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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

EYE MOVEMENT DESENSITIZATION AND REPROCESSING  
IN CONJOINT COUPLES THERAPY:  
A GROUNDED THEORY STUDY

A Dissertation Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Philosophy

Elizabeth Legg

College of Education and Behavioral Sciences  
Department of Counseling Psychology  
Counseling Psychology Program

August 2013

This Dissertation by: Elizabeth Legg

Entitled: *Eye Movement Desensitization and Reprocessing in Conjoint Couples Therapy: A Grounded Theory Study*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in  
College of Education and Behavioral Sciences, Program of Counseling Psychology

Accepted by the Doctoral Committee

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## ABSTRACT

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Eye movement desensitization and reprocessing (EMDR) is an evidence-based treatment for trauma, which is primarily conducted in the context of individual therapy (Shapiro, 2001). Although it has been incorporated into couples and family therapy in recent years (e.g., Capps, 2006; Errebo & Sommers-Flanagan, 2007; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke, & Sparks, 2001; Protinsky, Sparks, & Flemke, 2001), limited research has examined its use within conjoint couples therapy and none has included interviews with couples and therapists to explore this treatment modality. The purpose of this grounded theory study was to explore the experience of clients and therapists during conjoint EMDR. Interviews were conducted with 21 participants including seven couples who participated in conjoint EMDR as well as their therapists. These interviews were analyzed using Strauss and Corbin's (1998) grounded theory data analysis. The theory developed from the data, EMDR in Conjoint Couples Therapy: Relational Trauma Treatment Theory, provides perspectives not captured in previous research about the experience of conjoint EMDR and offers guidance about assessment and preparation procedures.

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## **CHAPTER I**

### **INTRODUCTION**

If another stands beside you when you face overwhelming terror and helplessness—whether you name this terror and helplessness a “dragon” or call it by some other name, such as traumatic stress—then everything is different. Shadows are not so terrifying. The struggle can be shared, and sometimes the fight can even be a thing of joy as, together, you defy the dragon. We all know it is better not to be alone in the dark and that connection with others makes us stronger. (Johnson, 2002, p. 3)

Through this grounded theory study, I sought to explore the experience of clients and therapists during eye movement desensitization and reprocessing (EMDR) treatment within conjoint couples therapy. I aimed to understand the factors and conditions that contribute to the change process as well as those that decrease or interfere with its effectiveness, using a qualitative research design. Through interviews with both partners, as well as their therapists who conducted the treatment, I strove to generate a theory about conjoint EMDR. This theory provides perspectives not captured in previous research and may facilitate decision making about when to integrate EMDR into couples counseling and when individual EMDR may be more appropriate. Participants of this study included a purposefully selected sample seven triads composed of EMDR trained therapists who had incorporated EMDR treatment into conjoint couples therapy and both members of couples who had participated in this treatment, resulting in a total of 21 participants.

This chapter begins with an overview of the background and context for the current study followed by the problem and purpose statements as well as the accompanying research questions. Furthermore, this chapter includes the research approach, assumptions, and researcher stance, and concludes with a discussion of the rationale and significance of the current study.

### **Background and Context**

We learn about trust and safety through our earliest relationships, namely those with our primary caretakers. When a traumatic experience causes a disruption in our sense of safety in the world at an early age, this event inevitably impacts our perception of ourselves, of others, and of the world as a whole (Herman, 1997; Janoff-Bulman, 1992; Johnson, 2008). Thus, in order to recover from such trauma, it is essential that this sense of safety and trust be re-established, and that healing occur within the context of a supportive relationship.

Exposure to traumatic experiences is not uncommon within the United States, though the majority of those who experience such traumatic events are able to recover without the need for professional intervention (Solomon, Solomon, & Heide, 2009; van der Kolk & McFarlane, 2007). A smaller percentage of individuals develop posttraumatic stress disorder (PTSD), which can lead to significant disturbances in emotional, cognitive, and relational functioning. Community-based studies suggest a lifetime prevalence of PTSD of approximately 8% within the U.S. adult population (Solomon et al., 2009). Furthermore, the majority of patients within psychiatric hospital settings have experienced severe trauma, with at least 15% meeting criteria for PTSD (van der Kolk & McFarlane, 2007). It is clear that the impact of trauma can be devastating on many levels,

particularly when it is compounded by instability in early life and a lack of supportive relationships (Briere & Scott, 2006; Pearlman & Courtois, 2005; Perry & Szalavitz, 2006; Solomon et al., 2009; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012).

Attachment is an innate force that motivates humans to bond with one another in order to survive and is learned through the primary relationship between mother and infant (Bowlby, 1969). That early experience creates a template for all future relationships by informing us about whether we can depend on ourselves and on others to meet our basic physical and emotional needs (Bowlby, 1969; Johnson, 2002, 2003a, 2008). We learn to anticipate future interpersonal responses and thereby develop an attachment style, or manner of relating with others, that reflects those early experiences (Johnson, 2002, 2003a, 2008; Johnson, Makinen, & Millikin, 2001; Schachner, Shaver, & Mikulincer, 2003). Those who develop a secure attachment style are confident in their ability to meet their own needs and to seek out closeness from others when appropriate.

Alternately, if children's early experience is that when they are distressed and cry, support is not forthcoming, they will likely develop an insecure attachment style, characterized by anxiety or avoidance (Johnson, 2002, 2003a, 2008). This early experience and resulting attachment style influence our expectations within intimate relationships as well as the way in which we relate in these future relationships. Thus, the development of attachment security requires the experience of consistency and responsiveness within a loving relationship, either in the first years of life or through a corrective emotional experience later in life (Briere & Scott, 2006; Johnson, 2002, 2003a, 2008; Teyber & McClure, 2011).

Eye movement desensitization and reprocessing (EMDR) is a comprehensive and evidence-based method of psychotherapy for trauma, which is primarily conducted in the context of individual therapy (Shapiro, 2001). Though it has been incorporated into couples and family therapy in recent years (Capps, 2006; Capps, Andrade, & Cade, 2005; D'Antonio, 2010; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Shapiro, 2005; Talan, 2007), researchers are only just beginning to examine its use within a conjoint couples therapy context (see Capps et al., 2005; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Talan, 2007 for examples of those who have), and none has included interviews to explore the *experience* of couples and therapists. Given that the therapeutic process is geared toward providing healing, increased insight, and both intrapersonal and interpersonal change, it is worthwhile to understand the clients' experience of that therapeutic process. Much research investigating the effects of EMDR treatment within couples therapy is from the perspective of the therapist, providing case examples to illustrate observed changes; none has explored the clients' perceptions of its value as a treatment modality and the conditions that they believe to contribute or detract from its usefulness within a couples therapy context.

One of the most powerful effects of integrating EMDR into couples therapy, when it has been done successfully, is the revelation of each partner's vulnerabilities which in turn, evokes empathy and support from the observing or witnessing partner (Capps, 2006; Capps et al., 2005; Litt, 2008, 2010; Moses, 2003, 2007). As noted above, traumatic experiences not only impact individuals' view of themselves, others, and the

world, but they also impact their relational and attachment patterns (Alexander, 2003; Herman, 1997; Turner, McFarlane, & van der Kolk, 2007). For example, individuals who experienced emotional neglect as children will likely be impacted in their attachment style as adults (Johnson, 2002; Perry, 2009; Schachner et al., 2003; Wesselmann & Potter, 2009), which may contribute to difficulties within intimate relationships.

Therefore, incorporating a trauma-focused treatment such as EMDR into couples therapy may contribute to positive changes within interpersonal factors such as communication, trust, empathy, and intimacy. In fact, Wesselmann and Potter (2009) demonstrated that clients' attachment status did change following EMDR therapy; furthermore, participants reported positive changes in terms of their emotions and relationships. However, their study involved EMDR applied individually and not within the context of conjoint couple sessions. The current study sought to explore the changes that both clients and therapists observe during the process of conjoint EMDR treatment.

Eye movement desensitization and reprocessing's protocol incorporates clients' assessment of personal change through rating their subjective unit of distress (SUD) and their validity of cognition (VoC); however, these number ratings provide a numerical baseline and a follow-up measure but not a descriptive narrative of their experienced change. In the current study, I explored how addressing past trauma through EMDR treatment within conjoint therapy was experienced by both members of the couple as well as by the therapist leading the sessions. By interviewing members of the couple and the therapist, more can be learned about the differences between EMDR therapy within the modalities of individual versus couples therapy and factors that contribute to the efficacy of EMDR treatment in conjoint therapy. This data could provide valuable information

regarding appropriate preparatory steps and assessment procedures prior to deciding how EMDR might be incorporated into the treatment plan. The more that is understood about the process of EMDR from clients' perspectives as well as from that of the therapist, the more effectively individual and relational issues impacted by trauma can be addressed and resolved.

### **Problem Statement**

Research indicates that eye movement desensitization and reprocessing (EMDR) is an effective and evidence based treatment for individuals with trauma-related symptoms (e.g., Bisson & Andrew, 2007; Chambless & Ollendick, 2001; Maxfield & Hyer, 2002; Shapiro, 2001). However, there is relatively little information about its effectiveness within a couples therapy context. Furthermore, in spite of the significant research that has been conducted since its inception in 1987, little work has captured the perspectives of clients themselves. Finally, there are recommendations proposed to assess a couple's readiness and appropriateness for conjoint EMDR, but these recommendations do not incorporate the perspective of the clients, nor do they provide a theory grounded in data to support its value.

### **Statement of Purpose and Research Questions**

The purpose of the current study was to explore the experience of clients and therapists during EMDR treatment within the context of conjoint couples therapy and, through interviews and document review, to develop a theory grounded in the data. This theory provides a preliminary understanding of the process of conjoint EMDR, including the related meanings and conditions that play a role for participants, and provides a theoretical explanation for how various factors and conditions contribute to the change



process as well as those that decrease or interfere with its usefulness as a treatment modality. Specifically, the research questions were:

- Q1     How do members of couples describe their experience of conjoint couples therapy involving EMDR treatment?
- Q2     How do therapists describe their experience of providing EMDR treatment within the context of conjoint couples therapy?
- Q3     What do participants perceive as valuable or meaningful about the process?
- Q4     What do they perceive as impeding the process or not valuable?
- Q5     How does each participant describe the status of the couple prior to and following EMDR, both individually and relationally?

### **Research Approach**

After approval from my dissertation committee and the university's Institutional Review Board (see Appendix A), interviews were conducted with a sample of 21 participants composed of seven triads of couples who had participated in EMDR treatment within conjoint couples therapy and the therapists. The final number of participants was based upon the point of saturation. Interviews were transcribed, after which both transcriptions and relevant therapeutic documents (e.g., therapist notes and client journal entries) were analyzed to investigate the experiences of these clients and their therapists with conjoint EMDR treatment. Furthermore, I sought to generate a theory regarding this treatment process, grounded in participant data, about the factors and conditions perceived to facilitate or interfere with its value.

Primary data collection methods included in-depth semi-structured interviews (Merriam, 1998) as well as relevant artifacts including measures completed by the client participants before, during, and/or after their treatment (e.g., treatment notes or EMDR

session records with SUDs and VoC ratings), and documents (e.g., poems or journal entries) that represented the therapeutic process or their status prior to, during, or after treatment. Interviews with clients and therapists were included and follow-up interviews were conducted in order to fill gaps in the data. The participants chose a pseudonym to protect their confidentiality. All interviews were digitally audio recorded and transcribed verbatim.

Data analysis was conducted through the use of Strauss and Corbin's (1998) grounded theory data analysis method including (a) open coding--to identify and develop categories,(b) axial coding--to identify the relationships among categories, and (c) selective coding--to synthesize the categories into a theoretical model. Grounded theory is a systematic methodology that involves both inductive and deductive methods, which results in the development of a theory about a particular phenomenon or process through the analysis of participant data (Charmaz, 2005, 2006; Creswell, 2007; Strauss & Corbin, 1998). Grounded theory methods include (a) simultaneous data collection and analysis, (b) a process for coding data, (c) comparative methods, (d) memo writing as a means of creating conceptual analyses, (e) theoretical sampling, and (f) development of a theoretical model (Charmaz, 2005).

Grounded theory methodology was used to generate a theoretical model to understand participants' experience of conjoint EMDR. According to Stern (1995), "The strongest case for the use of grounded theory is in investigations of relatively uncharted water, or to gain a fresh perspective in a familiar situation" (p. 30). Given the limited research investigating EMDR within couples therapy, a grounded theory exploration of this treatment modality was particularly appropriate.

Several methods were incorporated into the research process in order to increase the rigor and trustworthiness of the study including member checks, peer debriefing, and triangulation. I provided rich detail in the descriptions of participants' experiences, including personal quotes, in order to accurately capture their perspectives. Modal comparisons were utilized through the inclusion of multiple participants and perspectives in order to enhance the transferability of the study. Beyond those methods already mentioned, thorough memos were maintained throughout the research process detailing the process of data collection and analysis including ideas regarding codes, categories, and relationships among categories. These notes served as an audit trail to provide information about how the research was conducted and to authenticate the findings (Merriam, 1998). All of the methods noted above also increased the confirmability of the findings. A comprehensive review of the literature and a pilot study further contributed to the trustworthiness of the current study.

### **Assumptions**

Several assumptions were made in the development of this study based upon my experience as a Licensed Professional Counselor and a certified EMDR therapist, my specific orientation, as well as the literature in the field. First, this study is based upon the assumption that client participants would be willing and able to be genuine and open in sharing their impressions, beliefs, feelings, and experiences about their own history as well as that of their intimate relationship. This same assumption holds for therapist participants in terms of their clinical experience with the couple being interviewed. Second, I hold the assumption that individuals can and do heal from the impact of traumatic experience and that healing occurs within the context of a meaningful

relationship. Third, I assume that trauma is subjectively experienced and that small “t” traumas (those traumatic events that do not meet the *Diagnostic and Statistical Manual of Mental Disorders* criteria for PTSD, according to the American Psychiatric Association [APA], 2000) as well as big “T” traumas (those that do meet criteria for PTSD) may potentially be equally impactful to individuals (Shapiro, 2001); therefore, participants’ definition and personal meanings are viewed as more relevant than meeting a specific set of criteria (see Appendix B for definitions of key terminology). Fourth, I hold the assumption that clients’ perspectives are essential to understand in order to provide effective treatment; therefore, qualitative research is viewed as particularly valuable as a means of developing a thorough understanding of clients’ treatment experience.

### **The Researcher**

In qualitative research, the researcher is the primary instrument of data collection and analysis (Creswell, 2007). I assume Charmaz’s (2006) perspective that “neither data nor theories are discovered,” but rather “we are part of the world we study and the data we collect. We *construct* our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices” (p. 10, emphasis in original). Thus, throughout this research, I recognized that I would be offering an interpretation of participants’ experience rather than an objective reflection. Given my primary role in collecting and analyzing data as well as my own background that serves as a starting point, it was important for me to be reflexive and endeavor to be aware of my biases as well as remain open to participants’ experience throughout the process in order to allow their voices to guide the research.

Another characteristic of qualitative research is that it is flexible and always evolving, thus consisting of an emergent design (Creswell, 2007; Merriam, 1998). This flexibility allowed me to respond to emerging perspectives and themes as well as attend to the non-verbal communication during interviews. However, this emergent design and my role as the primary tool also meant that my decisions regarding data analysis and theory development were based on my own interpretation of the most relevant or important themes. Therefore, memo writing about my observations and impressions was essential as a means of working toward accurately capturing the experience of participants while remaining engaged and active throughout the process (Charmaz, 2005, 2006; Glaser & Strauss, 1967).

### **Choice of Research Topic**

My personal interest in this topic comes from my experience as a Licensed Professional Counselor over the past eight years. Much of the clinical work that I have conducted has been with children and adults who have experienced trauma, and whose behavior and interpersonal dynamics have been significantly impacted by that experience. I have witnessed the devastating impact of trauma on clients' perception of themselves and the world, just as I have had the privilege of witnessing powerful healing and transformation through clinical intervention and loving relationships.

I was trained in eye movement desensitization and reprocessing (EMDR) six years ago and obtained certification through EMDR International Association (EMDRIA) as an EMDRIA Certified Therapist. I have incorporated this approach into much of my therapeutic work with clients. Through this work, I have observed a powerful shift in clients' view of themselves, others, and the world as a result of reprocessing past

traumatic material. Over the past four years, I have integrated EMDR into couples therapy and have been strongly impacted by the depth of intimacy that I have observed in those sessions. I was inspired to further explore the experience of EMDR within couples counseling as a topic for my dissertation, after being deeply touched by the increased empathy, trust, understanding, and intimacy that I witnessed in clients who participated in this treatment with their partner. Furthermore, after conducting a pilot study with one couple and their therapist on this topic, I was further motivated to discover whether their experiences were reflective of the experiences of others.

Though I am an avid proponent of EMDR treatment for the impact of trauma, I also recognize that no single approach works with every client and that it is dangerous to impose an intervention that is not appropriate. I also am aware of the risks involved in therapists believing that they know what is best for a client without fully listening to the client's wishes and concerns. It is especially important for trauma therapists and for researchers working with participants who have experienced trauma to be attuned to power dynamics. Furthermore, it is also crucial to provide these clients and participants with as much control and patience as required in order to establish a sense of safety and security. Through this research, I hope to become more attuned to the experience of the clients I work with today and in the future, and thus continue to increase my skills as a therapist. I also hope that this research will provide valuable information to the field of EMDR, inspire further study in this area, and lead to more effective services to clients in the future.

## **Theoretical Perspective**

My theoretical orientation is an integration of an interpersonal process therapy (IPT) approach with elements of an Adlerian theory of personality. My perspective is humanistic, social-psychological, teleological, holistic, and phenomenological. I place an emphasis on the interpersonal process within the therapeutic setting and the importance of a corrective emotional experience within the therapeutic relationship as a vehicle for change (Teyber & McClure, 2011).

I consider clients within their social context, exploring the impact of early relationships on the development of the client. I believe in the motivating and healing nature of relationships, the importance of fostering clients' social interest, and the inherent desire that humans have to create a sense of social belongingness. I hold that individuals have a desire to make a place for themselves, and to contribute to society, consistent with Adlerian theory (Adler, 1929, 1964; Ansbacher & Ansbacher, 1956; Dreikurs, 1953). Adler believed we all have an innate social interest and that behavior cannot be understood outside of the social context, the latter of which is also consistent with IPT. Like Adler, I believe that our level of social interest is both a measure of and a determinant of our happiness and mental health (Adler, 1929, 1964; Dreikurs, 1953).

I view individuals as creative, unique, and capable of change and growth. I adopt Adler's belief that behavior is purposeful and that humans are attempting to move toward their goals (Adler, 1929, 1964; Ansbacher & Ansbacher, 1956; Dreikurs, 1953). I do believe all individuals have a life goal through which they are striving to compensate for their fears and insecurities and to maintain self-esteem. Similar to Adlerian therapy, the interpersonal process approach shares the view that individuals have the ability to make

significant and meaningful changes within their personal cognitive schema as well as in their interpersonal dynamics (Teyber & McClure, 2011). However, IPT states that this meaningful and lasting change requires a corrective emotional experience within a safe and secure interpersonal relationship. Teyber and McClure (2011) highlight the significant impact that early relationships with caretakers have on children's view of themselves and others, as well as on the way in which they relate to others; therefore overcoming that early experience requires a process of relearning. I adopt this view, which is compatible with the Adlerian perspective, while highlighting the importance of the interpersonal process within the therapeutic relationship.

Sullivan (1954) highlighted the importance of social influences in the development of personality, in how we view ourselves, and in ways in which we cope with anxiety. He believed that children develop their sense of self based on the expectations of parents and through parent-child interactional patterns. From an object-relations or attachment perspective, primary social relationships between children and their caregivers create the foundation for children's emotional security and sense of self-worth. Teyber and McClure (2011) speak to the importance of family interactions in the imparting of cultural norms and values, which in turn shape our identity and relationships with others. They also highlight the importance of early relationships in our learning of communication patterns and of responding to each client's unique needs and patterns, termed "client response specificity." I share these perspectives in my view of clients and incorporate them into the therapeutic process.

In my clinical work, I integrate the attachment perspective that children utilize cognitive and interpersonal strategies to protect against the separation anxiety that results



from a lack of emotional security. I incorporate the view that people develop ways of coping with unhealthy relationships early on to maintain self-esteem in the self-system. I integrate the cognitive behavior therapy concept of internalized self-schemas, which can contribute adaptively or maladaptively to interpersonal relationships (Teyber & McClure, 2011). I also adopt the IPT and family systems perspective that individuals take on adaptive roles within their primary relationships, which they often continue to hold, even after they become maladaptive. I believe that therapists must be alert in order to identify clients' maladaptive interpersonal patterns, explore how the same patterns might be occurring in the therapeutic relationship, engage the client to change this familiar and maladaptive pattern, respond in new and more adaptive ways to the client, and help the client to transfer this learning to other relationships.

Given this theoretical perspective that highlights the role of relationships in the development of personality and interpersonal patterns and in healing and change, as well as my experience working with victims of trauma, integrating EMDR into a systemic approach is a natural extension for me. Thus, it was essential for me to be aware and consistently reflexive of my biases throughout this research process in order to allow participants' experience to guide the process. In order to increase the trustworthiness of this study, I utilized a reflexive journal and memo writing (see Appendices C and D for samples) to enable me to find a balance between my own interpretations of participants' experiences and the meanings constructed by participants themselves.

### **Rationale and Significance**

One of the most devastating consequences of psychological trauma is disconnection from others, such that one's sense of trust and security in relationships and

one's way of relating to others in intimate relationships is significantly altered (Alexander, 2003; Herman, 1997; Johnson, 2002; Turner et al., 2007). Herman (1997) describes this disconnection in this way: "Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others" (p. 51). Research has consistently demonstrated that individuals who experienced emotional neglect during childhood are often impacted in terms of their attachment style as adults (Johnson, 2002; Perry, 2009; Schachner et al., 2003; Wesselmann & Potter, 2009), which may contribute to later difficulties within intimate relationships. In order to re-establish a sense of security within relationships, healing from the attachment injuries experienced earlier in life must occur within the context of a nurturing relationship (Alexander, 2003; Herman, 1997; Johnson et al., 2001).

Just as trauma can impact one's future relationships, one's security and trust within a current relationship can increase resilience when coping with traumatic events (Herman, 1997; Johnson, 2002). Johnson (2008), one of the founders of emotionally focused therapy (EFT; Johnson & Greenberg, 1995), described a secure connection to a loved one as "empowering," referencing hundreds of studies that have demonstrated the protective nature of such loving connections from stress and their role in increasing one's ability to cope more effectively with trauma. For example, Israeli researchers found that securely attached couples were better able to cope with dangers such as Scud missile attacks than were less securely attached couples, as indicated by less anxiety and fewer physical symptoms after the attacks (Mikulincer, Florian, & Weller, 1993).

Experiential couples therapy approaches such as EFT have been empirically validated and found to be effective in increasing attachment security and dyadic adjustment in couples (Errebo & Sommers-Flannagan, 2007; Makinen & Johnson, 2006). Therefore, incorporating an experiential trauma-focused treatment such as EMDR into couples therapy may result in positive changes, not only in PTSD symptoms, but also within dyadic adjustment, and attachment security. In line with this assertion, Wesselmann and Potter (2009) demonstrated that clients' attachment status did change following EMDR therapy and participants reported positive emotional and relational changes. However, their study examined the impact of EMDR treatment within individual therapy rather than within the context of conjoint couple sessions.

Healing from trauma within a couples therapy context may promote increased intimacy between partners and allow the partner to provide a corrective emotional experience to the other, thereby reducing dependence on the therapist. Thus, extending the research that has been conducted to date regarding EMDR to a couples therapy context and examining relational variables such as attachment security, intimacy, and empathy could provide important information regarding its effectiveness for couples in which one or both members has experienced trauma. Furthermore, developing a theory that is grounded in the data collected from client and therapist participants will facilitate our understanding of the conditions and factors that contribute to the change process as well as those that may serve as barriers to conjoint EMDR.

Johnson, Hunsley, Greenberg, and Schindler (1999) noted that within couples and family therapy research, the client's perspective on the change process has been generally neglected and recommended that this perspective should be explored in future research.

Since that time, researchers have argued that there is a gap between research and practice in that it is still not understood how conjoint therapy works and what factors lead to therapeutic outcomes (Heatherington, Friedlander, & Greenberg, 2005). Thus, it is worthwhile to understand the clients' perspective about the therapeutic process of conjoint EMDR to inform both research and practice in the fields of couples therapy and trauma treatment.

## **CHAPTER II**

### **A REVIEW OF THE LITERATURE**

#### **Overview**

The purpose of this grounded theory study was to develop a theory to explain the process of eye movement desensitization and reprocessing (EMDR) treatment within couples therapy and to discover factors that contribute to its effectiveness, grounded in data from participant interviews and documents. Specifically, I sought to understand clients' and therapists' experience of the process of EMDR within conjoint therapy, what changes they observed intra- and interpersonally, what elements of the therapeutic experience they found to be important, what elements were not important, and how the roles of participant and witness facilitated the observed changes. Furthermore, factors were perceived as unhelpful or as interfering with the effectiveness of this treatment modality were also investigated. Finally, guidelines for assessing in what circumstances conjoint EMDR might be indicated or contraindicated were explored, and what individual and relational factors should be in place prior to incorporating this treatment into couples counseling.

In this chapter, I present the research relevant to the current study, including literature related to trauma, attachment, couples therapy, and EMDR. I also outline the definition of trauma, its historical background, the prevalence of traumatic exposure, the effects of trauma, the role of relationships, as well as treatment approaches to

posttraumatic effects. In the section related to attachment, the history behind attachment theory as well as the theory itself are reviewed. The concept of internal working models is presented, attachment styles and the role of attachment in adult love relationships are discussed, and the effects of disrupted attachment are outlined. I conclude this section with a review of treatment approaches to disrupted attachment.

The section outlining the literature related to couples therapy begins with the historical background of this field, reviews emotionally focused couples therapy as a specific approach to couples work, and ends with the application of couples therapy for the treatment of trauma and attachment issues. In the last section, I present the research surrounding EMDR, including its historical development, the definition of and protocol for EMDR treatment, the adaptive information processing model that guides it, and the role of eye movements in this treatment. Furthermore, I review the empirical research on EMDR, cautions and contraindications for its use, the use of EMDR to address attachment issues, and the incorporation of EMDR treatment in the context of conjoint couples therapy.

Given that eye movement desensitization and reprocessing (EMDR) was originally used to address symptoms of trauma exposure, clients who have participated in this treatment modality are likely to have experienced some type of traumatic event (Shapiro, 1989, 2001). Given the relation between trauma exposure and disruptions in attachment, as well as the role of attachment in couples therapy, each of these areas is important to review. Multiple information sources were used in this literature review, including books, professional journal articles, and book chapters. These sources were accessed through PsychInfo, reference lists, bibliographies, and the Francine Shapiro

Library. No specific time delimitations were used given the nature of the topic areas and the relatively recent emergence of EMDR into the therapy field.

## **Trauma**

In this section, the topic of trauma is reviewed including its definition, historical background, the prevalence of traumatic exposure, the various effects of exposure to traumatic events, the importance of relationships and social support, and treatment and recovery from posttraumatic effects.

### **Definition**

There are multiple perspectives regarding what constitutes a traumatic event. McCann and Pearlman (1990) proposed that an experience is traumatic if it meets the following criteria: (a) it is sudden, unexpected, or non-normative; (b) it surpasses the individual's perceived ability to cope with it; and (c) it disrupts the individual's assumptions about oneself and the world. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000), for the diagnosis of Posttraumatic Stress Disorder (PTSD), a traumatic event must include the following criteria: (a) the individual experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or some other threat to the physical integrity of self or others; and (b) the individual's response included feelings of intense fear, helplessness, or horror. Herman (1997) described psychological trauma as "an affliction of the powerless" (p. 33) and highlighted the power of traumatic events to overwhelm an individual's systems of care that provide people with a sense of control, connection, and meaning. Such events call into question

our basic assumptions about ourselves and the world as they do not fit with our existing schemata.

Much debate has emerged regarding the DSM criteria for a traumatic event. For example, feminist authors have criticized the narrowness of these criteria (Herman, 1997), as such events are not considered uncommon, as suggested in the DSM. It has therefore been recommended that these criteria be modified to include the subjective experience of individuals of a traumatic event, with a focus on their perceived helplessness and/or lack of control, as well as on the severity of the event (Herman, 1997). Contextual factors, such as the social isolation and societal response that may occur following traumatic events, have also been highlighted as important considerations when examining the impact of such events (Herman, 1997). Furthermore, arguments have been made regarding the impact that certain events may have on children that might not be considered traumatic by an adult.

Researchers have referred to events such as humiliation or abandonment in childhood, infidelity by a partner, or a divorce as small “t” traumas as opposed to the large “T” traumas referenced in the DSM (Cvetek, 2008; Johnson, 2002; Schubert & Lee, 2009; Shapiro, 2001). Small “t” traumas have a lasting negative impact, particularly when experienced by a developing child. The essential element of traumatic stress is that the traumatic event, whether small “t” or large “T,” overwhelms the brain’s information processing system (Solomon et al., 2009) and is therefore dysfunctionally stored (Cvetek, 2008). Within this study, trauma was defined as one or more events subjectively experienced as distressing that negatively impacts current functioning. Furthermore, trauma may include small “t” and/or big “T” events.



## History

Though the formal diagnosis of posttraumatic stress disorder (PTSD) has only existed since 1980 when it was first introduced into the DSM (Johnson, 2002; Perry & Szalavitz, 2006), the effects of trauma have been documented for centuries (Schubert & Lee, 2009). For example, one of the earliest artifacts is a cuneiform tablet that contained a recording of people's reactions to the traumatic death of King Urnamma in 2094 B.C. during battle (Schubert & Lee, 2009). The term "traumatic neurosis" was developed by Hermann Oppenheim (1858-1919) in the 19<sup>th</sup> century, who argued that this neurosis was the result of organic processes (Schubert & Lee, 2009). In contrast, neurologist Jean Martin Charcot believed that the etiology of traumatic reactions was instead a result of predispositions held by individuals exposed to terrifying events, while Pierre Janet (1859-1947), a student of Charcot's, argued that "subconscious fixed ideas" or "cognitive schemas" rooted in childhood, led to neurotic responses to traumatic exposure (Schubert & Lee, 2009). Janet, as well as both Joseph Breuer and Sigmund Freud (1893) agreed that it was not the traumatic event itself that resulted in traumatic neurosis. While Janet believed the encoding and retrieval of memories of the event were more important in its etiology, Breuer and Freud believed the vulnerability of the symptomatic individual was responsible for traumatic neurosis (Schubert & Lee, 2009).

These pioneers outlined the symptoms that are now referred to as PTSD, primarily with regard to what they termed "hysteria" in women, thought to originate in the uterus (Herman, 1997). Freud believed hysteria was the result of psychological trauma, linking the altered states of consciousness and somatic symptoms experienced by

these women to sexual abuse. He then recanted and posited that fantasized memories of abuse were instead responsible for such hysterical symptoms (Herman, 1997).

Later, therapists such as Kardiner (1941) described similar symptoms experienced by men who had fought in world wars (Johnson, 2002). British psychologist, Meyers, coined the term “shell shock,” which resembled hysteria in men exposed to combat (Herman, 1997). Kardiner and Spiegel (1947) recognized the importance of the bond and relatedness among soldiers as protection against the terror of war (Johnson, 2002) and it was discovered that separating soldiers from their comrades aggravated their symptoms (Herman, 1997). In the mid-1970s, Vietnam veterans provided the information necessary to better understand the nature and effects of trauma, which later led to the formulation of the PTSD diagnosis (Johnson, 2002; Perry & Szalavitz, 2006). “Rap Groups” were developed during and after the Vietnam War as support groups led by these veterans.

Herman (1997) described the “combat neurosis of the sex war,” highlighting the effects of sexual abuse on the lives of women as a parallel to the impact of combat on men’s lives. As awareness increased about the effects of trauma, it became clear that the anxiety, sleep problems, intrusive thoughts, and increased startle response experienced by soldiers were similar in nature to those symptoms experienced by rape survivors, victims of natural disasters, and those who experienced or witnessed terrifying accidents or injuries (Perry & Szalavitz, 2006). The feminist movement increased awareness about the prevalence of rape and its effects as well as redefining rape as a crime of violence rather than a sexual act (Herman, 1997). It also became obvious that such traumatic reactions were not rare, as once was believed.

## **Prevalence**

Though estimates vary, more than half of the U.S. population has been impacted by psychological trauma and many who survive traumatic experiences develop PTSD (Solomon et al., 2009). Approximately 60% of men and 51% of women in the general population report having experienced at least one traumatic event during their lifetime (van der Kolk, Spinazzola et al., 2007). It has been estimated that the lifetime prevalence of exposure to traumatic events may reach as high as 89%. However, in spite of this high number, the large majority of individuals does not develop PTSD, with only 5 to 10% subsequently meeting criteria for PTSD (Schubert & Lee, 2009). In order to meet criteria for PTSD, the traumatic event must also meet the criteria delineated by the DSM. However, recent research has demonstrated that small “t” events can result in the PTSD syndrome and stressful experiences such as chronic illness or marital discord have been found to be as traumatic and result in as many PTSD symptoms as criterion A events (Schubert & Lee, 2009).

The types of traumatic events experienced by men and women differ, with the most common precipitants for the development of PTSD for men being combat and witnessing injury or death, and for women, physical attacks by intimate partners (van der Kolk, Spinazzola et al., 2007). Over 20% of returning veterans from Iraq are currently seeking mental health treatment (van der Kolk, Spinazzola et al., 2007) and 15.2% of American Vietnam theater veterans continued to meet criteria for PTSD twenty years after the end of the war (van der Kolk & McFarlane, 2007).

Persons of all ages may develop PTSD and if they do, they usually meet criteria for PTSD within the first three months after the traumatic incident; however, this time period is variable as is the duration of symptoms (Solomon et al., 2009). The severity of the symptoms can increase or decrease over time and approximately half of those who develop PTSD recover from the impact of the trauma within three months (Solomon et al., 2009). Those who do not recover may struggle with nightmares, flashbacks, and hypervigilance, and may also have difficulty maintaining employment or relationships. This is the population for which an effective treatment is most important, as the effects of PTSD can be devastating.

Community-based studies suggest a lifetime prevalence of PTSD of approximately 8% within the U.S. adult population (Solomon et al., 2009). Some researchers have reported that 10.3% of adult American women have histories of violent physical assaults (van der Kolk, Spinazzola et al., 2007), and up to 13% of women in the United States have been raped, though the minority will report such victimization (Johnson, 2002). As many as 46% of these women will develop PTSD symptoms, and this percentage increases for male victims of rape (Johnson, 2002). According to a large national sample in the United States, 12.3% of women reported having PTSD at some point in their lifetime, with 4.6% endorsing PTSD at the time of the survey (Johnson, 2002). One study of female rape and crime victims discovered that 16.5% of the women still met criteria for PTSD 15 years after the assault had occurred (Johnson, 2002), highlighting the lasting effects of trauma.

It has been reported that up to approximately 20% of female children are victims of sexual abuse within their own families (Johnson, 2002). The impact of trauma is more

profound and lasting for children than for adults (Perry & Szalavitz, 2006) as a result of their developing brains, and childhood sexual abuse is a strong predictor of PTSD (van der Kolk, Spinazzola et al., 2007). It has been estimated that at least 40% of American children will experience one or more potentially traumatizing event before they reach 18 years old (Perry & Szalavitz, 2006). According to a large survey, approximately one in eight children under the age of 17 reported having experienced some type of abuse by adults within the previous year, with 27% of women and 16% of men reporting a history of sexual abuse as children (Perry & Szalavitz, 2006). The incidence of sexual abuse is more than double for female children than for adult women (van der Kolk, Spinazzola et al., 2007).

### **Effects of Traumatic Exposure**

Trauma exposure has been linked with a variety of later problems and diagnoses, other than PTSD. It has been consistently found that most psychiatric inpatients have experienced severe trauma, with the majority of such trauma occurring within the family system, and at least 15% of these patients meet criteria for PTSD (van der Kolk & McFarlane, 2007).

**Posttraumatic stress disorder.** Posttraumatic stress disorder (PTSD) involves persistent re-experiencing of the trauma, persistent avoidance of stimuli associated with the trauma, a numbing of general responsiveness, and persistent symptoms of increased arousal, which result in clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000). Herman (1997) describes the three primary categories of PTSD symptoms as hyperarousal, intrusion, and constriction, noting that the dialectic between the contradictory responses of intrusion and

constriction prevents integration of the event, in spite of the individual's ongoing attempts to do just that. The imbalance and instability that result from these traumatic symptoms increase survivors' experience of unpredictability and feelings of powerlessness, resulting in a vicious cycle that perpetuates itself (Herman, 1997; Pearlman & Courtois, 2005).

Several authors have argued that the reliving of the traumatic event has the intrinsic function of processing and attempting to integrate the upsetting material (Briere & Scott, 2006; Herman, 1997), highlighting the inherent adaptive nature of this symptom. Unfortunately, this re-experiencing can take the form of an almost compulsive need to re-create the most terrifying elements of the event and, at times, individuals put themselves at increased risk of further harm in an attempt to undo the traumatic event or change its ending (Herman, 1997; Pearlman & Courtois, 2005). Individuals who develop PTSD begin to organize their lives around the trauma, such that the intrusive memories and feelings related to the trauma become so distressing that they result in significant interpersonal and occupational problems.

**Physiological effects.** Individuals who experience traumatic events may have long-term changes to their endocrine, autonomic, and central nervous systems, including changes in the regulation of norepinephrine and epinephrine (neurotransmitters involved in stress), and in both the structure and function of the brain, such as the amygdala and hippocampus, areas of the brain related to fear and memory (Herman, 1997; Perry, 2009; Perry & Szalavitz, 2006). In fact, brain scans of individuals with PTSD demonstrate that when they experience flashbacks, the areas of the brain related to language and communication appear to be inactivated (Herman, 1997). The psychiatrist, Bessel van der

Kolk, explains that when individuals experience trauma, their sympathetic nervous system is aroused, linguistic encoding of memory is impaired, and the central nervous system reverts to more primal functioning, where the limbic and brainstem areas of the brain predominate and the cortical areas are inaccessible, resulting in the inability to engage in higher order thinking (Herman, 1997). The complete current state of the research regarding the impact of traumatic exposure on neurological functioning is beyond the scope of the paper; therefore, only general findings are included in this section.

**Information processing.** Several authors (Cvetek, 2008; Schubert & Lee, 2009; Solomon et al., 2009; van der Kolk & McFarlane, 2007; Wesselmann & Potter, 2009) describe the impact of traumatic exposure on one's information processing system. Van der Kolk and McFarlane (2007) note six critical issues that impact information processing of individuals with PTSD: (a) persistent intrusive trauma-related memories, which interfere with the ability to attend to new and other incoming information; (b) the tendency for people to expose themselves to similar situations to the trauma, at times compulsively so; (c) active avoidance of specific triggers and a general numbing of responsiveness; (d) decreased ability to modulate physiological responses to stress and the resulting distrust of one's body responses; (e) difficulties with attention, distractibility, and stimulus discrimination; and (f) changes in individuals' sense of self and in their psychological defenses. These authors argue that these issues are critical in that they impact how incoming information is interpreted and encoded.

Whereas most information is available for revision and modification, traumatic memories appear to be encoded in the brain differently, such that the beliefs, emotions,

and physical sensations associated with the traumatic memory are imprinted on such a deep level that they are often re-experienced in the same form for months and years after the event occurred (Cvetek, 2008). These memories are thought to be dysfunctionally stored in an unintegrated and fragmented manner, with a disconnection between elements of the memory and the rest of the individual's experience (Wesselmann & Potter, 2009). This disconnection prevents integration of the memories and resolution of the traumatic experience (Cvetek, 2008), which can contribute to further disorientation. Thus, individuals with PTSD have difficulty experiencing their traumatic memories as an integrated whole and linking them to their personal narrative; instead the various elements of the memories remain disconnected, decontextualized, and with a timeless quality (Cvetek, 2008). Therefore, the physiological and psychological response remains strong, even long after the traumatic event.

Francine Shapiro (2001) argues that this dysfunctional storage of memory occurs due to the inability to access adaptive information processing when individuals are confronted with certain traumatic experiences. This lack of access to adaptive information processing prevents individuals from differentiating between the useful and destructive elements of the experience. As a result, people remain stuck between hyperarousal and emotional numbness rather than taking on a cautious yet flexible approach to new situations.

Thus, PTSD has been described as an information processing disorder (Schubert & Lee, 2009) where rather than the traumatic event being viewed as problematic, it is the processing, integration, and mental representation of the memory that are viewed as resulting in the anxiety that perpetuates PTSD symptoms. Solomon et al. (2009) explain



that as individuals process regular memories, they are transferred to the left cerebral cortex and integrated into one's life story, along with other memories, which can later be accessed as necessary. In contrast, traumatic experiences overwhelm the brain's adaptive information processing capabilities, resulting in an inability to integrate the memories and thus, episodic memories of that experience remain stuck in the limbic system rather than becoming semantic memories (Solomon et al., 2009) and being accessible for verbal processing. Therefore, based on this model, resolution requires that these memories become metabolized within one's memory networks and personal narrative (Wesselman & Potter, 2009).

**Shattered assumptions.** Psychological trauma can result in permanent changes in how individuals view themselves and relate to the world, shattering previously existing assumptions that the world is just and safe, that life is predictable, and that we are worthy of respect and compassion (Janoff-Bulman, 1992; Johnson, 2008). Trauma can trigger the re-emergence of developmental conflicts from childhood, even years later. Issues such as one's autonomy, initiative, competence, identity, and intimacy are called into question and must be revisited (Briere & Scott, 2006; Herman, 1997; van der Kolk & McFarlane, 2007).

When trauma occurs, one's autonomy is overridden by feelings of powerlessness, resulting in shame and doubt. Doubt emerges when individuals feel disconnected and alienated from others and shame is a result of helplessness (Herman, 1997; Johnson, 2008; Pearlman & Courtois, 2005; van der Kolk & McFarlane, 2007). What was once resolved and orderly is called into question and victims no longer trust themselves or others. They often feel guilty and inferior, incompetent and incapable, questioning their

ability to protect themselves and doubting their judgment, no matter the extent of their resources and skills (Briere & Scott, 2006; Herman, 1997; van der Kolk, Spinazzola et al., 2007).

**Relationships.** Trauma undermines one's connection to others, the meaning of relationships, and the sense of personal identity developed in relation to others (Briere & Scott, 2006; Herman, 1997; Johnson, 2002, 2008; Pearlman & Courtois, 2005; Perry, 2009; Tummala-Narra et al., 2012; Turner et al., 2007). Herman (1997) notes that "traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link individual and community" (p. 51). When the trauma involves interpersonal violence, the sense of betrayal is especially strong, particularly when it occurs within close relationships (Briere & Scott, 2006; Herman, 1997; Pearlman & Courtois, 2005; Turner et al., 2007). Survivors of trauma experience contradictory feelings regarding intimacy, both desperately craving close connection to others while simultaneously withdrawing from such relationships (Briere & Scott, 2006; Herman, 1997; Johnson, 2002, 2008; Pearlman & Courtois, 2005; Turner et al., 2007).

The opposing and confusing experience of survivors is often experienced by partners of these individuals. For example, partners of sexual abuse victims often report feelings of guilt and powerlessness as they watch the profound suffering of their mate (Shapiro, 2001). Sexual dysfunction, depression, and angry reactions on the part of the victim are common responses to sexual trauma and can exacerbate relationship stress for a couple (Shapiro, 2001). Survivors of sexual abuse often describe relationships

characterized by mistrust, interpersonal sensitivity, feelings of isolation, relationship dissatisfaction, ineffective communication, and high conflict (Alexander, 2003).

Individuals' capacity to tolerate intimacy can be impacted by traumatic experiences as well as mediate their response to trauma (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012; Turner et al., 2007). Johnson (2008) argues that it is critical for victims to be able to share their traumatic experience and resulting symptoms with their partners in order to heal. "Whether we explicitly share what has happened to us or not, trauma is always a couple issue. Partners feel the sting and stress as they watch their lovers cope with their wounds, and they also grieve their changed relationships" (Johnson, 2008, p. 238). In fact, partners of trauma survivors may develop what Figley (1986) refers to as secondary traumatic stress--experiencing symptoms that mimic PTSD such as vivid mental images of their partner's trauma and avoidance of reminders (Ein-Dor, Doron, Solomon, Mikulincer, & Shaver, 2010).

**Factors mediating the impact of trauma.** Though not all who experience significant trauma and an accompanying sense of helplessness, fear, and horror develop PTSD, it is evident that the impact of trauma becomes more pronounced when the trauma occurs early, is severe, and extends over a longer period of time (Briere & Scott, 2006; Pearlman & Courtois, 2005; Perry & Szalavitz, 2006; Tummala-Narra et al., 2012). It also appears that the more traumatic experiences a person is exposed to and the closer the individual is to the traumatic event, the more likely he is to developing PTSD. In fact, peri-traumatic and post-traumatic factors, previous traumatic exposure, and psychological history appear more important than the traumatic event itself in terms of predicting one's response (Pearlman & Courtois, 2005; Schubert & Lee, 2009).

The earlier an individual is exposed to trauma, the harder it is to treat and the more significant the impact (Briere & Scott, 2006; Pearlman & Courtois, 2005; Perry, 2009; Perry & Szalavitz, 2006; Tummala-Narra et al., 2012; van der Kolk & McFarlane, 2007). Crucial in determining the likelihood of recovery for children who experience trauma is their social environment (Perry & Szalavitz, 2006). If children are raised in supportive, predictable, and loving homes, the impact of trauma is significantly reduced.

Similarly, adults who have responsive partners have a secure base upon which to cope with the chaos of trauma (Johnson, 2008; Pearlman & Courtois, 2005). Individual differences in attachment appear to play a role in exacerbating or attenuating PTSD symptoms in traumatized individuals and their spouses (Ein-Dor et al., 2010). A review of PTSD studies found that perceived lack of partner support before and after a traumatic event is one of the most important factors determining vulnerability to PTSD (Ein-Dor et al., 2010). The sense of connection and support are essential for recovery and healing. For example, the prognosis for survivors of 9/11 who were near the World Trade Center was highly correlated to their use of social support (Johnson, 2008). Fraley, Fazzari, Bonanno, and Dekel (2006) found that 18 months after the attack, those who felt securely attached to loved ones had fewer flashbacks and less irritability and depression than those who did not reach out to their social support network. In fact, according to friends and family of the survivors, those who were securely attached appeared to have grown from the experience and became better adjusted.

Several factors increase the resiliency of individuals to the impact of trauma, including a strong social network, a thoughtful and active coping style, and an internal locus of control (Herman, 1997; Pearlman & Courtois, 2005; Tummala-Narra et al.,

2012). Furthermore, individuals may actually experience psychological growth after traumatic exposure. Posttraumatic growth can occur such that survivors of trauma develop increased psychological resilience, learn survival skills, develop greater self-awareness and sense of their own strength, increase their empathy for others, and form a more complex and mature perspective about life (Briere & Scott, 2006; Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009).

### **Importance of Relationships**

As noted above, the role of social support is vital in establishing a sense of safety and control. The response of loved ones can have a strong impact on the survivor's ability to recover from traumatic experiences, either mitigating or compounding its effects (Herman, 1997; Johnson, 2002, 2008; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Given the vulnerability of victims and the shattered assumptions that result from traumatic exposure (Janoff-Bulman, 1992), the response by others is highly impactful in healing and rebuilding a sense of connection with others. Herman (1997) noted that recovery time is related to the quality of individuals' intimate relationships, in research on rape survivors. Similarly, Perry, Difede, Musngi, Frances, and Jacobsberg (1992) found that the functioning of burn patients was most highly related to the amount of their social support rather than the severity of their burns (Johnson, 2002). However, beyond friends and family, it appears that close attachment bonds are particularly important for increasing resiliency to trauma, improving emotion regulation, and contributing to an integrated sense of self (Johnson, 2002; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012).

When such secure attachment is not present, individuals are more vulnerable to stress. This is especially true for children who are raised in abusive homes, who develop disorganized or fearful-avoidant attachment patterns. Van der Kolk (1996) describes the reciprocal relationship between childhood abuse and self-destructive behavior, such that each reinforces and perpetuates the other (Johnson, 2002; Pearlman & Courtois, 2005). Van der Kolk, McFarlane, and van der Hart (2007) observe that emotional attachment may be the most important protection from trauma and that, for children, emotionally and physically responsive parents contribute to children's resiliency.

As noted above, the response of others is critical in determining the impact of traumatic experiences. Johnson (2002) notes that the majority of rape victims do not report their victimization due to fear of retraumatization through the legal system. She also highlights the different response to veterans from the Vietnam War as compared with the response to veterans of World Wars I and II, noting the role of socially constructed meaning attributed to traumatic events in further contributing to the impact of such events. Survivors of trauma look to others to interpret and provide meaning to events, which determines their response. Given the importance of relationships in attributing meaning to events, relationships are essential in the healing and treatment process, particularly in response to what Herman (1997) describes as "violations of human connection" in redefining oneself and one's way of relating to others. Alexander (2003) views marriage as a potential source of solace and healing as much as it can prove to be a source of difficulty.

Just as we develop a sense of safety and our personal identity through our relationships to others, re-establishing a sense of safety and sense of self requires support

and empathy from others. Relationships are tested as they require tolerance of survivors' oscillating need for closeness and withdrawal (Herman, 1997; Pearlman & Courtois, 2005). Through such loving and supportive relationships, survivors can resolve their conflicts related to initiative, autonomy, and intimacy. As Herman (1997) notes, "In coming to terms with issues of guilt, the survivor needs the help of others who are willing to recognize that a traumatic event has occurred, to suspend their preconceived judgments, and simply to bear witness to her tale" (p. 68). This allows the survivor to accurately assess their personal responsibility rather than maintaining unrealistic guilt or dismissing any role in their traumatic experience.

Relationships provide a safe haven and secure base, which are viewed as essential conditions for healing (Johnson et al., 2001; Pearlman & Courtois, 2005). They provide corrective emotional experiences in order to re-establish a sense of belonging and efficacy (Johnson, 2002, 2008; Teyber & McClure, 2011). Johnson (2008) notes that a secure bond enables individuals to cope with and heal from trauma by (a) soothing one's pain and providing comfort, (b) sustaining hope, (c) providing reassurance that the victim is still valued and loved, and (d) supporting the survivor to make sense of the trauma.

### **Treatment and Recovery**

Herman (1997) describes the stages of recovery as "establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community" (p. 3). She notes that these stages of the treatment process must occur within the context of a healing relationship. Safety involves establishing control of oneself and then of one's environment. The second stage of remembrance and mourning involves telling the trauma narrative in depth and in detail in order to integrate the trauma into the

survivor's life story. This requires moving from a "prenarrative" in which emotional content is limited and the narrative is disconnected and disjointed, to an integrated narrative incorporated with emotions and context. Reconnection includes the reclaiming of faith, relationships, hope, and goals for the future and involves reconciling with oneself, reconnecting with others, and discovering a mission from survivorhood (Herman, 1997).

Similarly, McCann and Pearlman (1990) describe three stages of recovery: (a) stabilization, (b) working through the trauma and building self and relational capacities, and (c) consolidation and integration of the trauma. Briere and Scott (2006) present the following treatment principles for working with trauma survivors: (a) building a sense of safety, (b) establishing internal and external stability, (c) building a supportive and consistent therapeutic alliance, (d) individualizing treatment to the client's needs and circumstances, (e) incorporating gender and sociocultural issues into treatment, and (f) maintaining awareness and control of countertransference in the therapeutic relationship. They recommend a process of repeated exposure, activation, disparity, and counterconditioning in order to desensitize traumatic memories.

Pearlman and Courtois (2005) present the constructivist self-development theory (McCann & Pearlman, 1990), which emphasizes five primary areas of needs about self and others that are impacted by trauma and must be addressed during treatment: (a) safety, (b) trust, (c) esteem, (d) intimacy, and (d) control. Their theory highlights four key factors that must be present within the therapeutic relationship: (a) respect, (b) information, (c) connection, and (d) hope.



Regardless of the specific stages or principles set forth, clinicians consistently agree that treatment must begin with an establishment of safety and control within the therapeutic relationship, given the powerlessness and violation inherent in the experience of trauma (e.g., Alexander, 2003; Briere & Scott, 2006; Herman, 1997, Johnson, 2002; Pearlman & Courtois, 2005; Perry & Szalavitz, 2006; Rosenkranz & Muller, 2011; Tummala-Narra et al., 2012). Recovery necessitates restoring a survivor's sense of efficacy, control, and power (Briere & Scott, 2006; Herman, 1997; Johnson, 2002; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Kardiner (1941) described the goal of the therapist to support clients to complete the job that they are attempting to do on their own and to reinstate a sense of control (Herman, 1997).

Given the power that is taken away from victims at the time of trauma, it is especially vital that therapists take on the role of ally and witness, and to avoid any possibility of abusing the power that accompanies the therapeutic role (Herman, 1997). Furthermore, clinicians must be attuned to clients' negative schemas resulting from their traumatic experiences, such that they do not inadvertently reinforce those schemas (Briere & Scott, 2006; Pearlman & Courtois, 2005). It is not uncommon for issues related to abandonment, betrayal, or rejection to be triggered within the therapeutic relationship, particularly by survivors of childhood abuse (Briere & Scott, 2006; Pearlman & Courtois, 2005).

