodily sensations. Following suicide loss, survivors may attempt to avoid reminders of the deceased, suppress guilt or anger, refrain from discussing the death, or engage in distraction to escape painful emotional states. Although these responses may initially decrease distress, persistent avoidance can prevent adaptive emotional processing and prolong psychological difficulties. The present finding is consistent with evidence indicating that experiential avoidance is modifiable through psychological intervention. Ghasemi-Tagab et al. showed that acceptance and commitment therapy reduced experiential avoidance and depression among individuals experiencing severe emotional distress, suggesting that decreased avoidance is an important mechanism of psychological improvement (Ghasemi-Tagab et al., 2021). The psychometric work of

Moradi et al. also supports experiential avoidance as a multidimensional construct involving behavioral avoidance, distress aversion, suppression, denial, procrastination, and difficulties tolerating distress (Moradi et al., 2017). The present findings extend this literature by suggesting that EMDR may reduce several manifestations of avoidance through direct processing of painful bereavement-related memories.

A possible explanation for the reduction in experiential avoidance lies in the structured exposure and processing components of EMDR. During treatment, participants repeatedly attended to distressing memories, associated negative cognitions, emotional responses, and bodily sensations while simultaneously receiving bilateral stimulation. Rather than escaping or suppressing grief-related internal experiences, participants were encouraged to approach these experiences within a therapeutically safe and regulated context. According to the Adaptive Information Processing model, maladaptively stored memories remain isolated from more adaptive memory networks and can continue to generate distress when activated (Shapiro, 2018, 2021). Reprocessing allows these memories to become integrated with more adaptive information, thereby reducing their emotional intensity and perceived threat. Once a memory becomes less distressing, there may be less need to avoid the thoughts, feelings, or situations associated with it. Therefore, the observed reduction in experiential avoidance may have occurred because participants increasingly perceived grief-related memories and emotions as tolerable rather than psychologically overwhelming.

This interpretation is also compatible with findings concerning the effect of EMDR on emotion regulation. Yunitri and Kao concluded in their systematic review that EMDR can improve emotion-regulation capacities among trauma survivors (Yunitri & Kao, 2020). Improved emotion regulation can diminish reliance on avoidance because individuals who believe they can tolerate and manage emotional activation have less reason to suppress or escape from it. Research on suicide-related populations further demonstrates that difficulties in regulating emotions and maladaptive emotional processing are highly relevant to psychological functioning. Emami Rad et al. found meaningful differences in emotional schemas and emotion-regulation difficulties between individuals with and without self-harming behaviors (Emami Rad et al., 2020), while Kadkhodaei reported that cognitive emotion-regulation training could reduce suicidal ideation and maladaptive emotional schemas among people with suicide attempts

(Kadkhodaei, 2020). Taken together, these studies support the possibility that reducing avoidance requires improved tolerance, processing, and regulation of difficult affective experiences.

The second major finding was that EMDR significantly reduced participants' general psychological symptoms. Suicide bereavement can generate a broad spectrum of psychological difficulties rather than a single grief-related syndrome. Survivors may experience depression, anxiety, somatic distress, obsessive thinking, interpersonal sensitivity, hostility, phobic avoidance, and trauma-related symptoms. The improvement observed in the current study indicates that EMDR may have contributed to a broader reduction in psychological symptom burden. This finding is consistent with the established evidence base for EMDR in trauma treatment. Chen et al., in a meta-analysis of randomized controlled trials, found EMDR effective in reducing posttraumatic stress symptoms (Chen et al., 2014). Similarly, Valiente Gómez et al. concluded that EMDR has demonstrated therapeutic potential beyond PTSD, with applications across a variety of psychiatric and psychological conditions (Valiente Gómez et al., 2017). These findings support the interpretation that changing the emotional and cognitive processing of distressing memories may influence a wider network of symptoms.