Several treatment approaches have been demonstrated to be effective for posttraumatic symptoms. Cognitive-behavioral, psychodynamic, and humanistic experiential models have been utilized for trauma survivors in individual and group contexts (Johnson, 2002). Chambless and Ollendick (2001) classify eye movement

desensitization and reprocessing (EMDR), stress inoculation, and exposure therapy as empirically supported treatments. Trauma-focused cognitive-behavioral approaches (TFCBT) such as stimulus confrontation and cognitive restructuring have been found to be effective for posttraumatic symptoms (Seidler & Wagner, 2006). Methods such as prolonged in vivo and imaginal exposure to target the fear and anxiety components of PTSD have been particularly effective for rape victims (Johnson, 2002). Experiential and psychodynamic approaches have also been found to be effective for improving functioning and decreasing anxiety (Johnson, 2002). Exposure and flooding techniques have been successful in reducing intrusive and hyperarousal symptoms, however numbing and social withdrawal symptoms as well as difficulties in functioning within marital, social, and occupational areas are more resistant to such approaches (Herman, 1997; Johnson, 2002).

Herman (1997) notes that reconstructing the trauma is a necessary but not a sufficient factor in recovery, as it does not address the relational consequences of traumatic exposure. In contrast, survivor groups are a powerful context to address the shattered assumptions about oneself and the world to restore a sense of mutuality and connection to others (Herman, 1997; van der Kolk, McFarlane et al., 2007; van der Kolk, Spinazzola et al., 2007); however, intrusive symptoms tend to remain unresolved with this treatment (Herman, 1997). Herman proposes that both group and individual therapy focused toward desensitizing the traumatic memory may be essential for complete recovery from trauma. Similarly, Pearlman and Courtois (2005) emphasize the importance of addressing developmental, relational, and PTSD symptoms in the treatment of trauma.

Regardless of the approach used in the treatment of PTSD symptoms, the common goals of treatment of individual therapy are affect regulation and the creation of new meaning that allows for the integration of the traumatic experience into a new and empowered self; both goals require a meaningful interpersonal context in which the client can begin to rebuild trust in humanity and herself (Johnson, 2002; Pearlman & Courtois, 2005). Therapeutic approaches that involve some form of exposure and trauma processing within a safe and supportive relationship have been found to be effective (van der Kolk, Spinazzola et al., 2007). The efficacy of psychopharmacological approaches such as selective serotonin reuptake inhibitors (SSRIs) has also been demonstrated, though less so in veterans (van der Kolk, Spinazzola et al., 2007).

Both Herman (1997) and Johnson (2002, 2008) highlight the natural tendency for humans to bond in pairs and the value of the interpersonal connection in the healing process. As noted above, group treatments and individual approaches tend to be effective in targeting different symptoms, given the importance of desensitizing triggering trauma-related material as well as rebuilding a sense of connection to humanity. Therefore, intimate relationships appear to be a natural arena in which to foster healing and reconnection. In couples therapy, reconnection occurs within the therapeutic relationship as well as with one's partner.

Couples therapy can be especially appropriate when the traumatic event is one that intimately affects both members, such as the death of a child. Given the tendency of women to express their emotions and men to withdraw and attempt to protect their wife through "doing," such grief can interfere with a couple's level of connection and engagement (Johnson, 2002). In contrast, when couples remain engaged and process their

grief together, they are able to move through the grieving process and strengthen their bond (Johnson, 2002, 2008).

Interestingly, as healing as the group process can be for trauma survivors, research has demonstrated that married incest survivors have poorer outcomes for group therapy than unmarried survivors, suggesting that attachment-related anxiety may be increased and negatively impact one's intimate relationships when it is not addressed within the couples context (Alexander, 2003). Alexander highlights the need for a secure base from which to explore traumatic memories and the necessity for a strong and trusting relationship with a therapist as well as strong attachment ties before exploring such material with one's spouse. She also notes the value of couples therapy in order to strengthen the marital unit as a secure base to foster further healing and intimacy. Furthermore, she identifies the role of the therapist as the secure base during a transitional period until the partners can take on this role for one another.

Several authors (Alexander, 2003; Johnson, 2002, 2003a, 2008; Sherman, Zanotti, & Jones, 2005) emphasize the value of couples therapy in increasing trauma survivors' affect regulation within their primary relationship, the context in which attachment-related insecurities become triggered. Emotionally focused couples therapy has been applied to trauma survivors and their partners, and has been found to be effective for increasing affect tolerance and regulation, as well as increasing intimacy among partners and rebuilding a sense of self among survivors (Alexander, 2003; Johnson, 2002). Alexander notes the power of the partners of trauma survivors serving as a witness to their spouse's trauma narrative as survivors work toward developing an integrated and coherent story as part of the healing process. As Herman (1997) notes, "The core

experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections” (p. 133).

### **Attachment**

In this section, literature in the area of attachment is reviewed including the historical context of its emergence, attachment theory, internal working models, attachment styles and their application to adult love relationships, the impact of disrupted attachment, and finally, treatment for disrupted attachment issues.

### **History**

The importance of human connection and touch has been observed for centuries. As far back as 1760, a Spanish bishop observed to his superiors in Rome that children being raised in foundling homes were dying “from sadness,” in spite of the satisfaction of their needs for shelter and food. In the 1930s and 1940s, similar observations were made in American hospitals, where orphan children who were deprived of touch and emotional contact, were consistently dying (Johnson, 2008). During this same period, psychiatrist David Levy (1937) wrote about children who experienced “emotional starvation” who appeared callous, detached, and unable to connect with others. In the 1940s, René Spitz (1946) first used the term “failure to thrive,” referring to children who had been separated from their parents and seemed unable to move through their grief. However, not until the British psychiatrist, John Bowlby (1969), was there a clear understanding of the underlying mechanisms behind such observations (Johnson, 2008).

Bowlby (1969) worked in child guidance clinics in London, where he began to hypothesize about the impact of parental separation on children’s emotional

development. In 1938, under the supervision of the analyst Melanie Klein, Bowlby theorized that the quality of one's connections to loved ones and early deprivation of such connections are related to the development of personality and interpersonal styles of relating with others (Bowlby, 1969; Johnson, 2008). He argued that emotional connection was as crucial to survival as physical nutrition.

Canadian researcher, Mary Ainsworth became his assistant. Ainsworth studied infants' responses to separation and reunion with their mother in experiments which she termed "the strange situation" (Ainsworth, Blehar, Waters, & Wall, 1978). She observed that some infants modulated their distress when they were separated from their mother, provided clear signals about their needs, and sought out contact upon their mother's return. These same children were able to be soothed and within a short period of time, returned to exploration and play. These young children were labeled as "securely attached." In contrast, anxiously attached children exhibited extreme distress through desperate clinging or angry outbursts upon reunion. Furthermore, they were difficult to soothe and demonstrated increased attempts at contact with their mother after her return, seeming to distrust her availability or ongoing presence. The infants termed "avoidantly attached" exhibited physiological signs of distress but appeared emotionally detached and nonresponsive upon both separation and reunion, remaining focused on tasks and activities rather than seeking contact with their mother (Ainsworth et al., 1978; Johnson, 2003b).

Bowlby (1969) described the unique bond between parent and child as unlike any other social relationship, and together, he and Ainsworth created a theory of attachment that they believed was essential to survival of the human species (Wesselmann & Potter,

2009). Their colleague, psychologist Harry Harlow at the University of Wisconsin, researched “contact comfort” and demonstrated that young monkeys separated from their mothers at birth preferred a “mother” made out of cloth who did not provide food rather than one made of wire who did, providing further support for the importance of emotional and physical contact with one’s attachment figure (Johnson, 2008).

### **Attachment Theory**

Bowlby (1969) proposed that attachment is an innate motivating force that helps to maintain our survival and serves the functions of (a) proximity seeking, (b) the development of a secure base, (c) the development of a safe haven, and (d) reducing the likelihood of separation. He proposed that humans develop a sense of identity and efficacy through our interactions with those closest to us, which he describes as our attachment figures. Furthermore, separation from such figures, whether emotional or physical, leads to a predictable series of responses, beginning with angry protest, clinging and seeking, depression and despair, and eventually, detachment, after all other attempts at connection are unsuccessful (Johnson et al., 2001; Kobak, 1999).

This theory holds that secure dependence upon others complements autonomy rather than being dichotomous. In other words, when one has a secure attachment, one is confident in exploring the world and making autonomous decisions, with the knowledge that he has a home base, to which he can return. That safe haven and secure base is protective and serves as a buffer against the effects of stress (Briere & Scott, 2006; Johnson, 2002; Pearlman & Courtois, 2005).

This theory also holds that when attachment figures are accessible and responsive, the attachment bond is strengthened. For this reason, any type of engagement from an

attachment figure is better than none. That is, if there is no response, there is no bond and therefore no sense of self or connection to others (Bowlby, 1969, 1988; Johnson, 2002). According to Bowlby's (1969, 1988) theory, attachment needs are activated by fear and uncertainty (Johnson, 2002; Pearlman & Courtois, 2005), such that when a person feels threatened, her natural response is to reach out for protection, comfort, and connection. This proximity seeking serves as an emotional regulation mechanism.

According to attachment theory, when attachment figures demonstrate that they are consistently unavailable or unresponsive, children develop an insecure attachment that is organized along two dimensions: anxiety and avoidance (Johnson, 2002). That is, individuals desperately attempt to maintain the attachment bond and obtain an emotional response through behaviors such as anxious clinging or they learn that they cannot rely on others and instead suppress their attachment needs in an attempt to protect themselves, avoiding any emotional engagement with their attachment figure.

### **Internal Working Models**

It is through attachment relationships that humans develop a sense of self as worthy, lovable, and competent (Bowlby, 1969; Johnson, 2002; Pearlman & Courtois, 2005; Wesselmann & Potter, 2009). Research has demonstrated that individuals with secure attachment have higher self-efficacy (Johnson, 2002). They learn that they can obtain support when needed, increasing their sense of trust in themselves as well as trust in others' availability and willingness to provide that support. Through this learning process that results from a multitude of interactions with others, individuals develop cognitive schemas or internal working models of self and other. These models serve as templates for future relationships, providing expectations and biases that tend to mold



and reinforce old and familiar interactional patterns (Johnson, 2002; Pearlman & Courtois, 2005; Wesselmann & Potter, 2009).

When children grow up to believe that others will be available and responsive, they come to expect such responsiveness in new relationships, which results in an openness as they enter into new relationships. However, when they have learned that others will betray and reject them, they expect this same outcome in future relationships and thus develop strategies for self-protection, which can result in the development of intimacy difficulties within future relationships. According to Johnson (2002), “*Working models are formed, elaborated, maintained, and most important for the couple therapist, changed through emotional communication*” (p. 40, emphasis in original).

### **Attachment Styles and Adult Love Relationships**

In the late 1980s, social psychologists Phil Hazan and Cindy Shaver (1987) at the University of Denver extended Bowlby (1969, 1988) and Ainsworth et al.’s (1978) attachment theory to adult romantic relationships (Johnson, 2002, 2003a, 2008; Johnson et al., 2001; Schachner et al., 2003), creating a categorical measure that has come to be called “attachment style.” Paralleling findings with children, they found that adults described similar needs for emotional closeness with their romantic partners, reassurance and comfort when they were upset, feelings of distress when they felt distant or disconnected from their partners, and increased confidence to explore the world when they felt secure in their relationships (Johnson, 2008; Pearlman & Courtois, 2005). Hazan and Shaver also discovered similar patterns of responding between partners as had Bowlby and Ainsworth between children and their mothers. Therefore, they modeled their categorical system after the patterns described by Ainsworth and her colleagues and

developed the original self-report measure of adult romantic attachment, which has since been the foundation of several others.

They concluded that a secure connection between romantic partners is essential to healthy loving relationships and provides a strong resource for members of such relationships. They also discovered that individuals who are secure in their relationships (a) are better able to seek out and provide support to others; (b) are less reactive when hurt by their partners and less likely to become aggressive when angry with their mates; (c) are empowered by their secure connection to their partners, understand and like themselves more, are more curious and open to new information, and are more flexible and comfortable with ambiguity; and (d) are more autonomous and separate when they are able to reach out to a responsive partner (Johnson, 2002, 2008).

Maine and Hesse (1990) identified three categories of adult attachment corresponding to the same patterns observed by Bowlby (1969, 1988) and Ainsworth et al. (1978) between children and their mothers, which they labeled “secure,” “dismissive,” and “preoccupied,” paralleling the “secure,” “avoidant,” and “resistant”/“ambivalent” attachment categories in children (Wesselmann & Potter, 2009). These categories were specifically in response to individuals’ memories of their early attachment figures and their emotional response to such memories (Wesselmann & Potter, 2009). Shortly thereafter, Bartholomew and Horowitz (1991) developed and empirically validated a four- category model of adult attachment styles, which included the Hazan and Shaver (1987) styles but also included an additional avoidant classification, “dismissing-avoidance,” based on a similar category in the Adult Attachment Interview (Main, Kaplan, & Cassidy, 1985). Thus, their four-style scheme included “secure,”

“preoccupied,” and two avoidant styles, “dismissive” and “fearful,” and was based on the two dimensional space delineated by the continuums of anxiety and avoidance (Johnson et al., 2001; Schachner et al., 2003). These continuums were based upon individuals’ representational models of self and others (e.g., self as worthy, others as responsive), which contribute to their degree of security as well as their manner of relating to others. These authors developed a self-report questionnaire, The Relationships Questionnaire (RQ), and an interview to assess these four styles and the two underlying dimensions (Bartholomew & Horowitz, 1991).

Since that time, research utilizing taxometric techniques has demonstrated that adult attachment patterns are better conceptualized through a dimensional model consisting of two continuous and parallel scales rather than by a taxonomic model in which people are classified into discrete categories (Fraley & Waller, 1998). Previous measures were shown to suffer from psychometric shortcomings by using responses to single items to make such classifications, resulting in problems related to statistical power, measurement precision, and conceptual analyses (Fraley & Waller, 1998; Fraley, Waller, & Brennan, 2000). Thus, since that time, researchers have focused on creating multi-item inventories and have utilized dimensional rather than categorical models to assess individual differences in attachment. In 1998, Brennan, Clark, and Shaver conducted a large-sample factor analysis that included items from all available self-report attachment measures in an attempt to identify the optimal dimensional model for individual differences in adult romantic attachment. Their factor analysis revealed two relatively independent factors that correspond to the Anxiety and Avoidance dimensions. Subjects were clustered into four groups based on their scores on these two dimensions.

They developed a 36-item self-report attachment measure derived from this factor analysis, called the Experiences in Close Relationships Scale (ECR).

The research to date on adult attachment suggests that such dimensions impact how individuals process attachment information, regulate their emotions, and communicate with others, as well as what is accessible to memory (Alexander, 2003; Johnson, 2002; Johnson et al., 2001; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Attachment-related avoidance has been described as the degree to which individuals mistrust relationship partners, attempt to establish behavioral independence and emotional distance from significant others, and resort to deactivating emotion-regulation strategies, such as suppression of attachment needs (Ein-Dor et al., 2010). Attachment-related anxiety is the extent to which persons worry about the unavailability of their partner at times of need and depend on hyperactivating attachment behavior and distress regulation strategies in response to threats (Ein-Dor et al., 2010). In contrast, attachment security involves comfort with closeness and trust in the availability, responsiveness, and supportiveness of one's partner (Ein-Dor et al., 2010). As noted above, each of these dimensions is viewed as a continuum, such that individuals may be high or low on anxiety and high or low on avoidance; thus, a secure individual is low on both measures and an insecure individual is high on one or both dimensions (Brennan et al., 1998).

According to studies about adult romantic relationships and attachment styles, partners who are securely attached have longer, more stable, and more satisfying relationships with high commitment, interdependence, trust, and friendship, and describe relatively selfless style of love without game playing (Makinen & Johnson, 2006;

Schachner et al., 2003). Furthermore, they describe more openness to sexual exploration with a single long-term partner, frequent engagement in physical contact, and mutual initiation of sexual intimacy (Schachner et al., 2003). They are happier and are more likely to seek out and provide support to others, are better able to articulate their needs, and are less likely to become verbally aggressive or to withdraw during problem solving activities (Johnson, 2002).

In contrast, individuals with high anxiety and low avoidance are hypervigilant toward and preoccupied with their partners, describe low relationship satisfaction, and have higher relationship dissolution rates (Schachner et al., 2003). They tend to worry about abandonment and are more jealous than their secure counterparts (Johnson, 2002). Similarly, those high in attachment avoidance also report low relationship satisfaction and high breakup rates, but in contrast to those with high anxiety, they also experience low levels of intimacy (Schachner et al., 2003). They tend to be distrustful of their partners and are distant, resisting any dependence on their partner and withdrawing when their partners are most vulnerable and in need of support (Johnson, 2002). Finally, individuals who are high on both the avoidance and the anxiety dimensions tend to demonstrate similar emotional vulnerability and preoccupation as anxious partners while behaviorally exhibiting more avoidance, tending to withdraw from closeness. Research has demonstrated that this fearful avoidant style is related to parental alcoholism and abuse (Pearlman & Courtois, 2005; Schachner et al., 2003).

There has been controversy regarding the stability and nature of attachment patterns from infancy to adulthood (Fraley, 2002; Fraley, Vicary, Brumbaugh, & Roisman, 2011; Hazan & Shaver, 1987; Steele, Waters, Crowell, & Treboux, 1998).

Though there is considerable agreement about the influence of early caregiver experiences on adult relationships, researchers disagree about the source and degree of this connection (Fraley, 2002; Fraley et al., 2011; Hazan & Shaver, 1987; Steele et al., 1998). Most research has been cross-sectional or retrospective in nature, thereby limiting the confidence with which inferences that can be made across time. For example, Fraley (2002) demonstrated a modest correlation between the amount of security individuals reported toward their mothers and that toward their romantic partner (ranging between .20 and .50).

In a retrospective study, Hazan and Shaver (1987) found that adults who were securely attached with their romantic partner had more positive childhood recollections of their parental relationships, tending to describe their parents as affectionate, caring, and accepting. One unpublished longitudinal study examined the relation between security at one-year of age in the strange situation to the security within adult romantic relationships for the same individuals 20 years later, and found a correlation of .17 (Steele et al., 1998). Overall, research suggests at most, a moderate relation between attachment styles from childhood and those in adult romantic relationships, but one that is fairly stable.

Fraley and his colleagues (2011) examined two models of continuity and change within two longitudinal studies in an attempt to understand the mechanisms underlying the stability of adult attachment over time. Their analyses provided support for a prototype model, suggesting that individual differences in attachment are partly determined by specific information processing and behavioral strategies that develop in childhood and serve as a means of adapting to that early environment. This model

proposes that these mechanisms remain fairly stable over time, such that representational models of self and others developed in the first few years of life are preserved and play a role in future attachment relationships.

Research demonstrates that in nonclinical populations, approximately 60% exhibit secure attachment, 25% are classified as dismissive, 10% as preoccupied, and 5% are considered disorganized (Wesselmann & Potter, 2009). This research into adult romantic relationships is consistent with research by Gottman (1994) about relationship distress as well as research into the impact of close relationships on psychological and physical health (Johnson, 2003a). Attachment insecurity creates difficulties in partners' ability to emotionally engage with and respond to their significant other, and contributes to their tendency to become absorbed in negative affect and engage in constricted interactions such as criticism, defensiveness, and withdrawal, all of which are predictive of divorce (Gottman, 1994; Johnson et al., 2001; Pearlman & Courtois, 2005).

Relationship distress is characterized by ineffective communication, such that partners struggle with directly expressing their attachment needs and primary emotions. Relationship distress also involves reciprocal negative interactions, where couples become stuck in dysfunctional cycles as they are unable to understand and address the underlying issues. Such cycles often include pursuing, criticizing, and attacking in one partner and defending, withdrawing, and distancing in the other. At times, both members might engage in a combination of these behaviors.

Distressed relationships also are characterized by negative relationship schemas, where partners expect disappointment and rejection or criticism, and therefore put up defenses to protect themselves. If members of a couple have insecure attachment styles

related to their family of origin, they may enter into the relationship anticipating that their partner will be emotionally unresponsive or unavailable and believing that they are undeserving or unworthy of love and support, thus filtering their partner's behavior through this schema (Johnson et al., 2001; Pearlman & Courtois, 2005). Thus, present-day interactions trigger old unresolved wounds from childhood, reinforcing the internal working models of self and other developed within their primary attachment relationships (Briere & Scott, 2006; Pearlman & Courtois, 2005).

Such strong emotional reactions to apparently minor situations are often confusing and frustrating for partners, making emotional engagement and intimacy even more difficult to attain. When both partners are insecurely attached, difficulties are compounded. In fact, individuals who have histories of trauma often develop relationships with others with unresolved trauma, whose relational deficits and style complements their own, thus reenacting previous attachment relationships (Pearlman & Courtois, 2005). On the other hand, secure partners may serve as a buffer against the negative impact of their partner's insecurity, providing an opportunity for a secure base to develop and thereby increasing the security of both members, with the potential to modify the insecure partner's relationship schema (Schachner et al., 2003).

Bowlby (1969, 1973, 1980) noted that angry expressions in close relationships can be viewed as attempts to engage an inaccessible attachment figure (Johnson, 2002, 2003b). When this occurs in secure relationships, this protest is healthy, but when it occurs in insecure relationships, it may transform into desperate and coercive anger (Johnson, 2003b). As noted above, the two primary strategies to cope with unresponsive attachment figures are to increase and escalate one's attempts at connection through



behaviors such as anxious clinging and desperate protests or through detached avoidance (Johnson, 2002, 2003b). These strategies can become habitual and self-reinforcing forms of interpersonal interactions in future relationships, based on the developed internal working models of self and others from childhood.

Research has consistently demonstrated that supportive and loving connections with others buffer against the impact of stress and increase one's ability to cope with trauma (Briere & Scott, 2006; Herman, 1997; Johnson, 2002, 2008; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). For example, Mikulincer et al. (1993) found that securely attached Israeli couples demonstrated lower levels of anxiety and fewer physical repercussions after Scud missile attacks than less securely attached couples. Given the enduring impact of childhood attachment experiences, the establishment of security among romantic partners and the defining of their relationship as a safe haven and secure base is often one of the most difficult challenges for couples, and one that brings many into couples therapy (Johnson, 2003a). The essential component is to increase partners' availability to one another in order to provide for a corrective emotional experience for members of the couple and establish a sense of security in the current attachment relationship (Johnson, 2002, 2003a, 2008; Teyber & McClure, 2011).

### **Impact of Disrupted Attachment**

**Physiological effects.** The physiological response to sexual abuse and that experienced by individuals with disorganized attachment parallel one another in that both involve higher concentrations of the stress hormone, cortisol, as well as dysregulation of the hypothalamic-pituitary-adrenocortical axis, contributing to difficulties in regulating

affect (Alexander, 2003). Thus, individuals with disrupted attachment are less able to regulate their affect effectively. Patterned and repetitive stimulation is necessary in order to create the neural networks that connect pleasure to interpersonal interactions (Briere & Scott, 2006; Perry & Szalavitz, 2006). Without this connection, human contact does not provide the comfort and soothing necessary to regulate one's emotions when distressed. Therefore, not only are those with insecure attachment less able to effectively regulate their own emotions, but they are also less able to be soothed through current relationships (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012).

**Mental health.** Researchers now recognize that attachment needs are so powerful that isolation and loss are inherently traumatizing in and of themselves. Just as secure attachment increases one's resilience in the face of trauma and provides the context within which healing can occur, without such secure attachment, one's coping is severely impacted, increasing one's vulnerability and exacerbating the impact of stressful events. When children's attempts to maintain an emotional connection to their attachment figure fail, depression, despair, and detachment result (Herman, 1997; Johnson, 2002, 2003b; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Therefore, attachment theory has been described as a theory of trauma (Johnson, 2002), which helps to explain the powerful impact that future rejection or abandonment can have on an individual with insecure attachment. Particularly in survivors of chronic abuse who develop complex PTSD, such traumatic histories often result in an inability to regulate one's emotions and to self-soothe (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Researchers have described unresolved/disorganized attachment in similar ways to PTSD in that traumatic memories remain unintegrated into one's narrative and therefore no coherent

sense of self exists and one's memories and experiences are disjointed (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012; Wesselmann & Potter, 2009).

Children who are abused develop strategies that serve the primary purpose of preserving their attachment bond to their parents, in spite of severe maltreatment or neglect. Furthermore, they often develop one or more psychological defenses. For example, the extent of the abuse is suppressed or disconnected from conscious awareness, or it is rationalized or minimized in order to deny the reality that they were abused. When children are unable to control their external environment, they often find ways to alter their psychological realities in order to cope with the trauma (Briere & Scott, 2006; Herman, 1997; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012).

Attachment insecurity and disorganization is significantly higher in individuals seeking mental health treatment (Wesselmann & Potter, 2009). This is true both in adolescence and adulthood. For example, research has demonstrated that teen suicidal ideation is strongly correlated with a disorganized attachment status and that disorganized attachment in infancy is strongly correlated with dissociative symptoms during adolescent years. Furthermore, anxious/resistant attachment in infancy has been found to be linked with anxiety disorders during adolescence. Dozier, Stovall, and Albus (1999) noted that across psychiatric disorders, most individuals within clinical populations have insecure or disorganized attachment (Wesselmann & Potter, 2009). Research has also shown that survivors of childhood sexual abuse, who are more likely to develop complex PTSD, have a higher prevalence of fearful-avoidant attachment style (Johnson, 2002).

When individuals experience chronic childhood abuse, they are burdened with the effects of traumatic exposure as well as a history of chaotic and unavailable attachment

figures. The feelings of shame and unworthiness are common among both trauma survivors and those with unresolved or fearful attachment. When individuals feel unworthy of love and support, they are less likely to express their needs, reach out for support, or accept comfort when it is provided, thus reinforcing such feelings and contributing to further relationship conflict (Alexander, 2003; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012).

**Relationships.** Research has shown that disrupted attachment relationships during the first three years of life have an enduring impact on individuals' ability to relate behaviorally and emotionally with others (Briere & Scott, 2006; Pearlman & Courtois, 2005; Perry & Szalavitz, 2006; Tummala-Narra et al., 2012). As noted above, patterned, repetitive stimulation is essential to build the neural networks that connect pleasure to interpersonal interactions (Briere & Scott, 2006; Perry & Szalavitz, 2006). Without this connection, human contact does not provide the comfort and soothing necessary to regulate one's emotions when distressed. Furthermore, early attachment wounds taint every future relationship by interfering with one's ability to be vulnerable to current partners due to the expectation of further hurt. Those who have been hurt by attachment figures are more likely to protect themselves by not expecting support and by not allowing themselves to become vulnerable. Collins and Feeney (2000) found that individuals with avoidant attachment styles demonstrate ineffective support seeking while those with anxious attachment demonstrate poor caregiving (Schachner et al., 2003).

Securely attached individuals are better able to recognize and communicate their distress with their partner in a congruent manner that tends to elicit responsiveness in

their partner. They are more confident and able to integrate new information and remain cognitively flexible, even at times of stress and with ambiguous stimuli (Johnson, 2003a). In contrast, those who are insecurely attached are more rigid and inflexible cognitive and interaction styles, seeking confirming evidence and hanging onto pre-existing cognitive schemas, even with disconfirming information (Johnson, 2003a).

Just as separation or disconnection from a parent can be traumatizing for a child, distressed partners who feel isolated or emotionally disconnected from their spouse can respond as though their very life is being threatened. Furthermore, the more distressed and hopeless the relationship, the more rigid and cyclical the dynamics and emotional reactivity becomes, where each partner reinforces the other's automatic and defensive responses (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Though Bowlby (1988) highlights that individuals' attachment behavior is functional in that it involves attempts to engage one's attachment figure, they become problematic when they are ineffective and are globally and rigidly adhered to, without the ability to integrate new information (Johnson, 2003a; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Adult attachment behaviors are predictable and finite in number, just as is the case for children. Often one partner engages in an attempt to pursue closeness with a partner in an angry and critical manner, while the other tries to placate or withdraw from the partner to avoid criticism or conflict. Such rigid and reactive behaviors become mutually reinforcing and self-perpetuating (Johnson, 2003a; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012).

As noted above, children are more likely to blame themselves for abuse at the hands of a parent than to acknowledge to themselves that their parents were at fault, as

this would result in weakening the attachment bond. Thus, their negative internal working model of self is likely to impact their later capacity to develop and maintain meaningful connections with others. For example, such individuals may unwittingly seek out conflictual or chaotic relationships that parallel their early relationships or to sabotage meaningful connections (Briere & Scott, 2006; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Furthermore, empathy is developed through the feedback received during early childhood. If children learn that they do not matter to their caregivers or that their behavior is meaningless, they may not develop the empathy necessary to engage in rewarding and mutually satisfying relationships.

When adults have experienced trauma and suffer from posttraumatic stress, the lack of security they experience in their present romantic relationship can also exacerbate the trauma-related stress, inhibiting their ability to soothe themselves or receive comfort from their partner (Johnson, 2003a). Adults with relationship distress describe feelings of loss, aloneness, and helplessness (Johnson, 2003a). Because humans define themselves in relation to others, when one does not experience secure attachments with others, one lacks a clear sense of self or that sense of self can become tainted as unworthy or unlovable (Johnson, 2002, 2003a; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Such a perspective becomes the internal working model of self, which will inevitably influence one's future relationships and behavior within those relationships. They influence individuals selectively interpret and process information and, in the process, confirm their existing cognitive schema.

Mikulincer (1995) has noted that individuals who describe themselves as securely attached to their partners have a more complex, coherent, and positive view of

themselves and better communicate that sense of self, in contrast to those who are insecurely attached (Johnson, 2003a). Similarly, one's sense of safety in the world is developed in the earliest attachment relationships and is maintained over time, unless it is severely disrupted by a traumatic incident. This basic trust that is acquired in one's first relationships requires the stability and responsiveness of an attachment figure. Without that consistent availability, the world is unpredictable and chaotic (Herman, 1997; Johnson, 2002; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012).

Furthermore, individual differences in attachment appear to play a role in exacerbating or attenuating PTSD symptoms in both traumatized individuals and their spouses (Ein-Dor et al., 2010). Ein-Dor and colleagues (2010) examined the role of ex-POWs and their wives' attachment insecurities in the long-term repercussions of war captivity, and found associations among attachment-related dyadic processes, posttraumatic stress disorder in war veterans, and secondary traumatic stress (STS) in their wives. Specifically, they noted that anxious attachment is implicated in both PTSD and STS. Though intimate relationships appear to be highly influenced by one's early attachment experiences, adult intimate relationships can also provide a corrective experience and thereby attenuate the impact of such early experience. For example, the impact of early attachment disruptions on current levels of depression has been found to be moderated by one's current primary attachment relationship. As noted in an earlier section, trauma survivors have better outcomes when they have a strong social network and healing relationships that can buffer against the impact of the trauma.

## **Treatment for Attachment Disruptions**

Attachment theory suggests that attachment disruptions can only be resolved within primary attachment relationships (Briere & Scott, 2006; Johnson, 2002). This means that adults need not remain hostage to their childhood trauma forever, but rather, they may build a secure base and a safe haven in their current romantic relationship, if their partner can understand the underlying needs and remain emotionally engaged and responsive (Johnson, 2002, 2003a, 2008). One's spouse becomes the primary attachment figure for most adults and either will reinforce old cognitive schemas or provide security and comfort in a way that was never experienced in childhood.

However, it is the therapist's job to directly address that need for comfort and to facilitate the enhancement of safe emotional engagement and responsiveness within the couple. Without this, communication skills and increased awareness will not be sufficient to change interactional patterns (Johnson, 2003a). This is consistent with Gottman's (1994) findings that soothing and supportive responses from one's partner are essential for safe emotional engagement and a sense of emotional intimacy, emotionally responsive behavior that is cultivated through emotionally focused couples therapy (EFT; Johnson, 2002, 2003a, 2004). The process of EFT (Johnson & Greenberg, 1995), which will be described below, has been shown to increase the security of distressed partners' bond with their mate and improve their problem solving. This is consistent with evidence that suggests that secure individuals are more open to new evidence and better cope with ambiguity (Johnson, 2003a).

The majority of individuals diagnosed with borderline personality disorder, most of whom are survivors of childhood sexual abuse, have been found to stabilize later in



life when they engage in positive attachment relationships with a supportive partner (Johnson, 2002). In order to cope with the stress and challenges of life, we must be able to modify and revise our internal working models so they are accurate and congruent with incoming information. This necessitates a secure connection with another to increase one's ability to accurately interpret new information and risk modify existing schema (Herman, 1997; Johnson, 2002).

In working with clients with rigid and distorted internal working models, it is important that therapists communicate the adaptive role those schemas once served, even if they are no longer adaptive. Just as trauma survivors may have learned to dissociate and numb themselves to cope with chronic abuse, people who lacked consistent attachment figures may have learned to protect themselves from the pain of abandonment and rejection by avoiding closeness (Johnson, 2002, 2003a). Attachment styles can change over time, particularly when they experience consistent emotional engagement and comfort that disconfirms their earlier experience and resulting schema (Johnson, 2002).

Briere and Scott (2006) emphasize the importance of "counterconditioning" in the healing of attachment wounds and relational trauma, which they describe as the simultaneous presence of both (a) activated trauma-related distressing memories and (b) the comfort and connection produced by the supportive therapeutic environment. They propose that such counterconditioning can provide a corrective emotional experience, which can increase one's ability to modify existing cognitive schemas.

Levy et al. (2006) measured changes in attachment organization before and after therapeutic intervention and found that those who were treated with transference-focused

psychotherapy demonstrated a significant increase in attachment security, whereas it did not increase for those in dialectical behavior therapy or a modified psychodynamic supportive therapy treatment. However, resolution of loss and trauma was not impacted in any treatment modality (Wesselmann & Potter, 2009). In another study, it was found that survivors of childhood abuse who were treated with prolonged exposure lost their unresolved attachment status at a higher rate than those who received skills training (Wesselmann & Potter, 2009). Therefore, even though attachment status is generally stable over time, there is evidence that treatment and positive attachment relationships in adulthood can lead to increased attachment security.

### **Couples Therapy**

In this section, the topic of couples therapy is reviewed including its history as a field, emotionally focused couples therapy as a specific treatment approach, and the use of couples therapy for trauma and attachment injuries.

#### **History**

According to Litt (2009), the focus of couples therapy in the 1930s was on providing psychoeducation to support couples to move through normal developmental and normative transitional issues that were common at various life cycle stages. However, it was uncommon for couples to be seen conjointly during therapy sessions and not until the 1970s was conjoint couples therapy the primary modality for the treatment of marital distress (Litt, 2009). In the 1960s, family therapy emerged as a new discipline and became the overarching modality that subsumed couples/marital therapy, with a systemic focus that explored the reciprocal interactions between individual and relational issues (Litt, 2009).

While the psychoanalysts focused on intrapersonal issues, at times to the exclusion of interpersonal issues, the pendulum swung to the other side for family systems clinicians, who focused primarily on interpersonal dynamics, de-emphasizing intrapersonal issues (Litt, 2009). Presently, the pendulum appears to be closer to the middle, with an integrative trend in couples and family therapy toward a balance of intra- and interpersonal dynamics. Presently, systemic approaches incorporate assessment and treatment of both types of functioning and may include a combination of both individual and conjoint approaches to treatment (Litt, 2009).

### **Emotionally Focused Couples Therapy**

**Definition and rationale.** Emotionally focused couples therapy (EFT) is a brief systematic treatment approach developed in the 1980s by Susan Johnson and Les Greenberg, whose aim is to modify distressed couples' patterns of interaction and expand members' emotional responses in order to develop and strengthen the attachment bond between partners (Johnson et al., 1999). It is based on an attachment perspective that views trusting self-disclosure and emotional responsiveness and engagement as necessary for secure bonding and intimacy within the relationship (Johnson, 2002). Emotionally focused couples therapy (EFT) involves identifying and delineating problematic interactional cycles and emotional responses, and facilitating communication of needs and emotions while simultaneously fostering the partner's increased empathy and responsiveness, in order to create an environment in which each can serve as a safe haven and secure base for the other (Johnson et al., 2001; Schachner et al., 2003).

Individuals with secure attachment tend to disclose more and are more emotionally responsive toward their partner's disclosures (Johnson, 2002). On the other

hand, those with avoidant attachment are less willing to self-disclose and are often unresponsive to their partner's disclosures. Similarly, individuals who are anxious and preoccupied in their attachment style have difficulty being appropriately responsive to their partner's disclosures, perhaps related to their difficulty with empathy due to their own strong attachment needs. They tend to over disclose, having difficulty regulating the amount or intensity of disclosure, tending to be compulsive in their sharing and oblivious to their partner's needs (Johnson, 2002).

Negative cycles involving blaming/pursuing and withdrawing/distancing tend to interfere with couples' attachment bond; such interactional patterns commonly bring couples into treatment (Johnson, 2002). Ironically, those very behaviors tend to be attempts to initiate and maintain contact, but are done ineffectively and interpreted as hostility or abandonment, thereby triggering the partner's attachment insecurities, and thus reinforcing the dysfunctional cycle. Emotionally focused couples therapy posits that negative absorbing emotional states and rigid interactional patterns are mutually reinforcing, triggering and maintaining one another in distressed couples (Johnson, 2002).

Emotionally focused couples therapy is an integrative and experiential approach that combines the intrapsychic perspective from psychodynamic therapy with a systemic orientation into a change process composed of nine steps (Johnson et al., 1999). It is based on the premise that changing emotional responses between partners to softer and more responsive engagement will allow for shifts to take place in interactive patterns such that bonding is strengthened and more emotional contact occurs within the new

interactional processes, thus providing a positive self-reinforcing cycle (Johnson et al., 1999).

Emotionally focused couples therapy therapists focus on partners' attachment needs and fears, and highlight the importance of promoting experiences of emotional engagement and connection. They are attuned to the destructive and lasting impact of moments in which partners lack that connection and when one partner felt ignored, abandoned, or criticized during moments when attachment needs are high. Their goal is to help partners become more aware of their own attachment-related needs and emotions, and modify their interactions in order to increase emotional contact and thereby strengthen their bond (Johnson, 2002).

Emotion is viewed as key to redefining intimate relationships and EFT posits that partners require corrective emotional experiences and interactions in order for lasting change to occur (Johnson, 2002; Teyber & McClure, 2011). The primary interventions used by an EFT counselor are (a) reflecting emotional experience; (b) validating; (c) evocative responding; (d) heightening; (e) empathic conjecture or interpreting; (f) tracking, reflecting, and replaying interactions; (g) reframing in the context of the cycle and attachment processes; and (h) restructuring and shaping interactions (Johnson, 2003a).

**Emotionally focused couples therapy empirical support.** The specific targets for EFT have been identified through empirical research (Gottman, 1994) as the primary factors differentiating maritally distressed from non-distressed partners. For example, EFT targets “absorbing states of negative affect” (Johnson et al., 1999, p. 68), which are emotions such as anger and fear that tend to be enduring and can be toxic to healthy

functioning. Emotionally focused couples therapy also intervenes in the interactional patterns that tend to be self-reinforcing and difficult to extinguish such as blame/pursuit and withdrawal/distance (Johnson, 2002; Johnson et al., 1999). Gottman (1994) emphasized the role of negative affect as well as negative cycles of interaction such as criticism, stonewalling, defensiveness, and complaining as predictors of relationship dissatisfaction and divorce (Johnson, 2002). Gottman has demonstrated through his research on marital distress that the ability for partners to sustain emotional engagement and to be emotionally responsive to one another is essential to reconnecting after conflict and to creating satisfying relationships. This capacity allows members to soothe one another and strengthen their attachment connection (Johnson, 2002).

Emotionally focused couples therapy has been shown to be one of the most effective treatments for reducing marital distress and to promote continued improvement even after the termination of treatment (Johnson et al., 1999; Schachner et al., 2003). In fact, EFT appears to have a higher success rate than other approaches with empirical support and lower rates of relapse (Johnson et al., 1999, 2001). Research has demonstrated a very large effect size of 1.3, and studies have shown that between 70 and 75% of couples report that they are no longer distressed after 10 to 12 sessions, with 90% rating themselves as “significantly improved” (Johnson, 2003a, 2008; Makinen & Johnson, 2006).

Research supports the premise that the expression of underlying needs and feelings as well as modifications of interaction patterns promotes increased emotional accessibility and responsiveness (Johnson et al., 2001). Johnson and Greenberg (1988) describe “softenings” as bonding events during which an angry, blaming partner reaches

out for and receives emotional responsiveness and availability from the other. Research on EFT has demonstrated that such interactions are correlated with decreases in marital distress (Schachner et al., 2003). As with other treatment approaches, the therapeutic alliance is a strong predictor of success, though interestingly with EFT, it is a stronger predictor than the initial level of marital distress (Johnson et al., 2001). The American Psychological Association has deemed EFT an empirically supported treatment for marital discord (Chambless & Ollendick, 2001; Johnson, 2008).

### **Trauma**

Though individual therapy is the most often used modality to treat issues such as depression, anxiety, substance use, and eating disorders, couples therapy has been incorporated as an adjunct to individual therapy in recent years and has also been utilized as the primarily modality (Johnson, 2002). Research has demonstrated a significant increase in the success rate for clients when the spouses were included in treatment for anxiety, from 46 % to 82% (Barlow, O'Brien, & Last, 1984; Cerney, Barlow, Craske, & Himadi, 1987). Bowling (2002) found that female survivors of sexual assault in couples therapy experienced more reduction in depressive symptoms than those in individual treatment, while both treatment modality groups had comparable decreases in PTSD symptoms.

This recognition of the value of couples therapy reflects the growing awareness of the importance of relationships in coping and recovery from stressful events. Couples therapy can provide a context in which healing from trauma can occur and traumatized partners can re-establish a safe haven and secure base in their significant other (Johnson, 2002). Given the effects of traumatic exposure on one's interpersonal relationships that

were noted in a previous section, particularly those that involve “violations of human connection” (Herman, 1997), the use of an interpersonal approach to healing seems particularly appropriate. Johnson notes that for such clients, even more powerful than the corrective emotional relationship with the therapist is that opportunity within the relationship with the client’s intimate partner.

As was noted above, there is significant evidence regarding the impact of close relationships on both physical and mental health, and with one’s ability to cope with stress; similarly, when one lacks social support, one is at increased risk for mental health issues (Johnson, 2002). Though research has demonstrated the effectiveness of exposure-based therapies for re-experiencing symptoms, the numbing and detachment symptoms that are particularly impactful of interpersonal relationships tend to respond less well to individual therapies (Herman, 1997; Johnson, 2002). Johnson (2002) argues that “symptoms such as numbing and hyperawareness may be best addressed by the comfort and reassurance offered by a significant other” (p. 8). Recently, couples therapy has begun to be examined systematically as a treatment for the effects of trauma (Johnson, 2002).

It is the trauma survivor’s primary attachment relationship that has the capacity to serve as a safe haven during the healing process. As Johnson (2002) states, “*The therapist’s goal must be not just to lessen the distress in a survivor’s relationship, but to create the secure attachment that promotes active and optimal adaptation to a world that contains danger and terror, but is not necessarily defined by it*”(p. 10, emphasis in original). Gottman (1994) notes that the negative interactions of pursue-withdraw and criticize-defend significantly increase couples’ risk of separation. Such behaviors are



familiar to trauma survivors, as their trust in the safety of the world and their own self-worth is severely impacted. Even previously secure relationships can experience significant distress when one or both members of the couple experience a trauma.

As highlighted above, when a trauma involves interpersonal violence or violation, it often calls into question all relationships and the safety of every person in one's life (Herman, 1997; Johnson, 2002). For those who have suffered early childhood abuse or neglect, such trauma may interfere with the attachment security necessary as a foundation for the establishment of future intimate relationships. Thus, trauma and attachment security go hand in hand, and are mutually reinforcing, where partners may repeatedly engage in rigid interactional patterns that can exacerbate the effect of the trauma (Johnson, 2002).

Furthermore, vicarious trauma for the partner may further complicate the dynamics within the relationship and interfere with the healing of both partners and the reestablishment of security. As with children who experience abuse at the hands of a parent, the source of danger and comfort are one and the same, creating a continual paradoxical state of confusion and distrust. This experience parallels that of the fearful avoidant attachment or disorganized attachment styles described earlier, where the individual longs for closeness and comfort but is fearful and avoidant of it when it is offered due to the distrust of others and the negative view of self that often result from traumatic exposure (Johnson, 2002).

Johnson (2002) notes that such attachment insecurity negatively impacts affect regulation, information processing, and communication within the relationship. Despite the difficulty inherent in modifying the attachment style of individuals with fearful-

avoidant styles and the accompanying mental health sequelae, Johnson and her colleagues have had success in doing so through emotionally focused couples therapy, fostering changes in their internal working models of self (Johnson, 2002). Johnson has also argued that even one secure attachment relationship can be protective from the effects of trauma and reduce the fragmentation that can result from traumatic exposure, highlighting the importance of human connection in maintaining one's sense of self. Thus, one's partner can provide a stable source of feedback to protect one's sense of self and self-worth, potentially preventing the development of further mental health issues at a time when it may be particularly difficult to trust one's own perceptions.

Avoidance and numbing are common mechanisms of self-protection from traumatic reminders; such methods of coping can be particularly harmful to a relationship as it prevents emotional engagement and thus prevents the establishment of a secure attachment bond with one's partner (Johnson, 2002). Given that the focus of EFT is the creation of a secure attachment bond, trauma survivors must process the traumatic experience in order to have the capacity to establish a sense of safety and security (Herman, 1997; Johnson, 2002). Just as safety and stability must be established through a therapeutic alliance in individual therapy before clients are ready to process through the trauma narrative, such safety and security must be developed within the relationship and within the couples therapy context.

As was described in a section above, PTSD has significant effects on intimate relationships. For example, Kessler (2000) found that combat veterans experience higher rates of marital instability. Similarly, Jordan and colleagues (1992) discovered that Vietnam veterans with PTSD had marriages twice as likely to end in divorce and they

were three times more likely to have more than one divorce (Jordan et al., 1992). Cook, Riggs, Thompson, Coyne, and Sheikh (2004) found that former prisoners of war from World War II with PTSD experienced chronic problems such as poorer relationship adjustment and communication with significant others, and higher levels of difficulties with intimacy than those without PTSD.

Research has demonstrated that emotional intimacy is negatively impacted for veterans with posttraumatic stress disorder (PTSD), perhaps due to emotional numbing, difficulty expressing caring, lower levels of self-disclosure and emotional expressiveness, sexual disinterest, impaired interpersonal problem-solving skills, and the emotional connection with loss and survivor guilt, all of which are increased for this population (Johnson, 2002). Furthermore, partners of those with PTSD also report lower levels of relationship satisfaction. For example, Jordan et al. (1992) discovered that female partners of patients with PTSD were more likely to be unhappy with the relationship and to report relationship distress. Calhoun, Beckham, and Bosworth (2002) similarly found that the partners of veterans with PTSD reported lower satisfaction, increased caregiver burden, and poorer psychological adjustment than did the significant others of veterans without PTSD.

Given the relational impact of traumatic exposure as well as the power of relationships in the healing process, one's intimate relationship seems to be an appropriate context in which to address traumatic events. Addressing traumatic exposure in conjoint couples therapy may serve the functions of attending to posttraumatic symptoms, increasing the intimacy and security of the relationship, and addressing relationship dynamics that were created as a result of the PTSD. For example, Johnson

(2002) describes how a veteran with PTSD might become the focus of the couple and larger family dynamic, such that the partner's needs are ignored. In such a family system, couples therapy might seek to explore ways in which both partners' needs can be met.

**Attachment injuries.** Emotionally focused couples therapy (EFT) views relationship distress as a sign of attachment insecurity, and behaviors such as criticism and blame as attempts to re-establish contact by a partner who is feeling alone and insecure. At such times, emotional engagement becomes a high priority and when one partner is very distressed and the other is perceived as emotionally unavailable or critical, such response is perceived as a traumatic event that may further reinforce prior attachment insecurity (Johnson, 2002, 2003a). Such disruptions to attachment have been described as examples of small "t" traumas and some injured partners may, in fact, exhibit symptoms that parallel posttraumatic stress disorder, such as vacillation between hypo- and hyperarousal; furthermore, the relationship becomes redefined as a source of threat (Johnson, 2002; Makinen & Johnson, 2006). As with other types of trauma, attachment injuries shatter one's assumptions about the self, relationships, and the world (Johnson, 2002, 2008).

An attachment injury is a wound that occurs when one partner fails to meet the other partner's expectation that comfort and caring will be provided during times of danger or distress (Johnson et al., 2001; Schachner et al., 2003). This injury becomes a recurring theme within the relationship that tends to interfere with partners' ability to create emotional connection and to repair their relationship. In fact, it may result in severe marital distress and lead to rigid interactional patterns such as attack-defend or pursue-distance (Makinen & Johnson, 2006). Attachment injuries are "characterized by

an abandonment or betrayal of trust during a critical moment of need” (Johnson et al., 2001, p. 145). Attachment theorists have observed that such incidents seem to disproportionately impact the attachment relationship in that they become the template or benchmark upon which one partner determines the availability of the other (Johnson, 2002, 2003a).

This concept of attachment injury is based on observations of impasses in couples therapy where relationships improved but remained distressed (Johnson et al., 2001). Greenberg and Johnson (1988) observed during these sessions that when the more withdrawn partner became more emotionally available and the more blaming partner began to take risks through self-disclosure, “an emotionally laden incident, often first described in the beginning of therapy, would become the focus of the session” (Johnson et al., 2001, p. 146). They noted that such events would be replete with intense emotion, seeming to parallel a traumatic flashback and overwhelming the injured partner; often the wounded partner described having emotionally shut down and withdrawn from the relationship at the time of this injury.

Furthermore, the other partner would often be oblivious to the impact of his or her behavior and had not recognized the meaning of the event to the other (Johnson, 2003a; Johnson et al., 2001). Moreover, they observed that injured partners would use terminology that highlighted the traumatic meaning behind the incident, such as isolation and abandonment (Johnson, 2002). Johnson and her colleagues (2001) note that just as with big “T” trauma, the content of the event is less important than the interpretation of the event. As such, what one couple might experience as an impasse might not result in an attachment injury in another couple. For example, infidelity might result in an

attachment injury for one couple, but not for another, or an incident as apparently minor as a partner asking for help might result in an attachment injury for a partner who experienced significant neglect as a child and rarely risks rejection or abandonment by asking for support. The latter may result in confirmation that self-reliance is the only safe strategy and this partner may never again risk asking for help, even though the partner may be completely unaware that his or her behavior had such an impact.

### **Eye Movement Desensitization and Reprocessing**

In this section, the literature related to eye movement desensitization and reprocessing (EMDR) is reviewed including its historical development, the definition and protocol of EMDR, and the adaptive information processing model that guides it. Research related to the role eye movements, empirical support for EMDR's effectiveness, and cautions and contraindications for its use will also be outlined. Finally, this section discusses the application of EMDR to address attachment issues and concludes with a discussion of the incorporation of EMDR in conjoint couples therapy.

#### **History**

In 1987, psychologist Francine Shapiro stumbled upon the apparent healing effects of bilateral stimulation while walking around a lake and watching birds, thus moving her eyes from side to side. Shapiro (1989) began to study this effect systematically and two years later, she published her first research paper on EMDR. Since then, it has gained wide acceptance as an efficacious treatment for posttraumatic stress disorder and support has been offered for its usefulness with many other clinical disorders (Capps, 2006; Shapiro, 2001).

Eye movement desensitization and reprocessing initially received conflicting reactions from therapists and scientists, as it proposed a new way of treating trauma and appeared to be presented as a “one-session cure for PTSD” (Schubert & Lee, 2009, p. 120). Since that time, Shapiro (2001) clarified its eight phase protocol and three pronged approach to treating traumatic reactions. Unfortunately, some of the early studies examining its effectiveness included poor methodological designs, which further contributed to skepticism about its value as a treatment for PTSD (Rothbaum & Foa, 2007). However, over the past 20 years, many controlled studies and meta-analyses have been conducted and have demonstrated its efficacy, resulting in a changing perspective about its usefulness.

### **Definition and Protocol**

Eye movement desensitization and reprocessing (EMDR) is an eight phase approach guided by an adaptive information processing model that views pathology as the product of information that has been maladaptively stored (Shapiro, 2001). It follows a three-pronged approach in which past trauma (including small “t” trauma such as attachment injuries and big “T” trauma such as sexual or physical abuse), current triggers, and future events are targeted for reprocessing, thereby providing resolution and liberation from the uncomfortable “charge” that often accompanies such memories. During EMDR, a traumatic memory and associated cognitions, emotions, and somatic distress are identified by the client and then he engages in bilateral stimulation (BLS) while experiencing various aspects of the memory. The clinician stops the bilateral stimulation at regular intervals to ensure that the client is processing adequately. The client processes information about the negative experience, bringing it to an adaptive

resolution. It is a comprehensive approach that involves the following eight phases, which will be described below: (a) client history and treatment planning, (b) client preparation, (c) assessment, (d) desensitization, (e) installation, (f) body scan, (g) closure, and (h) re-evaluation.