The present result also aligns with studies conducted in Iranian populations. Baharvand found that EMDR was effective in reducing posttraumatic stress symptoms among women affected by floods, demonstrating the efficacy of memory-focused intervention following stressful and potentially traumatic experiences (Baharvand, 2020). Hekmatian Fard et al. similarly reported beneficial effects of EMDR on speech anxiety and academic self-efficacy among students with social anxiety (Hekmatian Fard et al., 2020). Beiranvand et al. compared EMDR with compassion-focused treatment in individuals who had recovered from COVID-19 and reported beneficial effects on coping self-efficacy (Beiranvand et al., 2022). Collectively, these studies indicate that EMDR can reduce distress and strengthen psychological functioning across different forms of adversity. The current study extends these findings to suicide bereavement, a context characterized by both grief and potentially traumatic memory processing.

The decrease in psychological symptoms may be explained by the fact that suicide bereavement often involves highly emotionally charged memories that continue to activate negative cognitions and autonomic arousal. Survivors may repeatedly replay the circumstances of the

death, imagine alternative outcomes, or interpret the suicide as evidence of personal failure or responsibility. These processes may sustain anxiety, depressive symptoms, sleep disturbance, somatic complaints, and interpersonal withdrawal. Through EMDR, negative cognitions associated with the loss are identified and progressively replaced by more adaptive beliefs, such as acknowledging realistic limits of responsibility or increasing confidence in one's ability to cope. As maladaptively stored memories become integrated, the frequency and intensity of intrusive activation may decline, thereby producing broader reductions in psychological symptoms. This explanation is compatible with Shapiro's model, which conceptualizes symptoms as manifestations of insufficiently processed memory networks rather than as entirely independent psychopathological phenomena (Shapiro, 2018, 2021).

The finding concerning psychological symptoms is also clinically plausible in light of the multidimensional effects of major stressful events. Vindegaard and Benros showed that exposure to a widespread and threatening crisis such as the COVID-19 pandemic was associated with elevated rates of anxiety, depression, and other psychological difficulties (Vindegaard & Benros, 2020). Bahrami similarly highlighted meaningful variation in psychological symptom profiles in individuals working under stressful occupational conditions (Bahrami, 2024). Although these contexts differ from suicide bereavement, they demonstrate that major stressors can disrupt multiple areas of psychological functioning simultaneously. Therefore, when an intervention reduces the central emotional impact of a traumatic or distressing experience, improvement may be observed across several symptom domains rather than only one specific outcome.

The third major finding of the present study was that EMDR significantly reduced maladaptive emotional schemas among individuals bereaved by suicide. Emotional schemas include individuals' beliefs about whether emotions are understandable, acceptable, controllable, valid, enduring, or dangerous. Suicide survivors may develop particularly maladaptive beliefs about emotional experience. For example, they may believe that their guilt should never diminish, that anger toward the deceased is unacceptable, that grief will continue indefinitely, or that experiencing moments of happiness represents disloyalty to the deceased. Such beliefs can intensify distress and sustain maladaptive strategies such as rumination, suppression, excessive reassurance seeking, or self-blame.

The present finding is consistent with research demonstrating the importance of emotional schemas in psychological distress. Bakhshandeh et al. reported that emotional schemas were meaningfully associated with alexithymia, anxiety sensitivity, and difficulties in emotion regulation (Bakhshandeh et al., 2023). Emami Rad et al. likewise found that individuals with self-harming behavior differed from those without such behavior in their emotional schemas and emotion-regulation difficulties (Emami Rad et al., 2020). Kadkhodaei demonstrated that cognitive emotion-regulation training could decrease maladaptive emotional schemas among individuals with a history of suicide attempts (Kadkhodaei, 2020). These findings indicate that emotional schemas are not fixed cognitive structures; rather, they can change through therapeutic experiences that modify how individuals understand and respond to emotions.

EMDR may influence emotional schemas through several interconnected mechanisms. First, repeated processing of emotionally charged memories provides experiential evidence that painful emotions can be tolerated without psychological collapse. Second, bilateral stimulation may reduce the vividness and emotional intensity of disturbing memory representations, making associated emotions seem less uncontrollable. Third, the installation phase strengthens adaptive cognitions, potentially replacing beliefs such as "I am responsible," "I am helpless," or "I cannot cope" with more balanced interpretations. Fourth, body scanning and emotional identification help clients recognize that emotions and physiological sensations are temporary and can change through processing. Consequently, participants may develop more adaptive beliefs about the legitimacy, controllability, comprehensibility, and duration of emotional experiences. This interpretation is supported by evidence that EMDR can improve emotion regulation among trauma survivors (Yunitri & Kao, 2020).