The first phase of this treatment involves gathering information about clients' history, assessing whether they are a good candidate for EMDR, and determining the targets for reprocessing. During the second phase, the therapeutic alliance is further developed and psychoeducation about EMDR is provided to clients. Depending on clients' readiness for EMDR and their emotion regulation skills, containment strategies and resource building may be developed in preparation for EMDR. Phase three includes identifying the initial target for EMDR and exploration of that target to determine the most disturbing image related to the traumatic event and articulate the negative cognition about themselves (e.g., "I am permanently damaged"), as well as the emotions and physical sensations associated with the traumatic memory. Clients also identify the positive belief about themselves that they would prefer to have when thinking about the memory (e.g., "I am OK as I am; I did the best I could"). Clients rate the disturbance level on a scale of 0 to 10 (Subjective Units of Distress; SUDs) experienced when reflecting on the negative belief, the most disturbing image associated with the memory, and the emerging emotions and physical sensations. They also rate the degree to which they believe the positive belief about themselves while thinking about the upsetting memory on a scale of 1 to 7 (Validity of Cognition; VoC), where 1 is "not at all true" and 7 is "completely true." These SUDs and VoC scores are the baseline measures and are reassessed intermittently throughout reprocessing.



During the fourth phase, desensitization, clients process the disturbing experience and the accompanying stimuli by holding the image in mind with the associated negative belief, emotions, and body sensations and engaging in bilateral stimulation. Bilateral stimulation may include following the therapist's fingers back and forth, listening to alternating tones in headphones, holding buzzers or tappers in their hands that vibrate alternating from left to right, or some other form of stimulation. After each set of 20 to 50 second stimulation, clients share what they noticed during that set and any changes experience. The bilateral stimulation is thought to provide a grounding mechanism that allows clients to be exposed to the disturbing memory, without becoming flooded, by maintaining what is termed "dual awareness" (Shapiro, 2001).

A second theory is that such bilateral stimulation allows both hemispheres to communicate, thus focusing the attention from the right and left sides of the brain; this may also shift the traumatic material from the right hemisphere to the left and allow access to the language center and higher order thinking, areas which tend to be inhibited during traumatic exposure when the limbic system is highly activated. Further, some have theorized that this process taps into the mechanism that occurs during rapid eye movement (REM) sleep and thus activates episodic memories to allow them to be integrated into semantic memory within the neural networks in the neocortex (Solomon et al., 2009). Whatever the neurophysiological mechanism, clinicians have consistently observed that EMDR seems to allow clients to experience the exposure necessary to desensitize the traumatic stimuli without becoming overwhelmed. The episodic memories are processed and clients describe modifications in their cognitions, emotions, and physical sensations, as the traumatic memory appears to become integrated and

consolidated into a more coherent narrative, moving toward adaptive resolution (Solomon et al., 2009).

The fifth phase involves installation of the positive belief and occurs when the disturbance level (SUDs) has decreased to an ecologically appropriate level, usually 0 or 1. That is, the reprocessing has occurred and the disturbing material has been desensitized. Clients then focused on the traumatic memory along with the positive belief that was identified as one they would like to associate with that event, and then engage in bilateral stimulation. This stimulation strengthens the association between the memory and the positive belief and existing positive cognitive networks, with the goal of generalizing the effects to associated neural networks (Solomon et al., 2009). Phase six is the body scan--clients identify and process through any remaining tension or discomfort in their body as they think about the traumatic memory during bilateral stimulation, if such tension remains.

The seventh phase involves closure and may incorporate a “safe place exercise,” during which clients focus on an image of a relaxing real or imagined place, along with the sights, smells, sounds, tastes, physical sensations, and emotions that are associated with that place. The purpose is to ground or stabilize clients when the traumatic memory is not fully reprocessed and clients remain emotionally aroused. The therapist provides some education about ongoing processing between sessions and asks that clients note any changes or observations, such as dreams, insights, related memories, etc. The therapist may also engage in safety planning and review coping tools with clients to manage any distressing emotions that may surface between sessions. Finally, the eighth phase occurs at the beginning of the following session and involves reviewing any material that

surfaced since the previous session as well as re-evaluating the SUDs and VoC levels to then continue processing the current target, if it was not fully processed. Clients' state at this stage determines the next step in reprocessing the dysfunctionally stored traumatic material (Solomon et al., 2009).

### **Adaptive Information Processing Model**

Eye movement desensitization and reprocessing is guided by Shapiro's (2001) adaptive information processing model, which proposes that trauma overwhelms the brain's natural information processing system, thus preventing the material from resolving naturally. This model posits that traumatic memories are dysfunctionally stored in neural networks in the brain, which prevents integration of the memories into one's autobiographical narrative and semantic memory, resulting in ongoing distress associated with such memories (Shapiro, 2001). Eye movement desensitization and reprocessing aims to target such "stalled" information processing to facilitate resolution of traumatic memories and allow the adaptive information processing that had been blocked to resume. This process is thought to allow individuals to attend to useful information and dismiss unimportant information, while letting go of disturbing and inhibiting elements of the traumatic experience, in order to more effectively respond in present situations (Cvetek, 2008; Shapiro, 2001).

Cvetek's (2008) randomized controlled study provided support for Shapiro's (2001) adaptive information processing model. He found that recalling a disturbing event that does not meet PTSD criteria (small "t" trauma) resulted in an increase in state anxiety. This is consistent with Shapiro's adaptive information processing model that

proposes that activation of dysfunctionally stored traumatic material leads to experiencing disturbance when recalling such memories.

### **Eye Movements**

There are conflicting opinions about the therapeutic contribution of the bilateral stimulation in the effectiveness of EMDR. Most research in this area has examined the role of eye movements specifically. Several dismantling studies have been conducted (e.g., Davidson & Parker, 2001), most of which have suggested that the effect from the eye movements are small or non-existent. However, it has been argued that the majority of such dismantling studies demonstrate numerous methodological flaws (Schubert & Lee, 2009; Seidler & Wagner, 2006).

Shapiro (2001) suggests that information processing during EMDR is facilitated by (a) deconditioning through a relaxation response, (b) neurological changes that activate and strengthen specific neural networks, and (c) the dual awareness or attention focus that occurs through bilateral stimulation. Baddeley's (1986) model of working memory is consistent with Shapiro's AIP model and suggests that bilateral stimulation results in decreased attention on the primary task of thinking about the upsetting memory, thereby decreasing the vividness and emotionality of the memory, and integrating it from working memory to long-term memory (Schubert & Lee, 2009). Stickgold (2002) hypothesized that bilateral stimulation induces a REM-like mechanism, activating and integrating episodic memories into semantic memory within the neural networks in the neocortex (Solomon et al., 2009), a hypothesis that has been supported by several studies. For example, bilateral stimulation through eye movements has been found to enhance episodic memory retrieval tasks while not impacting performance on narrative memory

retrieval tasks (Solomon et al., 2009). Furthermore, other research has discovered an activation of the parasympathetic system and inhibition of the sympathetic system during EMDR that resembles physiological responses during REM sleep (Solomon et al., 2009).

Davidson and Parker (2001) noted in their meta-analysis that eye movements appeared to be an unnecessary part of treatment. Seidler and Wagner (2006) also conducted a meta-analysis comparing the efficacy of EMDR and trauma-focused cognitive behavioral therapy (TFCBT) in the treatment of PTSD and noted that it is unclear what the contribution of the eye movement component is to the treatment. In contrast, several laboratory studies examining the effects of eye movements on non-traumatic memories found a decrease in the vividness and emotions of the treated autobiographical memories (Cvetek, 2008; Schubert & Lee, 2009). Research has also demonstrated that eye movements appear to enhance the retrieval of episodic memories, increase cognitive flexibility, and transfer interhemispheric material in frontal areas of the brain (Schubert & Lee, 2009).

Furthermore, several studies have shown a decrease in arousal based on physiological measures during EMDR when accessing distressing memories, suggestive of an orienting response and paralleling the physiological characteristics of REM sleep (Schubert & Lee, 2009). Brain imaging studies suggest that traumatic memories and associated emotional responses are stored in the right hemisphere, without access to language and reasoning abilities. Brain scans have provided evidence that both hemispheres are activated and that information is transferred from the right to the left hemisphere during EMDR (Capps, 2006; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001). Thus, as with the underlying mechanism of the change process

during EMDR, it remains uncertain what role bilateral stimulation plays in EMDR treatment, though there are some preliminary findings that it may contribute to EMDR's therapeutic impact. However, further research with improved methodological design is necessary to provide clarification in this area.

### **Empirical Support**

As noted above, early studies examining EMDR's effectiveness were plagued with methodological problems. Many were single case reports and/or did not include standardized outcome measures (Rothbaum & Foa, 2007; Turner et al., 2007). Since that time, multiple systematic studies of EMDR have been conducted. To date, EMDR has been empirically validated in over 20 randomized controlled trials with trauma survivors. Furthermore, at least six meta-analyses have demonstrated its effectiveness. Maxfield and Hyer (2002) discovered that effect size was highly correlated with the methodological standards in EMDR efficacy studies, such that higher effect sizes emerged for studies that were more rigorously designed. Equivocal and negative effects have been found in a small number of studies, though the populations included in those studies were chronic and have demonstrated resistance to pharmacological and cognitive-behavioral interventions (Turner et al., 2007).

Certain controlled studies of EMDR for civilian PTSD have demonstrated in the range of 77 to 100% success after 3 to 10 hours of EMDR treatment (Cvetek, 2008; Rothbaum, 1997; Wilson, Becker, & Tinker, 1995, 1997). Others have found lower rates of success but have provided validation of its effectiveness in the treatment of posttraumatic symptoms (Bisson & Andrew, 2007; Cvetek, 2008). In their randomized controlled trial, Wilson and her colleagues (1997) found that three 90-minute EMDR

sessions targeting traumatic memories led to decreased presenting complaints and anxiety and to increased ratings of positive cognitions in a sample of 80 participants, changes that were maintained at a 90-day follow-up. In contrast, the waiting list group demonstrated no change in these measures until treatment was provided, at which point they experienced similar effects. They performed an additional 15-month follow-up and found that these positive treatment effects were maintained with 84% remission of PTSD diagnosis (Wilson et al., 1997). They found that EMDR was effective irrespective of the type of trauma and for a range of posttraumatic symptoms.

Similarly, Cvetek (2008) found that EMDR was comparably effective for participants who did and did not meet criteria for PTSD, suggesting its usefulness in the treatment of subclinical responses to distressing events (Schubert & Lee, 2009). In his randomized controlled trial, Cvetek investigated the treatment effects for small “t” traumas in participants who did not meet criteria for PTSD and found that EMDR treatment resulted in significantly lower scores on the Impact of Events Scale than participants in an active listening or wait list group. He also found reduced anxiety responses in EMDR participants when recalling the target following EMDR treatment compared to those in the active listening and wait list groups.

In her randomized controlled study, Rothbaum (1997) found that three 90-minute sessions of EMDR treatment resulted in an elimination of PTSD in 90% of rape victims. Marcus, Marquis, and Sakai (2004a) conducted a randomized controlled study and demonstrated that participants receiving EMDR treatment had significantly greater improvement at a faster rate than those in the standard care group with regard to symptoms of PTSD, depression, and anxiety, among others. Furthermore, participants in

the EMDR treatment group made fewer medication appointments for psychological symptoms and required fewer therapy sessions. In their 3- and 6- month follow-up study, they discovered that a relatively small number of EMDR sessions resulted in the maintenance of significant benefits over time (Marcus, Marquis, & Sakai, 2004b).

Rothbaum, Astin, and Marsteller (2005) found that prolonged exposure and EMDR were equally effective treatments, though EMDR required less exposure and no homework between sessions. Karatzias et al. (2007) investigated predictors of treatment outcome for PTSD in a randomized controlled trial that compared EMDR to Imaginal Exposure and Cognitive Restructuring (E+CR) at treatment completion and at a 15-month follow-up. These authors found significant reductions between pre- and post-measures for both EMDR and E+CR compared to no change for the Waiting List group. The two treatments were comparable in both self and clinician-rated outcome measures. The authors found that baseline PTSD symptomatology, number of sessions, gender, and therapy type were the four variables that were predictive of significant treatment outcome, regardless of outcome measure and time of assessment. However, conflicting findings were noted regarding the correlation between baseline PTSD severity and treatment outcome, based on the type of measure used.

Van der Kolk, McFarlane et al. and van der Kolk, B., Spinazzola et al. (2007) conducted a randomized clinical trial of EMDR, Fluoxetine, and a pill placebo to compare their efficacy in the treatment of PTSD and the maintenance of those effects. The authors found that EMDR was more effective than both the medication and placebo to produce substantial and sustained reduction in PTSD symptoms, though they noted a distinct difference in the responsiveness of adult-onset survivors as compared to child-



onset trauma survivors. At a six-month follow-up, 75% of the adult-onset and 33.3% of the child-onset trauma survivors were symptom-free. In contrast, none of the subjects in the Fluoxetine group were asymptomatic at the six-month follow-up session, despite a significant decrease in PTSD symptoms.

Van der Kolk, McFarlane et al. and van der Kolk, B., Spinazzola et al.(2007) discuss the apparent efficacy of brief EMDR treatment with adult-onset trauma survivors for PTSD and depression as well as the important role for SSRIs as a “first-line intervention” for adults who experienced trauma as children. They note the need for future research to explore the impact of longer treatment interventions, combinations of treatments, and treatment specifically designed for adults with childhood-onset trauma. Furthermore, neuroimaging studies have examined brain scans before and after EMDR treatment, demonstrating increased bilateral activity in an area of the brain that modulates the limbic system and facilitates the determination of threat, which has been suggested to reflect a decrease in hypervigilance. Such studies have also demonstrated an increase in prefrontal lobe metabolism, which has been interpreted as modifications in the perception of incoming sensory stimulation (Cvetek, 2008).

Several meta-analyses have reviewed the research examining EMDR’s efficacy. For example, Van Etten and Taylor (1998) conducted a meta-analysis of 61 treatment outcome trials and compared three treatments for PTSD. They found that EMDR and behavior therapy were more effective than medication. They also reported that EMDR was more efficient than behavior therapy, requiring one-third of the time for a comparable reduction of symptoms than behavior therapy. Davidson and Parker (2001) found that EMDR was equivalent to exposure and other cognitive behavioral treatments

in their meta-analysis of 34 studies. In another meta-analysis, Maxfield and Hyer (2002) found that the more rigorous the studies, the larger the effect size in the effectiveness of EMDR treatment for PTSD. In their meta-analysis, Bradley, Greene, Russ, Dutra, and Westen (2005) found EMDR to be equivalent to exposure and other cognitive behavioral treatments and deemed that all are highly efficacious in the reduction of PTSD symptoms.

Seidler and Wagner (2006) conducted a meta-analysis comparing the efficacy of EMDR and trauma-focused cognitive behavioral therapy (TFCBT) in the treatment of PTSD. These authors conducted a systematic review of the literature from 1989, the year of the first published article related to EMDR, to 2005, including seven published articles that compared TFCBT with EMDR. They reported that based on the research available at the time, neither treatment approach could be said to be more efficacious than the other, though they noted the need for more randomized controlled trials and the importance of identifying which trauma survivors benefit more from one method over another.

Bisson and Andrew (2007) conducted a systematic review of 38 randomized controlled trials of psychological treatments for chronic PTSD. They found that TFCBT and EMDR showed benefits over waiting list or “usual care” therapies on most outcome measures of PTSD symptoms. They reported limited evidence for stress management and group CBT, but “other therapies” (supportive/non-directive, psychodynamic, and hypnotherapies) appeared to be least effective, resulting in no clinically meaningful decrease in PTSD symptoms. These authors suggested that the treatments that focus on the disturbing memories as well as on the personal meanings of the event and its consequences appeared to be most effective, including TFCBT and EMDR. They found

that direct comparison of TFEBT and EMDR did not result in significantly different treatment outcome or speed of therapeutic change, paralleling the findings of Seidler and Wagner (2006).

Ponniah and Hollon (2009) examined the efficacy of various psychological treatments for both acute stress disorder and PTSD in their meta-analysis of 57 studies, using the criteria set by Chambless and Hollon (1998). These authors concluded that when examining the literature without differentiating by trauma type, TFEBT and EMDR were efficacious for PTSD, that stress inoculation training, hypnotherapy, interpersonal psychotherapy, and psychodynamic therapy are possibly efficacious for PTSD, and that TFEBT is possibly efficacious for acute stress disorder. The authors also note that TFEBT and, to a lesser extent due to fewer studies and mixed trauma samples, EMDR are the treatments of choice for PTSD.

Eye movement desensitization and reprocessing is recognized by several professional associations, insurance companies, governmental agencies, and international organizations as a first-line treatment for PTSD including the American Psychiatric Association (2004), American Psychological Association (Chambless et al., 1998), Australian Centre for Posttraumatic Mental Health (2007), the California Evidence-Based Clearinghouse for Child Welfare (2010), the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (2010), the National Institute of Mental Health (Therapy Advisor, 2005), the Stockholm Medical Program Committee (Sjöblom et al., 2003), the United Kingdom Department of Health (2001), the Israeli National Council for Mental Health (Bleich, Kotler, Kutz, & Shalev, 2002), Veterans Health Administration and Department of Defense (2004), the

International Society for Traumatic Stress Studies (Foa, Keane, Friedman, & Cohen, 2009), Clinical Resource Efficiency Support Team of the Northern Ireland Department of Health (CREST; 2003), the French National Institute of Health and Medical Research (INSERM, 2004), the Dutch National Steering Committee Guidelines Mental Health Care (2003), and the National Institute of Clinical Excellence (2005; Capps, 2006; Cvetek, 2008; Ehlers et al., 2010; Karatzias et al., 2007; Schubert & Lee, 2009; Solomon et al., 2009).

### **Cautions and Contraindications for Use**

Shapiro (2001) and the EMDR Institute recommend that EMDR only be used when clients have adequate tools and capacity to regulate their affect and can sufficiently tolerate emotional distress while maintaining stability. Furthermore, if clients are reluctant to engage in EMDR, do not feel safe, have not established a therapeutic alliance, are dissociative, or are experiencing significant chaos or instability in their lives, it may be more appropriate to focus treatment on developing containment strategies and resources to establish stability before proceeding with EMDR.

### **Attachment**

According to Johnson (2002), “Attachment styles involve rules for processing and organizing information about the self, the world, and relationships” (p. 50). As noted above, these rules are based on the internal working models that develop in response to early attachment relationships and allow individuals to anticipate what to expect in future relationships. Situations in the present that conflict with those models when attachment figures were not accessible or responsive may provide a corrective emotional experience, but this requires attention and processing in order to do so (Johnson, 2002). It is more

common for individuals to misinterpret current relationship information to fit with the existing template. As noted above, EMDR appears to be effective in modifying information processing in order to allow individuals to better attend to, interpret, and respond to incoming information in the present.

As described in an earlier section, secure working models appear to encourage cognitive exploration and flexibility (Johnson, 2002), such that securely attached individuals demonstrate better ability to attend to new information and modify their schemas to incorporate this information, are more comfortable with ambiguity, and are better at problem solving (Johnson, 2002, 2008). In contrast, insecurely attached individuals tend to be more rigid and reactive in their response, become triggered by information that resembles prior attachment wounds and respond in similar ways as they did in earlier relationships, without fully attending to and integrating new information.

Eye movement desensitization and reprocessing seems to allow people to access and reprocess attachment-related traumatic memories (small “t” and big “T” traumatic events), and thereby contribute to their ability to be present in their current relationships, attending to the moment rather than being guided by past unresolved traumas (Wesselmann & Potter, 2009). In fact, EMDR has been demonstrated to have the capacity to increase the attachment bond between partners as well as between children and their parents (Moses, 2007; Protinsky, Sparks et al., 2001; Wesselmann & Potter, 2009), as individuals process through attachment-related trauma. Wesselmann and Potter (2009) presented three case studies in which participants who engaged in EMDR treatment experienced increased attachment security. They propose targeting negative beliefs, perceptions, and automatic responses related to early attachment relationships as well as

present-day relationships, emotional responses, and thought patterns through EMDR in order to modify the habitual patterns that have been developed. Furthermore, given the associations between secure attachment and sensitive caregiving toward children, stability in adult relationships, and mental health, they propose that EMDR may not only positively impact current intimate relationships, but also individuals' parenting and risk for mental illness (Wesselmann & Potter, 2009).

### **Couples**

In recent years, several authors have integrated the use of EMDR within the context of couples therapy (Capps, 2006; Capps et al., 2005; D'Antonio, 2010; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Shapiro, 2005; Snyder, 1996; Talan, 2007), though no evidence-based research yet exists to document its effectiveness (Litt, 2009). Most authors have provided case illustrations to demonstrate how EMDR may be incorporated into couples therapy and present their observations regarding relational changes from the perspective of the author and therapist, who are typically one and the same. To my knowledge, no literature has incorporated interviews with both therapists and clients to understand their perspective about the process of change.

Shapiro (2001) herself stated, "EMDR must be used within the context of an interactional dynamic. Couples therapy may be an appropriate intervention in order to help the client more easily integrate new perspectives and behaviors within the family context" (p. 286). She also proposed that negative emotional reactions within a couple's relationship may be a consequence of incompletely processed experiences that are stored

in the brain and that, in order for that information processing to be completed, those traumas must be accessed and reprocessed. Furthermore, she recommends individual therapy along with couples therapy in order to provide the context in which traumatic material can be processed safely individually when it may not feel emotionally safe to do so with one's partner present, while also providing a context in which both partners can address ways in which their responses trigger one another.

Snyder (1996) presented a case of a lesbian couple with whom she conducted couples therapy, including EMDR. She described the changes she observed with the couple and she included their voices in the article, providing a valuable contribution to the existing literature on conjoint EMDR. Both partners shared meaningful aspects of their therapeutic process and changes they experienced individually and relationally as well as changes they observed in one another. Snyder noted increased emotional intimacy and differentiation through combining EMDR and experiential couples therapy. The couple observed the power of EMDR to induce emotional expression that was usually inhibited by one of the partners by well-practiced defenses.

Protinsky, Flemke et al. (2001) incorporated EMDR with emotionally and experientially oriented conjoint couples therapy, which they referred to as eye movement relationship enhancement (EMRE) therapy. Their model involves "accessing and tolerating previously disowned emotion, reprocessing emotional experiences, and amplifying couple intimacy" (Protinsky, Flemke et al., 2001, p. 157). They described increased empathy and support generated by the observing partner, noting that "this process may take the form of compassionate witnessing and often creates a 'softening event' which research has shown is an important treatment success marker" (Protinsky,

Flemke et al., 2001, p.161). The authors present case examples to demonstrate the use of this model with couples who were experiencing significant distress and who had disowned their primary emotional experience.

Protinsky, Flemke et al. (2001) propose that EMDR is a valuable intervention in its facilitation of clients' accessing, experiencing, tolerating, and reprocessing of primary emotions. These authors incorporated EMDR into couples therapy within the following goals: "creating a safe therapeutic alliance, accessing and tolerating intense primary emotion, reprocessing of emotional experience, and amplifying couple intimacy" (Protinsky, Flemke et al., 2001, p. 157). Protinsky et al. described their work with one partner at a time in the presence of the other to activate primary emotions that trigger dysfunctional interactional patterns, thereby increasing the vulnerability and accessibility of that partner. Through their work, they reported that accessing such emotions would evoke memories from earlier traumatic experiences, which partners could then reprocess in order to be more fully present and responsive in their current relationship.

In their article, Protinsky, Sparks et al. (2001) reported on their clinical implementation of EMDR within the context of an emotionally based experiential approach to couples counseling and they present a case example to illustrate their work. They described this clinical work as the first step of task analysis, in which clinical implementation without empirical testing occurs, and is reported based upon the clinician's experience or therapeutic model. Protinsky, Sparks et al. reported their observations over seven years of experience that highly distressed couples who did not respond to standard therapeutic interventions did respond to EMDR, demonstrating the heightened emotional experience and emotional engagement that has been shown to be an



important outcome marker for couples therapy (Johnson, 2002, 2004; Johnson et al., 2001; Protinsky, Sparks et al., 2001).

Though not explicitly stated, positive change within these couples appeared to be based upon their own clinical observations of alterations within members' level of understanding, compassion, and intimacy, as well as upon self-reports from members of the couples. They posited that EMDR is a valuable treatment within conjoint couples therapy to facilitate the connection between reprocessing traumatic material and current couple interactions. They also propose that such a connection is necessary in order for both members to modify their emotional responses that negatively reinforce one another's dysfunctional patterns.

Flemke and Protinsky (2003) presented a model in which EMDR was incorporated into imago relationship therapy in order to facilitate movement through the obstacles of childhood traumas that seemed to be preventing certain couples from establishing intimacy during imago relationship therapy techniques. They provided case examples to illustrate their integration of these approaches. Flemke and Protinsky (2003) observed that strong emotional reactions between partners seem to be the result of past painful experiences that become projected onto their partner; therefore, they described their goal as supporting the couple to reprocess such woundings and for each member to view the other as "the greatest ally for healing" (p. 33). Furthermore, they argue that "in order to create a therapeutic level of emotional arousal, self-disclosure, and partner empathetic response..., there must be a therapeutic process that is successful in accessing previously disowned painful emotions, tolerating these emotions long enough to self-

disclose, and having that self-disclosure witnessed in a compassionate manner by one's partner" (Flemke & Protinsky, 2003, p. 36).

Moses (2003, 2007) presented his protocol for specifically targeting attachment injuries from the current relationship and/or the family of origin using EMDR as an experiential technique within conjoint couples therapy. Moses (2007) described his model as a combination of EFT, object relations and narrative therapy, and as an extension of the work by Protinsky, Sparks et al. (2001). He noted that when such issues are processed, interactional patterns often move toward increased intimacy and healthy attachment processes. He described the purpose of EMDR within the couples context, paralleling other authors noted above, as to move beyond impasses that emerge during couples therapy, thereby facilitating shifts within the interpersonal dynamics. He suggested that EMDR may be used once or multiple times during the therapy process.

Moses (2007) stated,

The aim of integrating EMDR into couple therapy is to repair attachment wounds while providing a tangible experience of availability, empathy, and the promise of reliability. This experience allows the couple to build trust by melting their defenses (protective attachment styles) and rekindling an intimate attachment. (p. 151)

Moses (2003, 2007) presented a detailed protocol as well as indications and contraindications for the use of EMDR within couples work, moving beyond previous literature.

As with previous authors, Capps et al. (2005) discussed the value of integrating EMDR with experiential couples therapy and they described the goal as "growth and integrity, that is, congruence between inner experience and outward behavior" (p. 107). They presented a study in which a consultant joined the couple and primary therapist

during couples therapy to incorporate EMDR into experiential conjoint therapy for one session in the treatment of the betrayal experienced as a result of sexual infidelity by one of the partners three years prior. In this case, the wounded partner was the only participant in EMDR treatment and was treated for the intrusive memories and images related to her partner's infidelity. After treatment, the witnessing partner rated the value of the treatment as a 7 on a scale of 1 to 7, with 7 being "the best experience you could imagine." Upon 30-day follow-up, the couple reported feeling closer than ever and had reunited after having previously separated. When contacted again for a 90-day follow-up, they continued to report a deeper level of intimacy and ongoing relief from trauma-related symptoms.

Robin Shapiro (2005) described her process of integrating EMDR into couples work and provided examples of targets from her use of EMDR with couples, though did not present case studies or data on the effectiveness of this approach. She argued that this treatment can be effective for developmental and trauma issues and for targets from both within and outside of the relationship. She noted her use of the standard EMDR protocol as well as a "future template" exercise with members of the couples she worked with, such that they would envision the future they would like to create, along with new behaviors, feelings, thoughts, etc. She identified the questions that she considers when assessing a couple's readiness for EMDR. As with Protinsky, Flemke et al. (2001), Shapiro uses EMDR to help the witnessing partner process through his or her reactions to the working partner's EMDR. She also highlighted the value of conjoint EMDR sessions to work through past trauma and a lack of differentiation.

Capps (2006) presented three case studies in which EMDR was incorporated into experientially based Gestalt therapy with couples in a single session to address relational trauma. He utilized EMDR with the “traumatized partner” and Gestalt therapy for the “supportive partner.” He followed Moses’ (2003) guidelines of safety, balance, and containment. The first case involved former substance abuse by one of the partners that had resulted in relational trauma. The injured partner reported no trauma-related symptoms throughout the year during the follow-up one year after treatment. In the second case, Capps modified the model by having the witnessing partner observe his partner’s EMDR processing through a closed-circuit television due to a history of domestic violence and the need to ensure safety. In this case, the traumatized partner reported trauma resolution at the end of treatment as well as at the 30-day follow-up. Both partners reported increased relationship satisfaction at both points, and the supportive partner reported decreased “raging.” However, after six months, the couple reported decreased marital satisfaction and reinitiated therapy.

The third case involved a perceived violation of physical intimacy boundaries with a family member for the male partner, which was distressing for his wife. Measures for all “traumatized partners” included the Validity of Cognition Scale (VoC) and Subjective Units of Disturbance Scale (SUDs) completed pre- and post-treatment. Awareness and empathy were measured qualitatively through clinical interviews for both members at pre- and post-treatment, and Capps (2006) created a Value of the Experience scale (VOE) with a 7-point Likert-type rating as an outcome measure for the supportive partner at post-treatment. In all cases, the supportive (witnessing) partners reported increased awareness of the impact of the relational trauma, increased empathy for their

partner, and commitment to abstain from the behavior that had led to relational trauma after completing treatment. The VOE scores ranged from 6 to 7 for all three supportive partners in their self-report of the value of the session. All traumatized partners reported relief from trauma symptoms after the single EMDR treatment session. Furthermore, all six partners reported increased empathy for their partner at post-treatment and follow-up. Capps acknowledged several limitations of this study including expectancy effects, lack of validated objective outcome measures, and a lack of data supporting the long-term impact of their EMDR session on the couple's relationship.

Errebo and Sommers-Flanagan (2007) presented a case example of EMDR for couples affected by war trauma, integrating EMDR with EFT. They provided their integrated model that was implemented over 25 to 45 sessions during a 12 to 24 month period, highlighting the tasks at each stage. In their model, they described meeting with partners conjointly as well as individually at various stages of treatment, depending on the tasks at that stage. These authors noted that in the *Practice Guideline* for individual treatment developed by the Veterans Health Administration and Department of Defense. (2004), EMDR is listed as one of the recommended therapies. They also noted the value of EFT with veteran couples and the natural integration of the two, given their commonalities. For example, they highlighted that both are trauma- and emotion-focused and that both are information processing treatments that hold the assumption that negative emotions and cognitions create barriers to inner resources and adaptive healing mechanisms. They described the goals of their treatment as the facilitation of the reprocessing of war memories and attachment injuries, an increase in congruence between the inner emotional experience of each partner and their relationship dynamic,

and the establishment of a safe haven within the relationship for both members. They noted the value of integrating EMDR into EFT for couples in that this model can reduce the reactivity of the partners with regard to current triggers related to past trauma while increasing the safety and stability of the relationship.

Talan (2007) presented an integration of EMDR with imago relationship therapy with couples during 12 conjoint sessions, including her specific protocol with each phase of treatment and a case example to illustrate this model. She highlighted the need for partners to process through early childhood wounds in order to become more deliberate and intentional as a couple rather than being reactive due to unresolved past issues. Her goal was to promote change within the couple's dynamics and resolution of old wounds as well as to increase compassion and intimacy within the relationship. She utilized Protinsky, Flemke et al.'s (2001) model, in which one partner processed an issue and the other would attune to the working partner's experience as well as to the witnessing partner's own reactions for later processing. As with Protinsky, Flemke et al., Talan's focus was on the couple rather than parallel individual work. She introduced EMDR into couples work when she recognized that past traumatic experiences had not been accessed or processed through imago relationship therapy or if the couple seemed to reach an impasse (Talan, 2007).

Litt (2008) proposed a three-phase treatment model, applying EMDR within couples therapy with an ego state and contextual therapy approach and provided an excerpt of a case that he described as a composite of clients he had worked with to demonstrate the use of this model. In contrast to other authors, he described his tendency to move flexibly from individual to conjoint sessions while maintaining the couple's

relational goals as the priority. He noted his development of individual treatment plans for each partner as well as a relational treatment plan with both members and his extensive use of EMDR in his work with couples. He noted that initial individual therapy as preparation for conjoint sessions can be helpful to increase ego strength and each member's ability to integrate the relational material during couples work. However, he stated that he prefers to use EMDR with the working partner while the witnessing partner serves as a witness to the other's experience in order to provide insight and empathy to the witnessing partner.

Litt (2008) noted that at times, conjoint sessions may be appropriate for one partner but not both, and he observed that both partners need not be ready to engage in EMDR with the partner present, which contrasts with Moses' (2003, 2007) principle of balance through the engagement of both partners in EMDR. Litt stated that developing a plan with the excluded partner when EMDR is provided individually to one partner can promote the engagement of both partners throughout the therapeutic process. However, Litt's (2010) view on balance differs from others in that he takes a contextual therapeutic stance where equality in terms of "talk time" is not emphasized; rather, he prioritizes the therapist's commitment to empathize with and hold accountable both partners, such that "a standard of adult responsibility characterized by compassion and mutuality" (p. 147) is achieved. He noted that this stance of "mutlidirected partiality" establishes trust and fairness.

Litt (2010) also observed that when deciding who will engage in EMDR first when both are good candidates, it may be useful to do so with an acting-out partner who is destabilizing the relationship, when such a dynamic exists. He stated,

EMDR augmented with ego state therapy techniques can be used to heal attachment injuries, leading to cooperation between, or eventually integration of, ego states. Developmentally structured processing facilitates mourning and efficiently resolves negative cognitions that wreak havoc in the contemporary relational domain. (Litt, 2010, p. 290)

In his 2010 chapter, Litt presented a script for a 5-step process to guide therapists in the development of a treatment plan to incorporate EMDR within the context of couples therapy, which he recommended applying to both partners whenever possible.

Recently, D'Antonio (2010) presented a protocol for incorporating EMDR into couples work with couples who have experienced a traumatic event during or prior to the relationship that has an ongoing negative impact on the relationship. As noted by Shapiro (2005), D'Antonio highlighted the importance of increasing differentiation between members of a couple and the value of EMDR with this task. Like Moses (2003, 2007), he also noted the importance of balancing treatment by providing EMDR to both members of the couple, either serially or in tandem. However, in contrast to the other authors noted above, D'Antonio described incorporating EMDR into therapy with partners separately and instructing members not to discuss their partner or the relationship during EMDR sessions. Thus, partners do not serve as compassionate witnesses to the other's work in his model.

Reicherzer (2011) presented a case of a male couple with whom she conducted conjoint EMDR for communication problems that were related to traumatic memories in each man's childhood. She conducted treatment within a relational-cultural theory model. Reicherzer noted that conjoint EMDR increased understanding and intimacy within the relationship, emotional responsiveness to one another, greater ability and willingness to



share vulnerability with the partner, and increased joy and commitment in their lives together.

A pilot study for the current research was conducted by Reicherzer (2011), which was phenomenological in nature, to explore the process of EMDR treatment within conjoint couples therapy; the purpose was to understand their shared experience of this phenomenon. Two members of a couple as well as their therapist participated in 90-minute interviews. The interviews were recorded and transcribed, and thematic analysis was conducted. The primary themes that emerged during this study include (a) awareness, (b) acceptance, (c) courage to change, (d) intimacy, (e) having the hard conversations, (f) this isn't about me/now, and (g) understanding loop. Furthermore, five factors were identified as important to creating the appropriate environment in which EMDR could be incorporated into conjoint couples counseling: (a) understanding each person's role and maintaining healthy boundaries, (b) openness and willingness, (c) ability to trust and tolerate the process, (d) safety and security, and (e) empathy and caring.

**Deepening affect.** As noted above, Protinsky, Flemke et al.'s (2001) eye movement relationship enhancement (EMRE) is designed to facilitate accessing primary emotions that underlie dysfunctional present relationship dynamics and that have been disowned and replaced by secondary emotions. Partners initially target their secondary emotions that are triggered in current interactional patterns in EMDR, which allows the primary emotions and previous traumatic memories to surface and be reprocessed. Such deepening of affect is thought to allow partners to be more emotionally available and responsive to one another. Protinsky, Sparks et al. (2001) found that when using EFT

with certain couples, some partners had difficulty accessing primary emotions, creating an obstacle in the therapeutic process. They discovered that EMDR allowed them to do so, perhaps due to the orienting response that seems to occur during bilateral stimulation that made the primary emotions more tolerable. They proposed that it is essential to reprocess past related traumatic events in order to change current dysfunctional patterns.

**Increasing empathy and understanding.** Moses (2003, 2007) observed that integrating EMDR into conjoint couples sessions can provide the witnessing partners with the opportunity to better understand their partner's experience, allowing them to be more compassionate and sensitive to their triggers. This may allow them to better function as partners to support one another through their own past hurts and wounds.

Capps et al. (2005) noted,

Combining EMDR with experiential therapy in couples therapy may provide the supportive partner the opportunity to experience the trauma and the trauma resolution of the traumatized partner at a deep level, thereby gaining awareness and empathy for the partner. (p. 107)

Capps (2006) also found that when EMDR was combined with Gestalt therapy with couples, the witnessing partner experienced increased awareness and empathy of the working partner, developing a better understanding of the impact of the relational trauma on the partner. Similarly, Litt (2008, 2010) observed increased compassion and insight gained and provided by the witnessing partner. The current researcher found a similar theme of increased awareness by both members of the couple as well as increased understanding of the impact of their behavior on others. This increased awareness seemed to contribute to a strong desire to modify dysfunctional patterns and to no longer contribute to further hurting the other partner. Furthermore, partners described increased

acceptance of oneself and feeling increased acceptance by the other, including a stronger sense of self-worth and self-respect.

**Enhancing intimacy.** Protinsky, Flemke et al. (2001) asked the observing partners to tune into their own emotional experience as well as that of their partner during EMDR, noting their own emotional responses to their partner's experience in a journal. Through this process, observing partners were able to recognize their own blocks to empathy and then target those blocks through EMDR, thereby increasing their ability to be emotionally present with and empathetic toward their partner. They observed that as each partner revealed their own vulnerabilities, a "softening event" often occurred, resulting in increasing intimacy. Protinsky, Sparks et al. (2001) stated that "enhancing intimacy with couples may be conceptualized as the creation of a context where the mutual healing of emotional pain takes place" (p. 161). Flemke and Protinsky (2003) noted the importance of each partner's emotional availability and ability to appropriately respond to the other's self-disclosure in order to create intimacy. They proposed that EMDR facilitates such compassionate witnessing by each partner in order to fully attend to, validate, and emotionally engage with one another. Similarly, Moses (2003, 2007) observed that when attachment injuries from partners' family of origin or from the current relationship are processed through EMDR, interactional patterns often move toward increased intimacy and sustained healthy attachment.

Capps et al. (2005) noted that the increased empathy and awareness by the witnessing partner in conjunction with the relief that comes with processing through trauma and the validation and reframing from one's partner can lead to a deeper level of emotional intimacy. Capps (2006) observed a deepening of intimacy when he combined

EMDR with Gestalt therapy in couples sessions. In two of the three cases that he presented, partners observed either maintenance or increased intimacy over time post-treatment. Similarly, the participants in the pilot study reported increased intimacy that resulted from the unconditional acceptance and vulnerability that was experienced during EMDR with one's partner serving as a compassionate witness. The therapist described the increased commitment that she observed within the couple and her sense that the intimacy that seemed to emerge during EMDR contributed to increased safety and intimacy within the relationship.

**Increasing differentiation.** Ironically, Robin Shapiro (2005) posited that conjoint EMDR can facilitate the development of differentiation of partners through witnessing one's partner processing through trauma from prior to their relationship in addition to increased understanding of one's partner. Such increased awareness and differentiation can result in reduced reactivity toward the partner. Similarly, Talan (2007) observed that "separation due to personal growth allows the couple to honor each other's differences and often results in greater connection" (p. 199). Thus, both intimacy and increased differentiation may result from the reprocessing of attachment and traumatic wounds through EMDR within couples therapy. Litt (2008) also noted that when partners have increased awareness of the context in which their negative cognitions and behaviors were developed, this awareness can reduce the burden of the relationship being perceived as both the source of the client's hurt and the solution to such hurt. In the process, each partner may become more supportive and understanding of the importance of individual growth, and thereby less dependent on the other and less invested in changing one's partner.

D'Antonio (2010) described the goal of treatment as “partners to become better differentiated and relationally more competent so that they become less defensive and reactive” (p. 97). He also observed that through this increased differentiation, partners “develop a greater ability to identify their own thoughts, feelings, and desires; they become more assertive without becoming aggressive; they develop greater empathy for themselves and one another; and they are open to greater emotional and physical intimacy” (p. 97). I found this theme emerged in the pilot study where partners were able to maintain “a sense of their own individuality, not losing themselves in each other,” as described by the EMDR couples’ therapist. Both members described the ability to depersonalize and therefore respond in more deliberate ways, once they had reprocessed past traumatic material and thus reduced its power in the current relationship.

**Necessary conditions.** Protinsky, Flemke et al. (2001) proposed that a therapeutic alliance in which trust and safety are established is essential prior to implementing EMRE, and that both clients and therapists must demonstrate the ability to tolerate intense emotions. Moses (2003, 2007) highlighted the importance of assessing each member’s sincerity and commitment to working on their relationship prior to initiating EMDR within the couples therapy context. He identified the principles of safety, balance, and containment as necessary conditions before proceeding, and argued that therapists must weigh the risks and benefits with members of the couple. Safety consists of ensuring client stability to cope with the emotional material that may emerge during sessions, following the EMDR protocol, and an agreement within the couple to limit deeper emotional processing to sessions rather than attempting to do so between sessions.

Moses (2003, 2007) recommended ensuring balance by having both members of the couple participate in EMDR to prevent one from taking on the “identified patient” role. However, he also noted the value of intentional unbalancing for therapeutic reasons as potentially beneficial. For example, when one partner is viewed as the identified patient, initiating EMDR with the other partner while the first partner serves as a compassionate witness to the other’s vulnerability may stabilize the relationship dynamics. Finally, providing containment involves thoroughly assessing both members’ internal and external resources, developing resources when appropriate, supporting the witnessing partner to take on the role of a container for the working partner (e.g., holding the partner’s hand, if mutually desired), providing the opportunity for closure at the end of each session, limiting each person’s processing to two or three sessions at a time, and being accessible to clients between sessions if necessary (Moses, 2003, 2007).

Robin Shapiro (2005) identified several questions she considers in the assessment of a couple’s readiness for EMDR including (a) whether there is sufficient safety within the relationship, which includes whether partners will use material disclosed by the other as a weapon and whether the witnessing partner can and will allow the working partner uninterrupted quiet and space to process; (b) whether partners are sufficiently differentiated or capable of becoming so to allow for the other’s processing; (c) whether they are able to provide reciprocal support; (d) whether each has the skills for self-soothing; (e) whether each partner can tolerate the traumatic material being processed by the other; (f) whether the issues contributing to dysfunction are the result of a personality disorder or rather are developmental or normative; (g) whether the therapeutic alliance

provides the containment necessary for reprocessing traumatic material; and finally (h) whether both partners are fully informed and have consented to EMDR treatment.

The pilot study (Legg, 2011) resulted in five factors that were identified as important to creating the appropriate environment in which EMDR could be incorporated into conjoint couples counseling: (a) understanding each person's role and maintaining healthy boundaries, (b) openness and willingness, (c) ability to trust and tolerate the process, (d) safety and security, and (e) empathy and caring. These conditions parallel several of those noted in previous work.

**Indications.** Authors have consistently identified the importance of both members being emotionally available and responsive to one another as well as willing to become vulnerable in order to shift interactional dynamics in a healthy way. Thus, EMDR within the couples therapy setting may be most appropriate when members of a couple have difficulty with empathy or sensitivity toward the other, struggle with obtaining a “softening event,” appear stuck in past attachment injuries or wounds, tend to personalize or project their feelings onto their partner, and need support through structure and rapid processing through attachment issues (Moses, 2003, 2007). Robin Shapiro (2005) proposed the following indications for the possible appropriateness of EMDR within conjoint couples session: (a) if clients are sufficiently differentiated that they can allow their partner to engage in EMDR without interrupting or becoming overwhelmed, (b) if partners can provide the necessary support to the other and not use material as a weapon for future retaliation, and (c) if members are experiencing traumatic or developmental issues rather than ones related to a personality disorder. She also noted that even if these criteria are not fully met but the couple appears capable and open to learning such skills,

EMDR may be appropriate. D'Antonio (2010) observed the value of EMDR for highly reactive couples as well as those who have experienced a traumatic event during or prior to their relationship that continues to negatively impact the relational dynamic. He also noted that it is appropriate to introduce it to couples when they are experiencing strong negative affect and a lack of hope, in addition to several of the indications listed above.

**Contraindications.** Shapiro (2001) cautioned the use of EMDR within couples work, highlighting the importance of a high level of commitment by the witnessing or supportive partners to provide the support and containment necessary to their partner, as well as the readiness of the working partners to self-disclose with their partner present. She noted that therapists must use their clinical judgment about the incorporation of EMDR into couples work, stating, "Since many treatment outcomes are obviously possible, the clinician needs to evaluate the couple carefully before making a decision about whether single or joint EMDR sessions would be more effective" (Shapiro, 2001, p. 289).

As with engaging in EMDR treatment in individual therapy, several issues must be considered to ensure the safety and stability of clients. Moses (2003, 2007) offered the following contraindications that parallel those for individual work: (a) one or both partners becomes significantly dissociative with emotional material, (b) partners are reluctant to engage in EMDR, (c) the therapist cannot ensure safety during sessions, and (d) any person is unable to tolerate the intensity of affect (including the witnessing or the working partner, as well as the therapist). Furthermore, specific to couples sessions, he also noted that if either partner is not fully committed to the relationship, has a complex or severe trauma history, may use the other's self-disclosures against them, or is



unwilling or unable to allow the working partner the attention and space necessary to process through material, EMDR is not appropriate. Finally, if there is such intense hostility or conflict within the relationship that safety cannot be established, he argued that these issues must first be addressed before proceeding (Moses, 2003, 2007).

Robin Shapiro (2005) presented similar recommendations and argued that when partners are not sufficiently differentiated from one another that one partner cannot or will not allow the other the space to process or becomes overwhelmed by the partner's material, or when one or both partners has a personality disorder that might prevent the other from engaging in the processing without interruption, it may be more appropriate to work separately. Errebo and Sommers-Flanagan (2007) stated that this treatment is not appropriate in the presence of active life-threatening abuse, high suicide risk, or domestic violence.

Litt (2008, 2010) noted several contraindications, some of which parallel those already mentioned. Furthermore, he argued that the following situations may serve as contraindications for conjoint EMDR: (a) the working partner is unable or unwilling to experience and express emotional material with the witnessing partner present and (b) the working partner is not ready to self-disclose to the witnessing partner.

### **Summary and Implications for Current Study**

This chapter reviewed the literature related to trauma, attachment, couples therapy, and EMDR treatment. Exposure to psychological trauma is not uncommon, though the vast majority of individuals recovers within the first few months and do not require therapeutic intervention. Several factors serve to enhance resilience to posttraumatic effects; one of the most important elements is one's social network.

Supportive relationships mediate the impact of trauma, either reducing or compounding its effects, depending on the response of others to traumatic events. When individuals develop posttraumatic symptoms as a result of traumatic exposure, such symptoms may result in extensive disruptions in multiple areas of functioning.

Various treatment approaches have been demonstrated to be effective in reducing PTSD symptoms; those that target the trauma-related symptoms through exposure and trauma processing within a safe and supportive relationship seem to be most effective (van der Kolk, Spinazzola et al., 2007). Exposure treatments have been found to be effective in reducing re-experiencing symptoms. In contrast, group therapy for survivors appears to be helpful in addressing the interpersonal effects of traumatic exposure such as the numbing and detachment symptoms (Herman, 1997; van der Kolk, Spinazzola et al., 2007). Incorporating EMDR, an experiential treatment that allows for reprocessing and integrating of traumatic material into a coherent narrative, within couples therapy may provide a corrective emotional experience for survivors that can facilitate healing and the rebuilding of a sense of connection to others.

The historical development of attachment theory was reviewed as well as the specific assumptions of the theory. Furthermore, the internal working models of self and others that develop as a result of early attachment relationships were outlined as was the application of attachment theory to adult romantic relationships. Finally, the impact of disrupted attachment and the concept of attachment theory as a trauma theory were discussed as well as treatment approaches to addressing attachment issues. Early attachment disruptions can result in attachment insecurity that serves as a template for future attachment relationships.

Just as trauma shatters assumptions about oneself, one's relationships, and the safety of the world, early attachment wounds inhibit the development of a coherent sense of self, trust in others, and a belief in the safety in the world. When primary attachment figures do not provide consistent and responsive support, individuals often develop a perception of oneself as unworthy and unlovable as well as the expectation that intimate partners will similarly be unavailable and unresponsive. Just as social support can either buffer against or compound the impact of trauma, adult intimate relationships can reinforce negative cognitive schemas about oneself and others and reinforce dysfunctional patterns or they can serve as a safe haven and secure base, thereby providing a corrective emotional experience for partners who have experienced early attachment wounds.

The literature related to couples therapy was outlined including its historical development as a discipline. Emotionally focused couples therapy was reviewed as an experiential, emotionally oriented treatment for couples that is empirically supported and is based in attachment theory. This approach as an effective treatment of trauma as well as attachment injuries within conjoint couples therapy was also reviewed. Recently, couples therapy has begun to be examined systematically as an effective treatment for the impact of trauma (Johnson, 2002). Emotionally focused couples therapy has been shown to increase trauma survivors' affect tolerance and regulation, and has been effective in increasing intimacy among partners and rebuilding a sense of self among survivors (Alexander, 2003; Johnson, 2002). Furthermore, the power of the partners of trauma survivors serving as witnesses to their spouse's trauma narrative has been noted as healing for both survivors and their significant other (Alexander; 2003).

The final section of the literature review outlined the research related to EMDR treatment, a comprehensive and empirically supported treatment for trauma symptoms that is primarily used within the context of individual therapy. Its development and protocol were reviewed as well as the adaptive information process model upon which it is based. The extensive research, including multiple randomized controlled trials and meta-analyses was presented, as well as perspectives regarding the role of eye movements.

Cautions and contraindications for the use of EMDR were discussed. This section concluded with a review of the application of EMDR for attachment issues as well as its incorporation into conjoint couples therapy. In spite of initial controversies and criticism regarding EMDR and the methodologically flawed studies during its early years, extensive research has provided support for its effectiveness in reducing posttraumatic symptoms. In recent years, several authors have examined its use within couples therapy, protocols have been presented, and guidelines how and when to apply EMDR within conjoint sessions.

Research has demonstrated the increase in success rates for anxiety, depression, and PTSD (Barlow et al., 1984; Bowling, 2002; Cerney et al., 1987) when couples therapy was incorporated into treatment. There appears to be a growing recognition of the value of couples therapy as well as an increased awareness of the importance of relationships in coping and recovery from stressful events. Couples therapy can provide a context in which healing from trauma can occur and where the traumatized partner can re-establish a safe haven and secure base within the relationship (Johnson; 2002). Given the relational effects of traumatic exposure, the incorporation of an interpersonal

approach to healing seems particularly appropriate. Furthermore, rather than the therapist serving as the corrective attachment figure, couples therapy allows the opportunity for one's intimate partner to provide that corrective experience.

Beyond big "T" traumatic events, this chapter described evidence that small "t" events and attachment wounds impact one's internal working models related to oneself as well as relationships. In order to modify those internal models, attention and processing within a corrective emotional relationship has been proposed as a necessary condition (Johnson, 2002). Emotionally focused couples therapy appears to be effective in modifying information processing in order to allow individuals to better attend to, interpret, and respond to incoming information in the present, providing additional support for its potential value for partners with a range of traumatic or distressing symptoms.

The following chapter presents the methodology for the current grounded theory study, whose aim is to develop a theory to explain the process of EMDR treatment within couples therapy and to discover factors that contribute to and inhibit its effectiveness. The present study incorporates the perspectives of both members of the couple as well as the therapist and will result in a theory that is grounded in the data from these interviews. The goal is to extend past research through grounded theory research, which has not been conducted in this area.

## **CHAPTER III**

### **METHODOLOGY**

#### **Introduction**

In this chapter, I outline the purpose of the study and research questions, introduce myself as the researcher, and provide a review of the research model and paradigm, methodology, and research methods used in the study. Furthermore, issues of rigor in qualitative research and methods to enhance the trustworthiness of the study are presented. As outlined in the first chapter, the purpose of the current study was to explore the experience of clients and therapists during eye movement desensitization and reprocessing (EMDR) treatment within the context of conjoint couples therapy and to develop a theory grounded in data from interviews and documents. This theory provides an understanding of the factors and conditions that contribute to the change process as well as those that decrease or interfere with the usefulness of EMDR within couples therapy. Specifically, the research questions were:

- Q1     How do members of couples describe their experience of conjoint couples therapy involving EMDR treatment?
- Q2     How do therapists describe their experience of providing EMDR treatment within the context of conjoint couples therapy?
- Q3     What do participants perceive as valuable or meaningful about the process?

- Q4 What do they perceive as impeding the process or not valuable? 5) How does each participant describe the status of the couple prior to and following EMDR, both individually and relationally?

### **Research Paradigm**

Within this section, four concepts are reviewed and applied to the current study: epistemology, theoretical perspective, methodology, and methods (Crotty, 1998).

#### **Epistemology**

Crotty (1998) defines epistemology as “the theory of knowledge embedded in the theoretical perspective and thereby in the methodology” (p. 3). It is a means of understanding and describing how we know what we know (Crotty, 1998). He identifies three primary epistemological perspectives: objectivism, constructionism, and subjectivism.

The current study was grounded in a constructivist theory of knowledge; that is, the view that meaning is constructed in unique ways by each individual and that the observer and that being observed become merged in the creation of meaning (Crotty, 1998). This view holds that there is no objective truth; rather, we discover the meaning of objects and situations in and out of our interaction with the world. Thus, meaning is constructed and therefore each person will hold a different meaning than another for the same phenomenon. This perspective takes into account different cultural backgrounds and generations, recognizing that the meaning we hold may change across cultures and time periods.

The current study was intended to provide an understanding of the meanings attributed by participants to the process of EMDR within couples therapy, as well as particular elements and conditions within the process that were experienced as

meaningful and those that were not. Thus, I was attentive to participants' meanings and deliberate in maintaining a reflexive approach about the meanings that I attribute to similar phenomenon. I clarified participants' meanings when I recognized times when I might have been unintentionally making assumptions. The incorporation of peer debriefing as well the use of a reflexive journal were tools to increase such awareness.

### **Theoretical Framework**

Crotty (1998) defined theoretical perspective as “the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria” (p. 3). He identified five primary theoretical perspectives or paradigms: positivism, interpretivism, critical inquiry, feminism, and postmodernism, though he notes that many other variants and sub-perspectives exist. Creswell (2007) identified four theoretical worldviews: post-positivism, constructivism, advocacy/participatory, and pragmatism. The theoretical perspective provides a conceptual framework to understanding the data and consists of assumptions that the researcher brings to the study.

As with the epistemological stance described above, a constructivist framework underlies the current study; this is the view that all meaningful reality is predicated on human practices and is constructed out of the interaction between humans and their world (Crotty, 1998). According to Merriam (1998), “the key philosophical assumption. . . upon which all types of qualitative research are based is the view that reality is constructed by individuals interacting with their social worlds” (p. 6). She stated that “qualitative researchers *are interested in understanding the meaning people have constructed*, that is,



how they make sense of their world and the experience they have in the world” (p. 6, emphasis in original).

Charmaz (2006) argued that the constructivist approach is appropriate for grounded theory research because such research involves grounding one’s theory in the perspectives of the participants. She posits that all data are constructed, as they may come from interviews, documents, observations, and other means, and thus are influenced by both the participant from which they originate and the researcher who interprets them, including each individual’s historical, social, and political backgrounds. Within the current study, I aimed to make sense of the constructed meaning for each participant and in doing so, generated a theory grounded in these data.

### **Methodology**

Methodology consists of the design that underlies the choice and use of specific research methods (Crotty, 1998). A grounded theory methodology was used to collect and analyze data for this study. Grounded theory research generates a theory from data that are systematically gathered from participants who experienced a particular event or process. This theory provides an explanation of a process, action, or interaction, based in the experiences of the participants interviewed (Creswell, 2007). Grounded theory methods include the following: (a) simultaneous data collection and analysis, (b) a process for coding data, (c) comparative methods, (d) memo writing as a means of creating conceptual analyses, (e) theoretical sampling, and (f) development of a theoretical model (Charmaz, 2005).

Glaser and Strauss developed the grounded theory approach to research in 1967. Through this methodological approach, they intended to provide a structured framework

for generating theory from empirical data (Echevarria-Doan & Tubbs, 2005). Despite the collaboration by these two researchers in the development of grounded theory, Glaser and Strauss proceeded in divergent directions regarding grounded theory methodology. Glaser's focus was on the emergent process of theory development and he criticized Strauss' perspective as overly prescribed and structured. In contrast, Strauss was focused on the systematic and coding aspects of data analysis and synthesis (Creswell, 2007; Echevarria-Doan & Tubbs).

Currently, the two most common approaches to grounded theory research are the systematic methodological procedures of Strauss and Corbin and the constructivist perspective of Charmaz (Creswell, 2007). In the current study, I share Charmaz's (2006) epistemological and theoretical approach, which is rooted in a constructivist perspective and highlights multiple realities, based on each individual's unique constructed meanings, shaped by one's culture and interactions with the world (Charmaz, 2006; Creswell, 2007). Mills, Bonner, and Francis (2006) express that in constructivist grounded theory, the researcher is repositioned "as the author of a reconstruction of experience and meaning" (p. 2). In contrast to Strauss and Corbin (1998), Charmaz does not endorse the researcher's aim to maintain objectivity in terms of the relation between participants and the data. I utilized the classic method of data analysis outlined by Strauss and Corbin and informed by Charmaz's constructivist approach.

### **Research Methods**

In this section, several aspects of the research methods are reviewed including the process of obtaining approval from the Institutional Review Board (IRB), the participants

and recruitment methods, and the setting. Procedures such as data collection methods and data analysis are also outlined.

### **Institutional Review Board Approval**

After approval of the current research proposal from my dissertation committee, an application for the university's Institutional Review Board (IRB; see Appendix A) was submitted and obtained prior to proceeding with the study. Once approval from the IRB was obtained, recruitment of participants was initiated.

### **Research Participants and Setting**

Participants for this study included a criterion sample of seven triads composed of individuals who had participated in conjoint couples therapy in which EMDR was utilized with one or both members of the couple, as well as the therapists who had provided the therapy to each couple, resulting in a total of 21 participants. The number of triads included in the study was based on saturation of the data. Creswell (2007) recommended including 20 to 30 participants to obtain a well-saturated theory.

Purposive sampling (Merriam, 1998) was initially utilized to identify participants, followed by theoretical sampling (Strauss & Corbin, 1998) in order to modify the sample as appropriate, based on the emerging data. In purposive or purposeful sampling, the selection criteria guide the selection of participants; these criteria reflect the purpose of the study (Merriam, 1998). Theoretical sampling provided the opportunity to modify data collection in order to meet the needs of the emerging data, consistent with the emergent nature of qualitative research (Creswell, 2007; Strauss & Corbin, 1998). Theoretical sampling involves the continual examination of the data throughout the research process in order to determine additional participants, observation sites, or documents that are

necessary to pursue in order to fill existing gaps in the data to contribute to the emerging theory (Strauss & Corbin; 1998). Follow-up interviews were conducted with two participants to provide missing information in the theory development.

The initial purposive sample included participants who had engaged in eye movement desensitization and reprocessing (EMDR) treatment within a conjoint couples therapy context to address little 't' or big 'T' traumatic events, either in the role of client or as the therapist. Inclusion criteria for clients consisted of the following: prospective client participants were adults involved in a committed relationship, had participated in conjoint EMDR treatment (as the working or witnessing partner, or in both roles), were willing to be interviewed about that experience, and were willing to provide permission for their partner and their therapist to be interviewed.

The participant recruitment process lasted five months and was intensive in nature, involving sending hundreds of emails, sending dozens of recruitment letters through the mail, and making many phone calls to potential participants. In order to recruit these participants, I contacted the EMDR Institute and the EMDR International Association (EMDRIA) to ask for permission to distribute information about the study to EMDR trained clinicians and consultants through listservs and internet discussion groups (see Appendix E). I also emailed EMDR trained clinicians and consultants identified through the EMDRIA directory as well as emotionally focused couples therapy (EFT) trained clinicians identified through the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT) website with information about the study (see Appendix E). Furthermore, I distributed information about the study to the following: EMDRIA Research Special Interest Group listserv, the EMDRIA Board of Directors, the

Editor for EMDR Journal: Research and Practice, a LinkedIn EMDR group, authors and researchers on the topic of EMDR in couples therapy, the EMDR Research Foundation, on-line therapy directories and networking groups, and trauma centers.

For clinicians who were interested in participating, informed consent (see Appendix F) was obtained and therapists were asked to provide additional informed consent forms (see Appendix G) to couples who were current or former clients to inquire whether they were willing to participate. For those who were, the couples were asked to complete an Authorization to Release Information form (see Appendix H) to provide permission to the therapists to be interviewed and to share clients' contact information. Members of the couple were then contacted directly to obtain written consent and to schedule interviews.

Participants were provided options regarding the location of interviews in order to accommodate transportation and scheduling limitations. Two participants were interviewed in their home, one was interviewed in his office, and the remaining were successfully interviewed by phone or through Skype due to distance and scheduling restrictions.

## **Procedures**

Once informed consent was obtained by both members of the couples and the therapist, all client participants were provided with referral information for mental health services (see Appendix I) in the unlikely case that the interview might provoke intense feelings requiring outside support, though most clients were participating in ongoing therapy at the time of the interviews.

**Data collection methods.** The quality of the data gathered determines the quality of the research as a whole. Thus, I sought to gather rich and ample data to provide as complete a picture of participants' experience as possible and to develop conceptual categories as well as relations between categories (Charmaz, 2006). Data collection and analysis were conducted simultaneously such that the concepts and processes that emerged during the initial interviews would guide the direction and focus of additional interviews, in an attempt to answer questions and fill conceptual gaps (Charmaz, 2006). As new concepts were derived, they were formed into categories that provided the framework for the developing theory (Strauss & Corbin, 1998).

**Interviews.** After providing consent, clients completed a demographic information sheet (see Appendix J). Clients and therapists then participated in separate initial 90 minute semi-structured interviews (Charmaz, 2006; Merriam, 1998) about their experience of conjoint couples therapy that included EMDR with at least one member of the couple (see Appendix K). According to Merriam (1998), this semi-structured format allows the researcher to respond to the situation at hand, to the emerging worldview of the respondent, and to new ideas on the topic. This format is consistent with the constructivist approach to the current study, which holds that participants are offering their constructed meaning during the interview. Charmaz (2006) said, "Both grounded theory methods and intensive interviewing are open-ended yet directed, shaped yet emergent, and paced yet unrestricted" (p. 28).

Both members of the couple and the therapist who provided therapy were interviewed separately to obtain each person's experience of this therapeutic process, as well as changes that they observed within individual members of the couple and within

the couple as a unit (see Appendix K). These interviews were audio recorded and transcribed. Follow-up interviews were conducted for two participants in order to fill in gaps within the data, in line with theoretical sampling (Charmaz, 2006). The grounded theory method allowed the flexibility to gather more data as certain themes emerged that require further investigation.

Participants were provided with the opportunity to review their personal transcriptions for accuracy. Member checks were incorporated at two points during this study. First, they were provided with copies of the transcription and initial coding of the interviews and were asked to provide feedback about whether the transcript and emerging categories accurately reflected their perspective. In response to this first check, eight of the 21 participants shared their feedback, all confirming that the content was accurate, one asking for a follow-up interview to provide an update and clarification, and another two participants providing email updates since their interviews. Second, participants were provided with a copy of the theory that was grounded in all of the participant data and were encouraged to provide feedback. In response to this second check, five participants responded, all expressing appreciation with being able to read the grounded theory and confirming that their experience fit with the final theory. These checks served to increase the trustworthiness of the study.

***Memo writing.*** Memo writing is the step between data collection and writing up the data, and involves the researcher reflecting upon his or her ideas about the chosen codes and emerging categories in an unstructured manner (Bryant & Charmaz, 2007). Memos included detailed notes about the participant recruitment process. They also included information regarding the analysis, possible directions for analysis, and general

ideas about the evolving theory; they served to organize and clarify ideas throughout the research process and were useful in the development of the theory. They allowed me to compare data and to consider various ideas about the categories, and they guided further data collection (Charmaz, 2006). Furthermore, memo writing served to increase the trustworthiness of the current study by providing an audit trail to authenticate the findings (Merriam, 1998).

***Document review.*** Client participants were invited to share for inclusion personal writings (e.g., journal entries, letters, or poems) or artwork that were representative of aspects of their therapeutic process, their relationship, or themselves at various stages of therapy. Therapist participants were also invited to share documents such as questionnaires, measures, or other data that provided baseline and outcome ratings and symptoms of clients' intra- and interpersonal functioning within their relationship. These documents or "extant texts" served as supplemental sources of data (Charmaz, 2006), providing a source of triangulation to enhance the trustworthiness of the study (Creswell, 2007; Guba & Lincoln, 1989; Lincoln & Guba, 1985). Several therapists shared parts of their session notes and data from pre- and post-measures.

***Data analysis procedures.*** Interviews for this research were audio recorded, transcribed, and analyzed. Themes that emerged during the interviews were coded, categorized, and analyzed for frequency. Documents were copied and used as supplemental sources of data that provided further triangulation. The analysis addressed the research questions by identifying the themes that emerged during the interviews related to each participant's experience of conjoint EMDR and generating a theory regarding this process.



Qualitative coding is the process of making sense of and identifying the meaning behind the data (Charmaz, 2006). It involves labeling sections of data in a way that provides a description and category for each piece of the data. I utilized the three-step coding process identified by Strauss and Corbin (1998), which includes open, axial, and selective coding. Throughout the analysis of the data from interviews, documents, and memos, I utilized the “constant comparative method” (Glaser & Strauss, 1967). That is, I made comparisons at each phase of the process, observing similarities and distinctions among data in order to refine the theory. Data were compared with other data and data were compared with codes. Furthermore, theoretical sampling guided the process of data analysis, which required seeking out data that served to clarify and refine the theory by filling in gaps and answering questions about emerging categories (Charmaz, 2006; Glaser & Strauss, 1967).

The grounded theory approach involves generating an abstract analytical schema or theory regarding a particular phenomenon that serves to explain the process and results in the development of a substantive or context-specific theory (Strauss & Corbin, 1998). Coding is the first step in the analysis and involves sorting the data and labeling them to develop theoretical categories (Charmaz, 2006). Codes portray meanings, actions, and processes, and build the framework for the analysis while developing an understanding of what is happening. Within this study, codes emerged from the data, from the participants’ words and meanings, as well as from my interpretations of their words about their experience throughout the conjoint EMDR process.

***Open coding.*** Open or substantive coding is the first step in the coding process and involves studying and categorizing fragments of data, including words, lines, or

sections, and providing labels to those segments based on themes. During this process, participants' terms or "in vivo" codes were utilized, when appropriate, to provide more richness and personal meaning to the categories. That is, language or terms used by participants were incorporated into codes in an attempt to preserve their meanings, though whether they were maintained later depended on what emerged during the constant comparative method. These initial codes provided analytic ideas that guided and were explored in further data collection and analysis.

Strauss and Corbin (1998) describe this initial phase like working on a jigsaw puzzle, where the pieces are sorted by color to gradually construct a picture. This step is open-ended and requires reflexivity and an ongoing awareness of the researcher's biases and preconceived ideas, so that they do not guide the coding process. As Charmaz (2006) states, "Initial codes are provisional, comparative, and grounded in the data" (p. 48). During open coding, I used the constant comparative method, comparing across interviews and participants in order to observe similarities and differences in their experiences, actions, and processes (Charmaz, 2006). This coding process continued until the point of saturation, where no further insight was gleaned from additional data in the development of categories (Creswell, 2007). During this process, I engaged in memo writing about ideas regarding codes and categories to use later in the analysis.

***Axial coding.*** Strauss and Corbin (1998) defined this second type of coding as "the process of relating categories to their subcategories, termed 'axial' because coding occurs around the axis of a category, linking categories at the level of properties and dimensions" (p. 123). After breaking down the data into distinct segments during open coding and reaching saturation, axial coding allowed me to synthesize the data into a

coherent whole (Charmaz, 2006). This phase helps to explain the central phenomenon being examined including (a) the influential factors that impact that phenomenon, which Strauss and Corbin (1998) term “conditions”; (b) the strategies utilized by participants to respond to the phenomenon and the context and intervening conditions that influence these strategies, which they refer to as “actions or interactions”; and (c) the outcomes of these strategies, called “consequences.” (Creswell, 2007; Strauss & Corbin, 1998).

This organizational structure allowed me to answer what, why, where, how, when, and by whom questions related to the EMDR process within couples therapy, and to understand how each aspect are related to one another, serving as hypotheses for that category (Strauss & Corbin, 1998). During this process, theoretical sampling was utilized to fill in gaps in the categories and further refine the emerging theory. Categories were compared and contrasted throughout the process until no further categories emerged, consistent with the constant comparative method. As during the open coding process, memo writing was conducted throughout this second coding process.

***Selective coding.*** Finally, selective coding involves the refinement and integration of the theory that is grounded in the collected data. During this process, data were organized into the six components of grounded theory: influential conditions, phenomenon, contextual factors, intervening conditions, actions/interactions, and consequences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Integrating the various categories provided a theoretical picture that illustrates participants’ experience of EMDR within conjoint couples therapy.

This process provided information about how the substantive codes that were identified during focused coding might relate to one another as an integrative theory

(Charmaz, 2006). It required identifying and then systematically connecting the central phenomenon or core category with other categories, thereby creating a theory grounded in the data. The theory continued to be refined through constant comparison among data and codes to ensure consistency and good fit within the theoretical scheme. Further theoretical sampling was conducted when needed (such as by conducting follow-up interviews and asking for documents to enable triangulation) in order to reach the point of theoretical saturation, where as much of the possible variation was accounted for by the analysis (Strauss & Corbin, 1998).

### **Ethical Considerations**

Charmaz (2006) stated that “respect for our research participants pervades how we collect data and shapes the content of our data” (p. 19). Throughout this research, I attempted to honor the openness and willingness with which participants entered into this study by striving to truly understand and capture their perspectives. To do so, I strove to be reflexive and aware of my biases and assumptions, and tested those assumptions rather than accepted them as reality, with the recognition that those assumptions are personal constructions and not those of participants (Charmaz, 2006). Each interview was approached with the utmost respect, curiosity, interest in fully understanding their experience, while attempting to capture varying perspectives and allow emerging data, rather than my preconceived ideas, to guide the process.

As data were collected and analyzed simultaneously, such an approach allowed an openness to new directions, depending on what emerged (Charmaz, 2006; Glaser & Strauss, 1967). This is congruent with the grounded theory emphasis on analysis of action and process. I was consistently seeking to understand what was happening, what social

and psychological processes contributed to what was happening, what processes were most and least important, what meanings participants attributed to the processes, and what conditions fostered such processes (Charmaz, 2006). To fully understand and capture participants' experience during the intensive interviews required listening for the meanings attributed by clients and tuning into specific words as well as non-verbal behavior (Charmaz, 2006).

Given the sensitive nature of the topic, it was especially important that participants felt respected, listened to, and honored throughout the process, beginning with reviewing the consent form and continuing with the questions asked, the way in which questions were asked, my patience and openness throughout the interview, and the member check process. Participants are the experts of their experience and it was my responsibility to provide the context in which they could share their story (Charmaz, 2006). Furthermore, ethical and respectful treatment of participants and awareness of their comfort level were priorities; participants set the pace in order to prevent my agenda from being intrusive or superseding their boundaries. I strove to remain cognizant of the sensitive nature of the research topic and to ensure that participants maintained a sense of emotional safety as much as possible.

Herman (1997) highlighted the importance of respecting the power inherent in the role of researcher with participants who have experienced trauma:

Particular care must be taken also to avoid the reenactment of a pattern of exploitative relationships within the research enterprise itself. Survivors of terrible events are often motivated to volunteer as research subjects in the hope that helping others may give meaning and dignity to their suffering. The relationship between survivor and investigator is subject to the same power imbalances and the same contagious emotions as any other relationship. (p. 240)

I attempted to remain attuned to the power dynamics between participants and me and I endeavored to communicate to them verbally and non-verbally that they are truly the experts of their experience. Furthermore, they were respected for whatever aspects they chose to share about that experience.

Though this issue was not verbalized, there may have been concern on the part of certain participants that the information they shared would be communicated with others, including their partner, therapist, or client. I informed participants that, given that their experience would become part of a larger study, their words would be captured, but their confidentiality would be maintained. It was my responsibility to explain to them the purpose of the study and how the findings would be used, so that participants were fully informed prior to consenting to participation.

Due to the possibility that certain participants might have provided information that they thought their therapist or I might hope to hear, I attempted to bracket any biases and prior experience in order to decrease their influence on what and how participants shared about their own experience. I did so through writing in a reflexive journal about reactions I had to participants, which I reviewed with my peer debriefer to assess together whether my reactions were influencing my interpretation of the data. The peer debriefing process also allowed us to compare themes that we each identified. I also was thoughtful about issues related to gender, class, age, race, ethnicity and other cultural dynamics between participants and myself.

Furthermore, as a therapist, it was important that I remained within the role of researcher rather than inadvertently shifting into the role of therapist. It was also important for me to be cognizant of times when participants seemed to communicate with

me in the role of therapist. I attempted to be as sensitive as possible about how I responded to such occurrences, in order to foster an environment of safety and openness, while reminding them of the context of the interview.

Beyond these measures, several procedural steps were taken to maintain an ethical approach throughout this research. For example, the informed consent form was thoroughly reviewed with all participants, any concerns were addressed, and participants were reminded of their option to withdraw at any point during the study, if concerns did arise. Each participant was provided with the opportunity to choose a pseudonym upon initiation of the interviews. Consent forms were stored separately from their data in order to increase the confidentiality of participants. Though participant quotes are used, the identity of participants is not connected to these quotes. Furthermore, all data were stored in a locked cabinet or in a locked electronic file, and no person other than my dissertation chair, peer reviewer, and research assistants had access to these data. Research assistants who assisted in transcription and data analysis participated in training regarding confidentiality and data storage procedures. Also, given the sensitive nature of the research topic and that client participants shared personal information regarding the impact of traumatic histories, mental health resources were provided to all client participants in the case that the interview might later trigger a significant emotional response.

### **Rigor in Qualitative Research**

With qualitative research, the methods of evaluating the quality of the research and of the findings are different than the concepts of reliability and validity used in quantitative research. The terms trustworthiness, credibility, transferability,

dependability, and confirmability are used instead (Creswell, 2007; Lincoln & Guba, 1985). These concepts are addressed below.

### **Trustworthiness**

Trustworthiness is the term that refers to the degree to which the research findings can be believed and how worthwhile they are to explain the phenomenon being examined. To increase the trustworthiness of qualitative research, several guidelines are recommended, including careful attention at every stage in the research process, including its design as well as during the collection, analysis, and interpretation of data, and finally in the presentation of the findings (Merriam, 1998). Lincoln and Guba (1985) described trustworthiness as the overarching quality and believability of the findings, with the following four elements that must be met in order to obtain trustworthiness: credibility, transferability, dependability, and confirmability.

### **Credibility**

Credibility is the degree to which the findings can be believed and are a true reflection of participants' perspectives. Within the current study, credibility was addressed through the use of peer debriefing/examination, member checks, triangulation, and providing information about my stance as the researcher. Peer debriefing or examination included consulting with a fellow doctoral student in order to discuss the data analysis process, emerging themes, theoretical constructs and relationships, and any concerns or questions that arose throughout the process. She read each of the transcriptions and developed categories for each, which we compared to those I had developed. When there were discrepancies in our categories, we discussed them until we reached agreement. She reviewed my reflexive journal after each interview in order to be



aware of my personal reactions and biases as an additional means of accountability. She also reviewed and provided feedback about the developing theory. Member checks were incorporated at two points during this study, first after the transcription and initial coding of the interviews to inquire with participants whether the transcript as well as the emerging themes and categories accurately reflected their perspective, and second after the generation of the theory to provide participants with the opportunity to provide feedback, if desired.

Triangulation refers to seeking out “corroborating evidence from different sources to shed light on a theme or perspective” (Creswell, 2007, p. 208). I incorporated triangulation into the research by interviewing both members of each couple as well as the therapist and by the inclusion of multiple triads of couples and therapists, in order to obtain a variety of perspectives that provide credibility to the themes that emerged. Triangulation was also incorporated into the study through peer debriefing, which resulted in two sets of eyes looking at the data to assess the accuracy and appropriateness of the categories. Furthermore, the use of multiple data collection sources, including interviews and document review, was used for triangulation. Finally, attempts were made to maintain a reflexive approach throughout the study, seeking to be aware of any biases and assumptions. Memo writing served as an outlet to note those as they surfaced in order to reduce the likelihood that they would interfere with the process of allowing the data to guide the process. Peer debriefing also provided an additional measure of accountability to increase that self-awareness.

**Transferability**

Transferability is the extent to which the findings ring true with the reader and seem to generalize or apply to their situation; it is based on the richness of the data gathered and presented in that such richness in descriptions provide information and context to the data (Guba & Lincoln, 1989). For the experiences of the participants and the findings of the research to resonate with the reader, descriptions must be thorough and rich in detail. It must capture the participants' perspectives so that the reader can understand their meanings and worldview. Doing so allows readers to assess their similarity with the participants and determine whether the findings apply to them and others. I attempted to understand participants' experiences and to capture them through the inclusion of rich detail and personal quotes, and by being attentive to similar themes among participants' stories.

Transferability is also increased through modal comparison (Merriam, 1998). Modal comparison involves comparing participants' experiences and perspectives with similar individuals, contexts, and situations (Merriam, 1998). Modal comparison was utilized throughout the current study through the constant comparative method of comparing data across participants and categories to look for similarities and differences. Such comparison was conducted until the point of saturation, where no new information contributed to any further understanding of categories or provided additional insight toward the categories or theory (Charmaz, 2006; Creswell, 2007).

**Dependability**

Dependability refers to the consistency between the findings and the data that are collected, and is demonstrated through recording any changes to the methodology and

research questions with the use of memo writing and providing an audit trail, as well as through triangulation, member checks, peer examination/debriefing, and researcher stance (Creswell, 2007; Guba & Lincoln, 1989).

Audit trail will be described here as the other methods were reviewed above. An audit trail is a written record of the conceptualization and process of decision making throughout the research process (Merriam, 1998). This included systematically documenting the steps in participant recruitment, data collection, and in decision making regarding codes, categories, emerging themes, theoretical constructs, and relationships among them. Such documentation provides the opportunity for others to understand the research process and authenticate research findings (Merriam, 1998). I maintained notes regarding these steps throughout the research process and reviewed these steps with my peer debriefer.

### **Confirmability**

Finally, confirmability is the degree to which the findings make sense and are accurately rooted in the collected data, which again is assessed with the use of an audit trail, and increased with member checks, and peer examination/debriefing, all of which were described above (Guba & Lincoln, 1989; Merriam, 1998).

### **Summary**

In this chapter, I outlined the purpose and research questions for the current study, provided information about myself as the researcher, and reviewed the research model and paradigm, methodology, and research methods used in the study. Finally, I concluded the chapter with the measures taken throughout the research process to enhance the trustworthiness of the study. In the next chapter, I present the findings of this study

including rich, thick descriptions of the participants' experiences and the theory that was developed based in participant data.

## **CHAPTER IV**

### **THE PARTICIPANTS**

#### **Introduction**

In this chapter, I introduce the 21 participants who were interviewed for this study, presented as seven triads that include both members of each couple as well as their eye movement desensitization and reprocessing (EMDR) couples' therapist. The age of the client participants ranged from 34 to 70 years old and that of therapist participants from 43 to 66 years old. The majority of participants were Caucasian, with two of the client participants identifying as Asian and one therapist participant as African American. One therapist resides in Japan, while all other participants live in the United States, ranging from the West to the East Coast, and from the northern United States to the north Pacific Ocean. Four participants were interviewed in person, two by Skype, and the remaining 15 by phone.

The length of the couples' relationships ranged from 2 to 47 years. All but one of the couples were married at the time of the interviews and one was engaged. The reasons for referral to couples therapy included infidelity, volatile conflicts, motor vehicle accident, and military combat, with five participants having been diagnosed with posttraumatic stress disorder (PTSD), and 9 of the 14 client participants having experienced childhood trauma resulting in attachment injuries. The therapist participants' professional experience in the psychotherapy field ranged from fewer than five to over 30

years, with all having attended at least both levels of the basic EMDR training. Among the seven therapists interviewed, five were EMDR Certified Clinicians, four Eye Movement Desensitization and Reprocessing International Association (EMDRIA) approved consultants, one a current trainer, another a former trainer, and a third working toward becoming a trainer.

In this chapter, I provide demographic information for each participant (see Table 1) as well as descriptions of the individual and relational functioning of each client and couple at the beginning of their couples therapy as well as at the time of the interview, after having participated in one or both roles (witnessing or working partner) within conjoint EMDR. Pseudonyms were chosen by participants and all identifying information was omitted to protect the confidentiality of participants.

Table 1

*Participant Demographic Information*

Participant	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	Triad 6	Triad 7
Therapist	Bill	Cat	Rich	Fred	Nancy	Michelle	Doris
Age	52	56	43	58	54	54	66
Gender	Male	Female	Male	Male	Female	Female	Female
Ethnicity	White	Eastern European/ Jewish	Caucasian	Anglo, Caucasian	Caucasian	African American	English/Irish
Title	MFT, Consultant, Trainer, AAMFT Approved Supervisor	MSW, LICSW, Consultant, Writer	LMFT, Supervisory Advocacy Clinical Counselor	Licensed Psychologist	LPC	LMFT, Owner of Private Practice	Licensed Psychologist
EMDR Training	EMDRIA Approved Consultant	EMDRIA Approved Consultant, Former Trainer, HAP Board	EMDRIA Approved Consultant, Facilitator, Working toward becoming a Trainer	Basic levels 1 and 2, Consultation group	EMDRIA Approved Consultant	Basic levels 1 and 2, Working toward Certification, Advanced trainings, Consultation groups, regional EMDRIA meetings	EMDRIA Certified Clinician

Table 1, continued

Participant	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	Triad 6	Triad 7
Partner 1	Rita	Nesse	NyxRN	Beth	Ursula	Bonnie	Louisa
Age	59	47	39	66	62	66	64
Gender	Female	Female	Female	Female	Female	Female	Female
Relationship Status	Married	Divorced	Married	Married	Married	Married	Married
Length of Relationship	36 years	2 years	3 years	47 years	42 years	47 years	34 years
Education	MSW	Bachelor's	Master's	BA	12 <sup>th</sup> grade	1 year college	MA
Ethnicity	French Canadian/ Caucasian	Asian	Asian	Caucasian	Irish/German	Caucasian	White
Religion	*	Buddhist	Lutheran	Protestant	Methodist	Episcopalian	"Not really"
Occupation	State Legislator	IT Manager	Registered Nurse	Retired	Retired	Retired	Homemaker



Table 1, continued

Participant	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	Triad 6	Triad 7
Partner 2	Matt	Richard	Huck	Sam	Algernon	Anthony	Roger
Age	59	37	34	70	68	68	59
Gender	Male	Male	Male	Male	Male	Male	Male
Relationship Status	Married	Single/In Relationship	Married	Married	Married	Married	Married
Length of Relationship	37 years	2 years, 2 months	3 years	47 years	42.5 years	47 years	34 years
Education	MD	*	Some College	BA	MBA	14 years	MA
Ethnicity	Caucasian	White/British	Caucasian	Caucasian	Caucasian	White	Caucasian
Religion	*	N/A	Catholic	Protestant	None	Episcopalian	*
Occupation	*	IT Manager	Military Police	Retired	Retired	Retired	University Professor

*\*Information not provided*

### **First Triad: Bill, Rita, and Matt**

#### **Bill**

Bill is a 52-year-old Caucasian male Marriage and Family Therapist (MFT), EMDRIA Approved Consultant and Trainer, American Association for Marriage and Family Therapy (AAMFT) Approved Supervisor, with 30 years of professional experience. He described his professional specializations and areas of expertise as the following: couples and family therapy; treatment of complex PTSD including dissociative disorders; and therapy with children. He identified himself as a generalist who works from a contextual theory perspective, which he described as an integration of psychodynamic thinking and systems theory.

#### **Rita**

Rita is a 59-year-old French Canadian Caucasian woman who had been married to Matt for almost 37 years and had been in a relationship with him for almost 43 years at the time of the interview. She identified this marriage as her first committed relationship and together, they have three grown children, one of whom lives at home with them. Rita shared that she was raised in a mill town of 34,000 persons that was very heavily Roman Catholic and French Canadian and she is the fifth of nine children. She had participated in three sessions of individual counseling in 1990 and eight sessions of couples counseling with a pastoral minister in 1996 prior to her couples therapy with Bill.

Upon the initiation of couples therapy six and a half years prior to the interview, according to Bill, Rita experienced a strong sense of worthlessness, presented with a dependent personality style, heavily relied on external validation, and was highly focused on changing her husband in order to make him more available to her. In response to her

husband's affair, she described feelings of betrayal, hurt, and anger. Bill observed that she engaged in compensatory behavior such as over functioning instrumentally within the relationship with Matt, particularly house cleaning, in an attempt to alleviate her sense of worthlessness. He also noted that she relied on alcohol use as a means of coping with her low self-worth and self-blame. She reported a tendency to take on responsibility for everything, acknowledged that she was very reactive, and said that she was highly invested in the need for her husband to change his behavior toward her in order for her to feel better.

According to Bill, she experienced relational and attachment trauma within the relationship as a result of Matt's extramarital affair, which led to a significant breach of trust for Rita, a pre-existing vulnerability due to a history of relational trauma during her childhood that were then exacerbated by the affair. Bill described her interpersonal style as "porcupine" in nature, in that she would desire to be close with Matt, but would vacillate from being dependent and needy to hostile and demanding. Rita described herself as having significant "angst" and fears, frequently taking on a victim role and being extremely angry.

Rita participated in an initial interview and a second follow-up interview approximately seven weeks later at her request, after having read the transcript from her first interview. At the time of the initial interview, Rita continued to be highly invested in changing Matt, experienced low self-worth (though stated that it had improved from previously and that she recognized that she was not actually as flawed as she felt), was still hurt and angry about her sense of victimization and experience of betrayal, had regrets about her marriage, and felt a sense of powerlessness and deprivation. In response

to the changes that Matt was experiencing and demonstrating during their couples therapy, Rita seemed to experience an initial increase in shame and worthlessness, due to feeling undeserving of his caring behavior and her inability to resort as easily to blaming him for her feelings of inadequacy, based on Bill's account. Furthermore, he said that her drinking initially increased and had become the central problem within their relationship. She did describe a decrease in the intensity of her feelings of betrayal through her experience of conjoint EMDR; however, she questioned whether she truly wanted to reduce that feeling, fearing that doing so would somehow invalidate her experience:

What I think is that [conjoint EMDR] lessened many things. So when I was feeling really really awful about something, my husband's neglect or whatever, I would feel less so. And I'm not sure that's a good thing because it lessens what one feels and I want to know what I feel. I want to be acknowledged for what I feel. EMDR, I think, helped me to say "Rita, you know what you're feeling is really kinda over the top" and it did help me in that way...helped me to put stuff, what I was feeling, back into reality so it wasn't totally emotional. It was like, "this is the way it is." So I would say EMDR was definitely definitely helpful...I didn't feel that with EMDR, what I was feeling was valid...I felt like what I was feeling was minimized and made better, softer, more in tune to what the hell was going on. But it was not addressing my direct important feelings.

At the time of follow-up interviews with both Rita and Bill approximately seven weeks after their first interviews, Rita had begun attending Alcoholics Anonymous after having recognized that alcohol had become a central problem. She acknowledged how much she had taken on a victim role within her relationship with Matt and had been resistant to EMDR and personal change. Over time, she and Bill both expressed that she had begun taking increasing ownership of her own feelings rather than putting the responsibility for them on Matt. She stated that she had become less reactive to Matt's behavior and was more consciously asking herself how well her behavior was working for her in order to ground herself and be more deliberate in her behavior.

She noted that she was taking less responsibility for everything and was more aware of how her own behavior had contributed to marital issues without taking on the responsibility for Matt's choice to engage in the affair. She stated that she had become more accepting toward herself and less judgmental of her feelings and responses, investing more in her own healing and becoming less filled with shame. She said that she was beginning to allow herself to be selfish, doing things for herself in contrast to previously, when she never believed that she was deserving of self-care. She reported feeling stronger and becoming more self-validating, and experiencing decreased anger as well as less fear and angst. Matt noted that she was more thoughtful and appeared to be coping better with current stressors than she had in the past. Furthermore, Rita expressed her love for Matt on several occasions during the second interview, demonstrating her softening and decreased anger.

### **Matt**

Matt is a 59-year-old Caucasian man who also identified this 37 year marriage as his first committed relationship. He did not disclose any previous counseling prior to his couples therapy with Bill. Based on accounts from Matt, Rita, and Bill, Matt had engaged in an extramarital affair with a colleague, which led to the initiation of couples therapy. According to Bill and Matt, he had experienced relational trauma within his family of origin, including abuse by a parent toward a sibling, and resulting feelings of guilt and shame for not having protected that sibling.

He described himself as very reactive and having difficulty being open and honest about his feelings at the beginning of couples therapy. Bill described him as having a dismissive attachment style with avoidant behaviors, and being highly defensive and

disengaged from his wife and children. He said that Matt longed for attachment and intimacy but was fearful of experiencing such closeness, becoming easily overwhelmed and maintaining an “arm’s length relationship” with his children. His avoidant behavior included not greeting his wife when they saw one another and not checking in with her when she was clearly upset. Bill noted that he would not acknowledge any conflict they had experienced the day after an argument, resulting in a lack of reparation or resolution. He was described as lacking social skills and lacking curiosity in others, not responding to other people, ignoring them, and having difficulty simultaneously monitoring his own behavior as well as that of others. His interpersonal style included a reliance on blame and was punitive in nature. Furthermore, Bill reported that Matt had untreated ADD and relied on alcohol as a means of coping.

When contrasting his previous functioning at the beginning of couples therapy to his functioning at the time of the interview, six and a half years later, Bill stated that he was no longer subjecting himself to Rita’s punishing behavior and setting limits with her. He said that Matt no longer would become paralyzed when she was belligerent or hostile toward him, recognized that he did not deserve such treatment, and was less dependent on external validation by Rita. Per the reports of both Bill and of Matt, he was less depressed, had resolved a phobia of heights, was more resilient and less reactive toward Rita, decreased his alcohol consumption both in terms of frequency and amount, and was less angry.

Bill reported that Matt became better able to listen, inquire, and explore in his interactions with Rita rather than resorting to defending, attacking, and avoiding behavior when she would become accusatory. He noted that Matt was no longer retreating in the

way he previously had and was not personalizing her defensiveness toward him. Matt described himself as “much less reactive, much less depressed than I was, much calmer in general, and much more in control than I used to be” and stated that he was less emotional in his encounters with others, experiencing the capacity to talk about issues without becoming angry and being able to think through things prior to responding. Matt said:

I know I’m much, much less reactive. I don’t get angry like I did. And I’m much less likely to be emotional during just about any encounter...not just to my wife, but also my other family members. I have a daughter that lives at home that can be a real pain in the ass. And when she does something irritating, it’s just like “oh that’s interesting.” You know, that allows me to talk about it and not get angry about it. So I think [EMDR]’s been really calming for me.

Bill noted that Matt became better able to interpret Rita’s actions when she would engage in attachment seeking behavior rather than perceiving such behavior as belligerence. He said that Matt was also demonstrating more caring and thoughtfulness toward Rita, inquiring when she would appear upset rather than withdrawing. Matt reported increased awareness when he became activated, was able to listen and respond more appropriately to Rita, was more direct in his communication toward her, and was expressing affection toward her. He stated that he was more able to focus on each of their concrete behavior and on making behavioral changes rather than his previous attitude of “good guy versus bad guy.”

### **Rita and Matt**

Rita and Matt initiated couples therapy with Bill six and a half years ago after Matt engaged in an extramarital affair that resulted in a breach of trust within their relationship and at which point, their long-standing relationship problems reached a point of critical mass per Bill’s account. Both participated in the roles of working and

witnessing partner, such that each engaged in EMDR as well as witnessed the other's EMDR process. Both Matt and Rita also chose to participate in several individual EMDR sessions with Bill, particularly when targeting issues within their relationship. Bill said that Rita and Matt had experienced long term marital difficulties including significant conflict, estrangement, and a lack of communication. Matt described their functioning in this way:

I think that I was a very reactive person and that my wife was also a very reactive person. We were playing off each other a lot and that there were major difficulties on my part emotionally opening up and being honest, as far as talking about my own feelings.

They had no method to seek repair or explore the factors that contributed to their conflict. Bill described their relationship as “hostile-dependent,” with a “rejection-intrusion pattern.” This included Rita engaging in demanding behavior around her needs for affection and becoming angry and hostile, to which Matt would respond by avoiding, shutting down, retreating, and freezing. Both were highly reactive to one another, frequently engaging in retributive actions to maintain homeostasis. Bill described an example of their dynamic as follows:

She would seek attachment security through affection (kissing and hugging) and also seek external validation through vie for praise and he would experience that as intrusive and get overwhelmed and defensive and often hostile and then would shut down or avoid. And then she might get drunk and belligerent and then shift into a very hostile, what I call her sadistic persona. She would be critical and mostly belligerent and so forth and he would just take it...he would be the whipping post. And then later that night, he would get drunk and then he would start calling her names and she would go to bed early and then he would turn the lights on and wake her up and call her names and be pushy and troubling and so forth and she would just take it.

Bill identified that their “proximal source of conflict” involved Matt leaving messes and Rita cleaning up after him, and that this “interlock of pathologies” served both of them



and was their “unconscious arrangement,” such that her cleaning up served as a means to cope with her sense of worthlessness and inadequacy.

At the time of the interviews, Matt and Rita had engaged in six and a half years of therapy, interspersed with EMDR to address current reactivity to one another as well as relational targets from childhood that contributed to the interpersonal patterns in which each of them engaged. Bill noted that Matt was better able to ask more directly for Rita’s company and to express his affection toward her, and he was better able to recognize her attempts at recruiting his affection, resulting in increasing intimacy and attachment security. They were beginning to engage in behavior that was supportive and collaborative rather than attempting to drag one another down or punishing one another. For example, Matt would check in with Rita when she looked upset rather than retreating, freezing, or running away, less creative and more reactive behavior in which he would historically engage. Bill said that this modified response to her apparent defensive or hostile behavior resulted in their ability to return to a “dialogic plane,” in that they could see, hear, and be available to one another in contrast to their previous experience of isolation and estrangement.

Rita and Matt reported increased communication as a result of each of their individual changes and their changing relational dynamic, with more direct communication about issues rather than the avoidance and periods of *détente* previously noted by Bill. Bill said that they developed increased resources and means for repair within their relationship. Matt stated that he could disagree with Rita and speak with her in a “neutral to caring fashion” rather than being angry and reactive as he had been in the past and that they could better focus on objective personal goals, recognizing when they

had not reached them rather than blaming one another. Matt described the value in his increased awareness and objectivity in this way:

I think it's made me stop and think before I do things. That allowed me to recognize when I'm becoming activated. And so, knowing what activates me is useful for both me and my spouse. Not necessarily avoiding them, but not intentionally using triggers that we know will put ourselves in a situation where it's going to become emotional and useless. For me, it's allowed me much more to walk away from things when my wife is agitated and at a point where she's not going to be reasonable or logical. You know, my habit would be to try to fix it and stay and I would feel very, very guilty if I went away. Now I go away and don't feel guilty and she loses her audience.

He also described increased differentiation:

When I don't get activated, it's much easier for me to see where the responsibility for some actions [is]. And it allows me to say, "those aren't my actions, they are someone else's and they're the ones who are responsible for them." And that further allows me not to get activated by them.

### **Second Triad: Cat, Nesse, and Richard**

#### **Cat**

Cat is a 56-year-old female therapist who identified herself as an "Eastern European Jewish person." She is a Licensed Independent Clinical Social Worker (LICSW), consultant, and writer within the psychotherapy field. She is an EMDRIA Approved Consultant and former trainer and has 31 years of professional experience. The majority of her current work and her areas of expertise include trauma, dissociation, anxiety, depression, couples therapy, gender and orientation, and attachment issues. She works primarily with adults, though also with adolescents. She said that she works from a number of theoretical orientations, stating that her goal has been to "learn as many therapies as possible and be able to see my clients through various therapeutic lenses and use the appropriate tools with the client in front of me." She identified that her theoretical

perspective involves “primarily, EMDR and ego state work, while looking at everything from a systems and cultural perspective.”

### **Nesse**

Nesse is a 47-year-old divorced Asian woman who reported having been in four previous committed relationships. She has two grown daughters from a previous relationship, one of whom lives at home. She moved to the United States from Vietnam in 1979. She and Richard had been together approximately two years at the time of the interview. She reported having been in weekly therapy for seven years prior to her couples therapy with Cat. Nesse said that she was born in Vietnam as the youngest of several siblings within a very dysfunctional family. She described herself as having felt “stuck between five and 15 years old” in terms of her behavior at the beginning of her couples therapy. Cat reported that Nesse had experienced physical and sexual abuse within her family of origin and moved away from her parents at 11-years-old. She also stated that Nesse had experienced war-related trauma and trauma related to moving to the United States as a new immigrant. Cat reported that Nesse had attachment and abandonment issues related to early childhood trauma, that her mother had worked a lot, and her father had been an “ineffectual kind of playboy.”

She moved to the United States to join several of her siblings who had previously emigrated from Vietnam, according to Cat. She had experienced emotional neglect as a child and was later married and divorced to a man who had been a “womanizer” and had “treated her like the maid” per Cat’s report. She described several relationships with men who had similar traits to her father. Nesse began individual therapy and EMDR with Cat prior to inviting Richard to join her for couples therapy. At the time of her initial couples

work, Cat reported that Nesse had PTSD as well as Borderline Personality Disorder. According to Cat, Nesse lacked differentiation, was highly reactive and offended by Richard's desire for female attention, and would shut down and threaten to end the relationship with Richard during such times of reactivity. Both Cat and Nesse stated that she experienced significant insecurity that she would lose Richard, would compare herself negatively to women he had dated previously, and would interpret his behavior as rejection and abandonment.

When she began individual therapy approximately nine months prior to initiating couples therapy with Richard, Nesse reported that she had experienced multiple life transitions at once including changes within her work environment that led to losing many close friends to layoffs, her daughter moving away, and a break up with her boyfriend. She noted that these changes resulted in difficulty sleeping, significant fear, becoming easily upset, feeling lost, feeling a sense of emptiness, and the experience of having a "dark cloud" around her at all times. She had had a long history of therapy and reported having always been searching for someone to help her sort through her feelings but that she had found herself "just sitting there and retelling my story" and that previous therapy "didn't do anything that really helped me." She described a history of failed relationships and a desire to change her relational pattern but an uncertainty about how to do so. She reported that she was "longing for love and could not hang onto love" and "seemed to always pick out the wrong people to love."

At the time of her interview, after a year and a half of conjoint couples therapy with Cat, Nesse had significantly increased her level of differentiation, had decreased her use of projection toward Richard, was less reactive, and demonstrated an increased ability

to set boundaries, according to Cat. Both Cat and Nesse described her ability to accept Richard for who he was rather than personalizing his behavior. In response to Richard flirting with another woman, Nesse described the following:

I thought to myself...“I see this is not about me, this is about him.” I held myself back. I didn’t get mad. I didn’t react. I was just detached and I watched. But I didn’t like it...I didn’t like what I saw for sure...But I didn’t make it about me at all.

Nesse also reported increased resilience in terms of how others reacted toward her:

“Before I met Cat, I lived in fear about what people thought about me. And now when people say mean things to hurt me, it still bothers me but it doesn’t destroy me anymore.”

She observed feeling more present and grounded, which as a Buddhist, she particularly valued. Cat described that change: “She’s much more present and she will say that. I mean, she’s just like... ‘I can’t believe it.’ She’s Buddhist, and ‘I am finally able to be present. I never had that capacity to be present’.” Nesse reported a sense of goodness about herself that she had never experienced previously and decreased self-blame about her previous traumatic experiences. She was able to separate what had happened to her from her identity as a person and had “stopped going and looking for pain.” She reported feeling more grown up, stating that she looked at things with a “more mature view” and “stopped regressing to the bad behavior I always had.” However, she described ongoing difficulty fully accepting and believing in Richard’s love for her, stating that she continued to question why he was choosing to be with her.

Nesse reported that the changes she had experienced resulted in losing people in her life. “I have lost more family members and friends since I started EMDR than I ever had before. There’s this sudden level of kindness and openness I have that scares people away.” Furthermore, she said:

I think I've become happier, confident and no nonsense in some ways. And you know, they label me a lot. They think it's because I've become wealthier, more successful in my career. I don't think so. I have this sense of clear perspective about things that I see through things.

She described an increased sense of integration as well as reduced fear and shame:

I've become very honest. I'm transparent. There isn't the duality to me anymore...I'm very straightforward. I'm no nonsense. I don't have that filter anymore. I don't have any need to soften the blow anymore. I think the shame is gone.

She also reported decreased pain and fading traumatic memories:

I can't even see the details anymore...I have to sit down and reflect on it. A lot of memories now have faded because of what I worked through...The happy moments I can still remember. But it's the trauma feelings or experiences that I used to have...I don't feel like I have this nagging pain that is so vivid.... It no longer feels like yesterday anymore. It feels like a lifetime ago.

She shared the following poem as a representation of the changes she has experienced throughout conjoint EMDR with Cat:

Spring  
 Is it possible that I am falling in love with life  
 Is it possible that I am letting go  
 of my fear  
 Smiling this morning on my way through the street  
 I noticed  
 sweet white and pink cherry blossoms  
 Grace the dry rock walls and broken down fences  
 Wet leaves and cold air overwhelmed my senses  
 Nature at its best,  
 the cycles of the continuing universe  
 Winter is leaving and spring has come to stay  
 Is it possible that I am falling in love with me?  
 Is it possible that I embrace all my being?  
 Every strand of hair,  
 every freckle on my skin  
 The crooked smile, the sad eyes  
 and the confusing process  
 Of learning and dropping all my acquired knowledge  
 Lessons of a certain yesterday  
 that no longer exist  
 Is it possible that every waking moment life can be good

Is it possible that I have arrived at the gate of my sky  
 This moment of inner peace, of knowing  
 Is it possible?

### **Richard**

Richard is a 37-year-old Caucasian British man who reported that his relationship of approximately two years with Nesse is his first committed relationship. He stated that he had no previous counseling prior to his experience of couples therapy with Cat. He is from a large working middle class loving family that was loud and “jokey.” Cat described him as a “raging extrovert.” At the beginning of couples therapy, he described himself as skeptical about therapy. “You can kind of hear I’ve done a 180 completely on this. If someone had told me two years ago, ‘you’ll be in therapy,’ I’d have said they were crazy.” He noted feeling both confused and frustrated with Nesse’s reactions: “I couldn’t understand what she was getting at, why she was reacting that way” and “I used to get frustrated. And literally, it would be draining, completely draining all the time.”

According to Cat, his interpersonal patterns included frequent deflection through the use of humor, which Nesse described as “jokey jokey” and a reliance on external validation, particularly women. Cat described him as lacking differentiation, impulsive, and reactive. Richard described himself in the following way:

I’m very European, very happy, smiley, and I’m looking all around...whether that be males, females, or whatever. One of the big issues that we had was that Nesse would constantly think I’m looking at everyone and yes I would be, but she would be looking at it as I wanted the other people.

According to Cat and to Nesse, he had become physically aggressive, grabbing Nesse by the neck, after drinking alcohol and becoming engaged in a heated conflict during which Nesse had threatened to leave.

At the time of the interview, almost two years after initiating conjoint couples therapy, Richard had increased his ability to provide space to Nesse, increased his level of differentiation, and become less reactive, per Cat's report. She observed that he had learned not to take her reactions as personally and how to self-soothe when she would withdraw or become agitated rather than seeking out attention from her or others. He reported that had developed an increased awareness of himself and Nesse through conjoint EMDR, was more aware of the impact of his behavior on others, and was better able to accept responsibility for his behavior. According to Cat, "He's learning a lot about himself...now, he's more aware of his behavior. He's not so blindly acting and saying things irresponsibly. He takes responsibility for what he says and does." He described his increased understanding of himself and the impact of his childhood experiences on himself and his relationship in this way:

It's interesting to know that your memories and experiences do form such a big impact in your current life that you don't even realize...It's interesting now to just see some of the things that I was doing and I'll be like "wow I can see that in all these other people and I see now why Nesse was getting so upset and so emotional." I look at it like "wow, I did that or I did that, that's why she was very upset and why emotionally she found it challenging to be in a relationship with me."...I find it very useful as a couple and as individuals to understand and learn why we react to what's triggered us...

Cat reported that he had decreased need for attention including female attention and both Nesse and Cat noted changes in his overall maturity and in his responsiveness and support toward her. Nesse observed that he no longer blamed himself for her reactions since he better understood the reasons for her feelings and behavior. He noted that he was less angry and more open, which positively impacted various areas of his life:

I've probably been more successful in my new job over the last seven months or so. I think some of that has to do the way I deal with things, the way I listen to people. And I get feedback at work now. People say "you're like a different



person, you're so much more approachable, you listen, you come back and verify with us.” And I think a lot of it is due to seeing how different people react and when they react strongly, I try to think “why did they just react like that?” Instead of before, I'd think “well they're having an off day; it's their problem.” I try to learn more about it...It's not just improved our relationship...it's improved how I look at others, react to others, and any communication with others. People see it in me as well as I see it in myself.

### **Nesse and Richard**

Nesse and Richard participated in a year and a half of couples therapy with Cat, after Nesse had been working with Cat individually and participated in individual EMDR with her over a two year period. During their couples therapy, they reported initially having participated in approximately 70% conjoint EMDR and 30% talk therapy and at the time of their interviews, that proportion had transitioned to approximately 40% conjoint EMDR and 60% talk therapy, with Nesse having been the working partner for about 70% and Richard about 30% throughout that period.