The nature of suicide bereavement makes such cognitive-emotional restructuring especially relevant. Research examining the lived emotional experiences surrounding suicide indicates that suicidal experiences are accompanied by highly complex emotional states, including helplessness, interpersonal distress, and intense negative affect (Shirani Esfahani et al., 2024). Survivors of a suicide may experience similarly complex reactions while also attempting to make sense of the deceased person's psychological state. Asgari's review of grief interventions for suicide-loss survivors emphasizes the distinctive treatment needs of this population and the importance of interventions capable of addressing the complicated emotional consequences of suicide

bereavement (Asgari, 2024). The present results therefore suggest that EMDR may be beneficial not merely because it reduces distressing memories but also because it alters how survivors interpret and respond to their emotional reactions.

Importantly, the current findings are consistent with the limited direct evidence concerning EMDR for suicide bereavement. Cotter and Duffy reported positive clinical outcomes in a case series involving bereaved survivors of suicide who received EMDR therapy (Cotter & Duffy, 2018). Their findings suggested that traumatic aspects of suicide loss could be processed effectively through EMDR. The current study provides further support for this clinical observation by demonstrating improvement across multiple psychological domains within a controlled design. The findings are also relevant to longitudinal evidence showing that suicide-bereaved individuals can experience prolonged trajectories of complicated grief and suicidal ideation and that interpersonal and psychological characteristics influence these trajectories over time (Levi-Belz & Aisenberg, 2021). Early intervention capable of modifying maladaptive emotional and cognitive processes may therefore contribute to healthier adaptation following suicide loss.

The maintenance of improvement at follow-up is another important finding. The persistence of reduced experiential avoidance, psychological symptoms, and maladaptive emotional schemas suggests that EMDR did not merely produce short-term relief during active therapy. Instead, participants may have developed more enduring changes in the way grief-related memories were stored and activated. This interpretation is compatible with the Adaptive Information Processing model, in which successful reprocessing is expected to create lasting integration of previously disturbing material with adaptive memory networks (Shapiro, 2021). Follow-up stability is particularly important in bereavement research because grief responses may fluctuate over time and may be reactivated by reminders, anniversaries, interpersonal events, or unresolved questions. Longitudinal research demonstrates that complicated grief after suicide can follow persistent trajectories for some individuals (Levi-Belz & Aisenberg, 2021); therefore, evidence of maintained therapeutic gains is clinically meaningful.

Recent EMDR literature also supports the robustness and adaptability of the intervention. De Roos et al. reported preliminary efficacy of EMDR among very young children with PTSD, indicating that the therapeutic principles of memory reprocessing can be applied across developmental

groups (de Roos et al., 2025). Callus demonstrated the feasibility of remotely delivered EMDR for PTSD in an adult with congenital heart disease, suggesting that the method can be adapted to different treatment contexts (Callus, 2025). Singla et al. reviewed EMDR for chronic pain and noted its potential relevance to conditions involving interactions among emotional memories, bodily experiences, and psychological distress (Singla et al., 2025). Palade and Goga likewise highlighted contemporary applications and conceptual developments associated with EMDR (Palade & Goga, 2024). These studies collectively reinforce the view that EMDR may affect broad processes related to distressing memory networks rather than operating exclusively within narrowly defined PTSD presentations.

Another consideration concerns the integrity of emotional memories during treatment. Aleksic et al. examined whether interventions such as EMDR, imagery rescripting, and imaginal exposure might influence memory accuracy when treating emotional memories (Aleksic et al., 2025). Such research is relevant because interventions for suicide bereavement necessarily involve working with highly meaningful autobiographical memories, and treatment should aim to reduce distress without invalidating the survivor's lived experience. EMDR does not require forgetting the deceased or eliminating the factual memory of the death. Instead, the therapeutic objective is to alter the dysfunctional emotional activation and maladaptive meaning associated with the memory. This distinction may be particularly valuable for bereaved survivors, who may resist treatment if they interpret reduction of grief intensity as equivalent to losing their connection with the deceased.