They reported that they have significant differences in terms of culture, age, and backgrounds. Nesse is 10 years older than Richard, was previously married, has two grown children, and is from Vietnam. Richard had never been in a committed relationship prior to becoming involved with Nesse, has no children, and is from the United Kingdom. Both Cat and Nesse noted that Nesse would interpret Richard's need for female attention as disrespectful, given the discrepancy in their cultural backgrounds and her history with womanizing men, including both her father and her ex-husband. Nesse had experienced significant trauma within her family of origin in contrast to Richard's upbringing in a happy and supportive family. Nesse described their cultural and gender differences in this way: “I'm Asian so I'm extremely standoffish. [Males] don't touch...we have a very clear line of separation between the opposite sexes. And for

him, as a Caucasian British, from a loving family, the line is not quite clear.” She also noted the challenges they faced in terms of their age difference:

We’re both very youthful, but he has this jokey jokey side of him that makes him even more young in person than the age number. And that bothers me a lot because I’ve had a house for the last 20 years. I’ve been a single mom for the last 20 years. I’m a manager at work. I’m a mother so...except when I’m around my friends, I’m jokey jokey, you would never see me joking. I’m a much more serious person than he is.

Their histories, especially for Nesse, were often triggered relationally, such that Nesse frequently experienced fear and became self-protective, to which Richard became reactive, resulting in an escalating pattern of withdrawal and pursuit. Cat described their dynamic in this way:

She would take offense and instead of intelligently backing up, he would rush forward to, as she says, “talk talk talk talk talk” and explain himself, “no you must see me differently.” She would shut down, and then she would say “it’s done; we’re over” and he would explode.”

Richard’s tendency to resort to humor would further escalate their conflicts: “My way of releasing stress is to joke and to laugh, whereas Nesse took that as an insult and that I wasn’t being serious. So that would explode into the argument even bigger than it needed to be.” His flirtation with other women also contributed to intense conflicts and exacerbated Nesse’s insecurity and fear of abandonment, according to Cat.

In contrast to their functioning at the beginning of couples therapy a year and a half previously, at the time of their interviews, they described increased levels of differentiation, increased tolerance and acceptance of one another, decreased reactivity, and an ability to intervene in their cycle. They noted that although they continued to have arguments, their intensity and duration had significantly decreased. Nesse said:

When we first met...we didn’t fight as often but we fought about things that were so major that they were enough to break our relationship and our fights usually

escalated to the point where there's no return. But now, it's just we're bickering about every little thing but we do not have any major explosive fights anymore.

Richard noted that his increased understanding of Nesse had resulted in increased effectiveness in his response to her:

In the past, I would pester her like crazy to know what's going on and she wouldn't speak to me. Now I understand when she goes quiet, she's obviously upset or something's triggered her off. And I let her go through that and that when she's in the right frame of mind and ready to speak to me, she'll speak to me. And listen to what she says and not react. Absorb it, input it, and understand that what she just said she said for a reason, and then be able to speak to her in a way that's not going to escalate the argument but be able to have a civil conversation.

They described increased maturity, hope for the future, and respect for one another. Though they continued to have significant differences, those differences no longer had the same impact that they had had previously. Nesse noted a newfound appreciation of their differences:

[The age difference] ...became a wedge between the two of us and Cat just pointed out eventually, slowly, to the two of us neither one of us wants to change. The only difference is to embrace why we're together. And I realize that it's because of his optimistic, youthful, jokey jokey side. I wouldn't date myself. I'm too serious and he's the opposite. I balance him out. I'm extremely ambitious in my own career because of fear of abandonment. I'm so solid. I don't want to rely on anybody... And it seems like in the past, he always dated women that were with him for one reason, to be taken care of and without ambitions...He said the qualities in me that he really appreciated are that I'm kind, loving, and I'm generous, but at the same time, the most amazing thing about me, he said to me, is that I'm smart, ambitious. I'm independent. I'm a leader of my own life and he found that quite attractive.

Through their conjoint EMDR process, they reported having both developed an increased understanding of themselves, of one another, and of their relationship dynamics. Richard noted, "I think that we see it a lot clearer nowadays. And I also think that we understand each other a lot more and have a much stronger relationship" and "we've got to understand... how our pasts have made us who we are today and how we

react. We definitely learned a lot about each other and how to live and be closer...”

Furthermore, they described an increased trust, closeness, and support within their relationship, as well as a commitment to ongoing change and partnership. They noted that the focus of therapy had shifted from their relationship to external issues such as family and work, given the positive strides they had made within their relationship dynamics.

Richard noted the value in having demonstrated their commitment to change in this way:

I think Nesse and I had to prove to each other that one, we realize the issue and we were doing things to correct it, and that we can actually learn and not repeat this. And that really is the basis of how we are today.... It's one, understanding, two, taking ownership, and three, actually making the effort to change to prove to the other person that this is important to me because it's important to us.

### **Third Triad: Rich, NyxRN, and Huck**

#### **Rich**

Rich is a 43-year-old Caucasian male Licensed Marriage and Family Therapist (LMFT) and EMDRIA Approved Consultant and Facilitator who is working toward becoming a Trainer. He has approximately 16 years of professional experience and is currently working abroad within a military setting with issues such as combat PTSD and military sexual trauma. His professional specializations and areas of expertise are EMDR and training in emergency response and trauma resolution. He described his theoretical orientation as structural strategic in terms of marriage and family therapy and stated that this is also his perspective for individual therapy but that the adaptive information processing lens fits for him in individual trauma resolution work.

#### **NyxRN**

NyxRN is a 39-year-old Asian woman who had been married to Huck for three years at the time of her interview. She identified her marriage with Huck as her first

committed relationship. They do not have any children together. NyxRN had not had any previous counseling or familiarity with EMDR prior to joining Huck for conjoint therapy with Rich. She noted that as a medical professional for many years, she believed that the previous experiences and understanding she had were helpful in supporting her husband as well as in her participation in the conjoint EMDR process.

NyxRN served as a supportive role and did not engage in EMDR herself; therefore, the information provided about her is primarily in reference to her relationship with Huck. At the beginning of her involvement in conjoint EMDR, she was at a loss about how to support her husband: “I didn’t want to be the nagging wife but at the same time I didn’t want to just let it go because it was something that we needed to deal with.” She was concerned about Huck’s alcohol consumption and his inconsistent attendance in his individual EMDR therapy and spoke with Rich about these concerns. Rich described her as a healthy and stable partner to Huck: “she presented as very healthy, very well put together, no mental health concerns on her end” and that given her stability as well as her professional experience, “there was no element of shock that was really going to phase her.” According to Rich, she was committed to supporting Huck in whatever capacity was appropriate and, therefore, did not hesitate when Rich suggested that she join him for his EMDR sessions.

After her experience of conjoint EMDR with Huck, she described a sense of increased strength and confidence, given her improved understanding of her husband and ways in which she could be supportive toward him: “I feel stronger. I feel more confident because I think I have more of an understanding of his past and what bothered him” and “It’s kind of hard to put into words but I think I have a much bigger understanding of

Huck and how I can be there for him.” Furthermore, she expressed a new level of respect for him and the experiences he had been through: “I have a much deeper respect for my husband. Like I kind of knew what he did but I have a much deeper respect for what he did.”

## **Huck**

Huck is a 34-year-old Caucasian man who reported that his marriage to NyxRN is also his first committed relationship. He had initially been meeting with Rich for individual EMDR sessions as a result of PTSD symptoms from combat trauma that had been exacerbated by the stress of transitioning out of the military. He completed six sessions with Rich including three sessions of individual EMDR. He had completed 12 sessions of cognitive processing therapy in 2009, which he had found helpful and after which he reported being symptom free. However, within two years of that treatment, he initiated therapy with Rich due to a resurgence of symptoms. At that time, according to Rich, he was experiencing flashbacks, nose bleeds, hypervigilance, nightmares, difficulty sleeping as a result of those nightmares, increased anger and irritability, intrusive imagery, anger when he felt “boxed in,” difficulty differentiating between threatening and non-threatening material while driving, and difficulty concentrating. He suffered from significant survivor guilt and self-doubt related to military experiences. NyxRN described it in this way:

He’s very kind hearted...that’s why he has PTSD is because all the things he had to do for his job greatly clashed with what he has grown up to know as the right thing to do...I mean he would never hurt a fly but he had to kill people; that was his job. So somewhere in there, he knew “okay we have to do this” because he could look at the bigger picture. But at the same time, he goes home and somewhere internally he’s saying “well that wasn’t the right thing; that’s not how I was raised. You don’t kill people.”

Per Rich's report, he was self-medicating through alcohol and was inconsistent in his attendance of EMDR sessions, given his desire to avoid thinking about traumatic material. Huck said:

I would sometimes miss sessions purposely because I didn't want to get back into those positions. I didn't want to feel the fear, the terror. I didn't want to feel the remorse, the guilt...I just didn't want to relive it sometimes so it was really hard to go.

Huck stated that his discharge from the military had been approaching, which increased his motivation to resolve the traumatic material, given that he knew he would not have the same opportunity for treatment elsewhere. He described having hit "rock bottom," which led to his initiation of EMDR with Rich:

I hit rock bottom one night. I remember I drank a little too much and started talking a little too much and got a little emotional and told my wife a few things that I haven't ever really told anybody else about my recent experiences and my previous experiences. She started listening to that and she goes, "if you want things to change, you have to change. You need to really get in there and talk to somebody." So I did and it really started helping.

Huck and NyxRN moved back to the United States from Japan and Huck transitioned out of the military, resulting in his inability to continue EMDR treatment due to lack of funding as well as lack of access to EMDR in their new state. After six months of sessions with Rich, including nine conjoint EMDR sessions, Huck continued to experience the ongoing impact of traumatic events, though both he and NyxRN noted a decrease in the intensity and frequency of his PTSD symptoms. Outcome measures shared by Rich demonstrated a decrease in anxiety, depression, and PTSD symptoms, as well as an increase in overall functioning. NyxRN stated: "there are still some things...to work on...but at least it's not forefront in his mind anymore." Huck said: "I still have a few nightmares here and there, little things that irritate me" but stated that he has been

sleeping much more peacefully. NyxRN stated that the intrusive thoughts, hypervigilance, and anger have decreased, and that his focus tends to be on current issues rather than ones from the past:

We haven't had any of the bits and pieces creeping up of his old life. None of that. A lot more has to do with his frustration, his anger, his feelings of betrayal by the [military branch]. He's stressed about ... what he's going to do. The current issues are what he's facing, not so much the other stuff when he was doing the EMDR.

He and NyxRN noted that his use of alcohol to self-medicate has continued but is less of an issue than it had been. NyxRN said:

[His alcohol use] is really not as much of an issue as it was before at least. But...he will have them occasionally here, [and] we continue to battle that, because his knee and his shoulder have just gotten worse and this whole transition process of trying to get his head out of the [military branch] and trying to figure out what to do with himself in the meantime.

Both he and NyxRN reported a decrease in his guilt, physical symptoms (such as nose bleeds and headaches), and an increased ability to talk about his traumatic experiences. NyxRN said:

He said that he'd known that it wasn't his fault but he felt that way for all these years and after the EMDR sessions, he was saying that "yeah, I get it. There was really nothing you could do about it. How would you know? It could have happened at any point to anyone." Huck noted his ability to talk more freely about his traumatic past and his improved ability to cope: "now I can completely and more easily talk about it where before, I didn't even want to talk about it." He described a new beginning:

Ever since I got out of the military, now that I'm here...and being able to dive every day and become a dive instructor and hopefully by the grace of God buying an old dive shop so I can start a new career, a new life, I feel that this stress-free life that I've put myself into after the fact, it's really helped considerably.



He noted the power of being able to live in his own “safe place”: “I go down to some of the coolest and deepest spots, 80 – 90 feet and I’ll just sit there on my back and I’ll put my hands behind my head. I’ll look up at the sun and the waves on top and I’ll just sit back and I’ll take a nice deep breath.”

### **NyxRN and Huck**

Prior to initiating conjoint EMDR, NyxRN and Huck reported conflict related to Huck’s alcohol use:

He was drinking a lot more at home. So I would sit down with him and then I said “you know, this is not helping you because...it worsens the condition. And I told him that he and I can’t really continue to do this together because I can’t support him, that I’m his wife and not his therapist, you know. So I can be there for him and support him with all these things but I cannot enable him to be an alcoholic so he can escape from his realities...It took him a little time till finally he decided to go.

They reported that their relationship and communication were strong, though his traumatic experiences were the one area where their communication had been limited.

NyxRN stated:

Many times before EMDR...I would catch bits and pieces of incidents that had happened to him because...when he starts to drink and he gets drunk, then there are like pieces of things that he says. And once in a while, I sort of put them together over the years that I have known him and prior to that when we were dating. But I actually have never known the whole story.

Huck shared the importance of the support he felt from his wife overall and in his decision to address his traumatic past:

My wife and I never really had any issues. We really have a strong marriage and I love that...I already know and I still know to this day that she’s not going anywhere, I’m not going anywhere. That really helps a lot. Having the right one with you and knowing that before was just really important too.

Since their conjoint EMDR experience and move back to the United States, both reported excitement about their new beginning and the increased strength of their

partnership, along with the stress of the transition and new responsibilities. Both shared disappointment that they cannot access EMDR in their current state, noting that more sessions might have been helpful. However, NyxRN noted the value in better understanding her husband and how to provide support at times when he continues to be triggered:

I think that without understanding that side of Huck, I think he'd probably be very frustrated all the time. Because a lot of times, it manifests in anger and he gets frustrated about the smallest little details some times and it can be very stressful. But understanding that it's not something he can just control right away because it's just a switch in his brain and his behavior changes...so I try to use little key things like I just say, "okay, Huck" so he knows. We have these little signals, you know, like "count to ten."

Huck observed NyxRN's increased understanding of his behavior and decreased reactivity toward him:

Ever since EMDR, I think, she's been able to read me a little better and understand me a little better and not take things so literally. Like sometimes if I am having a rough day and I want to have a few beers or a few drinks and I drink a little too much, she's not as mad at me.

Furthermore, NyxRN highlighted the value of conjoint EMDR in their ability to talk more openly about material that they had never talked about previously:

Having gone to EMDR together and knowing more details, it helps us to be more open because sometimes I think that he's not sure what he should share and what he shouldn't share...I think that now he knows that those are things that we can talk about and that helps us.

#### **Fourth Triad: Fred, Beth, and Sam**

##### **Fred**

Fred is a 58-year-old Caucasian male Licensed Psychologist with 25 years of professional experience. He went through both weekends of the basic EMDR training in 1999 and noted his areas of specialization as sex addiction treatment, marital therapy,

sexual therapy with couples, and trauma resolution therapy. He described his theoretical orientation as primarily interpersonal and reported that with Beth and Sam, he had done a significant amount of emotionally focused couples therapy (EFT) as well as body-based, enactment, psychodrama work “to help them experience really what’s the dance in the relationship” and “helping them do that differently.” Beyond this demographic and professional information, Fred volunteered that he is married and has three children.

### **Beth**

Beth is a 66-year-old Caucasian woman who identified her marriage to Sam of 47 years as her first committed relationship. She noted having had previous therapy experience on and off for 15 years prior to conjoint EMDR with Fred. She and Sam have two grown children together.

At the beginning of couples therapy, Beth experienced PTSD symptoms related to a motor home accident she and Sam had been in approximately a month prior to initiating therapy with Fred. Though her symptoms were not as apparent as Sam’s initially, Fred noted that after two or three sessions, it became evident that she too met criteria for PTSD. She said she had been experiencing mental and physical exhaustion, given her tendency to “over-function” for others. Fred reported that she was experiencing flashbacks, an increase in irritability, and was avoidant of material that reminded her of the trauma. She had been knocked unconscious and experienced a concussion during the accident, which also impacted her functioning at the beginning of therapy including physical tension, difficulty with focus, and serious headaches. Fred noted her difficulty in coping with the impact of the trauma:

She was very avoidant of discussing the accident, really had poor skills at being able to grieve it or talk about it and elicit support from other people. She didn’t

want to discuss it. She was the one who would drive them, so she drove to the sessions and all their driving needs for those first few months but lots of different traffic situations triggered her.

He also reported that though she had significant resources to cope with the accident and her reactivity to triggers were milder than Sam's, she resorted to a caretaker role and over-functioning for others that she described as being on "autopilot," which served as a distraction from her own symptoms: "I thought I was doing fine because I was so focused on taking care of Sam." Fred described her pattern as follows: "She is a person who is gracious to a fault, in terms of being so attuned and responsive to other people that she's never really known who she is or her needs. But her coping strategies are compulsive do-aholism."

At the time of her interview, after a year of couples therapy that included conjoint EMDR, she continued to experience ongoing symptoms related to her concussion: "I'm still having a lot of headaches, very serious headaches and having trouble always keeping on track mentally." However, she observed increased understanding about her own behavioral patterns:

Like the perfectionism and the over-functioning for the whole world...knowledge is healing. When you realize things that you'd known before but you really hadn't known before... And it's taught us a lot about, well me, a lot more about myself and it's given me tools.

She also noted decreased PTSD symptoms:

I think overall just feeling better physically, mentally feeling better, more hopeful. The headaches are going away...well I know a lot of that was from the concussion, but I think they were exacerbated by the stress and everything else, and those are settling down and overall just a whole lot better.

## Sam

Sam is a 70-year-old Caucasian man who also identified his 47 year marriage to Beth as his first committed relationship. He reported having gone to therapy “a few times” with his wife prior to their work with Fred. Sam and Beth were in a motor vehicle accident during which Sam had been driving their motor home, which resulted in the death of an individual who had been in another car. When he began couples counseling, he had been unable to drive: “In fact, I didn’t drive for three months afterward, about three to four months afterwards and then another month or so before I even got on the freeway to drive.” He experienced significant trauma related to his initial belief that the accident had also resulted in the death of his wife, Beth:

And so that was part of my trauma...she was dead for a few minutes there. And so I was having a hard time functioning...I had a hard time carrying on a conversation. My thought patterns were way out of whack. I had trouble concentrating on anything. And I also had some severe depression because of that. So, I basically was pretty well mixed up.

According to Fred, Sam was having difficulty putting sentences together, was dissociating, had frequent flashbacks, was experiencing regular nightmares, was often triggered in traffic, was avoidant of reminders of the trauma and of people in general, experienced significant guilt and self-condemnation, was anxious and depressed, and was not sleeping initially.

Sam described himself as a “type A personality,” stating that “for years, I was just able to accomplish most of what I wanted to do. And I didn’t probably look at my feelings very much. I would just go ahead and charge through and do what needed to be done.” This pattern contrasted greatly with the posttraumatic symptoms he experienced and his resulting dependence on Beth, creating significant cognitive dissonance for him.

At the time of the interview, after a year of couples therapy including conjoint EMDR, Sam described an increased awareness of his surroundings, decreased PTSD symptoms, decreased depression, increased self-understanding, greater focus, and a general slowing down and softening of his personality. He noted: “Fred’s helped me through part of this to understand what am I feeling, what am I thinking, where before that wasn’t really part of my lifestyle.” Furthermore, Sam stated:

For the most part, I didn’t express my feelings very much and I would just plow on through regardless what was going on to get the job done or accomplish what I wanted to do. And so I think I’ve slowed down in that sense and tried to enjoy what’s around me rather than being so task oriented...Since the accident, things have really come into focus a lot better and I know I enjoy the lifestyle we have now much more than before.

### **Beth and Sam**

Neither Beth nor Sam had any knowledge or familiarity with EMDR prior to Fred having introduced it to them. They participated in about a year’s worth of couples therapy at the time of the interviews, with Sam having participated in approximately twice as much as Beth, such that both took on the working as well as the witnessing partner role within conjoint EMDR. They estimated that they did EMDR about a quarter of their total sessions, with more at the beginning and an increase in EMDR sessions in preparation for return to the location of the accident.

Sam had retired five years prior to the accident, after which he and Beth had moved from the area they had lived for 40 years and built a home in a new state. Sam shared that after this three year moving process, he had had his gallbladder removed, experienced a urinary tract blockage, had hip replacement, and then had cataract surgery, all of which resulted in his increased dependence on Beth and contributed to significant stress for both of them. Fred noted that for years, Beth had wanted a closer relationship

with Sam and increased engagement from him and that in recent years, Sam had begun to reach out to play and enjoy retirement with her. However, Fred said that she struggled to transition out of her “do-aholic” mode and continued to blame Sam for not knowing how to have a close relationship. Fred stated, “The realities are that he had been asking for it for a couple of years and she is so busy taking care of the world, that she has little time to engage with him.” After the accident, Sam recognized how close he had been to losing Beth: “I kept picturing what it would be like if I didn’t have her with me. And so all of a sudden, the things she’s done, would be doing for me, or the time that we spent together just seemed much more real that it had before.”

Both described their co-dependency on one another, their emotional estrangement, and the “wake-up call” they had received about those patterns after the accident and through their engagement in the conjoint EMDR process. Beth described it in this way:

As far as the marriage relationship...we were each doing our own thing, as far as building the house...Before he had the surgery, I was a caretaker, and was the one who was holding everything together, the functioning one, so then when the accident happened, I just continued in that role...I’m very co-dependent and have over-functioned for him. I mean, just totally speak for him, and it bugs him even though he appreciates it. And I didn’t know I was doing it.

Fred described the dynamic between them similarly: “he was the workaholic and she was the mom; she was the social keeper. But he pretty much would work, come home and be cared for by her; without a lot of emotional intimacy at all in the marriage.” Fred described the wake-up call that Sam experienced as a result of the accident as well as each of their struggle in knowing how to change their well-rehearsed patterns:

For him it was this guilt and “I almost killed her” but also a big wake up call for him around “how have I squandered this relationship?”...For her, the accident really brought into focus these dynamics in the relationship...She experiences

herself as not knowing what to do with that and not knowing how to set aside all this compulsive housecleaning and care giving to other people to really engage in a relationship. I think sometimes her crisis has been more with herself...I think part of the crisis for her was “I could have died and I never lived” and so she’s struggling to find what she enjoys rather than always living her to-do list.

Since their conjoint EMDR process, they have noted an increased awareness about those relationship dynamics, have begun to change those patterns, such that Beth is increasingly giving Sam permission to speak for himself, and both have been healthier and generally more relaxed. They also described increased appreciation for one another and expressions of affection, increased closeness, and deeper communication. Beth described her transition out of the caretaker role in this way: “I’m stopping that and giving him permission to take care of himself.” Sam described his increased expressions of affection: “I think I’m much more appreciative of her...I express my love to her a lot more than I did before.” Beth described their increased closeness and understanding of one another:

We’ve learned things about each other in our marriage that we didn’t know and so the marriage is just so much richer and closer than it’s ever been...he has learned what I have known and I have learned what he has known...It’s taken down a wall...[There’s] an even stronger sense of partnership, and support of each other...almost a kind of a bonding...and maybe some of it’s attributed to the accident, but when you’ve gone through a tragedy and a trauma, you’re either pulled apart or drawn closer together and it’s definitely drawn us closer together.

### **Fifth Triad: Nancy, Ursula, and Algernon**

#### **Nancy**

Nancy is a 54-year-old Caucasian female Licensed Professional Counselor (LPC) and EMDRIA Approved Consultant who described her professional experience as a significant amount of work with trauma, victims of crime, and traumatized families, and she stated that she utilizes EMDR with “almost every client.” She identified her areas of



specialization and expertise as family systems, trauma, women's issues, and step-families, and she described her theoretical orientation as psychodynamic.

### **Ursula**

Ursula is a 62-year-old Caucasian woman who described her ethnicity as Irish and German. She had been married to Algernon for 42 years; together, they have three grown children, one of whom was living at home with them. She identified this as her first committed relationship. She reported having experienced "years of therapy," both individually and with Algernon. She noted that she had to leave her job due to disability involving chronic pelvic pain syndrome, major surgeries, allergies, and an auto-immune disease.

Prior to the initiation of couples therapy with Nancy, Ursula had asked Algernon for a divorce and had been very upset by Algernon's level of anger, stating that she did not want to be in his presence and felt the need to end the relationship in order to survive. Algernon shared confusion about her anger toward him, stating, "I thought the anger she expressed was disproportionate to what was going on." He noted, "Ursula's always run away...it's been her style to always threaten, escape..." Her initial goal for counseling, according to Nancy, was to "fix his anger." She had a history of trauma, such that her mother was killed in a car by a train at six years old, and she has questioned whether her death had been by suicide. According to Nancy, Ursula had lost a year of memory around the time of her mother's death. Ursula herself had also attempted suicide herself in the past and according to Algernon, "she has a diminished view of who she really is."

When Ursula and Algernon began therapy with Nancy, according to Ursula, their daughter had recently gone through significant medical trauma, which had caused

extreme stress and fear for Ursula. Furthermore, Ursula herself had had a long history of chronic body pain including significant pelvic pain. Her physical symptoms were exacerbated by her concern for her daughter. Ursula described it in this way: “I pulled in so tightly that physically, I could barely move...none of my muscles had any...relief; they were just so knotted. And so I just hurt physically and I was so exhausted emotionally...” She reported having been on autopilot and attempting “to just keep everything together,” describing herself as “empty.” However, she described having begun a journey of spiritual, social, and mind-body development, partly to address her physical pain, though she observed that this development created further isolation from Algernon:

I made a purposeful decision several years back that I wanted to live a life of joy and grace for the rest of my life. And I’ve been on that quest. I’ve been working towards that...And frankly, when I started that direction, I didn’t know where he fit in. And I was kind of like, “this is what I need for me...I have to have this no matter who else is involved in this.”

At the time of the interview, Ursula, Algernon, and Nancy all described a notable decrease in her need for pain medication and observable changes in her physical symptoms. Nancy stated:

After our first EMDR session, she came back and she said, “I’m getting off of all my pain meds, I don’t need them.”...also with the pain, when she came back at the next one, the physical therapist that does the pelvic work reported that some of the characteristics that she is used to when she does the physical therapy internally, they weren’t there. So, there weren’t knots; there wasn’t redness. Her experience was that, as receiving the physical therapy, that it was not disturbing at all. She was sleeping really well....

Ursula noted her experience of “opening” both emotionally and physically:

When he’s dry needling my back and getting into my muscles...And before, for years, anything that I did, it was like “okay oh that feels really good today” and I feel all relaxed and tomorrow I’m like back there again. It’s staying open, you

know, once he's gotten in there. And so I know without a doubt that it's all connected.

Similarly, Algernon described her lightness as the load that she had been carrying has been lifted: "she was always so tight and now she's much more relaxed so there's definitely a visceral experience that she's had...Somehow she's offloaded some of her issues, where it's lightened the load."

Both Nancy and Algernon observed a change in her self-worth. Ursula described her conjoint EMDR process as a culmination of the personal work she had started several years previously, noting a shift in her thought process as well as in who she is in her relationship with her husband. She also described increased differentiation between her past and her present, an increased sense of safety with Algernon, and a resulting increase in her ability to verbalize her feelings. Algernon described her increase in self-worth: "I think she feels more self-assured...I think she's liking herself more...she's started to put more value on who she is." She described the shift in her response to Algernon in this way:

I'm not that great at verbalizing, like, when he was angry and crotchety, I was thinking to myself, "this is what I should be saying..."But, I think for the first time in my marriage, truly...it's okay for me to verbalize those thoughts. And I felt very empowered again...that's really the main word for me, and I felt very safe and not judged by Algernon...I've always known that he's a very good, wonderful person. But for me to, I guess, know it in my soul, know it in my core...that I am safe...that's been the amazing part to me...emotionally, I am in a very "calm place".

### **Algernon**

Algernon is a 68-year-old Caucasian man who also identified his 42 year marriage to Ursula as his first committed relationship. He noted having had "decades" of previous therapy prior to his conjoint experience with Nancy. At the beginning of couples therapy,

Algernon reported having been motivated to end the threat of potential divorce, was cautious, and had an “arm’s length” approach to Ursula, not understanding what had led to her anger. He described having begun to engage in pragmatic steps in response to her threat of divorce in spite of her having taken divorce off the table at that point. He noted that taking such steps might have served as a distraction from the feelings that had been triggered for him:

Ursula had indicated to me, she communicated to me, that divorce was off the table, but I wasn’t quite sure...I was very unnerved...Her words were very much more poignant to me...So I’d say principally fear of not only being divorced but ultimately what that would mean...almost being an inconvenience like “oh God, I have to move”...In a sense, I was cloaking my feelings with being very objective and practical about it...I itemized the actual things I have to do without really addressing my feelings.

Though both Ursula and Nancy described Algernon as having been depressed, fearful, and anger, he noted his general lack of awareness and difficulty attuning to his own emotions as well as those of others. Ursula described his tendency to default to anger: “And when Algernon is afraid and cannot fix something, he gets very frustrated, and... his fear and frustration turn into anger.” Like Ursula and other family members, Nancy noted that Algernon also had attempted suicide in the past. Ursula said that he had felt threatened by her spiritual path and questioned how he would fit into her new journey.

When discussing plans for him to take on the working partner role in conjoint EMDR, he expressed ambivalence about engaging in EMDR himself and any potential benefit for him, describing reluctance to “trip down memory lane” about his childhood trauma:

Hell, I’m 68 years old...I know that there’s never going to be a revelation to me that “Wow, this is what it all means!” I still dislike my mother and father. The

concept of forgiveness is utterly foreign to me...I mean, they were terrible, terrible people...We lived in a terrorist state...I mean, literally, you didn't know how or when, why, or by what means you were going to be harmed...harmed severely. So it was truly the definition of terrorism. So that's the bottom line. I'm not interested in tripping down memory lane about that. I know what happened. I've tried to excuse it. You know, it's the times. It's how they were brought up. But I can't.

At the time of his interview, both he and Nancy identified his increase in awareness in terms of his behavior and a resulting change in that behavior to be more supportive toward Ursula. Nancy noted: "[Algernon] is now able to say 'I have a big voice; I know how it impacts her. I am very careful not to be so scary for her.' He understands now what that does to her." She also noted an overall decrease in his anger and from his journal entries, an appropriate expression of anger toward the actual targets of his anger rather than the previous projection and displacement in which he had engaged:

He wrote 'more revelations and things that make me communicate with Ursula that enhance my anger towards [names].' So you can see that shift of him attaching more, connecting more with his wife and putting the anger more appropriately where it goes.

He shared a significant amount of respect and admiration for Ursula: "She's a very bright, talented, and articulate individual. A very pretty woman." Furthermore, he reported relief about the improvement in their relationship but an ongoing sense of caution and concern about the potential of returning to a similar point of crisis due to his lack of clarity about what had led to Ursula's initial threat of divorce:

I'm much relieved...I think the relationship is great, but I guess being the cynic and pessimist that I am inherently, I still don't feel a very strong confidence that the wound is healed...and I'm still not in full comprehension of the wound. So although I think we're enjoying a good relationship...I have a niggling feeling that it's not done...certainly not as strong as it was initially, but because I don't understand...her anger...Since I'm ignorant, I guess I'm concerned about being guilty of the same provocation.

## **Ursula and Algernon**

Ursula and Algernon had participated in 19 sessions of couples therapy at the time of their initial interview, three of which involved EMDR, with Ursula having been the only one to have taken on the working partner role and Algernon serving as the witness to her EMDR. They engaged in a conjoint lightstream exercise and a conjoint EMDR safe place exercise in previous sessions. At the time of my interviews with them, they intended for Algernon to participate in EMDR, with Ursula serving as the witness in following sessions.

At the beginning of their work with Nancy, Ursula described having gone on “autopilot” in an attempt to “keep everything together” and that Algernon had been “uptight” and “angry,” as they were responding to the medical crisis that their daughter was experiencing. This combination led to what Ursula called a “blow-up” on Algernon’s part and she said that his level of anger had become so overwhelming to Ursula that she had asked for a divorce. Nancy described their interpersonal pattern as a reenactment of their childhood experiences: “It was around them just not knowing how to do anything differently so they functioned in ways that [were] dismissing and negating, that were self-protective. It was all they had ever known.” Ursula described a long history of explosiveness and both had participated in extensive individual and couples therapy but never found “the key:”

We had tried some couples counseling, here and there over the years. Most of it was individual stuff...it was kind of like...here’s this lock and we know...how the workings are in there...And so we knew that those were buttons and we knew that that was all there and that it was affecting us in our life now, but we just didn’t have that key.

They described a lack of attunement to the other, further isolating them from one another and contributing to a lack of understanding of what was required in order to reconnect and an inability to communicate effectively toward that end.

At the time of their interview, they reported an increased connection with one another, improved communication, and a greater degree of safety to be vulnerable. Nancy stated:

Their connection is completely different because now there is such a level of empathy and safety around it. By doing this modality, I think it helps them a lot. It cuts through some of those self-protective character traits that made me initially question their readiness for this work...I just think that vulnerability piece – that they reached a level of vulnerability...

Ursula described confidence in the tools they had acquired during their conjoint EMDR experience to be able to prevent the level of crisis they had encountered in the past:

Now that we've done all this EMDR and we've done all this therapy, I can see this pattern that we've had...When we had a blip in the past, the blips have just turned into atomic explosions...Now I feel that if we get to a blip, we really have the tools and that knowledge...I think for me that if... I have a thought or if I have a concern, it's valid, it's important and it's okay for me to talk about it.

Nancy reported a transformation, an increased level of cohesion, and a new level of warmth that have fostered healthy functioning in each avenue of their lives. Ursula contrasted the difference between the previous 42 years of their marriage to their current relationship:

Now I feel like, it's not moments anymore; this is the reality. This is what it is. This is who we are, and so we are that couple that we had glimpses of over the last 42 years... we have fought tooth and nail for 42 years to keep it together... This is truly the key that is going to make all those inner workings of that lock mesh and align like they're supposed to.

In an email to me, Ursula described the love that she and Algernon share in this way: "I feel our love for each other is getting closer to the 'unconditional,' 'don't have to prove

anything,' easy kind of love relationship we have always wanted.” Furthermore, she said: “The hurts and false/wrong messages that we encountered in the past don't hold much sway with us now. We are, indeed, on the right path this time and we don't need to leave a trail of bread crumbs because we are not going back that way anymore!”

### **Sixth Triad: Michelle, Bonnie, and Anthony**

#### **Michelle**

Michelle is a 54-year-old African American female Licensed Marriage and Family Therapist (LMFT) who completed both levels of the EMDR basic training as well as advanced EMDR training; she is currently working toward certification as an EMDR Clinician. At the time of the interview, she had been licensed for a year and a half after having changed careers from her 21-year long work in the law enforcement field. She described her professional specializations and areas of expertise as trauma recovery and work with emergency responders. At the time of her interview, she was working toward certification as an emotionally focused couples therapy (EFT) therapist as well. She described her theoretical orientation as attachment theory based, including EFT, for which she had received training by Sue Johnson and Leslie Greenberg, as well as object relations.

#### **Bonnie**

Bonnie is a 66-year-old Caucasian woman who had been married to Anthony for 47 years. She described her marriage as her first committed relationship. Together, they have three grown children, one of whom lives at home with them along with her husband, and another who also lives at home with them with her own two children. She reported having participated in five therapy sessions in 1990, after witnessing the violent death of



a teenage boy, and having participated in therapy again in 2000 after having been injured by a hit and run driver. Bonnie had been seeing Michelle for a few months individually and had participated in three individual EMDR sessions prior to Anthony and she began seeing Michelle together.

When Bonnie and Anthony began their couples therapy with Michelle, she met criteria for PTSD that had been exacerbated by an affair Anthony had had. Michelle reported that her symptoms included significant rumination, rigid thinking, depression, a lack of self-worth, feelings of betrayal, lack of trust, feeling out of control, emotional and behavioral reactivity, anger and aggressive behavior, and a sense of stuckness in trying to understand why Anthony engaged in an affair. Michelle described her initial functioning in this way:

Extremely adversarial, just a lot of resentment, a lot of anger that was seeded in that he chose another woman over her...and then with the rumination, she was just constantly seeing images of him on the computer with the other woman...and easily triggered and she was literally hitting him. I mean, she would come in with bruises along her arms [from attacking him physically] and she would pursue, run after him flailing and hitting him.

Her aggressive behavior toward Anthony and her level of anger and reactivity had alienated her daughters and her grandchildren living in the home, such that they were unsure how to respond to her, according to both Michelle and Bonnie.

She was highly conflicted in terms of her feelings about Anthony. Michelle described it this way:

As much as she wanted to get close to her husband because they both committed to staying in the relationship, it was constantly pushing him away and then asking him to come in and stay with her. So it was kind of like punch, punch, punch – come here.

About a month into her individual work and prior to commencing couples therapy, during the time of the year anniversary of Anthony's affair, per Michelle's recommendation, Bonnie had entered an intensive outpatient counseling program to address her significant depression, suicidal ideation, and violent behavior. Given her significant trauma history both as a child and as an adult, she was struggling with feelings of helplessness and powerlessness, which had been reinforced by Anthony's betrayal. She described the impact of that betrayal in this way:

The earth fell out from under me...because he was the one person in my life that I trusted. I had a lot of experiences with other people close to me that I was not able to trust so the fact that he turned out to be a person that I couldn't trust was devastating...Everything I believed, everything that I had trusted in was gone...I really got stuck...The sense of betrayal is simply...I mean, it's just utterly complete and I can't figure it out...I keep asking him "why, why would you do that?" and I never get an answer.

She initially felt hopeless about their marriage and even though she went into couples therapy making a commitment to the marriage, she noted that on some level, she anticipated that her relationship with Anthony was not going to last.

At the time of my interview with Bonnie, after eight months of couples therapy with Michelle including two EMDR sessions, around the time of the second anniversary of Anthony's affair, she reported extensive ongoing ruminations about her husband's affair, fear of being vulnerable and the potential for another betrayal, and limited social involvement. However, she and Michelle reported increased functioning, decreased posttraumatic symptoms, elimination of physically aggressive behavior, increased self-regulation and responsiveness to Anthony, and reduced reactivity. She described the roller coaster of emotions that she was experiencing at the time of the interview:

It seems like there are good times and then there are bad times. Bad times are really bad and the good times seem pretty good...I think the therapy helps a lot

but the bad times still come. You know, I think that my perceptions are... not as bad..."

In spite of her ongoing difficulty trusting her husband and moving beyond the impact of the affair, she described an increased understanding and clarity about herself, Anthony, and their relationship dynamics including the impact of each of their past experiences on the present and the impact of their behavior on one another. All three said that this increased awareness and insight have resulted in a new perspective about the present, increased compassion and empathy, decreased charge related to the affair, and a more healthy level of differentiation and personal responsibility. She described her increased understanding and compassion related to herself in this way:

I am seeing now things from my past that probably made me react the way I get...My perspective on a couple of those items has completely changed...It's still painful. I still wish it never would have happened but I can see those things with a different perspective now and not take responsibility for things that happened to me when I was two years old or seven years old. You know, where kids feel like they have a part in those choices that they don't. They really don't and the same with Anthony.

Similarly, she relayed her increased compassion and empathy toward Anthony:

I feel a lot of compassion for him and how he felt about himself and how he lived his life and how that must have been really awful for him. And I can feel really empathetic and sympathetic and...that's only happened through EMDR really. I don't think I would have ever known those things.

Michelle noted the impact of conjoint EMDR on their increased understanding of their individual and relational dynamics:

Her tolerance...her ability not to trigger her husband as much...because she has developed an understanding that she also triggers him. It's not just him having the responsibility for her. So that has decreased, thereby allowing him to remain present for longer periods of time when they're having challenging moments.

**Anthony**

Anthony is a 68-year-old Caucasian man whose 47 year marriage to Bonnie he also identified as his first committed relationship. He reported having participated in a year of therapy during 2010-2011. Anthony had engaged in an on-line affair with a woman in another country just over a year prior to their initiation of couples counseling with Michelle. Anthony had met with an individual counselor for approximately one year before that point, an experience he and Bonnie both noted was not as helpful as they had hoped.

At the beginning of his couples therapy, Michelle reported that Anthony lacked emotional self-awareness, exhibited a pattern of withdrawal and defensiveness, which she labeled “shame shutdown,” experienced significant self-loathing, and would present a façade of competence to the world to compensate for his feelings of shame and inadequacy. He identified having a history of developmental trauma as the child of alcoholic parents but had not yet begun to recognize the impact of that emotional neglect on his pattern of relating to himself and the world at the beginning of his couples therapy with Michelle.

Michelle stated that his defensiveness and shame were frequently triggered by Bonnie’s pain and, therefore, he was unable to provide the validation she was longing for, which further isolated him from her and reinforced his negative view of himself. She described how he compensated for such feelings, yet his ongoing inability to escape their impact on his relationship with Bonnie:

His view of self was “I’m defective” and basically he loathed himself. So it was important for him to keep a façade for others that he was competent and capable and he did that through work. And he feared doing it in his relationship with

Bonnie because feeling if she saw the real him, she would also loathe him and be disgusted and he would lose her.

Anthony described his pattern of escape and withdrawal in this way:

I thought our marriage was close to being over...And I ended up having an online affair with a woman in England, which lasted a couple months. And everything changed. I'm a Christian; my behavior certainly didn't say I was but I am, and I had been praying a lot about getting out of the circumstances I was in. It was just an escape mechanism for me that I now see. Most of my life, I've found ways to escape things, and this was a horrible experience to put on my family.

Anthony said that when he and Bonnie began couples therapy, he initially believed that most of their problems were the result of Bonnie's PTSD. He described himself as selfish, though stated that at the time, he hadn't viewed himself in that manner. Rather, he thought of himself as "somebody who always provided for the family well and deserved everybody's gratitude and respect. But now I just see how selfish I was and I never really honestly thought of anybody but myself." At that time, he also had significant remorse and was motivated to repair their marriage, though he recognized that he might lose Bonnie:

I certainly had hit bottom and realized I was going to lose the woman I loved. Whatever shell I had built around me, it cracked and started to let something else get in...Spending most of my life escaping...the monkeys I had on my back for all those years turned into gorillas and I just couldn't hold them up anymore. I wasn't strong enough to continue to hide everything from anybody.

At the time of his interview, Anthony reported an increased insight into himself, Bonnie, and their relationship dynamics, including the impact of each of their histories' on themselves in the present and their behavior on one another. Both he and Michelle noted that this newfound clarity resulted in greater depth of compassion and empathy, an ability to take responsibility for his behavior, while releasing him of responsibility that did not belong to him. Furthermore, these shifts allowed him to be more affectionate and

emotionally available to Bonnie, per Michelle, Anthony, and Bonnie. He described his recognition of his role in their dynamics:

What the therapy has shown me with Michelle is my part of the problem, which I just had never realized. I hid those kinds of things all my life and never wanted to face it and never thought about having been raised in a dysfunctional household and how that affected me.

During his time in couples therapy, he began attending Adult Children of Alcoholics, which he identified as being extremely beneficial, contributing to letting go of the shame and responsibility from his childhood:

I guess what has stuck through it was that it wasn't my responsibility, that there was really nothing I could have done to make my parents' life any different. I know through ACA, I'm supposed to think they did the best they could do at the time and I guess they probably were. I'm not completely at peace with that yet.

Michelle described how his increased recognition of the impact of his childhood on his relational dynamics empowered him to be more available to Bonnie:

He's able to see how his early experiences, especially his relationship in his family of origin, how that is significant in how he has behaved with his wife...the affair, the lying, and the betrayal. And an understanding that the shame takes him further away and so having a greater understanding of kind of the foundation for what happened helps relieve, or decrease some of the responsibility, some of the inappropriate responsibility he had, you know, as a little boy...That helps him to remain present in the relationship more often.

Furthermore, she noted his increased genuineness: "he's been peeling back layers of who he really is rather than the façade that he's put up for others." Bonnie also observed changes in his openness, affection, and desire to connect with others:

He's able to share feelings with me and tell me how he feels about things. He's much more affectionate. Not just in a sexual way. I'm talking about affection, but both. But able to be more affectionate with me and with other people too. And I think that he is at a place where he would really like some men friends. And he's never done that before.

Anthony noted the bitter-sweet nature of his self-awareness, expressing the pain he feels in facing his flaws, but his eagerness to continue to challenge himself to be open and honest with himself and others:

So it's definitely hard to have to address your issues and faults. It's much easier just to turn a blind eye to them and escape, but that's not the way I want the rest of my life to be...I started to see things and feel things differently and became very open to expanding that side of me. I like the feeling of not hiding things. I like the feeling of being able to tell somebody what I feel...sometimes I feel like a toddler in a lot of ways...Then I get to feeling real guilty at the price that Bonnie had to pay for me to finally start realizing what my problems were and to start feeling better.

He shared his excitement about this personal development and his curiosity about his ongoing process:

I feel like I put the outside edge of a puzzle together because I can find the straight edges and put it together, but I don't know what the picture's gonna look like once it gets filled in yet...I discover stuff about myself almost on a daily basis now...thinking this picture is going to be me and I don't want to look at the box cover to see what it looks like because then that will influence me. I want to continue to stay open on a daily basis to see what the picture's gonna look like....

### **Bonnie and Anthony**

Bonnie and Anthony participated in approximately eight months of weekly couples therapy, with each partner having taken on both the working and the witnessing partner role. Bonnie participated in two conjoint EMDR sessions and Anthony engaged in four. Bonnie's discovery of Anthony's internet affair led to each pursuing individual therapy and then couples therapy with Michelle. They described themselves at the beginning of their work with Michelle as living separate lives and having a lonely marriage, such that Anthony was emotionally unavailable, paralleling other relationships Bonnie had experienced through her life. Michelle noted that she turned to her passion for horses and dressage as a means to alleviate that void. Anthony said he had been

jealous of her love affair with her horses because he wanted to experience the depth of love that she held for them. For Anthony, work and then the affair became his means of meeting his emotional needs as he did not know how to directly express his feelings or connect on a genuine level. Bonnie said it this way:

He never felt comfortable letting people see him emotionally so it was kind of a lonely marriage for me because I wanted a partner and he thought what he was doing was good enough. You know, he provided well. He was jolly sometimes and he bought us all gifts, meaning me and the kids. And he always rescued everybody and...that was the way he showed his feelings. He would kind of give you everything except himself.

Michelle reported that Bonnie had suffered a severe injury during a hit and run incident, resulting in her inability to ride horses anymore and in her becoming dependent on Anthony, which subsequently triggered Anthony's sense of inadequacy. According to Michelle, he responded by withdrawing further, perceiving that Bonnie hated him and his "shame shutdown" was further reinforced by Bonnie's strong reactivity toward him. Thus, they found themselves stuck in a self-perpetuating cycle of aggressive pursuit and emotional withdrawal. Michelle described the cycle this way:

He would be so overwhelmed with shame for his actions and it reinforced his view of himself that he would also kind of implode where he would go inside this big black bubble and just go deeper and deeper inside which took him further and further away from her. And then she had a way of just evoking his shame and that was part of her reactivity. And so she was constantly, at home as well as in session, triggering his shame which would drive him further away, which would make her more reactive...he wasn't able to hear or validate her pain. He could see her pain and then that would activate his shame, which would further separate him from his wife.

At the time of the interviews, Anthony, Bonnie, and Michelle described significant changes in both Anthony and Bonnie's ability to remain present to one another and reduced time caught up in their negative cycle, due to their increased understanding of themselves, one another, and their relationship dynamics. However,



they both expressed ongoing discouragement and intermittently reverting to old behavior. Michelle described their increased level of differentiation and the impact of Bonnie's increased understanding of her role in their pattern:

She has developed an understanding that she also triggers him. It's not just him having the responsibility for her. So that has decreased, thereby allowing him to remain present for longer periods of time when they're having challenging moments.

She also noted that Anthony's understanding of the contribution of his childhood experiences to the shame he had been holding has helped him to remain more present, which leads to less triggering of his wife's experience of abandonment, and reduced the intensity and time they spend in their negative cycle.

In spite of Bonnie's ongoing intense ruminations and difficulty trusting Anthony, she described greater understanding for her husband: "I think that I can understand now his need to escape. You know, if things become emotional or overwhelming for him, he definitely wants... he wants to escape them." She observed the significant change in Anthony's emotional availability and responsiveness to her now, in contrast to how he had been in the past, though she noted lasting anger and cognitive dissonance about his betrayal:

He's so different than before. I mean this is a person I really like to be with. But then I get stuck again and it's me who stops. It's not really him. He would be happy to just go on like that and I'm stuck. I'm going "but how could you do that to me?" and then it just starts all over again. It's like "how could this person be that person?" It's the same human being and of course I always have a fear that with the right set of circumstances, he could turn back into that person...

She noted his increased empathy:

He can feel a lot more empathy for my experiences in the past than he did before. I remember times in way way way in the past... when I told him for instance that I had been sexually abused as a child and he didn't say anything....That's one of

the things I processed while he was there and he was crying and he just felt so bad for me..

They both reported a commitment to working on their relationship in spite of their ongoing struggle, hope for the future, and the recognition that they have a foundation upon which they can build something new. Anthony stated:

Bonnie and I still have our struggles. I still need to be able to stay present more during her ruminations but you know, I think that there is light at the end of the tunnel now. I'm not sure how we get there or how bright it's going to be but we're still doing it together, so that, to me, is the most important thing in the world...we certainly have a lot more to do, but it was like we finally had hit some bedrock...there was something we could build on and it wasn't just quicksand anymore.

### **Seventh Triad: Doris, Louisa, and Roger**

#### **Doris**

Doris is a 66-year-old Caucasian female Licensed Psychologist and Certified EMDR Clinician who identified her heritage as English and Irish. At the time of the interview, she had been practicing as a Psychologist for 34 years and described her areas of professional specializations and expertise as family, couples, systemic, trauma, training, supervision/consultation with young professionals, feminism, and group work. She identified her theoretical orientation as family systems, with various shifting theoretical paradigms, beginning with Minuchin Structural family therapy and then Milan Systemic and Strategic work. She said that when she works with individuals, she takes on a psychodynamic-interpersonal-relational orientation. Beyond this demographic and professional information, she volunteered that she identifies as a Lesbian, is currently not in a relationship, has been married to a man, has been married to a woman, and has a grown son.

**Louisa**

Louisa is a 64-year-old Caucasian woman who had been married to Roger for 31 years, involved with him for 34 years altogether, and she identified this relationship as her first committed relationship. Together, they have three grown children, all of whom were living away from home at the time of the interview. She volunteered that she had lived within the same general area of the United States her entire life. She reported that she had participated in 30 individual therapy sessions between 2010 and the time of her interview. She began individual therapy in 2009, prior to initiating couples therapy with Doris, but reported that she discontinued because she did not like the pressure she receiving from her therapist to confront Roger about his withdrawal from her and her suspicions about his behavior. She then began seeing another individual therapist in 2010, who was an EMDR therapist, and she continued to see her during couples therapy with Doris. She participated in about four EMDR sessions with her individual therapist, particularly around the impact of Roger's affair.

When she began couples therapy with Doris, Louisa reported that she was experiencing "shock and terror" and feeling fragile after having recently discovered that her husband had been involved with prostitutes. Doris described her as desperate to save the marriage, codependent, and hypervigilant, expressing that "her eyes were on Roger" and she wanted to blame herself for his behavior in order to increase her sense of control over the outcome. Louisa talked about her self-blame in this way: "[I was] feeling like it was my fault somehow that betrayal happened because somehow I didn't measure up to the person and get [his] needs." She noted that she was frequently triggered by reminders of his infidelity:

Every time I would see [his bank]...you know, he was spending a lot of cash and he was charging things on his credit card from the [bank]. And it was really just...I would sort of traumatize myself. Or when I would see a couple that looked like they clearly were not really a couple but perhaps in a betraying mode...even if it was just totally irrational, I would see them that way...And the places that he had charged, if we passed them, I would always have a reaction.

Doris identified her as having insecure attachment, rooted in her childhood with parents whom Doris described as “lost souls” and an older adopted older sister who was very valued by their parents like “peas in a pod.” Doris stated that Louisa’s sister would attempt to exclude her from the family system in an attempt to maintain the family the way it had been prior to Louisa’s birth, her sister perceiving Louisa as a threat to her special position. Many of Louisa’s childhood memories relate to her desperate attempts to connect with her older sister and therefore to be accepted into the family system. Doris noted that even as an adult, Louisa continued to struggle with insecurity around “crossing her sister.” Doris described a similar relational pattern of “wanting to get in, be accepted and feeling like it’s because of her that [Roger]’s not there.” She would frequently become preoccupied that something that she or Doris would say during sessions might push Roger further away, per Doris’ report.

After her discovery of Roger’s infidelity, Louisa noted that she chose not to tell anyone, even after he gave his support that she could tell any of her friends. She shared having been concerned about others’ judgments about either of them. She described herself as “stuck in my fear,” stating, “I was just constantly holding my breath and feeling like I didn’t know whether to step right or step left or to ask him anything.” She noted that even when they began seeing Doris for couples therapy, she remained paralyzed by fear: “I was holding my breath the entire time, just not knowing if Roger

would stay or go or what was going to push him over the edge. So I felt like I was in a tiny little box of not knowing what to do.”

At the time of her interview, she was less reactive and setting more appropriate boundaries, experiencing a higher level of differentiation from Roger. Doris described her changing perspective:

She has increasingly come to look beyond her own reactivity and really see him instead of just her projection of who he might be or she's afraid he is or whatever, you know. She's more genuinely connected to him and in a way, she used to be over-concerned and kind of over-parental with him and now she's more appropriately concerned. And she will even say, “I don't want to be overstepping my bounds. If this is too much, please let me know.” She's much more sensitive that way.

Louisa observed that places, things, and situations that had been triggering for her had lost their charge:

It wasn't an aha change but it was like over the next few weeks, bills would come in or I'd drive by [the bank] and then I'd realize I had no reaction....I began to see that [bank] didn't have a charge and some of the visuals I would have of Roger with somebody else would disappear.

However, she noted continued fear and uncertainty about her relationship and the future, recognizing that there are no guarantees in the security of their relationship. She said:

“I'm not fully evolved by any means. I'm old enough to know better. But you can't protect your heart to the degree that it needed protecting through this one.” She also noted: “Now I'm so afraid to make any assumptions about anything in my life; nothing feels secure.” At the time of the interview, she said she was also still feeling outrage and having difficulty tolerating Roger's infidelity. Doris described it this way:

I don't think Louisa has quite come all the way in terms of being able to bear that he was seeing prostitutes. To make that picture of him big enough that she could see how he went down that particular vein...but I think that she will and she wants to. And, but when she thinks about it, she has outrage on a number of

levels...She's not quite there in being able to hold it... but I think she's come an awful long way.

### **Roger**

Roger is a 59-year-old Caucasian man who identified his 34-year marriage to Louisa as his first committed relationship. He reported having had six sessions of couples therapy and 48 individual sessions prior to his interview. Like Louisa, he began individual therapy in 2009 before initiating couples therapy and continued his individual work during couples therapy. Initially, Louisa noted that Roger had been angry and hadn't wanted to engage in couples therapy, but had instead agreed to individual therapy. More recently, Louisa had suggested that because his individual therapist didn't do EMDR, he might meet with Doris individually to participate in EMDR with her beyond the conjoint EMDR session he participated in with Louisa. A few weeks before his interview, he had participated in one individual EMDR session with Doris, which Louisa stated he described to her as helpful.

When Roger began couples therapy, he said he had been willing to commit to the relationship and to monogamy but did not have any concrete goals for therapy. According to Doris, he was experiencing significant shame and was struggling with some lasting symptoms of depression, though he stated that when he began work with Doris, he had been starting to feel less depressed. Doris described him as quiet, having little to no spontaneous speech, having limited relational skills, being withdrawn, having poor attachment, and being "under the radar." She noted the impact of his childhood experiences on his relational patterns as an adult:

[His] father died when he was around 10 and then [he was] surrounded by women, whom he perceived were too stressed to do anything for him, pay any attention to him—he learned a whole style of staying out of the way and never

asking for anything...He never took any risks...He didn't ask questions about what was going on. He just stayed under the radar.

Doris also described him as lacking a sense of self with such unmet needs that he felt as though he was missing a piece of himself, a void Doris believes resulted in his involvement with prostitutes:

This [withdrawn and shame-filled] presentation was just a fragment of his personality...better skills coexisted with the trauma piece but he was out of touch with them...His child mind said to him "... I didn't really have an adolescence because I was just trying to not rock the boat, therefore, maybe I have a missing piece and that's why I feel so bad. And maybe if I had more sexual experience, like if I had a period of promiscuity or something, I would feel more real." And that's how he got into the prostitutes; he was trying to make up for having been a teenage boy who never had a real girlfriend.

At the time of his interview, after about a year and a half of conjoint couples therapy with Doris, he reported having more understanding and insight into himself including the impact of his past. Furthermore, he noted an increased ability to differentiate between the past and the present and have a larger view of his experiences, such that the pain he experienced was recognized as just one part of his childhood. He also noted decreased shame and increased freedom to more fully engage in the present and in his marriage. Doris highlighted his increased clarity and self-compassion:

He said "I couldn't figure out another way to grow myself up. I felt like I'd left something out. I felt like I was never going to be whole or right, that I was always going to be depressed and inadequate." I could see that he was getting that for the first time as he was saying it. It wasn't like a defense, but it was really an opening.

He described his ability to perceive the "big picture" this way:

In general, I am more aware of trying to see the big picture and aware that one painful thing isn't the whole story. I couldn't say that I am able to put that into direct practice in my daily relational life but I am aware of it; it's in the back of my mind.

Louisa said that he is “much happier,” stating that their daughter whom she described as a “barometer” has also observed his increased happiness. Doris noted that Roger has become more invested and present in his relationship with Louisa, such that he has demonstrated a desire to support her in her attempts to negotiate relationships with her own family of origin: “he has stepped up to the plate to help her think through some relational difficulties she has with her own family...whereas before, he really just pulled out.” Roger said it this way: “I surprised both of them when I spoke up very clearly and forcefully about her relationship with her sister...And maybe that clarity came from that experience of really being able to reflect on it and think about it [during conjoint EMDR].”

### **Louisa and Roger**

Louisa and Roger had been participating in couples therapy with Doris for approximately a year and a half, initially once per week for a short period of time, then sporadically due to vacations and scheduling issues. At the time of the interviews, they were meeting once every six weeks and they noted that they were contemplating termination. Louisa described their status prior to and upon initiation of couples therapy. She said that she and Roger had “drifted apart” and that she had sensed that something was going on with Roger as their relationship became increasingly distant. Their communication was poor and Louisa identified each of their roles in enabling that lack of communication prior to beginning couples therapy with Doris:

It’s always been hard for me to ask him questions and he doesn’t reveal very much...I was stuck in a box because I had no idea why Roger ended up where he did with me. So I didn’t know who to be, and how to be, and how to behave and what he wanted from me. And he wasn’t good at talking about that with me.



After Louisa's discovery of Roger's involvement with prostitutes, Doris noted that Louisa's attachment insecurities magnified and she became stuck in shock and fear, while Roger was filled with shame and silence. At the beginning of therapy together, they had been engaged in a pattern such that Louisa varied between anxious pursuit and avoidance, and Roger would shut down and withdraw. They noted that this dynamic was not working for either of them, but that they had become stuck and had no alternative methods of negotiating their needs. Doris highlighted the power of their intersecting traumas and described the concept of the "ritual impasse fight":

The stuck place is where one member's trauma intersects the other person's trauma. And that if their problems weren't sitting on each other, they would have more flexibility and be more able to come through the developmental stuck place...And the more I got to know the stories of these two people, the more I could see that he was very very stuck in his inability to converse, to initiate, to go inside and give a reason for anything he'd done, to name a feeling. And that she was very very panicked about his inaccessibility.... The center of my thinking is here's a systemic impasse that's made up of components of his withdrawal and her anxious pursuit...the more she tries to get in his space and get really deeply close to him, the more he freezes...I just saw her as panicked about the loss of relationship...It was really just kind of this shock and terror that this thing had happened for Louisa and for Roger, shame and silence.

Louisa described her lack of capacity to break their pattern:

I didn't have tools for stopping and saying, "this isn't working for me" because it wasn't working for me either. It's not like it was just him that was unhappy. I mean, neither of us was really communicating with the other. But I just didn't have any tools that weren't too scary to put out there or until it practically all blew up in my face. It did and we've been trying to put it back together.

Similarly, Roger noted that each had resorted to withdrawal and avoidance, further reinforcing their lack of connection and engagement with one another:

I think we both had the tendency to shut down and withdraw. When things got difficult, we each had our own ways of disengaging and shutting down, that we hadn't really found good mechanisms for engaging with each other when there were difficult issues. And we had had a long history of sort of avoiding dealing with difficult issues and had become more and more withdrawn from one another.

Louisa described how her fear and their lack of communication fueled their disconnection from one another:

I finally asked him the question, which I had not dared ask, which was “how close to leaving were you?” I had never asked that question. And it turned out it was part of his thinking, but I don’t think he was anywhere near as close to walking out as I thought he was....he said...he was upset and depressed and...thought about divorce but I don’t think he thought every day, “well this is the day I’m going to leave” and every single day, I thought was the day he was going to leave. So you know, we lived in very different worlds for quite a long time. But I just didn’t feel safe asking him.

In spite of their uncertainty about the future of their relationship and their sense of isolation when they began couples therapy, both viewed their decision to begin couples work as a gesture of their commitment to their marriage and their investment in trying to reconcile. Roger stated: “I think, in my mind, the act of doing the therapy together, the couples therapy was a commitment to say, ‘yeah I want to try to make our relationship work and this is one way to do that.’ ”

At the time of their interviews, they noted significant changes within their relationship and hope for the future of their marriage. Doris observed that they were engaged in more giving and receiving of support with one another. She presented this example:

Something that’s happened, beginning about when we did EMDR, is that he brought his mother from wherever she was living, more down in the south, to be in assisted living in [local city]. So they both have a lot of contact with her and it is evocative for him and Louisa helps him a lot with her, including doing some of the visiting and being sure their kids visit her...He has felt really legitimately helped by her with something that is quite difficult for him and without that, he wouldn’t be able to feel like he’d made some peace with his mother in this chapter of life.

She also noted the genuine love and gratitude they feel toward one another as they are now able to truly see the other:

I think [conjoint EMDR] just moved them from a place where when they stood and looked at each other, they just saw a projection of dynamics of their own to a place where when they stand and look at each other, they really see the person...I think they were attached but I think now, they genuinely love each other...I think it's made their relationship more precious to them because there's space to be...genuinely in relationship to the complexity of who the partner is.

Roger shared his hope in the future of their relationship, his recognition of how far they had come since initiating their work with Doris, and their newfound ability to move toward rather than away from one another:

I think just having had the experience of talking about a lot of those things and sharing the facts or describing to each other how stuck we were and how much we each withdrew has allowed us to start working on moving towards each other instead of withdrawing.

Louisa reported a similar sense of hope, though tempered by her awareness that nothing is ever certain, as she continued to integrate and heal from the crisis that she and Roger had faced:

I began to realize that maybe there was hope somewhere in the marriage...I feel that both of us feel pretty positive about where we are. And I'm assuming that he won't say anything different from that to you, although you never know. Now I'm so afraid to make any assumptions about anything in my life; nothing feels secure...[I thought] the likelihood of our staying together was pretty small initially. And now I think that the likelihood of breaking apart is pretty small.

They both said they intend to discontinue individual therapy and to continue to spread out their couples therapy sessions with Doris, given their increased tools and confidence in their ability to move toward one another as well as their desire to rely less on couples therapy to communicate about difficult issues with one another.

Furthermore, they verbalized increased contentment and connection and a sense of lightness with one another, as their self-awareness had grown and their relational functioning had improved. Louisa stated, "[we have] come to a much better place. There's much more of a physical connection, and emotional connection and a paying

attention connection than we've had for quite a long time." Doris noted their increased connectedness and the lightening of the load that they had both been carrying for so long:

I think they're doing a lot better. They've been traveling together. When he goes to [work] in foreign countries, she often goes with him. And I think they're just both more content in their lives...they're playful with each other. They're fun to be with. They tease each other. It just feels so much more open...much lighter.

### **Summary**

In this chapter, I introduced the 21 participants who were individually interviewed about their experience of conjoint EMDR including both members of seven couples and the therapists who conducted their EMDR within couples therapy. Demographic information was presented about each individual; professional experience and orientation were provided for the therapist participants and the individual functioning as well as relational functioning for each couple were described for both the initiation of couples therapy and at the time of the interviews after they had engaged in conjoint EMDR.

In the following chapter, data from each interview are presented in an integrated form as a theory about conjoint EMDR. Specifically, the grounded theory includes the influential factors related to assessment prior to initiating conjoint EMDR, intervening conditions related to preparation and re-evaluation, contextual factors, the phenomenon of conjoint EMDR as a relational trauma treatment, the actions and interactions involved in the conjoint EMDR process, and the consequences or outcomes experienced by participants after conjoint EMDR.

## **CHAPTER V**

### **FINDINGS**

#### **Introduction**

This chapter presents the process of EMDR within conjoint couples therapy based on interviews and documents from 21 participants. Strauss and Corbin's (1998) grounded theory data analysis methods were used to develop a theoretical model to understand clients' and therapists' experience of conjoint EMDR. The grounded theory, Conjoint EMDR: Relational Trauma Treatment Theory, has as its central category that trauma is experienced relationally and is healed relationally. Specific research questions that investigated in the development of this grounded theory model include:

- Q1     How do members of couples describe their experience of conjoint couples therapy involving EMDR treatment?
- Q2     How do therapists describe their experience of providing EMDR treatment within the context of conjoint couples therapy?
- Q3     What do participants perceive as valuable or meaningful about the process?
- Q4     What do they perceive as impeding the process or not valuable? 5) How does each participant describe the status of the couple prior to and following EMDR, both individually and relationally?

The grounded theory approach involves generating an abstract analytical schema or theory regarding a particular phenomenon that serves to explain the process and results in the development of a substantive or context-specific theory (Strauss & Corbin, 1998).

Open or substantive coding is the first step in the coding process and involved studying and categorizing fragments of the data, including words, lines, or sections, and providing labels to those segments based on themes. Strauss and Corbin (1998) refer to the second phase as axial coding, during which data were synthesized into a coherent whole (Charmaz, 2006) to help explain the central phenomenon of conjoint EMDR. Finally, selective coding involved the refinement and integration of the theory that is grounded in the collected data. During this process, data were organized into the six components of grounded theory: influential conditions, phenomenon, context, intervening conditions, actions/interactions, and consequences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Integrating the various categories provided a theoretical picture that illustrates participants' experience of EMDR within conjoint couples therapy.

The assessment as well as the preparation and re-evaluation stages are included within the theory as influential factors and intervening conditions to the process of conjoint EMDR. Contextual factors and the phenomenon of conjoint EMDR as a relational trauma treatment are presented. Furthermore, the actions and interactions involved in the conjoint EMDR process are described. Finally, the consequences or outcomes experienced by participants after EMDR are discussed. In her constructivist grounded theory approach, Charmaz (2000) argues that "Data do not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts" (p. 524). Thus, it is worth noting that the following theory is but one of many potential interpretations of the data and is influenced by my own history, value system, and understandings as well as the contexts of the participants themselves. The table below (see Table 2) summarizes the emergent

components of the relational trauma treatment grounded theory of conjoint EMDR.

Unless otherwise noted (e.g., “therapist participants”), these themes were grounded in data from both client and therapist participants (referred to as “participants”).

Table 2

*Components of Conjoint Eye Movement Desensitization and Reprocessing: Relational Trauma Treatment Theory*

Influential Conditions	Contextual Factors	Phenomenon	Intervening Conditions	Actions / Interactions	Consequences
Assessment:	1. Previous familiarity with EMDR	Core Category: Trauma is Experienced Relationally and is Healed Relationally	1. Preparation	1. Length/speed/amount of conjoint EMDR	1. Working partner
1. Therapist			2. Re-Evaluation		2. Witnessing partner
2. Working partner	2. Roles			2. Roles	3. Relationship and common themes between partners
3. Witnessing partner	3. Reasons for referral			3. Targets: present vs. float back	
4. Relationship				4. Unexpected directions and insights	
				5. Indirect Communication	
				6. Power of conjoint EMDR vs. verbal processing	
				7. Working partner	
				8. Witnessing partner	
				9. Obstacles	



### **Conjoint Eye Movement Desensitization and Reprocessing: Relational Trauma Treatment Theory**

Based on data from interviews and documents from the 21 participants who shared their experience of conjoint EMDR, a grounded theory of conjoint EMDR treatment as a relational trauma treatment was developed. This theory outlines the assessment process of determining whether a couple is appropriate and likely to benefit from conjoint EMDR as well as preparation steps and re-evaluation procedures to appropriately integrate EMDR within couples therapy. Contextual factors are presented, including clients' previous level of familiarity with EMDR, the roles (witnessing or working partner) that each member of the couples took on during the conjoint EMDR process, and the reasons for referral. The experience of the conjoint EMDR process itself is described including the variations in the length, speed, and amount of conjoint EMDR for the seven couples who participated in this research; the roles taken on by each member of the couples; the targets addressed; challenges to the conjoint EMDR process experienced by participants; and themes identified by either or both the working and witnessing partners about their process of EMDR within couples therapy. Furthermore, the outcomes from conjoint EMDR for each member and for the relationship as a whole are presented including the most commonly reported intra- and inter-personal changes. The pseudonyms for the participants are presented in Table 3 below.

Table 3

*Pseudonyms for Participants by Triad*

Participant	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	Triad 6	Triad 7
Therapist	Bill	Cat	Rich	Fred	Nancy	Michelle	Doris
Partner 1	Rita	Nesse	NyxRN*	Beth	Ursula	Bonnie	Louisa
Partner 2	Matt	Richard	Huck	Sam	Algernon*	Anthony	Roger

*\*These participants served only as witnesses to their partner's EMDR.*

**Influential Conditions: Assessment**

The participants identified several steps in the assessment process to determine whether a couple is appropriate and ready for conjoint EMDR treatment. Beyond assessing whether both partners and the relationship as a whole meet criteria for appropriateness, participants also identified important therapist-related conditions to successfully facilitate conjoint EMDR treatment. This assessment procedure parallels phase one of the standard EMDR protocol, client history and treatment planning, during which information is gathered about clients' history and clients are assessed to determine whether they are good candidates for EMDR. These factors are useful in predicting potential obstacles and guiding preparation. The influential conditions within the assessment process are presented in Table 4 below and then in narrative form, with themes separated into four sections including those related to the therapist, the working partner, the witnessing partner, and the relationship. Specific ways in which such assessment can be conducted are included within each section below.

Table 4

*Influential Conditions: Assessment*

Therapist	Working Partner	Witnessing Partner	Relationship
1. Integrative approach	1. General intra- and inter-personal functioning	1. General intra- and inter-personal functioning	1. General relational functioning
2. Competence and alliance	2. Trauma history	2. Stability and resources	2. Level of engagement in therapy
	3. Stability and resources	3. Trauma history	3. Alignment of goals
	4. Willingness to be vulnerable	4. Support and safety	4. Strength and commitment within relationship

**Therapist.** In this section, themes related to the therapist identified as important to effective conjoint EMDR treatment are presented.

***Integrative approach.*** Participants highlighted the importance of therapists maintaining an integrative approach to couples therapy that balances individual and systemic dynamics. They noted that such a balance fosters sufficient depth to reveal and address intra-psychic dynamics, while successfully addressing relational issues. The importance of clinical judgment and the ability to provide a rationale to couples for differential attention to one member of the couple at various times were also emphasized. Bill noted that incorporating EMDR within couples therapy “emphasizes personal responsibility in a context that otherwise lends itself to reliance on blame,” stating that “couples tend to come into treatment wanting to fix the partner and laying their troubles at their partner’s feet.” He described EMDR as being about “healing intra-psychic

wounds and increasing interpersonal resilience of the individual” and that it maintains the focus on personal responsibility such that each individual is encouraged to become part of the solution rather than trying to change the other. Similarly, Cat talked about the value of conjoint EMDR in increasing differentiation. Participants valued emphasis on personal responsibility and the goal of increasing differentiation.

Eye movement desensitization and reprocessing (EMDR) was seen as a valuable tool integrated into a systemic model of couples therapy, and was frequently viewed through various theoretical lenses and incorporated with techniques from several approaches. Participants noted that EMDR is not sufficient in and of itself, and highlighted the importance of the therapist’s responsiveness, approach, and skill in attuning to each partner’s perspective. Several therapists identified models and techniques found complementary to EMDR including a differentiation model based on the work of Schnarch (1997) and of Bader and Pearson (1988), Gottman’s (1994) approach to couples work, Kitchur’s (2005) strategic developmental model, ego state work (Watkins & Watkins, 1997), attachment focus (Bowlby, 1988), emotionally focused couples therapy (Johnson, 2004), and body-based enactment and psychodrama work (Blatner & Blatner, 1988).

***Competence and alliance.*** Several client participants noted the importance of finding a competent and experienced therapist. Therapist participants identified the ability to successfully manage reactivity as an important criterion for successful conjoint EMDR. Furthermore, several therapists mentioned having significant experience with couples work as well as with EMDR, noting a high level of comfort in their ability to

successfully integrate it within couples therapy, particularly after having learned, through previous experience, strategies to appropriately assess and prepare couples for this work.

Similarly, client participants noted the need to be confident in their therapist's abilities, the importance of fit, and the need for safety and trust with their therapist in order to participate in conjoint EMDR. Ursula valued having shared religious beliefs with her therapist, Nancy:

the fact that she was a Christian was very very important to me” and she spoke to the connection and understanding she felt from her: “the empathy and the compassion is there, and the understanding...That was very very meaningful and important to me.

Both clients and therapists discussed the importance of the therapeutic relationship relative to the successful outcomes experienced by couples. Bill said: “I would attribute [the positive changes] to the progress [Matt has] made based on doing EMDR but also based on the constancy of a secure attachment with his therapist.” Bonnie noted her confidence in Fred and her resulting trust in the process: “we had confidence in what he was doing and we knew that it was going to help and so...I just trusted him to get me through, to know how to direct it.” Nesse described her appreciation for Cat in this way: “my mother gave birth to me but Cat gave me my life back...I look at her like my second mother...When I sit in front of her, I am safe.”

**Working partner.** To assess whether a member of a couple is appropriate to take on the working role, several steps and criteria were identified by participants: evaluating overall intra- and inter-personal functioning, obtaining a thorough trauma history, and assessing the stability and resources of this partner. Specific ways in which such assessment can be conducted are included below. Participants noted the importance of the

working partner's ability and willingness to be open as well and to be vulnerable in front of both the therapist and the partner.

***General intra- and inter-personal functioning.*** Therapist participants noted the need to evaluate partners both individually and together to gather background information and observe functioning. Several therapists utilized tools such as genograms, Myers-Briggs testing, and intake paperwork. These tools served to provide information about personal and family history, trans-generational patterns, personality traits, expectations of self and others, goals, symptoms, etc. Furthermore, they stated that identifying the negative cognitions that impact relational dynamic and assessing each partner's ability to follow the expectations were important. They also valued the exploration of attachment security, level of hostility and anger, investment in personal change, and degree of differentiation in anticipating the progress of conjoint EMDR.

Formal and informal assessment of the working partner's intrapersonal and interpersonal functioning includes identifying the repeating emotional, cognitive, and behavioral patterns and roles that occur through the use of interviews, questionnaires, and observation during sessions. All participants reported positive outcomes from conjoint EMDR; however, the working members of couples who were most angry, invested in their partner's change rather than personal growth, highly fearful about the dissolution of their marriage, overly anxious about their partner's reaction, or dependent on external validation demonstrated the least amount of positive change.

***Trauma history.*** As with individual EMDR, participants noted the importance of obtaining a thorough history from the working partner, particularly related to trauma. This history should include big "T" and "t" trauma events (Shapiro, 2001), both within

and outside of the present relationship. Given that members might be more forthcoming individually, information gathering may be more appropriate to conduct without the partner present.

***Stability and resources.*** Similarly to individual EMDR, therapists highlighted the importance of evaluating the stability and resources of both partners. Specifically, therapists noted the need for working partners to be able to tolerate their own and their partner's affect and to be sufficiently differentiated to not be overly preoccupied by their partner or the outcome of the EMDR process. Clients who relied on alcohol or on their partner to soothe, distract, or numb their emotions benefited the least from conjoint EMDR, though still reported positive change.

***Willingness to be vulnerable.*** One of the most commonly identified necessary criteria for working partners was their willingness to be forthcoming in front of their partner, not censoring themselves or downplaying their experience to protect themselves or their partner. Meeting with members of the couple individually as well as together is one way to identify any tendency to withhold information, by attending to differences in their level of openness in both contexts and by asking individual members whether they have shared or would be willing to share vulnerable emotions with their partner. Matt said that successful conjoint EMDR requires "keeping an open mind, being willing to let your guard down and go with it."

Willingness to be vulnerable in front of the therapist as well as one's partner requires sufficient differentiation to face the reaction of others and an uncertain outcome. Several client participants noted a heightened awareness about the presence of their partner initially, often followed by an immersion in the EMDR process that allowed them

to trust that it was safe to be exposed. In her follow-up interview, Rita said that her resistance prevented her from being as open and willing as was necessary and served as a barrier to the process. She became more willing to be vulnerable over time, which allowed her to gain more benefit from treatment.

**Witnessing partner.** Participants identified many of the same criteria for both the working and the witnessing partners in terms of assessing their readiness for participation in conjoint EMDR. Unique to the witnessing partner, participants noted the importance of determining the degree to which partners knew about the working partner's trauma, as well as their ability to provide the support and safety necessary for their partner to openly share their experience.

***General intra- and inter-personal functioning.*** As with the working partner, a general assessment of the witnessing partner's intra- and inter-personal functioning appears to be crucial in obtaining a preliminary picture of potential obstacles and benefits of conjoint EMDR. In particular, it is useful to evaluate the degree of attachment security for the witnessing partner to anticipate what might emerge during conjoint EMDR. Such assessment can be conducted informally through observing interpersonal dynamics or formally through attachment measures (the latter was not done by therapists in the current study).

This overall assessment is related to the other criteria below and appears to be best obtained through meeting with each member of the couple individually as well as together. For example, therapists should be alert to anxious clinging or avoidance of intimacy, the degree of emotional responsiveness to vulnerability expressed by the partner, over-reliance or avoidance of soothing by the other, and reactivity to or



preoccupation with one's partner, as these can provide information about the level of attachment security (Johnson, 2002, 2008; Wesselman & Potter, 2009). As noted for the working partner, the level of hostility, investment in personal change, and degree of differentiation impacted the witnessing partner's ability to be fully present in a supportive role.

***Stability and resources.*** Participants noted the importance of stability and resources above all other criteria for assessing the witnessing partner's ability to provide the appropriate level of support to their partner during conjoint EMDR. This involves providing silent support and not interrupting their partner's processing. It also includes being capable of self-soothing and maintaining a sufficient level of differentiation to not personalize material being processed by their partner, and to remain present rather than being preoccupied with the outcome or overwhelmed by their own emotions or impulses. Rich noted that he assesses the resources that are in place for both partners, including their strengths, skills, abilities, talents, resources, achievements, etc. When asked what advice clients would give to couples considering participating in conjoint EMDR, several client participants noted the need to be prepared to hear potentially distressing material and to remain present for themselves and their partner. NyxRN said it this way: "I think that they have to have a very open mind about each other. And not to take everything that happens personally...You have to be prepared...If you're going to secretly look into somebody's closet, you have to be prepared for what you might see." Similarly, Nancy stated that she warns prospective clients about the need for tolerance to hear disturbing material and that she expresses to them: "I need you to really think about are you okay

hearing whatever you might hear because once you know something, you can't un-know it."

**Trauma history.** Participants highlighted the potential impact of learning difficult material for the first time during conjoint EMDR. Though this may be inevitable and part of what contributes to its benefit, therapists highlighted value in determining whether the working partners had shared at least a certain degree of their trauma history with their partner. If they had not, not only would the working partner likely be apprehensive about doing so during EMDR but the witnessing partner may be less likely to remain fully present. Rich said:

If there's only a partial history that's known then I'd want to talk to the trauma survivor and say "what about these other parts that your wife doesn't know?" Because the last thing we want to have happen is for her to go in with only a half truth and then wind up being very surprised and potentially triggered herself in the work.

Furthermore, therapist participants emphasized the importance of being familiar with the witnessing partners' trauma history in order to anticipate how witnessing their partner's processing of traumatic material may impact them. Rich noted: "The last thing you want to have happen is when you do EMDR... to wind up having the spouse triggered in the same session." This assessment should include evaluating both big "T" and small "t" trauma history, as with the working partner (Shapiro, 2001).

**Support and safety.** Participants noted the need for the witnessing partner to be silent, respectful, and supportive without judging or questioning the validity of the material being disclosed. A common theme was the importance of trusting that a partner will not use disclosures as weapons of retaliation in the future. Nancy underscored the importance of safety and assurance that material will not be used as a weapon:

This would be in the safety realm, that there is pretty solid surety that nothing that comes out in the EMDR will be used against the processing partner...that is part of the things we need to assess...before we ever start anything is “will this be safe enough that there will be tenderness and empathy and understanding so that even in a fit of anger, nothing will be brought up and flung back in a negative, hurtful way?”

Nesse highlighted this same need for safety and support by a witnessing partner:

It can build trust between a couple but it can break it too if the other person has issues themselves and then can't handle this kind of scenario and becomes very judgmental. It would break the trust. It's very important to establish or manage the expectations, knowing that when you come into that room, they have to leave the judgmental hat out of the door and be here for good together.

**Relationship.** Beyond the criteria and assessment procedures outlined above to determine whether individual members of the couple are ready to engage in conjoint EMDR, participants also identified important requirements for the couple and the relationship as a whole: their general relational functioning, both partners' ability and willingness to follow the expectations for conjoint EMDR, their level of engagement and investment in therapy, the alignment of their goals with one another, and the level of strength and commitment within the relationship.

**General relational functioning.** Participants noted that conjoint EMDR is helpful for couples who experience interpersonal reactivity and interlocking trauma reactions, such that one person's trauma-related reactivity triggers that of his or her partner, noting that traditional talk therapy may be less successful for such couples. Thus, part of the assessment should consist of exploring how this reactivity occurs within the relationship, such as asking the couple about their predominant negative interaction patterns, including common triggers to pursuing, withdrawing, or attacking and how the partner responds to such behavior. The assessment also involves observing for such reactivity within the sessions. Though such interpersonal reactivity may be an indication for the potential

benefit of conjoint EMDR, volatile reactivity may also serve as an obstacle to conjoint EMDR. For example, if partners are so hostile with one another that there is insufficient respect, trust, and safety to engage in EMDR together, therapist participants noted that individual EMDR may be more appropriate.

Formal and informal assessment of the couple's interpersonal functioning includes identifying the repeating patterns and roles that occur within the relationship through interviews, questionnaires, and observation during sessions. Determining that there is a withdrawer-pursuer dynamic that recurs within the couple, the therapist may anticipate that such a dynamic is likely to occur within the therapy room and during the conjoint EMDR process. Thus, the assessment procedures guide the next steps in terms of the degree and type of preparation that is necessary for each member and the couple as a whole prior to engaging in conjoint EMDR, if determined to be indicated.

Doris described her perspective on the benefits of conjoint EMDR in addressing a systemic impasse in this way:

I believed that [conjoint EMDR] would be a really amazing tool for getting people past the impasses that can take years of repetition in couples therapy... You may be able to get that change seeing them individually but you'll get a more powerful change if they're both a part of the whole thing.

The other therapists were similarly passionate about the potential value of conjoint EMDR in resolving such impasses. However, it is also worth noting the value in anticipating what may result from changing these dynamics, as those who benefited less from EMDR appear to be those who were ambivalent about change and about reducing the intensity of their emotional reactivity, likely because it served them in some way. Thus, assessing the way in which their patterns are purposeful and the potential resistance to changing them may be valuable in anticipating obstacles to the conjoint EMDR

process. Included in the assessment of the general relational functioning within the couple is ensuring that there is safety present, such that neither partner is so volatile that there might be a risk to either partner physically or emotionally.

***Level of engagement in therapy.*** Another common criterion for determining a couple's readiness to participate in conjoint EMDR is their level of engagement and investment in couples therapy. That is, are they attending regularly? Do they follow through with homework? Are they responsive to the therapist and one another within sessions? Participants noted the importance of both members being invested in and "bought into" the value of couples therapy. Participants noted the need for both members of the couple to be able and willing to "abide by the rules of engagement," as described by Rich: "Namely, sit by each other quietly, not process with each other verbally about what happens in between the sets [sets are the period of 20 to 50 seconds of bilateral stimulation that accompany the desensitization phase of EMDR]. In other words, they're not going to do anything, either one of them, to sabotage the process."

***Alignment of goals.*** As noted above, Bill highlighted the benefit of conjoint EMDR in its emphasis on personal responsibility rather than blaming one's partner. His comments underscore the importance of both members being in agreement about their goals for conjoint EMDR. If both partners are not invested in personal growth, insight, or increased awareness into their own role within the relational dynamics, it is unlikely that they will obtain the same degree of benefit from treatment.

This was observed in the differing investment, openness, and self-reflection between Rita and Matt as well as between Bonnie and Anthony. Rita discussed her desire to change Matt and her reluctance to soften the intensity of her anger toward him,

apparently fearing that letting go of her anger might result in less change on his part. Furthermore, her pattern of engaging him through pursuit and attack served to maintain her connection to Matt. To let go of that anger or of her reactivity would likely be threatening as it would mean risking that attachment. Doing so would require a level of ego strength and differentiation that she did not appear to have.

Bill noted the term “primary gain” rather than “secondary gain” when referring to Rita’s desire to hang onto her reliance on blame and attack as ways of relating to Matt:

It’s really primary gain...Our attachment system trumps...personal suffering and it trumps personal growth and it trumps cognitive notions of ideal relating...All that is so much noise when it gets down to what really makes us tick...It’s about relationship first. It’s the most deep seated core of my personality. This change means that I lose my relationship...

Ursula spoke of the need for self-reflection and investment in personal work: “You have to be invested...in not just fixing the relationship, but seeing what you’re contributing to it and owning up to that...You have to have some sense of humbleness and humility going into it.” She also noted the value of trusting that the conjoint EMDR process will be beneficial for the individual, even if the relationship does not survive.

***Strength and commitment within relationship.*** Participants also noted the need to evaluate the strength of the relationship and the level of commitment by both members to the relationship. This includes assessing any unresolved issues that might interfere in the progress of EMDR. Rich identified the following guiding questions:

What is the nature of their relationship now? Do they have any unresolved problems that are relational that could come up in the work? Like my husband had an affair three years ago and we never talked about it. Well that’s going to be a clear problem and probably will be a disqualifier as it relates to having them both in the same room doing trauma work, unless that stuff gets worked out first. And so, that adds another layer of complexity to the assessment process...Are they going to be able to provide quiet structured support or are they going to be activating each other?

Ursula noted the need for commitment by both members in order to engage in the EMDR process together: “I think unless you’re both absolutely invested, it’s not going to work.” Doris said that she would not do conjoint EMDR with couples who are coming apart rather than coming together, a sentiment shared by several other participants.

**Summary of influential conditions.** The influential conditions that were identified as important in the assessment process to determine a couple’s readiness for conjoint EMDR included factors related to the therapist: (a) integrative approach and (b) competence and alliance; the working partner: (a) general intra- and inter-personal functioning, (b) trauma history, (c) stability and resources, and (d) willingness to be vulnerable; the witnessing partner: (a) general intra- and inter-personal functioning, (b) stability and resources, (c) trauma history, and (d) support and safety; and the relationship: (a) general relational functioning, (b) level of engagement in therapy, (c) alignment of goals, and (d) strength and commitment within the relationship.

### **Contextual Factors**

Contextual factors involve the participants’ background and circumstances related to their process of conjoint EMDR: their previous familiarity with EMDR, the roles taken on during the conjoint EMDR process by each member, and the reasons for referral that resulted in their initiating couples therapy. These factors are presented in Table 5 below, followed by a narrative description.

Table 5

*Contextual Factors*

Previous Familiarity with EMDR	Roles	Reasons for Referral
1. Prior EMDR for one partner	1. One working partner	1. Infidelity
2. History of EMDR with couples' therapist for one partner	2. Both partners take on each role	2. Volatile conflicts
		3. Motor vehicle accident
		4. Military combat

**Previous familiarity with eye movement desensitization and reprocessing.**

There was a wide range of previous knowledge and experience with EMDR, with four of the 14 client participants (Nesse, Huck, Bonnie, and Louisa) having participated in EMDR prior and/or during their initiation of couples therapy. Two of these four clients with previous experience (Nesse and Huck) had worked individually with the therapist who became their couples' therapist. One of these participants (Rita) had heard about EMDR and specifically sought out a couples' therapist who had this training but had not previously engaged in EMDR treatment. Five client participants, including two couples (Beth and Sam, and Ursula and Algernon) and Matt, had never heard of EMDR prior to it being introduced by their couples' therapist, and the remaining four had minimal knowledge about it. This varying degree of familiarity with EMDR falls within both of the grounded theory categories of contextual factor as well as influential factor (Strauss & Corbin, 1998), given that it influenced the nature and amount of assessment and preparation for these clients.



***Prior individual eye movement desensitization and reprocessing for one partner.*** When one member of the couple had previously engaged in individual EMDR treatment, several themes emerged. Most participants reported little to no preparation when they had previously participated in EMDR. Some participants wanted more preparation, particularly given the increase in vulnerability when transitioning to having one's partner present. Furthermore, the partners who had not previously engaged in EMDR wished they had had more preparation and a better understanding about EMDR, given the imbalance in familiarity with EMDR within the couple. One participant had talked about her experience of EMDR with her partner, which was perceived as helpful by both members.

Another theme was that the partner who had previously engaged in EMDR was selected as the first working partner, which provided the other partner with the opportunity to learn about EMDR by serving as the witness. This protocol was described positively by participants, given the increased anxiety for the partner previously unfamiliar with EMDR. Useful preparation for couples in which one member had previous experience with EMDR might involve (a) anticipating the benefits as well as potential challenges of engaging in conjoint EMDR for each partner and how engaging in EMDR might be different than doing so individually, (b) having the partner who had previous familiarity with EMDR share his or her experience with the other partner, and (c) having the member with previous experience be the first working partner.

***History of individual eye movement desensitization and reprocessing with couples' therapist.*** One partner from three of the triads (Nesse, Huck, and Bonnie) had initially participated in individual therapy, including EMDR, with the therapist who later

became their conjoint therapist. Primary themes noted by these couples were (a) the importance of obtaining a thorough explanation of the process, (b) an opportunity to ask questions, and (c) preparation that included observing the partner who had previously engaged in EMDR. Members who joined their partners for conjoint sessions reported a desire for more preparation and better understanding of what to expect during EMDR prior to taking on the working role themselves, noting discomfort and anxiety about what EMDR would involve.

**Roles.** Of the 14 clients in this study, 12 had taken on the role of working partner, engaging in EMDR with their partner present, and two had served only as witnesses to their partner's EMDR processing. Only one out of the seven triads went into conjoint EMDR with the intention of having only one member of the couple engage in EMDR. NyxRN joined Huck and his therapist, Rich, with the explicit role of supporting him during his EMDR to address the PTSD he had developed due to his military combat experience. All other couples had planned to take on each role in order to address issues from the past that were impacting their relationship and/or current problems or symptoms.

***One working partner.*** When one partner engaged in EMDR and the other served only as the witness, participants noted having minimal preparation for the witnessing partner, which several described as sufficient. In this situation, the witnessing partner seemed to intuitively understand what was expected within their role. One participant noted the importance of balancing individual and couples dynamics when only one partner engaged in EMDR, given the increased focus on the working partner. That is, ensuring that the witnessing partner has sufficient time to share his or her experience after

the partner's EMDR is helpful in engaging both partners throughout the process.

Algernon observed his initial impatience and confusion about the relevance of Ursula processing childhood memories during couples counseling. However, he noted that as the parallels between her childhood experience and their current relational dynamics emerged, those feelings quickly faded and his investment increased.

***Each partner takes on working and witnessing roles.*** Five of the seven couples' experience of conjoint EMDR involved both partners taking on each of the roles: working and witnessing partner. This allowed the opportunity to balance the focus on each partner in a concrete way. Two participants noted having initially perceived that the problem lay with their partner and that they entered into couples therapy to support their partner's change process. However, they both appreciated engaging in EMDR themselves and the increased awareness they gained of their own role within the relational dynamics. The amount of EMDR that each partner engaged in varied significantly from couple to couple, primarily impacted by the amount of trauma and current symptoms and reactivity experienced by the members. Two participants noted their preference for the witnessing role, while the others did not note a preference either way. Those who preferred the witnessing role seemed to have benefited less than their partner and were preoccupied by external factors including their partner's reactions and the outcome of treatment.

**Reasons for referral.** Couples sought therapy for many reasons. These reasons provided context for their conjoint EMDR process, given that this history impacted their interpersonal patterns, level of trust, and symptoms. Three couples sought treatment due to infidelity by one member of the couple and the resulting sense of betrayal, anger, hurt, and confusion for the partner. Two other couples sought therapy due to volatile conflicts.

One couple was on the verge of divorce as a result of intense anger and reactivity within the relationship. The sixth couple had experienced a motor vehicle accident that had resulted in the death of an individual in the other car. The final couple sought counseling for the male partner who had participated in individual therapy initially to address military combat and then transitioned to couples therapy.

The targets for EMDR occasionally were directly related to their reason for referral; however, for several couples, it became clear that earlier life events had exacerbated their current response to stressors and those events became the targets. Common themes among these couples included interpersonal reactivity, impasses that resulted from interlocking trauma reactions, attachment or relational trauma (either within the current relationship or a prior one, often related to family of origin), and a lack of differentiation.

***Infidelity.*** Matt engaged in an extra-marital affair and Rita experienced significant anger, betrayal, resentment, and hurt as a result, which led to their seeking couples therapy. Roger had been involved with prostitutes and Louisa struggled with hurt, fear, betrayal, and a sense of powerlessness. Anthony engaged in a long-distance internet affair and Bonnie experienced feelings similar to Rita. Bonnie also had PTSD, which was exacerbated by the discovery of her husband's affair. Furthermore, the majority of these participants had experienced attachment trauma within their family of origin (e.g., parental abuse, emotional neglect, and death of a parent) that contributed to their current relational dynamics.

***Volatile conflicts.*** Cat encouraged Nesse to invite Richard to join them for couples therapy due to significant interpersonal reactivity and volatile conflicts that

frequently resulted in Nesse threatening to leave. On two of these occasions, the conflict escalated such that Richard became physically aggressive toward Nesse while intoxicated. Ursula and Algernon described one another as angry and Ursula had threatened divorce when she reported she had reached her limit and no longer wanted to be near him. Algernon reported confusion and the belief that she had reacted out of proportion to the situation, stating that he was uncertain how to repair the relationship. Nesse, Ursula, and Algernon had experienced significant trauma as children within their family of origin, which contributed to their interpersonal reactivity and attachment insecurity.

***Motor vehicle accident.*** Sam and Beth had experienced a motor vehicle accident during which an individual in the other vehicle had been killed. The accident was Sam's fault and Beth nearly died in the accident. Though they had a long history of codependence within their relationship and had grown increasingly emotionally distant, their initial reason for referral was Sam's accident-related PTSD. As they engaged in couples therapy, it became clear that Beth also had developed PTSD as a result of the accident. Neither spoke of their childhood experiences or prior relational trauma. However, the focus shifted from the accident to the dynamics within their relationship. These dynamics were highlighted at the time of the accident when Sam almost lost his wife and Beth realized she almost died and "had never truly lived" given how dependent she had been on Sam.

***Military combat.*** Huck's attendance in individual EMDR therapy with Rich became inconsistent and he resorted to self-medicating through alcohol use, which contributed to tension and conflict within his relationship with NyxRN. She approached

Rich due to her concerns about his intermittent attendance and his fast approaching discharge from the military and their move, which would result in his lack of ongoing access to EMDR treatment. Rich invited her to join the sessions to provide support and with the hope of increasing his attendance. Thus, the focus of conjoint therapy was on Huck's EMDR around his combat experience with the goal of alleviating his PTSD symptoms. Neither spoke of their childhood experiences or prior relational trauma.

**Summary of contextual factors.** Participants identified several circumstances related to their backgrounds and presented issues that differentiated them from one another and were relevant to this study, given their impact on the couple's dynamics and on the process of conjoint EMDR. These factors included previous familiarity with EMDR (one partner having participated in individual EMDR in the past and one partner having participated in EMDR individually with the couples' therapist prior to conjoint treatment), the roles taken on during conjoint EMDR (working, witnessing, or both), and the reasons for referral (infidelity, volatile conflicts, motor vehicle accident, and military combat).

### **Phenomenon: Conjoint Eye Movement Desensitization and Reprocessing**

Though EMDR includes an eight phase protocol, the first three (client history and treatment planning, client preparation, assessment) are addressed under "influential conditions" above and "intervening conditions" below. The phenomenon of conjoint EMDR discussed in this section consists of phases four through seven: desensitization, installation, body scan, and closure. Thus, it includes (a) one partner engaging in bilateral stimulation (BLS) while recalling a traumatic or disturbing memory, (b) installing a positive cognition related to that event, and (c) processing any remaining discomfort with

BLS after resolution of a target with his or her partner serving as a witness. It also includes the closure phase, which may incorporate (a) a safe place exercise or another means of increasing stabilization when a target is not fully processed; (b) education about ongoing processing between sessions; (c) instructions to either partner to note any observations related to the target; (d) safety planning; (e) the imagining of a “container” to store images, feelings, thoughts, and sensations related to an unfinished target between sessions; and (f) a discussion with the couple about whether to engage in verbal processing of the conjoint EMDR session outside of the therapy room.

**Core category: Trauma experienced and healed relationally.** Strauss and Corbin (1998) referred to the role of the researcher’s “gut sense” (p. 150) in identifying the core category of grounded theory based on the participant data, highlighting the position of the researcher as the “author of theoretical reconstruction.” (Mills et al., 2006, p. 6). The core category is the main theme of the research that links together the other categories to create a structure to the theory (Strauss & Corbin, 1998). The primary theme that emerged from the data was that traumatic experiences occur within relationship to others and that the impact of such trauma is also healed within relationship.

Several participants referred to EMDR as a mode of healing relational and attachment trauma. The importance of feeling safe, trusting, and connected with the therapist was highlighted by several client participants. Furthermore, participants noted that conjoint EMDR would not be effective if there were not sufficient trust with both one’s partner and the therapist. Bill noted the relation between trust and one’s woundedness:

The delicate process of building trust is inextricable from healing one’s own woundedness. It’s that old axiom we’ve heard a thousand times that to love

someone else, you must love yourself. Well, to put a finer point on it, to the extent that I accept myself is the extent to which I can deeply trust another, at least offer trust and then what's reciprocated determines whether that actually accumulates and grows.

Nesse observed the value of conjoint EMDR in that having Richard present in the room allowed her to face a primary trigger to her attachment trauma experientially, which she could then reprocess through EMDR, while providing Richard the opportunity to witness that process and better understand her fears and needs:

Being in a relationship brings out a lot of old fears and past trauma for me and because of the couples EMDR it has allowed me to work through it in front of my partner...and because he pushed my buttons, I was able to move through them. So there's a benefit that all of the issues arise now so we can work through it.

Similarly, Doris referred to the overlapping trauma histories of both partners as the “stuck place” or “impasse” that she finds conjoint EMDR effective at shifting and she noted the value of a relationship intervention to move through relational trauma.

Sam and Beth's experience of conjoint EMDR captured how much trauma occurs within relationships and the extent to which healing occurs relationally. Sam described his surprise at how the direction of EMDR shifted from the initial target related to having accidentally killed the person in the other vehicle to his relationship with Beth and having almost lost her during the accident.

In the first EMDR session...one of the images that came across was my wife lying there on the floor beside me unconscious...At first I thought [the primary impact was due to] the death of that individual, but I think I was more affected by the image of Beth there and thinking that she was dead. And so ... it became more of a relationship thing between my wife and myself as the EMDR progressed....I didn't realize how much [almost having lost my wife] affected me before I started EMDR...I went there seeking help for the accident. And it ended up being more on the relationship between Beth and myself than the accident.



Fred noted:

I think one of the things that was most meaningful...is that this main trauma of the accident for him was this thought of losing her...I think it was very poignant in the therapy where he would, after the EMDR sessions, or in related sessions when he would talk to her about "that was my wake up call." I'm aware now how much she means to him but also his regret over those years of not loving her better, not giving her a voice, and not being more attentive to her needs.

Similarly, Beth's experience of trauma was highly related to her relationship with Sam and her role within that relationship. Fred described it in this way:

Much of the work..., especially for her, was related around her life and the dynamics of the marriage and even her negative cognition of the first memory that we worked on. The picture was being in the motor home, and waking up from being unconscious and seeing salad strewn all over the place...Seeing the salad all over, immediately she had this need to clean up. And so she saw that it was kind of symbolic of, "this is my home. He makes the mess. I almost get killed and the first thought that comes to my mind is I've got to clean up the mess."

Beth became increasingly active in her witnessing role to Sam's EMDR, being encouraged by Fred to utilize relational interweaves with Sam during his healing process related to the near loss of his wife. In the following excerpt from the interview, Fred captures the importance of healing occurring within the relationship between Sam and Beth:

So we're doing very normal kind of EMDR with the pads...But I had her do the responding... [He said] "I caused you so much pain." She said "I'm doing just fine"....He said "you're still suffering the consequences." She said "it was an accident."... He said "All the pain Beth has suffered because of this. I wish that Beth could hold me." And so, I had him lie down in her lap... I had her do tapping...Then he said "How good to see her alive." He said "I love you. I don't want to hurt you." ...So really precious and he's laying in her lap.

Fred described his view of how conjoint EMDR heals relational trauma in this way:

I think what is able to happen in couples EMDR or with this couple is that latter, more adult ego state part of the brain is literally those parts of the brain that are wired to their partner. So it's wired to their Broca's area, that's expressive and the Wernicke's area, that is receptive language and it's wired into introjects of their partner and a road map within the brain of communicating with their partner. And

so EMDR is, in one sense, wiring from their trauma to that part of their brain that is neurologically connected to, not physically but communicatively, in this attachment relationship with their partner.

### **Intervening Conditions: Preparation and Re-Evaluation**

Intervening conditions are those that mitigate the influence of the assessment process on the conjoint EMDR experience. That is, these are processes that are initiated by the therapist's determination of a couple's readiness for conjoint EMDR and they impact the couple's experience of that treatment including potential benefits and obstacles. These conditions include preparation for integrating EMDR in couples therapy and re-evaluation of treatment progress over time. Themes related to preparation and re-evaluation are presented in Table 6 below, followed by a narrative description.

Table 6

#### *Intervening Conditions*

Preparation	Re-Evaluation
1. Introduction of EMDR	1. Assessment of conjoint EMDR process
2. Psycho-education	2. Attunement to needs in the moment
3. Presentation of potential benefits and obstacles	3. Post-EMDR debriefing by each partner
4. Review of requirements for both partners	
5. Empowerment of couples in decision making	
6. Conjoint resource development and installation	
7. Review of ongoing processing outside of session	

**Preparation.** The preparation phase for conjoint EMDR parallels phases two and three of the standard EMDR protocol, though each stage is modified for the unique needs of the couples therapy context. Participants reported a wide range of preparation prior to engaging in conjoint EMDR from minimal to significant, depending on previous familiarity with and exposure to EMDR by clients. In general, preparation was valued by client participants and a small number wished for more preparation. Two therapists noted that preparation is one of the most important keys to the success of conjoint EMDR. Bill said:

I see a lot of therapeutic impasses or errors made because of inadequate attention to the preparation phase, meaning the therapist was too quick to jump in...and wants to move into phase four...They may be in too much of a rush to plow ahead at the expense of being where the client is at.

Seven facets of the preparation for conjoint EMDR were identified by participants as having occurred and were described as helpful. They are described below.

***Introduction of eye movement desensitization and reprocessing.*** Participants noted the importance and timing of preparation, emphasizing the value of introducing conjoint EMDR early in therapy as therapeutic rapport is developing and after the impact of past trauma on current dynamics has been established. Doris stated: “I wait until the couple is showing me that they feel well held and they trust me.” Roger said:

I think it was helpful to us that we did not do it until we were well into our therapy with Doris...So in that way, a lot of work had already been done; a lot of issues were already out there for us....Identifying the roots of...why we each had these issues of withdrawing and feeling fearful of confrontation and things like that...that were part of who we were from our childhood.

Several client participants suggested that therapists introduce conjoint EMDR early on as an option if it appears to be an appropriate intervention. Several participants also noted the importance of introducing it when the couple demonstrates commitment to

their relationship and after trust has been established with the therapist and within the couple. Though Louisa questioned whether they might have gained more from therapy had they initiated conjoint EMDR earlier, she also noted that when they initiated EMDR, their relationship was more stable than it had been previously: “We had moved from really a dark, dark place well into the light....I felt safe enough [for conjoint EMDR].”

Several participants mentioned that part of the preparation had occurred prior to conjoint EMDR being introduced in that the core themes and negative cognitions had been identified in many cases; thus processing through the impact of attachment injuries and other traumatic events in addressing current patterns was a natural next step. Part of the early preparation involved gathering history through the intake and EMDR-related paperwork such as completing a list of significant events. Several participants noted the use of EMDR concepts and language from the first session and the value of being oriented to the language early such as having been exposed to a list of negative and positive cognitions. Nancy discussed EMDR from the very beginning of counseling and noted the value of linking the past to the present:

I start to really help them to see the link between what is happening today in their relationship and how they are responding to the other based on core beliefs and experiences from way back...How the past is present, basically....I will make comments on various things...what is the theme, what is the core belief around that?...The preparation is happening through each session, so by the time we actually get to doing any kind of trauma processing, they seem to be quite ready.

***Psycho-education.*** A second preparation theme related to psycho-education included educating clients about the impact of trauma and the role of EMDR in trauma resolution, a description of the EMDR process, reference to outcome research about EMDR, and sharing materials such as an EMDR brochure or websites for further research

about EMDR. Several therapist participants had a standard introduction to EMDR they would provide to clients. Rich talked about how he introduced EMDR to NyxRN:

I give the spouse the same kind of opening spiel that I do the service member. You know, the impact their trauma...I front load the education piece as it relates to traumatic stress response, and the impact in their daily lives and then the role of EMDR in being able to address that...I explain the rationale [and]... what EMDR sessions look like...That we're not just going to be talking at length about the painful incident...I try to give the complete description not only of the rationale but kind of the blow by blow account of what happens in session. So I really want there to be very, very few surprises as it relates to this process.