Overall, the findings support a multidimensional conceptualization of EMDR effects in suicide bereavement. Reduced experiential avoidance may increase willingness to encounter painful memories and emotions; improvement in emotional schemas may facilitate more accepting and realistic interpretations of those emotions; and reductions in psychological symptoms may emerge as these underlying processes become less dysfunctional. These mechanisms are likely mutually reinforcing rather than independent. As avoidance decreases, opportunities for emotional processing increase; as emotional schemas become more adaptive, emotions may appear less threatening; and as distress declines, individuals may become less reliant on suppression, withdrawal, or rumination. In this way, EMDR may contribute to a broader restructuring of the bereavement experience rather than simply reducing isolated symptoms.

Several limitations should be considered when interpreting the findings. First, the study involved a relatively small sample of 30 participants selected through convenience sampling from individuals experiencing suicide bereavement in Isfahan, which limits the statistical power of the analyses and restricts the extent to which the results can be generalized to broader populations. Suicide bereavement is heterogeneous, and participants may differ substantially in terms of their relationship with the deceased, time elapsed since the death, circumstances of the suicide, previous trauma exposure, social support, and baseline severity of psychological symptoms. Second, the use of self-report questionnaires may have introduced response biases, including social desirability, recall bias, and differences in participants' willingness to disclose emotionally sensitive experiences. Third, the control group did not receive an active comparison intervention; therefore, nonspecific therapeutic factors such as therapist attention, group support, expectancy, and regular engagement cannot be fully separated from the specific effects of EMDR. Fourth, although the inclusion of a two-month follow-up provided evidence regarding short-term maintenance of treatment effects, this period was insufficient to determine whether improvements remained stable over longer intervals. Finally, potentially influential variables such as medication use, previous psychological treatment, severity of complicated grief, characteristics of the deceased, family functioning, and concurrent life stressors were not examined as moderators of treatment response.

Future studies should replicate the present research with larger and more diverse samples recruited through multiple clinical and community settings and should consider stratifying participants according to relationship with the deceased, time since suicide, severity of grief, and the presence of trauma-related symptoms. Randomized controlled trials comparing EMDR with active interventions such as cognitive-behavioral grief therapy, acceptance-based approaches, compassion-focused therapy, or other trauma-focused treatments would provide stronger evidence regarding the specific efficacy of EMDR. Future investigations should also incorporate longer follow-up periods of six months, one year, or longer to determine the durability of treatment effects and the possibility of delayed changes in grief adaptation. In addition to self-report measures, researcher-administered diagnostic interviews, behavioral indicators, physiological indices, and reports from significant others could be incorporated to improve measurement validity. Research examining mediating

mechanisms would also be valuable; for example, investigators could test whether reductions in experiential avoidance or changes in emotional schemas mediate subsequent decreases in psychological symptoms. Finally, qualitative interviews could be combined with quantitative assessment to explore how suicide-bereaved individuals subjectively experience EMDR and which components of the intervention they perceive as most influential in reconstructing the meaning of the loss.

The findings suggest that mental health professionals working with individuals bereaved by suicide may consider incorporating EMDR into comprehensive postvention and grief-care programs, particularly when survivors exhibit intrusive memories, persistent guilt, emotional avoidance, maladaptive beliefs, or broad psychological distress. Before initiating memory processing, clinicians should conduct careful assessment of psychological stability, suicide risk, readiness for trauma-focused work, coping resources, and available social support. Adequate preparation, stabilization, and emotion-regulation skills should be established before distressing memories are targeted, and therapists should remain sensitive to the distinction between processing traumatic aspects of the loss and attempting to eliminate normal grief. Intervention plans should be individualized according to the survivor's relationship with the deceased, the nature of traumatic memories, cultural beliefs surrounding suicide and bereavement, and the presence of shame or stigma. Clinical services may also benefit from integrating EMDR with psychoeducation, family support, suicide postvention resources, and monitoring of ongoing psychological risk so that treatment addresses both the traumatic and relational dimensions of suicide bereavement.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