*Presentation of potential benefits and obstacles.* Therapist participants presented the potential benefits of conjoint EMDR to couples including its value to promote symptom relief, heal earlier traumas, and reduce interpersonal reactivity. Client participants noted having been informed about its value and some wished that the benefits had been presented more clearly. Matt shared Bill's description of its benefits: "EMDR was presented as something that could help us cope, help with our feelings, and with our responsiveness, that it would help us to be less emotional and less activated by them." Several participants noted the potential value of having been informed of the pros and cons of individual vs. conjoint EMDR. Nesse said:

If I were at the beginning again, I would have loved to have someone say, "okay this is exactly what this is for, and if you do this individually, this is the benefit we can provide you. If you do this as a couple... You get insight into how that person is...I think it needs to be understanding what an individual session's benefit vs. a couple...If you could explain it...it would set people up as a couple to kind of accept that.

Few participants noted having been informed about contraindications, but several had been prepared for difficult material to surface. Matt stated: "Bill prepared us that it could be an emotional experience, could be embarrassing, and could bring up emotions

that the other person might be uncomfortable with.” Doris frequently explains to couples the value of conjoint EMDR in overcoming impasses:

I said “it’s often helpful in really getting where your partner is, to see what this place is where they’re caught. So if you’re a witness, you get to know them better. And when they’re a witness, they get to know you better. And meanwhile, the point is turning down the volume in this reactivity. And probably the reactivity is at least partly from an ancient source, a young source.”...I often explain to couples that if we can just break the impasse, which is probably the intersection of these two stories, that probably they’d be in a much different place.

A few client participants noted the potential value of therapists sharing with couples examples of changes they have observed in those who have engaged in conjoint EMDR. Several participants also suggested that therapists explain the potential benefits and obstacles for both the witnessing and the working partner, such as those noted in the assessment section (e.g., one cannot “un-know” what might be learned by witnessing one’s partner’s EMDR).

***Review of requirements for both partners.*** Both client and therapist participants mentioned the importance of reviewing each partner’s role in conjoint EMDR including the requirements from both members to increase the potential benefit of the process. These expectations and requirements include those presented in the assessment section (e.g., focus on self versus on changing one’s partner). Bill noted the importance of ensuring that the couple is aligned in terms of their goals in this way:

In the preparation phase, phase two, the expectation is that someone knows what they’re doing and why they’re doing it.... I know why I’m doing this EMDR and what’s the intended goal. If the goal is that I feel better about myself when my spouse is treating me poorly, that’s incompatible with my mission, which is to have my spouse treat me better. I’m not here to feel better. I’m here to have him make me feel better. You see, as part of a preparation phase issue, the therapist must be hip to the fact that what constitutes a wise therapeutic goal might be incompatible with a client’s motivation at the time....

Rich assesses and prepares couples for the conjoint EMDR process simultaneously:

I say this to both of them “when we do the work, I will not be asking your spouse for input, whether in between sets or to comment whatsoever.” Is this an arrangement that is agreeable with both of you? If the spouse sits to the side of you, you can hold hands if that’s what you’d like to do or put your arm around each other or whatever’s a good fit for you physically.... And the reason why I want them to sit side by side is I don’t want the spouse to be in another sitting arrangement where the trauma survivor is going off the spouse’s cues....

Participants also noted that preparation should (and frequently did) include providing the witnessing partner with information about what to expect during the process for the working partner and with instructions about how to manage emotions that might arise. Two of the couples discussed the witnessing partner having written in a journal their thoughts, feelings, and impressions that came up for them while observing their partner. Nancy said:

The way that I prep the observer is I just say “just write down whatever comes to mind. So you might be shocked by something. Write that down. You might think about your shopping list, your grocery store list - write that down. Whatever comes to mind as you are observing any thoughts. There are no wrong answers.

Algernon noted the value of the journal as an outlet for intense feelings and helped him to feel more engaged rather than a passive witness to the process. Informing the couple about what to expect also included asking the working partner to pay attention to his or her feelings, thoughts, and body sensations and to allow whatever happens during EMDR to happen. Preparation also involved developing a stop signal for the working partner and providing information to the witnessing partner about what he or she might observe during the process.

***Empowerment of couples in decision making.*** Participants appreciated the collaborative approach taken by the therapists in introducing EMDR as an option, either

individually or conjointly. They recommended that when therapists introduce the option of conjoint EMDR to couples that they suggest it but not force it. Huck stated:

Actually I did it all by myself in the beginning and then eventually Rich was like “how would you feel if NyxRN was in here with you?” He’s like “if you don’t want to, it’s perfectly understandable.”...Rich thought it was important that she also be in there for those sessions but he didn’t want to force it...He said “it’s up to you; this is your life. If you don’t want your wife in here, that’s okay. But I think it’d be good for NyxRN to hear some of this stuff because all this stuff is a big deal.”

Participants also noted that empowerment in decision making included not only whether they wanted to participate in EMDR and whether they wanted to do so individually or conjointly, but also their readiness to do so and preferred timing, type of bilateral stimulation, which partner would participate first, and the choice of target. Bill emphasized the couple taking personal responsibility for electing whether and when to engage in EMDR rather than him deciding for them. A few participants noted the value of being offered the opportunity to engage in EMDR individually prior to doing so conjointly, particularly for those whose partner had prior EMDR experience but they did not.

***Conjoint resource development and installation.*** Several participants engaged in a safe place exercise conjointly prior to trauma reprocessing with bilateral stimulation. Nancy incorporated resource development and installation conjointly, including both safe place and light stream and said that resource development and installation can serve as both part of assessment for safety and readiness for conjoint EMDR as well as preparation. She noted the power of utilizing resource development and installation with both members conjointly that cannot be achieved individually.



***Review of ongoing processing outside of session.*** The final preparation theme was discussing ongoing processing between sessions. Beth appreciated Fred having prepared Sam and her for the ongoing processing that occurs after EMDR and his recommendation that they not plan anything for the day after EMDR to allow space for continued processing. Participants also differed in the degree to which they discussed whether to verbally process their experience of conjoint EMDR after the session or limit such discussion to the therapy room. Michelle noted her use of “container-ing” material for the working partner when targets were incomplete. Anthony described this: “we locked it up and put it in a box and put it away until next time.” However, Michelle recognized during her interview that it had not occurred to her to have the witnessing partner do the same. Anthony said that he and Bonnie would often verbally process their experience after sessions but that such processing was limited to their subjective experience rather than the content, which he found valuable:

Yeah [the processing of the conjoint EMDR sessions] was some sitting in the car afterwards and then some that evening when we got home and we touched on it a little since then...Not so much in the detail, but that she was happy to be there...not delving into the subject itself. It got locked up in a box...Since the sessions, we’ve talked some about hers and my sessions, not in a detailed way, but just to try and remember how we felt listening to the other person.

He also trusted Michelle’s guidance about locking away the material between sessions:

Michelle said to think of something to lock it up in and where to hide it away until our next session...Other than talking to Bonnie for a few minutes when we got into the car, I pretty much tried to honor that and just let it sit there and not think about it or worry about “gosh did I say the right things or what did it mean and stuff?”...I just trusted Michelle and put it in the box until the following week.

Similarly, Doris instructs couples not to verbally process between sessions: “And sometimes I say things like ‘why don’t you not talk about this at home’ or ‘why don’t

you not talk about this until tomorrow’ or something that preserves the integrity of the experience.”

**Re-evaluation.** The re-evaluation stage described by participants parallels phase eight of the standard protocol but factors related to this phase are integrated in unique ways within the couples therapy modality. This phase involves ongoing assessment after EMDR sessions and determines the next step including further preparation, moving forward with conjoint EMDR, or potentially shifting to individual EMDR. Re-evaluation was discussed by participants in terms of assessing the EMDR process during initial and ongoing sessions, attuning to the needs of the couple during each session and post-EMDR debriefing.

*Assessment of conjoint eye movement desensitization and reprocessing process.* Participants discussed the importance of initial and ongoing EMDR sessions as a means of assessing safety and readiness for conjoint EMDR. They noted that it is the therapist’s job to observe how EMDR proceeds in session and whether both members are demonstrating an ability to tolerate the affect and material that emerges, to self-soothe, and to maintain a level of safety and respect throughout the process. The way in which sessions proceeds will determine whether more preparation is needed.

*Attunement to needs in the moment.* This concept of attunement to the current needs involves reading body language, exploring triggers between sessions, and watching for in-session reactivity. It includes revisiting the previous session (and re-assessing the SUDs and VoC levels) and processing any reactions or new material that surfaced, any apprehensions about moving forward, evaluating the helpfulness of the container as a tool (if it was used), assessing the current safety and stability of both partners and the

relationship (including whether material was used as a weapon). Louisa regretted that more follow-up on their conjoint EMDR sessions was not had, particularly because she was not able to remember the specific content of her own EMDR session:

I feel like when you're doing it in individual therapy, you can revisit it whenever you want and you have a one-on-one experience of it. When somebody witnesses you, it's different and it needs a lot of follow-up. Now that I'm thinking about it...I'm kind of sad I didn't work on it more to know what it was...I think it's actually not a bad idea if you stay in therapy with the person to just sort of say "well let's go back to that. What did you think? What did you get from that, Roger? What did you get, Louisa, now that it's been two months."

Bill noted the importance of re-evaluation every session: "Each session begins with phase two: 'what are they needing now?' They might be invited to debrief about the last session and encouraged to continue, but they lead, based on their agenda and current needs." Several participants said that the direction of each session depended on the needs in the moment. Bill identified that conjoint EMDR might occur in a planned way to reprocess an earlier event that is identified as a target or it might be "in situ," such that one partner is reactive within the session and that reaction is targeted with EMDR. Cat also used EMDR when Nesse came to session triggered and defended, using a float back technique, where she would float back in her mind to a previous time when she remembered feeling similarly and target that memory.

***Post-eye movement desensitization and reprocessing debriefing by each partner.***

Many of the participants identified the usefulness of the debriefing period after EMDR processing. This might include discussing their conjoint EMDR experience, what it was like to be witnessed or to be the witness, exploring any apprehensions about moving forward, and reviewing journal entries by the witnessing partner. Nancy said that debriefing often looks as follows:

When we are finished, I take time to talk with the person who processed. “How was that for you? How was it to have this person in the room?” And then I always take some time with the observing person. “Tell me what that was like for you?” So that they are able to verbalize it because I find that often times, they have a lot to say because the experience was so profound for them that they are like “oh my gosh, it was really...I never knew it was like this. I get it now.” I want to be sure that they get some process time.

Some mentioned that only the working partners verbally processed their experience, whereas other therapists included the witnessing partner in that processing. Rich noted the clinical judgment involved in how much time to allow for post-EMDR debriefing with the witnessing partner:

[How much processing happens with the witnessing partner] is absolutely a judgment call and I think part of it depends on how much time we have left in the session and all that. But clearly if the spouse were to become agitated, I would want to make time to explore that. What exactly had been triggered...And it could suggest that maybe the spouse needs some attention to whatever that trauma trigger is.

Bonnie shared her appreciation for the opportunity to process her experience as the witness, even when it was painful:

Michelle’s really good at asking the right questions and kind of finding out “What’s that like for you?” “What do you see from that?” “How did you feel when he said this?” “How did you feel when she said this?”...I thought it was really helpful. Sometimes it’s really painful...but even if it’s painful, it’s still helpful.

A couple of the witnessing partners shared a wish for more debriefing. Doris noted that when a target is incomplete, she frequently will hold off on verbal processing: “what I’m trying to prevent is some upsurge in reactivity that might come from some piece of work that’s not completely finished in session.” Anthony appreciated the opportunity to debrief once he “took it back out of the box” and completed the target, stating that “it felt like it was handled properly.” A few participants noted the value of balancing individual and systems dynamics during this debriefing in order to provide

space for any reactions to determine the next step in treatment. Participants also valued verbal processing immediately after EMDR as well as in the next and future sessions, given that reactions may change over time.

### **Actions and Interactions**

The process of conjoint EMDR consisted of significant variation across participants, depending on a number of factors. The variability was primarily in terms of the length, speed, amount, and frequency of EMDR, as well as in the targets that were reprocessed for each participant. However, there were several common themes identified by participants about their experience of conjoint EMDR. Those themes related to the actions and interactions of conjoint EMDR are described below. The initial themes were common for both witnessing and working partners. Themes unique to the working partners and then to the witnessing partners are presented separately, followed by obstacles identified by several participants including couples and therapists.

**Length, speed, and amount of conjoint eye movement desensitization and reprocessing.** Participants varied significantly in the amount of conjoint EMDR in which they participated and there was a great deal of variation in the frequency, amount, and length of conjoint EMDR for each client, depending on the philosophy of the therapist, amount of trauma experienced, and phase of treatment. The amount of conjoint EMDR varied across therapists between one session and almost every session for one of the partners. Most couples began with talk therapy for a period of time, during which the alliance was built, there was an exploration of the relational dynamics, a foundation of trust and communication was developed, and the connection between past events and current patterns was made. After that initial period, the majority of couples participated in

more frequent conjoint EMDR, followed by decreasing frequency over time as the reactivity and presenting symptoms subsided.

More EMDR was integrated when clients were anticipating potentially triggering events or after having experienced such events. The amount of EMDR in which partners participated also depended on the extent of trauma experienced, such that if one partner had a more traumatic history, that partner generally served as the working partner more frequently. Similarly, Nesse observed that the speed of processing varied significantly between Richard and herself, stating:

He's lucky because his sessions can be very short. He moves through things much quicker than I do. It takes me time to work through the emotions. For him, it takes like three minutes and Cat explained to me that it has to do with our childhoods, our backgrounds, our experiences.

Doris was unique in that she reported that she typically will do EMDR one to three sessions for each partner. Both she and Nancy spoke about the significant shift that is generally experienced as a result of conjoint EMDR. Nancy noted that EMDR "turbo boosted" couples therapy for Ursula and Algernon. Similarly, Doris referred to conjoint EMDR as a tool to "get from stuck to unstuck" and to "unjam a system," stating that once that shift occurs and she observes an increased fluidity, she returns to talk therapy. She said: "if the first session of EMDR goes pretty well for that person and for the partner as the witness, that's probably going to be enough shift to really change how the couple can function."

**Roles.** The majority of the couples who participated in this research consisted of partners who had each taken on both the working and the witnessing partner roles. At the time of my interviews with them, for only two of the couples was this not the case. One of those couples, Ursula and Algernon, was planning to switch roles shortly after their

interviews, leaving only one couple, Huck and NyxRN, who intended to limit EMDR participation to one partner, with the other consistently serving as the witness.

Generally, the witnessing partners' role consisted of just that: witnessing, and they did so silently in the background. However, in the case of Sam and Beth, Fred encouraged Beth to take on a more active role during Sam's reprocessing, particularly as they prepared for in vivo exposure to significant triggers: test driving a motor home and returning to the location of the accident itself. In anticipation of those events, Sam participated in conjoint EMDR in sessions with Fred but they also did planning during sessions for Beth to later deliver bilateral stimulation to Sam during those in vivo experiences. Fred described his rationale for Beth's active involvement:

My judgments were that Beth has a lot more resources around the accident itself and so while she certainly qualified for PTSD, her reactivity to the different triggers were much milder than Sam's. His were much more debilitating. We did some EMDR in preparation for that trip that...I basically taught her to do EMDR with him...I did a protocol...to assess his SUDs level beforehand and identify the negative cognition and then basically for him to process through it with her doing the tapping. And they found that very calming and very reassuring, that they would have this tool and could process it in vivo...What I did not want to happen is for them to go back to [that state], then to get into the motor home and all of sudden, he's having these flashbacks and they don't have any tools for dealing with it.

Beth described her experience as the active witness and facilitator:

[Sam] would close his eyes, I would face him and he would be sitting and I would use my hands to tap on the top of his legs in a rhythmic form and then Fred had given me questions and the proper things to say. So Sam would start visualizing something and we would go from there.... So we would say ...“What are you dreading?” “What is the negative meaning?” “What are you feeling?” We would do a SUDs rating. “What is my positive belief?” Then we do the rhythmic tapping while doing that and he would state what he was seeing or feeling and I was quick to take notes once the tapping stopped, and in between about every thirty seconds, I would stop and say “What are you experiencing now?” then go with focusing on that....

As noted in an earlier section, Fred also integrated Beth into Sam's EMDR when reprocessing relational targets, such that she delivered relational interweaves between sets. Thus, her level of involvement as the witnessing partner was more active than that of other participants.

**Targets: Present versus float back.** Though naturally the targets themselves varied from client to client, the common theme regarding the nature of those targets for all but Huck, whose focus of EMDR related to his military combat experience, was previous (often childhood) experiences that played out within the current relationship and roles each took on within that relationship in an attempt to meet unmet attachment needs. Current reactivity would occasionally be targeted with EMDR. However even in that instance, frequently that reactivity would link back to a previous attachment injury that would be reprocessed during EMDR. Doris discussed her use of float back with Roger and Louisa: "if either of them seemed to be in a particularly stirred up or vulnerable place, I would have them take that back in time and see if they could identify a young time that they'd felt like that." Roger described his choice of targets:

I tried to think about one of the most painful, difficult experiences that I ever had, a moment in which I really felt something was difficult or painful for me even when I think about it as an adult...it still had a lot of power and a lot of charge for me...it seemed to really touch on a lot of issues that continue to affect me as an adult...not so much directly but it certainly had defined who I am in a lot of ways and how I deal with problems and issues.

Several client participants noted that choosing a target from the past that paralleled current dynamics was useful for both the working and the witnessing partners. The reprocessing of that target helped the working partner gain insights into how the past impacts the present and how to change current dynamics. Simultaneously, the witnessing partner was able to remain more present and open rather than becoming defensive as he



or she might otherwise, were the target to be related to their current relationship. Louisa stated:

I think the helpful thing was we were each able to take on a core issue related to our childhood...so it wasn't threatening for the other person because it didn't link specifically with our relationship...I think if we had just came in and said we are going to do EMDR about our relationship, that could be very intimidating and defensive making.

She also noted the connection between those core childhood events and their current relationship patterns: "Identifying the roots of some of...why we each had these issues of withdrawing and feeling fearful of confrontation and things like that. We had already identified some of those issues that were part of who we were from our childhood." Though Louisa, Doris, and Roger all forgot the specifics of Louisa's target, Roger noted the general theme and how it linked to their relationship:

You know, it's funny it seemed like the three of us all forgot exactly what Louisa's issue was, but it had to do with her relationship with her sister and her parents and that she felt, in some ways, locked out, literally and figuratively, within their family...That's a pivotal relationship and gets played out in our relationship and others for her.

**Unexpected directions and insights.** A common theme among participants' description of their conjoint EMDR experience was that they were surprised by the unexpected direction of EMDR and new insights gained through the process. Sam said: "I was just amazed at where sometimes some of those sessions would end up...After we reviewed everything about it, I even had a hard time figuring out how we got from one point to where we ended." He also noted his surprise at how much the direction of EMDR led to his relationship with Beth, in spite of his expectation that the focus would be on the accident. Similarly, Beth was struck by the symbolic nature of the accident in terms of their relationship and her expectations of herself: "It was amazing to us, both of

us,...how the things that our minds would dwell on during the EMDR were...symbolic, of how we processed life, how our temperaments work, and then down the line, how we interacted in our relationship....” She discussed the way in which images that came up during EMDR represented her way of relating to the world:

When I started with the EMDR,...one of the huge things I was focusing on that I couldn’t get past was that a salad that I had been making before the accident was all over the sofa...I kept looking at it after the accident and thinking that I have to clean this up, people are going to think I’m a messy person...and I was there cleaning up the mess...We were able to tie that to how I have, almost my whole life, had to please other people, had to clean up messes and had take care of everybody, had to make sure everything was perfect...It was a huge aha moment.

**Indirect communication.** Participants repeatedly noted the unique value of conjoint EMDR as a method of indirect communication between members of the couple and as a way to communicate “beyond words.” NyxRN learned things during conjoint EMDR that she would never have known otherwise, given Huck’s inability to verbalize his thoughts and feelings directly to her in an equally impactful manner. Huck described its value: “She does hear but...it’s like you told her but you didn’t have to go through the hard part of telling her.” Bill highlighted the role of EMDR in moderating the intimacy within the partners’ exchange:

EMDR served to mitigate the intensity of an intimate encounter while providing the benefits of intimacy: shared knowing, mutual understanding, and disclosure...These are issues that he locked away for decades and hadn’t ever addressed, so avoidance is both an avoidance of interpersonal exchanges but also a phobic avoidance of his own internal experience, a phobia of his own memory, phobia of his own feelings. And so, the EMDR opened him up to experiencing his own intense affect in a safe and secure environment that emboldened him...He’s opening himself up vis-a-vis his wife.

**Power of conjoint eye movement desensitization and reprocessing.** Many participants noted the power of conjoint EMDR in comparison to verbal processing, with several noting the physical exhaustion they experienced and others observing the power

of the insights, emotions, and understandings that emerged. Beth noted the powerful impact of EMDR on Sam in the room and the exhaustion they both experienced after

EMDR:

We both commented on...how strange it is and how amazing it is, the way the brain and the body work. Like, there would be times where, especially in the beginning, when his body would just be shaking from the trauma of what he was dealing with ...it's just an amazing thing to observe afterwards what your mind had done...what we both realized is afterwards, we were completely exhausted physically and mentally. Two weeks ago, he was exhausted for two or three days and was having trouble thinking and processing and just kind of confused and then all the sudden, clarity started to come and he started feeling a lot better....

Sam shared his similar experience of emotional and physical exhaustion:

After I had most of the EMDR sessions, I would just be physically and emotionally wiped out. So I think we realized that if I had it, she'd have to drive home and if she had it, I'd have to drive home... sometimes for a day or two days afterwards, I was just completely drained...Sometimes I couldn't stay awake on the way home but other times, I'd be awake and not be able to function.

**Working partner.** Several themes emerged that were specific to the working partner's experience of conjoint EMDR. They are outlined here.

***Initial skepticism.*** Participants reported skepticism about EMDR prior to experiencing it firsthand. Huck said:

I was over there going to Rich, just me and Rich were talking for quite some time and eventually he said "Let's try some EMDR and see if that will help." And I'm like "Yeah what is it?" Well there were a bunch of flashing lights and I'm thinking "Are you crazy? Who does this guy think he is?" I was like "You're crazy. This isn't going to do any good."

Similarly, Matt noted that he initially wanted to "test out" EMDR to see whether it truly worked and, in the process, overcame his fear of heights. Richard also needed to experience EMDR firsthand in order to believe in its effectiveness: "It wasn't until we did sessions that were directly about our relationship...Then I go 'wow this actually

works!’...Unless I physically have the experience and see it and know it works, it’s very hard to be convinced.”

***Powerful and meaningful process.*** Several participants said that while engaged in EMDR, they were so deeply involved that their partner’s presence became a non-issue. Some noted their gratitude for the vulnerability and intimacy in sharing the experience with them. Huck described how vividly he experienced the details of the events he was reprocessing:

After, the first couple sessions...somehow I could detract from where I was in the room and I could actually go back to where I could feel I was back in that position. My breathing started to be elevated...I started to mentally put myself back into that position and I can remember, even though my eyes were rolling back and forth with the light, I could still see myself looking up and around, I could still see my weapon, I could see the guy in the window....It brought up a lot of stuff I didn’t know was still there.

Roger noted a similar experience, becoming deeply immersed in the process, similar to when he did EMDR individually. He was generally unaware of Louisa in the room: “I didn’t really think about her being there. I sort of opened my eyes and there she was. I felt very much immersed in it and I wasn’t very aware of her even being there for most of it.” Louisa observed how profound Roger’s EMDR experience was: “He really moved in the way that you shift on those scales...It really broke through something for him...He was very present and taking in the experience.” Anthony shared his gratitude for the opportunity to have Bonnie present to allow her to truly see him, as if for the first time: “I was happy that I had given her a window to really see me, you know in an honest way...A lot of the stuff I was saying I was admitting to myself for the first time really. She was hearing it with me.”

***Building a bigger picture.*** The final theme that emerged from the working partners' descriptions was that EMDR provided the opportunity to understand the impact of past experiences and to observe the parallel between those experiences and current relationship triggers. Richard noted his surprise in recognizing the impact of a childhood experience on his current functioning:

Emotions would automatically pop up and I would feel angry or sad or something would really just get to me...At a younger age, a lot of my friends were just taking the mick out of me and I didn't realize it or even remember it until we went through the sessions...Some of my younger years, I was challenged with learning. We don't know why but for three or four years, I just had a struggle with learning and of course, people would call me names and I would find school very hard. So when people say to me even now, "you can't do that,"...I will prove that I can do it...I found out afterwards part of that quick reaction for me was because of my past, a past that I'd completely forgotten about.

***Witnessing partner.*** A number of themes emerged that were specific to the witnessing partner's experience of conjoint EMDR. These themes are outlined below.

***Providing support and grounding to partner.*** Every couple noted some element of this theme including the respectful, quiet, attentive, accepting, and non-reactive support demonstrated by the witnessing partner that provided comfort and grounding. Richard observed his impulse to react while serving as a witness to Nesse's EMDR and his conscious decision to withhold that reaction and to provide quiet support:

When I first heard what went on with her as a kid, when she moved from Asia to America, and how she got married off and how she was treated, you instantly want to react and protect but you can't. You've got to support that individual, because it's their issues that they went through and it may be impacting your relationship but that's part of that sessions that you work as a couple.

Rich noted how grounded and supportive NyxRN was during Huck's processing:

What I observed was she was not the slightest bit distressed; she was one hundred percent present...and her non-verbals were very supportive with the hand holding or hand on the leg or wherever it was going to be and so I got nothing but caring

and compassion for her husband from her and no inkling whatsoever that she was distressed by the material.

He said: “She seemed to serve as a security blanket for him to explore his material.”

Similarly, Louisa noted her desire to be a quiet and supportive witness to Roger’s

EMDR: “I just remember wanting to be very present and really not getting in the way, not drawing any attention away from him.”

*Intuitive awareness of partner’s needs.* Several participants noted an apparent intuitive understanding of the importance of being an unobtrusive observer, such that little instruction or redirection were provided to the witnessing partner about their role.

Richard shared his concern about intruding on Nesse’s process:

I think the first session, I was very, very quiet...Afterwards, I would ask a lot of questions. Because I didn’t feel like I should ask questions at that point. I also felt very bizarre in the first few sessions...I felt like I couldn’t be close with Nesse...If she’s working with Cat, she needs to be grounded and me being close to her may impact the exercise...I’m just here to observe.

Doris attributes the tendency of clients to treat EMDR with respect to the fact that it is out of the ordinary:

There’s something about the protocol for EMDR that it seems so unusual and special and out of the ordinary that it seems like people do treat it with a lot of respect and so...they use care. That it feels like it’s something precious and that they shouldn’t be messing with it.

NyxRN noted her intuitive sense of what Huck needed and what he was feeling:

I don’t know if the emotional connection is true for everyone, but I can easily tell when he’s distressed. He knows when I’m distressed and I just know a lot of times when I can just touch his arm or touch his leg or hold his hand or whatever. You don’t want to intrude into his session because I want him to focus and not think about me when he’s doing his session...I wanted to be close enough that he knows that I’m there when he needed me but at the same time, I didn’t want to be intrusive. I wanted him to not think about me.

***Initial skepticism and bewilderment.*** Similarly to the working partners, witnessing partners observed their initial skepticism about EMDR and their sense of bewilderment about the process. Richard said that even as he witnessed Nesse's EMDR process, he doubted that it could be as impactful for him: "I can see it going on but what's it really like? I'm not convinced... The first few sessions, I could see it was helping Nesse but for me, I was like 'I don't know'." He went on to express his shock at the intensity of her emotions:

Seeing Nesse go through it and seeing how all of a sudden, she'd have really strong emotions and reactions was one, kind of shocking. I was like "what just happened there? How can she have that reaction so quickly?" And for Cat to work through with her and pick out what the issue is...I would sit there and think "I don't know what she just did, how she just got that."

Algernon shared his similar bafflement and struggle to understand the EMDR process: "I did do some reading but I still don't understand it...I think maybe that's one of the reasons why I'm more inclined to experience the EMDR personally. To understand." He further noted:

It's a continuum...it didn't seem like we started here and stopped there and started again....and we made this discovery at this moment....it was a lot more subtle...As subtle as it was, the results were amazing. I don't understand it. Ok. Very simply. I just don't. It was an enormous help to Ursula and it was a mystical experience for me.

***Impact of witnessing emotional expression.*** Several participants noted the value of witnessing their partner's EMDR in that they were able to hear material that they might have heard previously in segments and on a cognitive level, but never as meaningfully in its entirety and with the emotional impact on their partner. Algernon noted his experience of this with Ursula:

Perhaps the story line was more condensed. I heard all of it at once...in a consolidated format. It gave...at least to me, more meaning going from one place

to another and understanding how Ursula felt...I didn't really understand the full meaning and impact...So understanding, getting a better grasp of those feelings...and what provoked them...really drew me in.

He also shared his observation of the more powerful impact on her as she processed material through EMDR that she had previously discussed verbally: "It had a greater impact on Ursula. They were more salient...The process was much more meaningful to Ursula. I could feel it. I could sense it, watching it and witnessing it." Michelle noted a similar power for Anthony to see the impact of Bonnie's past experiences through conjoint EMDR: "To be able to just not in fragments over a period of years knowing these instances, but just compact in the room. And not just hearing it in a cognitive way but seeing her emotional response with it and how strong that was for him." Matt valued having Rita witness the power of the emotion he felt during reprocessing that added credibility to his experience and decreased the likelihood that she would dismiss his experience:

She didn't believe it at first, but when she saw the emotion that was carried with it, she acknowledged that that was the case and we were able to deal with that as an issue...It allows the observer to see the emotional energy that people have tied up with issues that the observer may think are untrue or are over exaggerated.

*Admiration, respect, and empathy for partner.* Participants were deeply moved by witnessing their partner's EMDR process and experienced significant empathy, admiration, and love. They also noted gratitude as they observed the relief experienced by their partner during EMDR. Fred discussed his impressions of Beth serving as a witness to Sam's EMDR: "I have memories of after his EMDR, her experiencing some relief and appreciation...relief around him getting some healing.... He reported his PTSD symptoms improving in a significant way with each EMDR session." Similarly, Louisa was grateful to witness the healing that Roger experienced through EMDR: "What I



gained in being a witness to him, I would never trade. I think it was so worth it just for that experience of seeing how effective it was. If it hadn't been effective, I don't know....But it was clear it had made a difference right then for him."

Algernon shared the awe and love he felt for Ursula as he witnessed her EMDR: "I recall a sense of admiration. The élan and aplomb that Ursula had through it all was incredible...I would look at Ursula and I'd marvel at her." Nancy sensed how moved Algernon was while watching Ursula: "I could feel the love in the room; it was just lovely, really lovely...I think sometimes it was hard for [Algernon] to not just wrap his arms around his wife. That was just my impression, that he could have just picked her up and taken her away." Anthony felt similarly for Bonnie during her processing: "The only obstacle that I would say is that I knew I just couldn't go up and put my arms around her. Cause I really wanted to."

***Vicarious healing and shared journey.*** Participants said that conjoint EMDR allowed the opportunity for a shared journey, such that the witnessing partners experienced such empathy for their partner that it was as though they were experiencing the events with them and vicariously healing through their partner's EMDR process. Beth noted this phenomenon with Sam: "For him to actually see it and unbeknownst to me heal with me, it's a beautiful thing." Fred observed the vicarious healing between Sam and Beth:

By being present in the session, there were a lot of benefits to doing the conjoint sessions...[It] indirectly benefited the other person, to process and understand the healing journey that their partner was on, was a significant contribution to their own healing journey. I think just the vicarious benefits spill over to the second person.

Nancy highlighted the same notion of the shared healing journey that occurs during conjoint EMDR:

By doing it conjointly, I believe it was even more powerful in many ways than an individual EMDR session...It is a shared experience...I also feel that, for the observer, there is something that clicks in a way that doesn't seem to click through talking, through talk therapy. It's almost like they are experiencing the experience with the person and they get to see the pain.

Algernon found it powerful to experience Ursula's emotions with her:

My feelings were really in concert and attuned to Ursula's because as she was relating something, I shared her emotion...we really had a strong link...I can't say I was in her head, but that's what it felt like...and it wasn't just because I could relate to that...that I have my own story...I was feeling *her* story...It was very much special because I was *with* Ursula. I don't want to use platitudes like "in her head" but I was *with* her...I really felt a very very strong connection...and feeling her and not feeling me...I became emotionally involved in listening...I was swept into the moment.

***"Eye opening."*** Witnessing partners also described the process as "eye opening" to learn the parallels between their partner's past and their current dynamics and to learn information for the first time. Algernon obtained a new understanding about Ursula's discomfort when he became angry:

I started getting a better feeling or understanding of how my actions or words unrelated to anything that Ursula does still has an impact on her...For instance, she said if I used profanity, that it's violence. She feels violence is being perpetrated on her. Even if it has nothing to do with her....if I slam my thumb with a hammer...(roars) like that, it's violence.... It was an eye opener...that was a wake-up, that it has an effect.

Similarly, Richard was shocked to learn details about Nesse's childhood experiences:

Going through those sessions and having Cat work with her to understand some of the issues she's had over her life, not having her parents around, not having her family bring her up and really push her into an early marriage...I've never had that; I've had a very different upbringing. For me, the first sessions were very eye opening.

Michelle noted how moving it was for Anthony to see the parallels between Bonnie's childhood experiences and dynamics that occurred within their relationship. She read statements he had made during conjoint EMDR sessions from her notes:

For him to see the parallels in her reactivity, the parallels between her previous trauma to the betrayal in the affair in the present relationship...He was able to...have a greater understanding of how some of his behavior triggers these old wounds...[Reading from notes:] "It was eye-opening the things that she had said about our situation."...What she was saying about the molestation was the same things at another time she had told him about their relationship and the affair that he had. And it says, "I feel worse about what I did. It created a deeper understanding of her."

**Obstacles.** When participants were asked about obstacles they experienced during conjoint EMDR, overwhelmingly clients and therapists directly denied having encountered any obstacles that interfered with benefits to the process and stated that any material that came up served as "grist for the mill." However, a few participants did identify obstacles, particularly initially during the conjoint EMDR process, though they still were grateful for and benefited from conjoint EMDR. Thus, any obstacles that were identified did not seem to interfere with the benefits of the process, though they may have decreased the potential degree of benefit that might have been obtained with further assessment or preparation. These obstacles are noted below.

***Over-focus on partner and external factors.*** The most mentioned obstacle for participants related to preoccupation with their partner, desire for external validation, and focus on the potential outcome of EMDR and the therapy process as a whole. This focus on external factors seemed to be a distraction for some participants from full engagement in their own EMDR process. Matt said that at times, he felt "in the hot seat," "unduly exposed," and that conjoint EMDR seemed to have a "voyeuristic" aspect to it, such that he sometimes felt "pried" or "intruded upon" by Rita. However, he stated that he was

“willing to put that aside to help my wife understand me and be more open minded about me and for the sake of our goals as a couple.”

Louisa noted a similar preoccupation with “being watched” and wondered whether that interfered with her ability to gain as much from the experience and be able to remember the details of her EMDR process as she might have otherwise. Anthony observed anxiety about whether he would be able to “perform” during EMDR, followed by a sense of increasing comfort as he gained benefit from the treatment:

I gotta admit too, all the times I’ve done it, I’ve been apprehensive about it. Just wondering, “Gosh, am I going to be able to...? I’m never going to be able to answer the questions, ‘what are you thinking now?’ ” But it always seems to be there...I guess because it’s helped, I feel comfortable with it, almost wondering when the next times is going to be.

Louisa found herself comparing her progress during EMDR to Roger’s, demonstrating similar performance anxiety: “Perhaps I was embarrassed because I wasn’t as good at it as Roger. He really moved along and I was trying so hard to be a good client and also to be true to my own feelings about it.”

Rita demonstrated a strong need for external validation from both her husband, Matt, and from their therapist, Bill, which appeared to be an obstacle to her ability to fully trust the EMDR process. She shared her desire to change Matt and concern that her feelings might be “minimized” through EMDR. She observed some “resistance,” which she believed did prevent her from gaining as much from EMDR initially as she might have otherwise. She also noted frustration that EMDR did not change Matt’s behavior, suggesting she was focused on the outcome of EMDR and perhaps was less present for the process both as the working and as the witnessing partner.

***Initial reluctance to share vulnerability.*** A second theme regarding obstacles that relates to the first is participants' initial apprehension about experiencing and sharing the vulnerability involved in conjoint EMDR. Anthony was anxious about not knowing what to expect and had a desire to understand more about the "mechanics of it" in order to feel an increased sense of control:

I had some apprehension about what it would be like, but once it started, those went out the window. I didn't know quite what to expect...I think the only thing that would have made it a little bit easier would be understanding the mechanics of it. What was going to happen, what the light bar was doing.... Once it started, it was fine. It was just the apprehension, the worry part...what it was going to be like.

Sam shared a similar apprehension as he anticipated each EMDR session. Beth said: "I guess it's like going in for a root canal, you don't look forward to it but you know it needs to be done and you're going to feel better when it's over."

NyxRN noted Huck's concern about her witnessing his vulnerable emotions and his fear of disappointing her: "He doesn't want me to think that he's weak in some way." Huck confirmed this hesitation but his resulting gratitude and relief when he did share vulnerability with NyxRN:

I always put my guys first and I always was the stronger one...as a leader, you got to be a strong leader - physically, mentally, and emotionally...In a lot of aspects, I think that's who she fell in love with. But now that I have to break down and show a little bit of the weakness, it is kind of frustrating.... You can't help tears. It just comes, it just flows...And if you have the confidence enough to let yourself open up like that, that's when EMDR starts to help more and more and more.

***Initial reactivity by witnessing partner.*** Several participants noted initial reactivity or intrusiveness by the witnessing partner, either during or following the first conjoint EMDR sessions, though each said that they were able to effectively overcome this obstacle through various means. Michelle stated that Bonnie was initially intrusive

during Anthony's first EMDR session (though, interestingly, neither Anthony nor Bonnie mentioned this themselves): "If she didn't agree, she wanted to correct it. One of the issues is that Bonnie can be very rigid in her thinking and it's like black and white. There really aren't any grey areas. It's right or wrong and she has an expectation of how things should be." Michelle described her response to Bonnie's intrusiveness and she noted the value of Bonnie's use of a notebook to express her reactions:

A lot of times, I'll kind of physically contain her.... Sometimes I've gone over and sat on the floor and put my hand on her knee or sat next to her and just kind of helped regulate her. That was enough.... Just reminding her of the importance of staying in the moment with the processing.... The notebook seemed to help her contain and regulate herself and I guess putting it down satisfied where she didn't have to express it verbally in the moment.

Nesse initially experienced Richard as judgmental after her first conjoint EMDR sessions: "At first, when we got into a fight, he could play dirty and he blamed it on my past." She noted how they were able to work through this:

We would talk even more at home after the EMDR sessions.... The first time I brought [my abuse history] up in front of Richard...it really shocked him. And it took a while for us to get to an understanding, for him to understand the impact of some abuse on what I think or how I react.... You know, going through all the emotions and removing the blame and be able to speak very factually and to the point.

Richard stated that they could better support one another as they learned to listen and accept what they heard from one another without judgment.

### **Consequences**

Participants noted multiple positive changes both individually and relationally as a result of their conjoint EMDR experience on emotional, cognitive, and behavioral levels. Client participants appreciated conjoint EMDR, with each one of them saying that they would encourage others to engage in this treatment. All clients also noted gratitude

and respect for their therapist. No negative consequences were mentioned. The consequences of the conjoint EMDR process are noted below in Table 7 and then in narrative form, separated into two sections: working partner and relationship.

Table 7

*Consequences*

Working Partner	Relationship
1. Healing trauma	1. Satisfaction and changes on outcome measures
2. Increased self-worth and decreased self-blame	2. Increased differentiation
	3. Reduced interpersonal reactivity
	4. Increased empathy, compassion, and intimacy
	5. Increased understanding
	6. Increased ability to intervene in cycle
	7. Increased commitment and hope
	8. Increased communication
	9. Increased happiness and enjoyment

**Working partner.** Working partners noted several common themes related to changes from conjoint EMDR including healing relational and attachment trauma, improved self-worth, and decreased self-blame. These are discussed below.

**Healing trauma.** Many participants who had served in the working partner role during conjoint EMDR reported significant decrease in trauma symptoms overall and healing of relational trauma. Nesse noted that after her experience of EMDR, when she

thought about her childhood trauma, “I can’t even see the details anymore” and that she no longer feels the “nagging pain” that used to be “so vivid like yesterday”; it now feels like a “lifetime ago.” Beth observed that EMDR was helpful in moving through the impact of the accident and that her depression was greatly reduced. Louisa noted that places and things that used to be triggering of Roger’s infidelity no longer had the “charge” they once did and that the recurring images of Roger with other women disappeared.

Several participants observed decreased hyper-vigilance, anger, and agitation. Huck said: “I don’t get as stressed out or pissed off or freaked out as much.” Rich noted that Huck was less agitated, calmer, less angry, and more relaxed in traffic. Huck reported decreased physical symptoms related to the trauma (nose bleeds, headaches, and sleep difficulties), and that he is now able to talk openly about traumatic events he previously avoided.

Beth stated that she was “feeling better physically, mentally feeling better, more hopeful” and that her headaches were going away. Ursula also experienced decreased physical pain and need for reliance on pain medication, less physical tension, and more relaxation. Ursula noted a “paradigm shift,” a “whole shift in my thought process and how I am and who I am in this relationship.” She observed her ability to differentiate between issues from her past and her current response to Algernon, describing herself as more accepting and understanding of him today.

***Increased self-worth and decreased self-blame.*** A second common theme that emerged among clients who had engaged in EMDR with their partner present was an increase in self-worth and a decrease in guilt or self-blame. Nesse noted “a sense of



goodness” that she experienced through conjoint EMDR, reduced shame and fear, and decreased self-blame. She said that she has “stopped going and looking for pain.” She reported an increased sense of integration, noting that “there isn’t the duality to me anymore.” NyxRN noted that Huck no longer blames himself for events during his military combat experience. Bill reported that Matt no longer believes that he deserves punishment and that he has “cognitively shed his reliance on external validation by her and is emotionally depending on this less.”

Rita noted an increase in self-worth, stating that she feels stronger now and that she is now allowing herself to be “selfish:” going shopping and doing things for herself rather than placing everyone else first. She also observed that she feels less fear and angst, and that she validates herself more, though she also stated that she continues to struggle with issues of self-worth. Both Nancy and Algernon observed an increase in Ursula’s self-worth; Algernon said: “I think she feels more self-assured...I think she’s liking herself more. I think she’s started to put more value on who she is.”

**Relationship.** Participants identified several significant relationship changes experienced through conjoint EMDR and common themes for both witnessing and working partners. These changes include increases in differentiation, empathy, compassion, intimacy, understanding of individual and relational dynamics, ability to intervene in negative relationship patterns, hope, commitment to their relationship, communication, happiness, and enjoyment. They also observed reductions in interpersonal reactivity and reported high levels of satisfaction in their conjoint EMDR experience and in their therapist. Outcome measures reflected positive changes both individually and relationally for both the witnessing and the working partners.

***Satisfaction and changes on outcome measures.*** Participants consistently shared appreciation for conjoint EMDR, stating that they would recommend it to others. All therapists noted improvements in the SUDs and VoC scales for EMDR clients. Rich utilized the Outcome Rating Scale with Huck and NyxRN to measure overall life satisfaction from week to week as well as the Session Rating Scale to measure their satisfaction with the sessions themselves. He said: “throughout our EMDR work together, not only were they consistently reporting high relational satisfaction but they were also reporting very high levels of satisfaction with the treatment itself.”

Algernon reported significant changes through conjoint EMDR, results he had never experienced in his many years of therapy: “Ursula and I have had a great deal of experience with therapy...And this is the most remarkable results that I’ve witnessed, compared to those other experiences.” Similarly, Anthony shared his appreciation for conjoint EMDR: “Certainly, I feel like the reformed drunk, somebody who would most of my adult life, think that therapy was just a joke...I wish it was something that I would have started years ago, but I just realize I wasn’t in a place to do it.”

***Increased differentiation and secure attachment.*** A second theme across both the witnessing and the working partners was an increase in their levels of differentiation and of secure attachment within their relationship. Several participants noted an ability to better recognize where their personal responsibility lies and to let go of inappropriate responsibility they had been carrying, whether related to their partner or to events from their past. Nesse said that Richard’s witnessing of her EMDR allowed him to better understand her triggers, to be more conscious in not engaging in behavior that is

triggering for her, to let go of self-blame, and to recognize his responsibility in their dynamics.

Cat noted that in watching their partner's work, the witnessing partners are able to recognize "It's not about me." Matt shared that he became better able to disengage from conflict and to let go of his sense of responsibility to "fix" or soothe Rita when she became escalated: "[Conjoint EMDR] helps me to walk away versus staying and trying to fix it or feeling very guilty if leave." Similarly, Nesse said that witnessing Richard's EMDR helped her to accept him as he is: "[Watching him do EMDR taught me] I can't change him. He's just who he is."

Bonnie shared a change in her level of shame and responsibility for events that had happened during her childhood that she now recognizes are not hers to carry, and a similar compassion for the burden Anthony had been carrying for years:

I can see those things with a different perspective now and not take responsibility for things that happened to me when I was two years old or seven years old. You know, where kids feel like they have a part in those choices that they don't. They really don't and the same with Anthony.

Another consequence of this increased level of differentiation is the increased sense of appropriate responsibility and clarity about each partner's role in the current problems, resulting in better capacity to interrupt their unhealthy dynamics. Anthony noted his increased awareness of the impact of his past and his responsibility in their relational patterns: "What the therapy has shown me with Michelle is my part of the problem, which I just had never realized. I hid those kinds of things all my life and never wanted to face it."

***Reduced interpersonal reactivity.*** One of the most commonly observed changes by all participants was the reduction in interpersonal reactivity, both within their romantic

relationship and beyond. Doris stated her belief that EMDR creates a “neurobiological shift...so that people, when they hit that material again, have more range in how they respond.” Cat noted that Nesse became more differentiated and less reactive with Richard, projecting her past experiences on him less, and becoming better able to ask for space without threatening him. Nesse stated that she is now able to see “this is not about me; this is about him” when she sees Richard flirting with another woman, allowing her to be less reactive and angry, but instead asking for what she wants from him. She reported having less concern about what others think and being direct without worrying about hurting other people’s feelings. Similarly, Cat and Richard both noted that Richard is better able to allow Nesse space, is able to self-soothe, and is both less reactive and less angry.

Doris observed that Louisa became increasingly able to “look beyond her own reactivity and really see him instead of just her projection of who he might be or she’s afraid he is.” Similarly, Michelle noted the decreased projection, triggering, and reactivity between Anthony and Bonnie that has allowed them to be more tolerant and present for one another: “She has developed an understanding that she also triggers him. It’s not just him having the responsibility for her. So that has decreased, thereby allowing him to remain present for longer periods of time when they’re having challenging moments.” She observed the contrast between Anthony’s high level of defensiveness and shame initially that alienated him from Bonnie to his current level of self-compassion and differentiation that allow him to be present in his relationship with Bonnie:

Anthony...was very defensive. So he wasn’t able to hear or validate her pain. He could see her pain and then that would activate his shame, which would further separate him from his wife. He’s able to see how his early experiences, especially his relationship in his family of origin, how that is significant in how he has

behaved with his wife... the affair, the lying, and the betrayal. And an understanding that the shame takes him further away and so having a greater understanding of kind of the foundation for what happened helps relieve, or decrease some of the responsibility, some of the inappropriate responsibility he had, you know, as a little boy.... That helps him to remain present in the relationship more often.

*Increased empathy, compassion, and intimacy.* Participants also noted increased levels of empathy, compassion, and intimacy within their relationship following conjoint EMDR. Beth observed the depth of intimacy that she experienced as a result of EMDR with Sam:

I can't imagine having done it alone because way down deep inside, you get to the heart when you're doing EMDR and when you can see and feel each other's heart when you're in a different state of consciousness almost, it brings you together on a deeper level.

Sam observed an increase in empathy during and after sessions. Rita noted that Matt is more thoughtful and considerate, thinking about her as he makes decisions and becoming more available to her. Nesse observed that Richard is more loving toward her since their conjoint EMDR experience.

Anthony experienced admiration and inspiration as he observed Bonnie openly share her feelings and he noted a shift in their ability to talk honestly with one another about meaningful events. Bonnie described increased compassion and empathy she now has for Anthony after having witnessed his EMDR process and the impact of his past:

I feel a lot of compassion for him and how he felt about himself and how he lived his life and how that must have been really awful for him. And I can feel really empathetic and...that's only happened through EMDR really. I don't think I would have ever known those things...It made me have a lot of empathy and compassion for him....I just think about that little boy, you know.

Similarly, Anthony was moved when he witnessed Bonnie process through childhood trauma, recognizing how much it had continued to impact her:

I didn't realize all those years that she was suffering from PTSD...Even though she would put a pretty hardened face on it... that she had dealt with it and stuff, it was really quite evident how raw the wounds still were...It's really been helpful for me to keep that picture of the seven year old in my mind...I think the key word in all the sessions would be empathy. I have not been a very empathetic person most of my life...It was really hard...to see the woman you love as a seven year old suffering... I just felt like my heart was being ripped out.

***Increased understanding.*** Another common change through conjoint EMDR was an increased understanding of themselves, of their partner, and of the dynamics within their relationship. They described an increased awareness of their triggers, of their environment, and of their own emotional experience. They shared greater understanding of how their past influences the present, the impact of their own behavior on others, and a resulting increase in understanding of how to better support their partner and motivation to change their own behavior.

Witnessing partners reported that learning more about the impact of their partner's past helped them to better understand their partner's reaction to current events, helping them to be less reactive themselves, and increasing their level of confidence in terms of their ability to support their partner. Richard noted that his understanding of Nesse's reaction allows him to better support her: "I got to understand when she reacts a certain way or when she does something, where that's come from, so I don't react in a way that adds to the issue, but I can actually do something to support."

Nesse observed Richard's increased awareness and the resulting intentionality with which he behaves: "He's learning a lot about himself...He's more aware of his behavior. He's not so blindly acting and saying things irresponsibly. He takes responsibility for what he says and does." Richard noted his increased awareness of the impact of his past:

It's interesting to know that your memories and experiences do form such a big impact in your current life that you don't even realize...It's interesting now to just see some of the things that I was doing and I'll be like "wow I can see that in all these other people and I see now why Nesse was getting so upset and so emotional."

Bonnie observed greater understanding about her own behavior and reactions as well as those of Anthony. She noted the sense of empowerment and clarity she now has, having the words for her experience:

Now I have words for it...It's like, "you've always done that and I just didn't understand what you were doing. And now I understand it's because you... felt awful about yourself and so that presents itself to me as anger and you act like you're blaming me for what you're feeling. You know, you're saying I hated you when really I didn't but you meant I hate myself."

Michelle noted how much Anthony's increased understanding and compassion toward himself have allowed him to be more genuine and emotionally available:

As an individual, he has grown so much in developing just a deeper understanding and a more compassionate understanding of himself...And that is increasing his ability to be genuine, not just with himself but with others, like his wife...He's been peeling back layers of who he really is rather than the facade that he's put up for others.

***Increased ability to intervene in cycle.*** Participants reported that their increased understanding of themselves and one another, their greater level of differentiation, and their decreased reactivity have allowed them to respond deliberately with one another, thereby intervening in or bypassing their negative relationship cycle. Nesse said that she and Richard used to escalate to the point of "no return," and that now, they argue more often, but the arguments are bickering about little things rather than explosive as in the past. Richard observed their ability to circumvent their previous cycle:

I truly believe that the sessions have helped in the way I react. And that's the biggest issue we had was our very strong reactions that would end up in big arguments to the point where Nesse would be hysterical and want to get away

from me, get rid of me, whereas now it's just an argument. We speak about it and then we're done.

Richard noted his increased ability to allow Nesse space and to not personalize her needs at such times:

Now when things come up, I know the signs. I know that Nesse goes very quiet. In the past, I would pester her like crazy to know what's going on and she wouldn't speak to me. Now I understand when she goes quiet, she's obviously upset or something's triggered her off. And I let her go through that and that when she's in the right frame of mind and ready to speak to me, she'll speak to me.

Matt noted that when he is less triggered, he is better able to recognize where the responsibility lies, which in turn helps him to remain calm and walk away when Rita is escalated and not able to respond. Beth said that she is now giving Sam "permission to take care of himself" rather than being his "caretaker." Ursula noted that she and Algernon can use humor, without anxiety about hidden messages, and trust that each "blip" will pass:

In the past, an attempt at humor was taken as, "okay, there's a, there's a veiled message there...this is like trying to make nice without really trying to make nice."...And now it's like, "yeah this is really funny... It's not the end of the world...This too shall pass." ...Now that we've done all this EMDR...I can see this pattern that we've had...When we had a blip in the past, the blips have just turned into atomic explosions...Now I feel that if we get to a blip, we really have the tools and that knowledge.

***Increased commitment and hope.*** Participants noted a greater sense of hope in general and specifically, hope in the future of their relationship. Though they seemed more aware of the uncertainty of the outcome, there was an increased trust in their ability to cope with difficulties and a commitment to continuing the work they had started.