References

- Alavi, F., Seyed Hossein, H., Safaei, I., & Nejat, A. (2022). Studying the effect of inhaled aromatherapy of rose and lavender on competitive anxiety in athletes. *Karafen Quarterly Scientific Journal*, 19(2), 623-638. <https://doi.org/10.48301/kssa.300624.1685>
- Aleksic, M., Ehring, T., Kunze, A. E., & Wolkenstein, L. (2025). Does Treating Emotional Memories Come at a Price? Comparing the Effects of Imagery Rescripting, Eye Movement Desensitization and Reprocessing and Imaginal Exposure on Memory Accuracy. https://doi.org/10.31219/osf.io/qvwhu_v1
- Asadi, Y., Shirbagi, N., Salimi, J., & Rahimi, A. (2020). Evaluating the level of managers' tendency toward self-regulation and self-improvement skills: A study of executive managers of the University of Kurdistan. *Karafen Quarterly Scientific Journal*, 19(Special Issue), 157-180. <https://doi.org/10.48301/kssa.2021.285548.1600>
- Asgari, Z. (2024). Grief interventions for survivors of suicide loss: A review of studies. *Journal of Principles of Mental Health*, 26(6), 343-350. <https://doi.org/10.22038/jfmh.2024.81448.3146>
- Azimoghli Oskoue, P., Farahbakhsh, K., & Moradi, O. (2020). Staying in grief: A phenomenological study of the experience of abnormal grief after the death of a family member. *Knowledge and research in applied psychology*, 22(4), 28-42.
- Baharvand, V. (2020). Comparing the effectiveness of cognitive behavioral therapy with cognitive hypnotherapy and eye movement desensitization and reprocessing (EMDR) on reducing posttraumatic stress symptoms in flood-affected women. (pp. 203-212).
- Bahrami, E. (2024). Comparison of psychological symptom profiles of nurses working in specialized and non-COVID-19 wards and its relationship with their organizational well-being. *Rooyesh-e-Psikho*, 12(11), 1-10.
- Bakhshandeh, S., Mousavi Nasab, M., & Khezri Moghadam, N. (2023). Causal model of emotional schema and alexithymia with anxiety sensitivity via the mediating role of difficulties in emotion regulation in students. *Journal of Modern Psychological Researches*, 17(68), 53-62. <https://doi.org/10.22034/jmpr.2023.15345>
- Beiranvand, N., Chin-Oh, M., & Bahrami, M. (2022). Comparison of the effectiveness of compassion therapy and eye movement desensitization therapy and reprocessing on coping self-efficacy in patients recovered from COVID-19. *Disability Studies*.
- Callus, E. (2025). Remote Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder in Adult Congenital Heart Disease: A Clinical Case Study. *Clinical Case Studies*, 24(6), 409-426. <https://doi.org/10.1177/15346501251386456>
- Chen, Y. R., Hung, K. W., Tsai, J. C., Chu, H., Chung, M. H., Chen, S. R., Liu, C. Y., & Chou, K. R. (2014). Efficacy of eye movement desensitization and reprocessing for patients with posttraumatic stress disorder: A meta-analysis of randomized controlled trials. *PLoS One*, 9(8), e103676. <https://doi.org/10.1371/journal.pone.0103676>
- Cotter, P., & Duffy, T. (2018). EMDR therapy with bereaved survivors of suicide: A clinical case series. *European Journal of Trauma & Dissociation*, 2(4), 197-204. <https://doi.org/10.1016/j.ejtd.2018.07.003>
- de Roos, C., Offermans, J., Bouwmeester, S., Lindauer, R., & Scheper, F. (2025). Preliminary efficacy of eye movement desensitization and reprocessing for children aged 1.5–8 years with PTSD: a multiple baseline experimental design (N=19). *European Journal of Psychotraumatology*, 16(1), 2447654. <https://doi.org/10.1080/2008066.2024.2447654>
- Emami Rad, R., Zanjani, Z., Hosseinpour, S., & Jokar, S. (2020). A comparative study of emotional schemas and different dimensions of difficulty in emotion regulation between students with self-harming behaviors and students without these behaviors. 25(4), 1090-1100.
- Ghasemi-Tagab, F., Bakhshipour-Rodsari, A., & Farnam, A. (2021). The effectiveness of acceptance and commitment therapy on experiential avoidance and depression in female students with love trauma syndrome. *Quarterly Journal of Clinical Psychology*, 14(2), 51-61. <https://doi.org/10.22075/jcp.2022.24914.2294>
- Hekmatian Fard, S., Rajabi, S., & Hosseini, F. A.-S. (2020). The effectiveness of eye movement desensitization and reprocessing therapy on speech anxiety and academic self-efficacy of students with social anxiety. *Journal of Counseling and Psychotherapy*, 12(45), 269-294.
- Kadkhodaei, M. (2020). The effectiveness of group training in cognitive emotion regulation on reducing suicidal thoughts and emotional schemas in individuals with suicide attempts. *New Achievements in Humanities Studies*, 5(50), 95-104.
- Levi-Belz, Y., & Aisenberg, D. (2021). Interpersonal predictors of suicide ideation and complicated-grief trajectories among suicide bereaved individuals: A four-year longitudinal study. *Journal of affective disorders*, 282, 1030-1035.
- Maple, M., Cerel, J., Sanford, R., Pearce, T., & Jordan, J. (2017). Is exposure to suicide beyond kin associated with risk for suicidal behavior? A systematic review of the evidence. *Suicide and Life-Threatening Behavior*, 47(4), 461-474.
- Moradi, A. S., Barki Iranian, Z., Bagian Koleh-e-Marz, M., Karimi Nejad, K., & Zabit, M. (2017). Factor determination and psychometric properties of the Multidimensional Experiential Avoidance Questionnaire (MEAQ). *Social Cognition*, 6(2), 57-82.
- Palade, R.-E., & Goga, N. (2024). Eye Movement Desensitization and Reprocessing (EMDR). 1-8. <https://doi.org/10.1109/smartblock4africa61928.2024.10779488>
- Salehian, N., & Moradi, S. (2022). The effect of intensive short-term dynamic psychotherapy (ISTDP) on psychological

- symptoms in patients with antisocial personality disorder. *Journal of Psychology New Ideas*, 14(18), 1-20.
- Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures* (3rd ed.). Guilford Press.
- Shapiro, F. (2021). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*. Guilford Press.
- Shirani Esfahani, N., Mohammadpanah Ardakan, A., & Rezapour Mirsaleh, Y. (2024). Emotional lived experience of women who attempt suicide. *Journal of Health System Research*, 19(4), 325-335.
- Singla, A., Futela, P., Arora, K., Toussaint, L., Ahmad, Z., Murawska Baptista, A., Anstine, C. V., Hurt, R. T., Philpot, L. M., & Mohabbat, A. B. (2025). Eye Movement Desensitization and Reprocessing for Chronic Pain: A Systematic Review. *Journal of Integrative and Complementary Medicine*, 31(12), 1045-1055. <https://doi.org/10.1177/27683605251362035>
- Valiente Gómez, A., Moreno Alcázar, A., Treen, D., Cedrón, C., Colom, F., Pérez, V., & Amann, B. L. (2017). EMDR beyond PTSD: A systematic literature review. *Frontiers in psychology*, 8, 1668. <https://doi.org/10.3389/fpsyg.2017.01668>
- Vindegaard, N., & Benros, M. E. (2020). COVID-19 pandemic and mental health consequences: Systematic review of the current evidence. *Brain, behavior, and immunity*, 89, 531-542.
- Yunitri, N., & Kao, C. C. (2020). The effectiveness of eye movement desensitization and reprocessing toward emotion regulation among trauma survivors: A systematic review. *Journal of psychiatric research*, 125, 121-128.