Ursula shared her increased sense of safety with Algernon:

I think that this has just enhanced that journey...it's not just that individual trip...I have definitely been enjoying the results of the growth that Algernon and I have made in the real intimacy of our relationship. The hurts and false/wrong messages



that we encountered in the past don't hold much sway with us now. We are, indeed, on the right path this time and we don't need to leave a trail of bread crumbs because we are not going back that way anymore.

She also noted security in the changes she and Algernon have made in their relationship:

“It’s not moments anymore; this is the reality...we are that couple that we had glimpses of over the last 42 years.”

Beth shared her hope and empowerment, based on what she and Sam learned and experienced together through conjoint EMDR, and their resulting closeness:

I’m trying to think of how to phrase it, for me, the things that we have learned about and how we have been able to turn those things into positives and hope, and it’s like, when you know something you can finally do something about it....Knowledge is healing...We’ve learned things about each other in our marriage that we didn’t know and so the marriage is just so much richer and closer than it’s ever been.

Bonnie noted that both she and Anthony are committed to their relationship, in spite of their ongoing struggles, stating “we’re willing to do whatever it takes.” Anthony said that in spite of the pain that comes with being honest with himself, he is committed to continuing the work that he started:

It certainly showed me that there was a lot inside that I had kept hidden...I look and try hard to stay open and not let my mind close things off or shut things down because this is way I used to do or this is the way I’m comfortable with. I know if I’m feeling comfortable in the situation, I’d better look at what’s going on...I feel as long as I can stay open, things can happen.

***Increased communication.*** Participants reported a significant change in their openness, noting increased depth and honesty in their communication. Anthony shared the pleasure he feels in being able to be fully open with others, a new experience for him:

I started to see things and feel things differently and became very open to expanding that side of me. I like the feeling of not hiding things. I like the feeling of being able to tell somebody what I feel...Sometimes I feel like a toddler in a lot of ways because I just had never experienced them...I can’t tell you the difference

in being able to talk to somebody on a real level and not the superficial level like conversations used to be on.

Rita said that she and Matt are better at both listening and sharing with one another. Bill noted that Matt is now able to express affection and ask for companionship from Rita, whereas in the past, he would have been indirect and resorted to shaming messages. Beth observed that she and Sam are communicating more openly and on a deeper level.

NyxRN stated that she and Huck are communicating more as he is now able to sit down and talk with her calmly and directly about things as they come up: “Having gone to EMDR together and knowing more details, it helps us to be more open...I think that now he knows that those are things that we can talk about and that helps us.” Louisa shared hope that she and Roger can maintain the open communication they started with Doris and no longer rely on couples therapy.

***Increased happiness and enjoyment.*** The final theme shared by participants was their increased happiness and enjoyment of life. Many used the term “light” and referred to laughter and humor as they spoke about the changes in their relationship and life as a whole. Cat observed that Nesse and Richard are “a lot happier” and “have more fun.” Ursula noted a sense of empowerment and that “emotionally, I am in a very ‘calm place’.” Louisa said that Roger is much happier, and that even their daughter has observed that change. Nesse stated that she has become “happier, confident and no nonsense” and that she has gained a “clear perspective.” Cat noted Nesse’s newfound capacity to be present. Similarly, Sam mentioned having slowed down, that “things have really come into focus a lot better,” a softening of his personality, and more enjoyment of life.

Richard stated that they engage in more activities that they enjoy together. Doris noted that Roger and Louisa have been traveling together, that they are both “more content in their lives,” and that “they’re playful with each other,” stating that they are “fun to be with,” and that their relationship feels “much more open” and “lighter.” Ursula said: “Our conversations are easier and I do not feel I need to be guarded about what I might want to express. We are genuinely laughing a lot more.”

### **Summary**

In this chapter, I presented data grounded in the interviews and documents from 21 participants in the form of a theory about conjoint EMDR as a relational trauma treatment. These data were integrated into a theoretical model using Strauss and Corbin’s (1998) grounded theory data analysis. The central category of the theory is that trauma is experienced relationally and is healed relationally. Within the theory, I outlined the assessment process identified by participants as important to determining whether a couple is appropriate and likely to benefit from conjoint EMDR and the preparation steps and re-evaluation procedures that were identified as facilitative to the conjoint EMDR process. Contextual factors for the client participants were presented and the experience of the conjoint EMDR process itself was described. Furthermore, the consequences from the conjoint EMDR process for each member and for the relationship as a whole were described including the most commonly reported intra- and inter-personal changes.

In the following chapter, I provide a summary of the study and a discussion of the grounded theory developed from the data. The findings are examined in relation to previous research. The implications and limitations of the study are explored and directions for future research are examined.

## **CHAPTER VI**

### **DISCUSSION**

The purpose of this study was to explore the experience of clients and therapists throughout the process of eye movement desensitization and reprocessing (EMDR) treatment within couples therapy to understand the factors and conditions perceived as facilitative as well as those perceived as obstacles to the change process. Specifically, the research questions were:

- Q1     How do members of couples describe their experience of conjoint couples therapy involving EMDR treatment?
- Q2     How do therapists describe their experience of providing EMDR treatment within the context of conjoint couples therapy?
- Q3     What do participants perceive as valuable or meaningful about the process?
- Q4     What do they perceive as impeding the process or not valuable?
- Q5     How does each participant describe the status of the couple prior to and following EMDR, both individually and relationally?

Based on data from the interviews and documents, a theoretical model was developed entitled EMDR in Conjoint Couples Therapy: Relational Trauma Treatment Theory. This chapter includes an overview of the study and of the grounded theory as well as a discussion of primary themes and their relation to previous research. The chapter concludes with implications and limitations of the current study, and directions for future research.

### **Summary of the Study**

Martin Buber (1958) held that in order to heal, we must be fully seen to the depth of our being. We learn about trust and safety through our earliest relationships, namely those with our primary caretakers. When a traumatic experience causes a disruption in our sense of safety in the world, this event inevitably impacts our perception of ourselves, others, and the world as a whole. Thus, in order to recover from such trauma, it is essential that safety and trust be re-established, and that healing occur within the context of a supportive relationship.

Several treatment approaches are effective in reducing posttraumatic stress disorder (PTSD) symptoms--those that target the trauma-related symptoms through exposure and trauma processing (including in vivo as well as imaginal exposure) within a safe and supportive relationship seem to be most effective (van der Kolk, Spinazzola et al., 2007). Exposure treatments are effective in reducing re-experiencing symptoms, while group therapy for survivors is helpful in addressing the interpersonal effects of traumatic exposure such as the numbing and detachment symptoms (Herman, 1997; van der Kolk, Spinazzola et al., 2007). Eye movement desensitization and reprocessing (EMDR) is a comprehensive and evidence-based method of psychotherapy for trauma, which is primarily conducted within individual therapy. Eye movement desensitization and reprocessing is an experiential treatment that allows for imaginal exposure, reprocessing, and integration of traumatic material into a coherent narrative.

Research demonstrates increased success rates for anxiety, depression, and PTSD (Barlow et al., 1984; Bowling, 2002; Cerney et al., 1987) when couples therapy is incorporated into treatment. Couples therapy provides a context in which healing from

trauma can occur and where the traumatized partner can re-establish a safe haven and secure base within the relationship, when both partners are invested and committed to this process (Johnson, 2002). Integrating EMDR into conjoint counseling provides the opportunity for such couples to reveal each partner's vulnerabilities which in turn, can evoke empathy and support from the witnessing partner, thereby facilitating healing and rebuilding connection. Alexander (2003) notes the power of the partners of trauma survivors witnessing their spouse's trauma narrative as survivors work toward developing an integrated and coherent story. Furthermore, rather than the therapist serving as the corrective attachment figure as with individual therapy, a couples therapy context allows the opportunity for one's intimate partner to contribute to that corrective experience.

Though EMDR has been incorporated into couples and family therapy in recent years (Capps, 2006; Capps et al., 2005; D'Antonio, 2010; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Koedam, 2007; Litt, 2008, 2010, Moses, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Shapiro, 2005; Talan, 2007), little research has examined its use within a conjoint couples therapy context and none has included the perspectives of both the therapist and the couple. The existing literature related to conjoint EMDR is primarily from the perspective of therapists and is generally in the form of case illustrations and proposed protocols for integration of EMDR within couples therapy without systematic research of the conjoint EMDR process.

After approval from the university's Institutional Review Board, semi-structured interviews were conducted with a sample of 21 participants composed of seven triads of couples who had participated in conjoint EMDR and the therapist who had facilitated

their treatment. Interviews were transcribed, after which both transcriptions and relevant therapeutic documents (including journal entries by clients, a client poem, emails, therapist notes, and pre- and post-treatment measures) were analyzed through the use of grounded theory data analysis by Strauss and Corbin (1998) to investigate the experiences of these clients and their therapists. Grounded theory was chosen as the methodology given the limited research conducted on this area of study. According to Stern (1995), “the strongest case for the use of grounded theory is in investigations of relatively uncharted water, or to gain a fresh perspective in a familiar situation” (p. 30).

Grounded theory research generates a theory from data that are systematically gathered from participants who experienced a particular event or process. This theory provides an explanation of a process, action, or interaction, based in the experiences of the participants interviewed (Creswell, 2007). Grounded theory methods include the following: (a) simultaneous data collection and analysis, (b) a process for coding data, (c) comparative methods, (d) memo writing as a means of creating conceptual analyses, (e) theoretical sampling, and (f) development of a theoretical model (Charmaz, 2005).

Member checks were conducted with participants to allow them the opportunity to review their transcriptions for accuracy. Two follow-up interviews were conducted to fill gaps within the data. Participants were also provided with the emerging categories identified from their interviews during the open coding process to confirm, correct, or comment on the congruence of those data with their experience. Data analysis included open coding during which data were broken down, examined, compared, and developed into categories: axial coding, during which those categories were restructured and integrated into new categories; and selective coding, during which those new categories

were systematically related with one another to produce a meaningful theoretical model (Strauss & Corbin, 1998). A summary of the research findings is presented below.

### **Conjoint Eye Movement Desensitization and Reprocessing: Relational Trauma Treatment Theory**

The grounded theory developed from the data illustrates the phenomenon of conjoint eye movement desensitization and reprocessing (EMDR); the influential conditions related to the assessment process that includes those related to the therapist, each partner, and the relationship; contextual factors, such as the degree of previous familiarity with EMDR by members of the couple, the roles taken on by each partner during the conjoint EMDR process (witnessing and/or working partner), and the couples' reasons for referral to treatment; the intervening conditions related to preparation for conjoint EMDR and ongoing re-evaluation of the treatment process; the actions and interactions identified as common across participants; and the consequences of conjoint EMDR for each partner and their relationship as a whole. A summary of the results from each of the grounded theory components is presented here.

#### **Influential Conditions: Assessment**

Participants noted four influential conditions associated with the assessment process to determine clients' appropriateness and readiness for conjoint EMDR. They identified three therapist factors, four factors related to each member of the couple, and four related to the relationship. These influential conditions parallel phase one of the standard EMDR protocol: client history and treatment planning during which information is gathered about clients' history, clients are assessed to determine whether they are good candidates for EMDR, and targets are identified for reprocessing. However, many of the



conditions identified by participants are specific to conjoint EMDR given the needs and factors that are unique to this modality. Based on data from participants, these influential conditions are useful to predict potential obstacles, guide preparation, and provide information that is necessary in determining whether conjoint EMDR is appropriate for a particular couple.

Three primary therapist factors are considered important to effectively conduct EMDR within a couples therapy context: (a) an integrative approach that balances individual and systemic dynamics and that emphasizes personal responsibility, (b) sufficient experience and competence in EMDR and couples treatment, and (c) confidence in the therapist's abilities and alliance between clients and therapist.

Participants noted the following critical conditions to consider for the working partner:

(a) general intra- and interpersonal functioning including such factors as attachment security, hostility, anger, role within the relationship, and investment in change; (b) trauma history; (c) stability and resources; and (d) willingness to be vulnerable.

The findings related to therapist conditions extend past literature on EMDR with couples (Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Shapiro, 2005). Protinsky, Flemke et al. (2001) proposed that a therapeutic alliance in which trust and safety are established is essential prior to implementing eye movement relationship enhancement (EMRE) therapy, their model for integrating EMDR within couples therapy to access and tolerate previously disowned emotions. They also noted that both clients and therapists must demonstrate the ability to tolerate intense emotions. These are consistent with the current findings; however, the emphasis on therapist having an integrative approach that balances individual and systemic dynamics and that

emphasizes personal responsibility is unique to this study. Furthermore, previous research did not emphasize the importance of therapists having sufficient experience and competence in EMDR and couples treatment.

Moses (2003, 2007) highlighted the importance of assessing each member's sincerity and commitment to working on their relationship prior to initiating EMDR within the couples therapy context. This condition was supported by the participants in the current study. Moses also identified the principles of safety, balance, and containment as necessary conditions before proceeding and argued that therapists must weigh the risks and benefits with members of the couple. Safety consists of ensuring client stability to cope with the emotional material that may emerge during sessions, following the EMDR protocol, and an agreement within the couple to limit deeper emotional processing to sessions rather than attempting to do so between sessions. Moses recommended ensuring balance by having both members of the couple participate in EMDR to prevent one from taking on the "identified patient" role. Finally, providing containment involves thoroughly assessing both members' internal and external resources, developing resources when appropriate, supporting the witnessing partner to take on the role of a container for the working partner (e.g., holding the partner's hand, if mutually desired), providing the opportunity for closure at the end of each session, limiting each person's processing to two or three sessions at a time, and being accessible to clients between sessions if necessary (Moses, 2003, 2007). Each of these conditions is consistent with the current findings.

The current study supported Shapiro's (2005) identification of the following factors as important in the assessment process: safety, differentiation, ability to provide

support, self-soothing skills, ability to tolerate difficult emotions and traumatic material, characterological traits, therapeutic alliance, and partners' understanding and consent to participate in conjoint EMDR. Given that these previous studies did not include systematic research that included both therapists' and clients' perspectives, the current study offers validation for those recommended conditions in contributing to positive outcomes for conjoint EMDR. Several other influential conditions from the current study extend previous research and are highlighted below. The areas of assessment for the witnessing partner include (a) general intra- and interpersonal functioning; (b) trauma history; (c) stability and resources, including the ability to provide silent support to one's partner, capacity to self-soothe, sufficient differentiation to not personalize material, tolerance for intense affect, and ability to inhibit any desire to interrupt the partner's process; (d) knowledge of partner's trauma history; and (e) support and safety including not using the partner's disclosures in retaliation and not challenging the validity of the partner's experience.

Several elements related to intra- and interpersonal functioning went beyond previous findings. Participants noted the importance of evaluating attachment security, level of hostility and anger, investment in personal change, and degree of differentiation in anticipating the progress of conjoint eye movement desensitization and reprocessing (EMDR). All participants reported positive outcomes from conjoint EMDR; however, the working members of couples who were most angry, invested in their partner's change rather than personal growth, highly fearful about the dissolution of their marriage, and overly anxious about their partner's reaction or dependent on external validation demonstrated the least amount of positive change. Though previous research (Moses,

2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Shapiro, 2005) highlighted the importance of assessing stability and resources of each partner, the current study suggests that clients who rely on alcohol or their partner to soothe, distract, or numb their emotions may benefit less from conjoint EMDR. Therapist participants in this study also emphasized the importance of being familiar with the witnessing partners' trauma history in order to anticipate how witnessing their partner's processing of traumatic material may impact them and to prevent the witness from being triggered by learning new information. This factor was unique to the current study.

Finally, relationship variables identified as important to the assessment process include (a) general relational functioning including safety and respect, interlocking trauma reactions and interpersonal reactivity, level of differentiation, and relational dynamics (e.g., withdrawer/pursuer); (b) ability and willingness to follow expectations; (c) level of engagement in therapy; (d) alignment of goals (e.g., focusing on personal change rather than changing the partner); and (e) strength and commitment within the relationship. These themes were consistent with previous research (Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Shapiro, 2005), though the current study resulted in several considerations that extend prior literature. Though interpersonal reactivity is an indication for conjoint EMDR that has been noted within existing research (D'Antonio, 2010; Moses, 2003, 2007), the current study suggests that volatile reactivity may also serve as an obstacle to conjoint EMDR. For example, if partners are so hostile with one another that there is insufficient respect, trust, and safety to engage in EMDR together, therapist participants noted that individual EMDR may be more appropriate.

Furthermore, the current study pointed to the value of assessing the repeating patterns and roles that occur within the relationship. For example, if there is a withdrawer-pursuer dynamic that recurs within the couple, the therapist may anticipate that such a dynamic is likely to occur within the therapy room and during the conjoint EMDR process. Similarly, the data from the current study suggest that it is also worth noting the value of dysfunctional interpersonal dynamics for members of the couple in order to anticipate potential resistance to changing such dynamics. Those who gained less benefit from conjoint EMDR within the current study were those ambivalent about change and about reducing the intensity of their emotional reactivity, likely because it served them in some way. Thus, assessing the way in which their patterns are purposeful and the potential resistance to changing them may be valuable in anticipating obstacles to the conjoint EMDR process. Thus, the assessment procedures guide the next steps in terms of the degree and type of preparation that is necessary for each member and the couple as a whole prior to engaging in conjoint EMDR, if determined to be indicated. The value of assessing these dynamics in guiding preparation extends previous literature.

### **Contextual Factors**

Context consists of a particular set of properties or circumstances within which the phenomenon being studied (in this case, EMDR within conjoint couples therapy) occurs. In the current study, contextual factors for the participants included their previous familiarity with EMDR, the roles taken on during the conjoint EMDR process by each member, and the reasons for referral that resulted in their initiating couples therapy. Previous familiarity with EMDR varied among participants; several participants had previously engaged in individual EMDR, others had participated in EMDR individually

with the therapist who subsequently became the couples' therapist, and the remaining participants had no previous experience with EMDR. Partners of those who had previously engaged in EMDR had some level of familiarity based on the information shared by their partner.

The degree of familiarity with EMDR served as both a contextual and an influential factor, as it impacted the type and extent of assessment and preparation required for those clients. Moses (2003, 2007) identified balance as one of the necessary conditions before conducting conjoint EMDR. He recommended creating balance through having both members of the couple participate in EMDR in order to prevent one partner from becoming the "identified patient." However, the importance of considering previous familiarity with EMDR to provide balance in terms of preparation and initiation of conjoint EMDR (e.g., which partner takes on the working role first) extends previous literature (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007), which has not addressed the situation in which one of the members had previous experience with EMDR.

The current study suggests that when one partner is less familiar with EMDR (e.g., his or her partner previously engaged in individual EMDR with their couples' therapist), he or she may benefit from more preparation (e.g., psycho-education about EMDR, each partner's role, and what to expect during the process) and from taking on the witnessing role first as methods of ensuring balance. Furthermore, preparation should include anticipating the benefits and the potential challenges of engaging in conjoint

EMDR for each partner as well as how doing so conjointly might be different than individually. It may also be beneficial for the partner who has more familiarity with EMDR to share his or her experience with the partner who has not engaged in EMDR as part of preparation. Several partners with no previous familiarity with EMDR wished they had had more preparation and better understanding of what to expect from EMDR prior to taking on the working role themselves.

Most participants took on both the working and the witnessing roles during conjoint EMDR; however, for one couple (Huck and NyxRN), only one partner engaged in EMDR. Furthermore, at the time of the interviews, one other couple (Ursula and Algernon) had consisted of only one working partner, but they were intending to change roles in future sessions. Most of the existing literature (e.g., Flemke & Protinsky, 2003; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Shapiro, 2005; Talan, 2007) included couples in which both partners engaged in EMDR and both served as the witness to the other's EMDR. However, in their study, Capps et al. (2005) had a consultant join the couple and primary therapist to incorporate EMDR with conjoint couples therapy for one session.

In another article, Capps (2006) presented three case studies in which EMDR was incorporated into experientially based Gestalt therapy with couples in a single session to address relational trauma. He utilized EMDR with the "traumatized partner" and Gestalt therapy for the "supportive partner." Litt (2008) noted that at times, conjoint sessions may be appropriate for one partner but not both, and he observed that both partners need not be ready to engage in EMDR with the partner present, which contrasts with Moses' (2003, 2007) principle of balance through the engagement of both partners in EMDR.

However, Litt did address this need for balance and stated that it can be accomplished by developing a plan with the excluded partner when EMDR is provided individually to one partner, to promote the engagement of both partners throughout the therapeutic process. Litt (2010) recommended applying EMDR to both partners whenever possible. The current study was unique in its inclusion of couples in which both partners engaged in conjoint EMDR as well as couples in which only one member took on the working role.

Finally, the reasons for referral were varied for participants within this study and included infidelity, volatile conflicts, a motor vehicle accident, and military combat. Several of the participants were noted to have met criteria for PTSD at the beginning of treatment. Previous studies (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007) included a variety of presenting issues (e.g., childhood trauma, attachment injuries within the current relationship, infidelity, war trauma), and targeted attachment wounds and traumatic events from both within and outside of the current relationship, similar to the current study. Thus, the present findings provide support to the existing literature about the value of conjoint EMDR for a broad range of small “t” and big “T” traumatic events.

### **Phenomenon: Conjoint Eye Movement Desensitization and Reprocessing**

This section includes an outline of participants’ experience of phases four through seven of the standard eye movement desensitization and reprocessing (EMDR) protocol (desensitization, installation, body scan, and closure) as it relates to conjoint EMDR. The central category of the phenomenon that emerged from the data is that trauma is both



experienced and healed relationally. This core theme is discussed further below and related to previous literature.

### **Intervening Conditions: Preparation and Re-Evaluation**

Participants identified several preparatory and re-evaluation procedures within their conjoint EMDR treatment as beneficial. The seven conditions for effective preparation are included here. The first involves introducing EMDR early while building an alliance and emphasizing the ongoing impact of the past on clients' current functioning. Thus, clients are exposed to EMDR language and concepts from the beginning. Furthermore, both the therapist and the couples recognize the negative cognition(s) related to past trauma that continue(s) to play a role. The second condition is providing psycho-education to couples. This education includes the impact of trauma, the role of EMDR in trauma resolution, the EMDR process, and research on EMDR. It also involves sharing material with clients to do further research about EMDR. The third condition includes presenting the potential benefits and obstacles to engaging in conjoint EMDR.

The fourth condition is a review of expectations and requirements for both partners, including those identified in the assessment section. The fifth is empowering couples in decision making, such that couples are provided with choices regarding (a) whether to engage in EMDR or not and whether to do so individually or conjointly, (b) the type of bilateral stimulation, (c) the timing of EMDR, (d) which partner will take on the working role first, and (e) the target. The sixth preparation condition identified by participants includes conjoint resource development and installation, depending on the stability and previous experience of the clients. The final condition for preparation is a

discussion of ongoing processing outside of sessions. This includes informing the working partner about processing that continues after EMDR as well as decision making about whether members will engage in verbal processing about the conjoint EMDR process or container the material in session. Many of these specific steps are unique to conjoint EMDR and extend past literature (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007) including the emphasis that participants placed on the timing and nature of how conjoint EMDR is introduced to the couple, the value in building familiarity with the concepts of EMDR, the ongoing impact of the past on present dynamics, explicitly identifying the potential benefits and obstacles of the process, and a discussion regarding whether and/or how to discuss EMDR between sessions.

Participants identified three re-evaluation conditions. First, the EMDR process is assessed during initial and ongoing sessions, with the option of returning to the preparation stage if needed. Second, therapists must be attuned to the needs of partners in the moment, including body language, in-session reactivity, and triggers between sessions. Finally, therapists should facilitate post-EMDR debriefing by each partner. Verbal processing of the conjoint EMDR experience at the end of each session and in future sessions provides a balance between individual and systemic dynamics. The emphasis participants placed on each of these conditions is unique to the current study.

## **Actions and Interactions**

The process of conjoint eye movement desensitization and reprocessing (EMDR) varied significantly across participants, depending on a number of factors. The variability was primarily in the length, speed, amount, and frequency of EMDR, as well as in the targets that were reprocessed for each participant. Beyond these individual differences, participants identified several common themes related to their experience of conjoint EMDR, including actions and interactions. Those shared categories include the following for both members of the couples: (a) unexpected directions and insights; (b) indirect communication (conjoint EMDR served to mitigate the intensity of an intimate encounter); and (c) power of EMDR versus verbal processing (described as exhausting but providing a sense of comfort). Though these themes may not be surprising to EMDR therapists, they extend past research on conjoint EMDR (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007).

The following themes were noted for working partners about their conjoint EMDR experience: (a) initial skepticism, (b) powerful and meaningful process, and (c) building a bigger picture. The latter theme included increased understanding of the impact of the past on the present, new insights, and parallels between past and current relationship dynamics. The following categories were identified for the witnessing partners: (a) providing support and grounding to partner; (b) intuitive awareness of partner's needs; (c) initial skepticism and bewilderment; (d) impact of witnessing emotional expression in session; (e) admiration, respect, and empathy for partner; (f)

vicarious healing and shared journey; and (g) “eye opening.” These themes were consistent with previous literature (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007) and with the findings from the pilot study.

Finally, when participants were asked about obstacles experienced during conjoint EMDR, almost all denied any or noted that when they did occur, they served as “grist for the mill.” However, several obstacles were experienced, though participants received benefit from the process nonetheless and were grateful for having engaged in conjoint EMDR. The following obstacles were noted: (a) over-focus on partner and external factors (e.g., performance anxiety, distracted by the partner, and preoccupation with the outcome); (b) initial reluctance to experience and share vulnerability; and (c) initial reactivity by witnessing partner during or directly following conjoint EMDR. The first of these themes was unique to the current study, extending previous research (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007) related to EMDR within couples therapy. That theme is discussed further below and related to previous literature.

### **Consequences**

Participants identified numerous benefits from their conjoint eye movement desensitization and reprocessing (EMDR) experience, both individually and relationally, and no negative consequences were noted. Working partners observed the following

outcomes of the conjoint EMDR process: healing trauma (including a decrease in trauma symptoms), increased self-worth, and decreased self-blame. Several relationship and individual consequences were commonly noted by both partners across multiple couples: (a) high levels of satisfaction and changes on outcome measures; (b) increased differentiation; (c) reduced interpersonal reactivity; (d) increased empathy, compassion, and depth of intimacy; (e) increased understanding of self, partner, and relational dynamics (including how the past influences their present, the impact of their own behavior on others, how to support their partner, and resulting motivation to change their own behavior); (f) increased ability to intervene in cycle; (g) increased commitment and hope; (h) increased communication; and (i) increased happiness and enjoyment. These consequences are consistent with findings noted within existing literature (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007).

### **Summary of the Grounded Theory**

Eye movement desensitization and reprocessing (EMDR) in Conjoint Couples Therapy: Relational Trauma Treatment Theory illustrates the phenomenon of conjoint EMDR among couples and therapists who participated in this treatment process. The theory highlights that trauma is experienced relationally and that healing from trauma also occurs relationally. It suggests that conjoint EMDR can provide a corrective experience for both members of couples, resulting in numerous positive changes on both individual and relational levels. The theory incorporates specific assessment and

preparation guidelines, based on several contextual factors. The common themes noted by participants about their conjoint EMDR experience are included.

### **Discussion**

The limited research to date that has explored the use of eye movement desensitization and reprocessing (EMDR) treatment within a couples therapy context (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007) suggests numerous benefits to both the working and the witnessing partners. Protocols have also been presented for the assessment and preparation for conjoint EMDR (Errebo & Sommers-Flanagan, 2007; Litt, 2008, 2010; Moses, 2003, 2007; Talan, 2007); however, no systematic research has been conducted to include the perspectives of both members of couples as well as the therapists who participated in this treatment. In this section, the current findings are related to the existing literature.

### **Trauma is Relational**

One of the primary themes from the participants' interviews is the relational nature of their traumatic experience and the ongoing impact of that trauma on current relationships. Participants repeatedly identified issues related to safety, trust, and attachment, as well as the power of healing that occurred within the relationship with their partner. Perry and Szalavitz (2006) highlighted the power of human relationships in both harming and healing one another: "Fire can warm or consume, water can quench or drown, wind can caress or cut. And so it is with human relationships: we can both create and destroy, nurture and terrorize, traumatize and heal each other" (p. 5). Similarly,

Flemke and Protinsky (2003) state, “We are born into relationship, we become wounded in relationship, and we heal within relationship” and that “we exist within relationship at all times” (p. 32). Johnson (2008) noted that trauma is always a couple’s issue.

**Attachment and intimacy.** Nine of the 14 client participants in the current study had suffered the impact of attachment wounds early in life, which were repeatedly triggered within their current relationships, both by daily interactions and by more significant traumatic events such as infidelity. Though no attachment interviews or questionnaires were completed by participants, therapists identified several of the client participants as having an insecure attachment that impacted their tolerance of and response toward intimacy. This is relevant to conjoint EMDR, given the number of authors within the research literature that have observed enhanced intimacy through EMDR within couples therapy (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Protinsky, Flemke et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996). Moses (2003) highlighted the value of conjoint EMDR for couples “who need the safety of a structure to rapidly process the triggers from attachment injuries that block the closeness in the relationship” (p. 6), resulting in increased intimacy.

There has been controversy regarding the stability and nature of attachment patterns from infancy to adulthood (Fraley, 2002; Fraley, Vicary, Brumbaugh, & Roisman, 2011; Hazan & Shaver, 1987; Steele, Waters, Crowell, & Treboux, 1998). Though there is considerable agreement about the influence of early caregiver experiences on adult relationships, researchers disagree about the source and degree of this connection (Fraley, 2002; Fraley et al., 2011; Hazan & Shaver, 1987; Steele et al., 1998). Most research has been cross-sectional or retrospective in nature, thereby limiting

the confidence with which inferences that can be made across time. For example, Fraley (2002) demonstrated a modest correlation between the amount of security individuals reported toward their mothers and that toward their romantic partner (ranging between .20 and .50). In a retrospective study, Hazan and Shaver (1987) found that adults who were securely attached with their romantic partner had more positive childhood recollections of their parental relationships, tending to describe their parents as affectionate, caring, and accepting.

One unpublished longitudinal study examined the relation between security at one-year of age in the strange situation to the security within adult romantic relationships for the same individuals 20 years later and found a correlation of .17 (Steele et al., 1998). Overall, research suggests at most, a moderate relation between attachment styles from childhood and those in adult romantic relationships, but one that is fairly stable. Fraley et al. (2011) examined two models of continuity and change within two longitudinal studies in an attempt to understand the mechanisms underlying the stability of adult attachment over time. Their analyses provided support for a prototype model, suggesting that individual differences in attachment are partly determined by specific information processing and behavioral strategies that develop in childhood and serve as a means of adapting to that early environment. This model proposes that these mechanisms remain fairly stable over time, such that representational models of self and others developed in the first few years of life are preserved and play a role in future attachment relationships.

More recent research has demonstrated that individuals who experienced emotional neglect during childhood are, in fact, often impacted in terms of their attachment style as adults (Johnson, 2002; Perry, 2009; Schachner et al., 2003;



Wesselmann & Potter, 2009), which may contribute to later difficulties within intimate relationships. In order to re-establish a sense of security within relationships, healing from the attachment injuries experienced earlier in life must occur within the context of a nurturing relationship (Alexander, 2003; Herman, 1997; Johnson et al., 2001). Eye movement desensitization and reprocessing (EMDR) has been demonstrated to increase the attachment bond between partners as well as between children and their parents (Moses, 2007; Protinsky, Sparks et al., 2001; Wesselmann & Potter, 2009), as individuals process through attachment-related trauma. Wesselmann and Potter (2009) presented three case studies in which participants who engaged in EMDR treatment experienced increased attachment security. However, their study involved EMDR applied individually and not within the context of conjoint couple sessions. Thus, the current study extends their findings to the couples therapy context.

Individuals' capacity to tolerate intimacy can be impacted by traumatic experiences as well as mediate their response to trauma (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012; Turner et al., 2007). Turner et al. (2007) noted the varying levels of tolerance for intimacy within trauma survivors:

Independent of the trauma that brings an individual to treatment, different people have different capacities to tolerate...intimacy. This ability is an important determinant not only of the success of treatment, but also of the individual's initial reaction to the trauma...Intimacy involves a capacity to relate to oneself and others in a modulated and open manner. This potential for intimacy is primarily an ability to tolerate one's inner world and the contradictions it presents. Withdrawal from intimacy in personal relationships is one of the more enduring effects of trauma. (pp. 538-539)

Survivors of trauma experience contradictory feelings regarding intimacy, both desperately craving close connection to others while simultaneously withdrawing from such relationships (Briere & Scott, 2006; Herman, 1997; Johnson, 2002, 2008; Pearlman

& Courtois, 2005; Turner et al., 2007). Relationships are tested as they require tolerance of survivors' oscillating need for closeness and withdrawal (Herman, 1997; Pearlman & Courtois, 2005). The importance of one's ability to tolerate intimacy in the success of couples therapy noted by Turner et al. (2007) highlights the distinct value of conjoint EMDR for clients whose trauma history resulted in difficulty tolerating intimacy.

Bill noted that conjoint eye movement desensitization and reprocessing (EMDR) "mitigates the intensity of an intimate encounter;" thus, it seems to provide an advantage as a couples therapy intervention in that it both increases the intimacy experienced between partners while simultaneously serving to increase partners' tolerance of the intimacy experienced during the process. Previous research (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Protinsky, Flemke et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996) has consistently found that conjoint EMDR increases intimacy between partners. Shapiro (2001) referred to bilateral stimulation (such as eye movements) as a method of providing dual awareness or attention. Shapiro's adaptive information processing model proposes that bilateral stimulation results in decreased attention on the primary task of thinking about the upsetting memory, thereby decreasing the vividness and emotionality of the memory, and integrating it from working memory to long-term memory (Schubert & Lee, 2009; Shapiro, 2001). Several studies have shown a decrease in arousal based on physiological measures during EMDR when accessing distressing memories, suggestive of an orienting response and paralleling the physiological characteristics of REM sleep (Schubert & Lee, 2009). Thus, bilateral stimulation is a method of grounding or maintaining "one foot in and one foot out" of the traumatic event, such that it is not overwhelming (Shapiro, 1989, 2001). Eye movement

desensitization and reprocessing within couples therapy seems to offer a similar benefit to couples who would otherwise be overwhelmed by the intimacy of couples therapy.

Several of the current participants noted the value of targeting a childhood traumatic event that paralleled issues within their intimate relationship. Choosing a target that is external but related to their relationship seems to reduce the intimacy and the reactivity that might otherwise accompany such processing. This distance appears to increase the likelihood that the witnessing partner will remain present and gain the resulting awareness, insight, and empathy that participants reported to have achieved. The current study suggests that one unique benefit of conjoint EMDR is the balance of deepening intimacy, understanding, and compassion along with the mitigation factor and indirect communication that serve to increase the safety in such a vulnerable encounter, particularly for those with insecure attachment.

Several factors increase the resiliency of individuals to the impact of trauma, including a strong social network, a thoughtful and active coping style, and an internal locus of control (Herman, 1997; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). It is through attachment relationships that humans develop a sense of self as worthy, lovable, and competent (Bowlby, 1969; Johnson, 2002; Pearlman & Courtois, 2005; Wesselmann & Potter, 2009). Research has demonstrated that individuals with secure attachment have higher self-efficacy (Johnson, 2002). Alexander (2003) examined the healing power for both trauma survivors and their significant other when the partners of trauma survivors served as a witness to their spouse's trauma narrative.

Alexander (2003) stated: "The negative self-construal associated with many individuals' experience of abuse appears to mediate many of the long-term effects" (p.

349). Many participants within the current study endorsed feelings of inadequacy and shame at the beginning of therapy and reported increased self-worth as well as decreased shame following conjoint EMDR. Alexander pointed to the connection between shame and attachment insecurity, such that “the self is considered unlovable and unentitled, making it very difficult to either express needs or to accept the nurturing of others” (p. 349).

Alexander’s (2003) observations are consistent with the current findings that following conjoint EMDR, individuals are more emotionally available and differentiated, allowing them to give and receive caring more freely. However, it is worth noting that in spite of improved relationship satisfaction and security within the relationship, several participants with high levels of initial attachment insecurity continued to experience anger and betrayal toward their partner; these feelings seemed to serve as a means of maintaining a connection to their partner and as a sense of control. Thus, it appears that attachment security may play a mediating role in one’s response to conjoint EMDR, particularly with respect to changes in intimacy, caring behavior, and vulnerability with one’s partner, but this is an area that warrants further investigation. Such a hypothesis is consistent with existing literature, which demonstrates that attachment insecurity creates difficulties in partners’ ability to emotionally engage with and respond to their significant other (Gottman, 1994; Johnson et al., 2001; Pearlman & Courtois, 2005).

Attachment insecurity also contributes to partners’ tendency to become absorbed in negative affect and engage in constricted interactions such as criticism, defensiveness, and withdrawal, all of which are predictive of divorce (Gottman, 1994; Johnson et al., 2001; Pearlman & Courtois, 2005). Research supports the premise that the expression of

underlying needs and feelings as well as modifications of interaction patterns promote increased emotional accessibility and responsiveness (Johnson et al., 2001). Research on EFT has demonstrated that such interactions are correlated with decreases in marital distress (Schachner et al., 2003).

According to studies on adult romantic relationships and attachment styles, partners who are securely attached have longer, more stable, and more satisfying relationships with high commitment, interdependence, trust, and friendship, and describe relatively selfless style of love without game playing (Makinen & Johnson, 2006; Schachner et al., 2003). Furthermore, they describe more openness to sexual exploration with a single long-term partner, frequent engagement in physical contact, and mutual initiation of sexual intimacy (Schachner et al., 2003). They are happier and are more likely to seek out and provide support to others, are better able to articulate their needs, and are less likely to become verbally aggressive or to withdraw during problem solving activities (Johnson, 2002). These findings support the value of conjoint EMDR in increasing differentiation through positive changes in attachment security within one's intimate relationship.

Johnson (2002) noted that "negative attachment-related events, particularly abandonments and betrayals, often cause seemingly irreparable damage to close relationships" (p. 181). Such attachment injuries become a recurring theme within the relationship that interferes with partners' ability to create emotional connection and to repair their relationship. In fact, they can result in severe marital distress and lead to rigid interactional patterns such as attack-defend or pursue-distance (Makinen & Johnson,

2006). Attachment injuries are “characterized by an abandonment or betrayal of trust during a critical moment of need” (Johnson et al., 2001, p. 145).

This concept of attachment injury is based on observations of impasses in couples therapy where relationships improved but remained distressed (Johnson et al., 2001). Greenberg and Johnson (1988) observed during these sessions that when the more withdrawn partner became more emotionally available and the more blaming partner began to take risks through self-disclosure, “an emotionally laden incident, often first described in the beginning of therapy, would become the focus of the session” (Johnson et al., 2001, p. 146). They noted that such events would be replete with intense emotion, seeming to parallel a traumatic flashback and overwhelming the injured partner; often the wounded partner described having emotionally shut down and withdrawn from the relationship at the time of this injury. Furthermore, they observed that injured partners would use terminology that highlighted the traumatic meaning behind the incident, such as isolation and abandonment (Johnson, 2002). Several participants in the current study had experienced significant attachment injuries within their relationships, such that they experienced their partner as failing to respond at times of urgent need or as betraying their trust. Thus, it is understandable that partners would be hesitant to risk being vulnerable after such an experience.

Individual differences in attachment exacerbate or attenuate PTSD symptoms in traumatized individuals and their spouses (Ein-Dor et al., 2010). A review of PTSD studies found that perceived lack of partner support before and after a traumatic event is one of the most important factors determining vulnerability to PTSD (Ein-Dor et al., 2010). Ein-Dor et al. (2010) examined the role of ex-POWs’ and their wives’ attachment

insecurities in the long-term repercussions of war captivity, and found associations among attachment-related dyadic processes, posttraumatic stress disorder in war veterans, and secondary traumatic stress (STS) in their wives. Specifically, they noted that anxious attachment is implicated in both PTSD and STS. Though intimate relationships appear to be highly influenced by one's early attachment experiences, adult intimate relationships can also provide a corrective experience and thereby attenuate the impact of such early experience.

This finding supports the theory that differences in response to conjoint EMDR may therefore be at least partly related to differences in attachment. Research shows that adult attachment impacts how individuals process attachment information, regulate their emotions, and communicate with others, as well as what is accessible to memory (Alexander, 2003; Johnson, 2002; Johnson et al., 2001; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). These are also areas of functioning impacted by EMDR (Shapiro, 2001). Consistent with these findings, the current study found that for individuals who had experienced trauma as well as those with attachment injuries, conjoint EMDR resulted in decreased reactivity, improved communication, greater relationship satisfaction, and deeper intimacy.

The sense of connection and support are essential for recovery and healing from trauma. The impact of early attachment disruptions on current levels of depression has been found to be moderated by one's current primary attachment relationship and current relationships have been found to mediate the impact of trauma. For example, the prognosis for survivors of 9/11 who were near the World Trade Center was highly correlated to their use of social support (Johnson, 2008). Fraley and his colleagues (2006)

found that 18 months after the attack, those who felt securely attached to loved ones had fewer flashbacks, and less irritability and depression than those who did not reach out to their social support network. In fact, according to friends and family of the survivors, those who were securely attached appeared to have grown from the experience and became better adjusted. Close attachment bonds are particularly important for increasing resiliency to trauma, improving emotion regulation, and contributing to an integrated sense of self (Johnson, 2002; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). This existing literature and the current study emphasize the increased healing benefit of including one's partner in the treatment of traumatic events not only in trauma recovery and relationship enhancement, but also in increasing resiliency for future stressors.

**Over-focus on partner and external factors.** All client participants shared their appreciation for their conjoint EMDR experience and noted both individual and relational benefits. However, those who seemed to have the most ongoing reactivity within their relationship were those who were overly focused on their partner or on other external factors, such as the potential outcome of the conjoint EMDR process. These findings are consistent with research about attachment insecurity.

Attachment-related anxiety is the extent to which persons worry about the unavailability of their partner at times of need and depend on hyperactivating attachment behavior and distress regulation strategies in response to threats (Ein-Dor et al., 2010). In contrast, attachment security involves comfort with closeness and trust in the availability, responsiveness, and supportiveness of one's partner (Ein-Dor et al., 2010). Individuals with high anxiety and low avoidance are hypervigilant toward and preoccupied with their partners, describe low relationship satisfaction, and have higher relationship dissolution



rates (Schachner et al., 2003). They tend to worry about abandonment and are more jealous than their secure counterparts (Johnson, 2002).

Similarly, those high in attachment avoidance also report low relationship satisfaction and high breakup rates, but in contrast to those with high anxiety, they also experience low levels of intimacy (Schachner et al., 2003). They tend to be distrustful of their partners and are distant, resisting any dependence on their partner and withdrawing when their partners are most vulnerable and in need of support (Johnson, 2002). Finally, individuals who are high on both the avoidance and the anxiety dimensions tend to demonstrate similar emotional vulnerability and preoccupation as anxious partners while behaviorally exhibiting more avoidance, tending to withdraw from closeness. Research has demonstrated that this fearful avoidant style is related to parental alcoholism and abuse (Pearlman & Courtois, 2005; Schachner et al., 2003).

Several authors (Alexander, 2003; Johnson, 2002, 2003a, 2008; Sherman et al., 2005) emphasize the value of couples therapy in increasing trauma survivors' affect regulation within their primary relationship, the context in which attachment-related insecurities become triggered. Using EFT with trauma survivors and their partners has been found to be effective for increasing affect tolerance and regulation, as well as increasing intimacy among partners and rebuilding a sense of self among survivors (Alexander, 2003; Johnson, 2002). Research on the effectiveness of EFT is consistent with findings about the benefits of conjoint EMDR in existing literature (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Protinsky, Flemke et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996) and within the current study in deepening affect, increasing empathy and understanding, reducing interpersonal reactivity,

enhancing intimacy, and increasing differentiation among both partners, as well as healing trauma, increasing self-worth and decreasing self-blame for the working partner. The current study extends past literature (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Protinsky, Flemke et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996) by providing information about the factors and conditions related to positive outcomes within conjoint EMDR, including sufficient attachment security, investment in personal change, and differentiation to remain open during EMDR with one's partner present.

According to findings from this study, participants strongly invested in changing their partners and who were ambivalent about decreasing the intensity of their own feelings (particularly anger) related to partner betrayal perceived such a decrease as a potential threat to their attachment. Schachner et al. (2003) noted the relation between attachment and preoccupation with one's partner: "People who are insecurely attached exhibit different patterns in intimate relationships. Those high in anxiety and low in avoidance tend to become vigilant toward and preoccupied with their romantic partners" (p. 26). Participants who relied on external validation and who had an external locus of control were likely fearful that decreasing the intensity of their own emotional response could reduce the likelihood that their partner would maintain or continue the positive changes in their attachment behavior.

Participants who were overly focused on their partner (and whose preoccupation suggests anxious attachment) tended to prefer the role of witnessing partner, which makes sense, given the reduced exposure and vulnerability within this position. Litt (2008), who proposed a treatment model to apply EMDR within couples therapy with an

ego state and contextual therapy approach, noted the value in engaging the “acting out” partner first when both are good candidates for conjoint EMDR. That is, he suggested that the partner who tends to destabilize the relationship be the first to participate in EMDR; thus, the “acting out” (and anxiously attached) partner is encouraged to experience a “softening event” (Johnson & Greenberg, 1995). Johnson and Greenberg (1995) describe “softenings” as bonding events during which an angry, blaming partner reaches out for and receives emotional responsiveness and availability from the other. Research has demonstrated that such interactions are correlated with decreases in marital distress (Schachner et al., 2003).

Thus, it may be that in spite of the tendency of certain clients to prefer the witnessing role, there is benefit to increase their participation within the working role in order to soften such individuals’ reactivity, increase their differentiation, and foster a more internal locus of control. Several authors have pointed to the benefit of conjoint EMDR for those who are highly reactive, have strong negative affect (D’Antonio, 2010), lack empathy or sensitivity toward the other, struggle with obtaining a “softening event,” are “stuck” in past attachment wounds, and personalize or project feelings onto their partner (Moses, 2003, 2007). Furthermore, research has demonstrated the value of conjoint EMDR in targeting secondary emotions, such as anger, that are triggered within current interactional patterns in order to allow primary emotions (such as hurt and fear) and previous traumatic memories to surface and be reprocessed (Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001).

However, engaging in conjoint EMDR as the working partner requires a willingness to relinquish former unhealthy ways of relating to oneself and one’s partner.

These issues relate to the importance of both partners having compatible goals for the therapy process, a criterion identified by several participants as essential to obtaining benefit from this treatment process. Participants also noted the importance of entering into conjoint EMDR with an open mind and a focus on their own change and healing process, irrespective of the outcome. For some, arriving at the point where they were sufficiently unhappy about the state of their relationship and in significant distress seemed to create the necessary motivation to invest in personal change such that they could “trust the process.” In such a state, they were willing to risk the possibility of losing their relationship and remain engaged in their own goals without having their partner’s presence distract her. This state seemed to differentiate those who obtained the greatest benefit from the conjoint EMDR process.

Protinsky, Flemke et al. (2001) highlighted the relation between acceptance and intimacy:

The paradox of acceptance is an important aspect of increasing intimacy. Letting go of attempts to change our partners paradoxically creates a context for change. There is an important caveat to this process. If partners have difficulty accepting themselves, they will have difficulty validating each other. (p. 160)

This is consistent with findings that those with an internal locus of control are more resilient to the impact of trauma than those with an external locus (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Johnson et al. (2001) pointed to the tendency for distressed couples to interpret one another’s behavior in a manner that further perpetuates dissatisfaction by making blameworthy and global attributions for their partner’s behavior, and remembering relationship events that are consistent with that negative schema. The current study highlights the paradox that conjoint EMDR facilitates increased differentiation that fosters intimacy and relationship satisfaction, but engaging

in such treatment requires willingness to risk an uncertain outcome. This finding was unique to the present study, extending existing literature related to conjoint EMDR.

**Simultaneous activation and corrective experience.** Several participants noted being activated by having their partner present during EMDR, given that the partner was often a trigger related to trauma. Participants also pointed to the value of having that “trigger” present during EMDR, while reprocessing traumatic experiences. Briere and Scott (2006) emphasized the importance of “counterconditioning” in the healing of attachment wounds and relational trauma, which they described as the simultaneous presence of both (a) activated trauma-related distressing memories and (b) the comfort and connection produced by the supportive therapeutic environment. Research supports the benefit of exposure to traumatic material in the treatment of PTSD within structured modalities. Chambless and Ollendick (2001) classify EMDR, stress inoculation, and exposure therapy as empirically supported treatments for PTSD. Trauma-focused cognitive-behavioral approaches (TFCBT) such as stimulus confrontation and cognitive restructuring have been found to be effective for posttraumatic symptoms (Seidler & Wagner, 2006). Methods such as prolonged in vivo and imaginal exposure to target the fear and anxiety components of PTSD have been particularly effective for rape victims (Johnson, 2002). Experiential and psychodynamic approaches have also been found to be effective for improving functioning and decreasing anxiety (Johnson, 2002).

Exposure and flooding techniques have been successful in reducing intrusive and hyperarousal symptoms; however, numbing and social withdrawal symptoms as well as difficulties in functioning within marital, social, and occupational areas are more resistant to such approaches (Herman, 1997; Johnson, 2002). Herman (1997) noted that

reconstructing the trauma is a necessary but not a sufficient factor in recovery, as it does not address the relational consequences of traumatic exposure. In contrast, survivor groups are a powerful context to address the shattered assumptions about oneself and the world to restore a sense of mutuality and connection to others; however, intrusive symptoms tend to remain unresolved with this treatment (Herman, 1997). Herman (1997) proposed that both group and individual therapy focused toward desensitizing the traumatic memory may be essential for complete recovery from trauma. Similarly, Pearlman and Courtois (2005) emphasized the importance of addressing developmental, relational, and PTSD symptoms in the treatment of trauma.

Briere and Scott (2006) propose that counterconditioning may provide a corrective emotional experience, which can increase one's ability to modify existing cognitive schemas. Eye movement desensitization and reprocessing (EMDR) serves these purposes; however, conjoint EMDR does so on multiple levels, such that clients are not only activating memories as they identify their target but they are also being activated by their partner's presence. None of the current participants reported having felt overwhelmed by the presence of their partner; thus, it appears that the level of activation experienced was in proportion to the sense of safety within the relationship and within their window of tolerance. This theme was unique to the current study, extending previous findings (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Protinsky, Flemke et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996).

**Relational trauma treatment.** To date, eye movement desensitization and reprocessing (EMDR) as an individual treatment modality with trauma survivors has been empirically validated in over 20 randomized controlled trials. For example, van der

Kolk, Spinazzola et al. (2007) conducted a randomized clinical trial of EMDR, Fluoxetine, and a pill placebo to compare their efficacy in the treatment of PTSD and the maintenance of those effects. The authors found that EMDR was more effective than both the medication and placebo to produce substantial and sustained reduction in PTSD symptoms.

Furthermore, at least six meta-analyses have demonstrated the effectiveness of EMDR in the treatment of post-traumatic symptoms. Maxfield and Hyer (2002) discovered that effect size was highly correlated with the methodological standards in EMDR efficacy studies, such that higher effect sizes emerged for studies that were more rigorously designed. Bisson and Andrew (2007) conducted a systematic review of 38 randomized controlled trials of psychological treatments for chronic PTSD. They found that TFCBT and EMDR showed benefits over waiting list or “usual care” therapies on most outcome measures of PTSD symptoms. They reported limited evidence for stress management and group cognitive behavioral therapy but “other therapies” (supportive/non-directive, psychodynamic, and hypnotherapies) appeared to be least effective, resulting in no clinically meaningful decrease in PTSD symptoms. These authors suggested that the treatments that focus on the disturbing memories as well as on the personal meanings of the event and its consequences appeared to be most effective, including TFCBT and EMDR. They found that direct comparison of TFCBT and EMDR did not result in significantly different treatment outcome or speed of therapeutic change.

As has been described, PTSD has significant effects on intimate relationships. For example, Kessler (2000) found that combat veterans experience higher rates of marital instability. Similarly, Jordan and colleagues (1992) discovered that Vietnam veterans

with PTSD had marriages twice as likely to end in divorce and they were three times more likely to have more than one divorce. Cook and colleagues (2004) found that former prisoners of war from World War II with PTSD experienced chronic problems such as poorer relationship adjustment and communication with significant others, and higher levels of difficulties with intimacy than those without PTSD. Research has demonstrated that emotional intimacy is negatively impacted for veterans with PTSD, perhaps due to emotional numbing, difficulty expressing caring, lower levels of self-disclosure and emotional expressiveness, sexual disinterest, impaired interpersonal problem-solving skills, and the emotional connection with loss and survivor guilt, all of which are increased for this population (Johnson, 2002).

Furthermore, partners of those with PTSD also report lower levels of relationship satisfaction. For example, Jordan et al. (1992) discovered that female partners of patients with PTSD were more likely to be unhappy with the relationship and to report relationship distress. Calhoun et al. (2002) similarly found that the partners of veterans with PTSD reported lower satisfaction, increased caregiver burden, and poorer psychological adjustment than did the significant others of veterans without PTSD. Furthermore, partners of trauma survivors may develop secondary traumatic stress (Figley, 1986), experiencing symptoms that mimic PTSD such as vivid mental images of their partner's trauma and avoidance of reminders (Ein-Dor et al., 2010). Thus, significant research demonstrates the impact of trauma on the survivor as well as the survivor's intimate partner.

Herman (1997) described the impact of trauma as "disempowerment and disconnection from others" and stated that recovery is therefore "based upon the



empowerment of the survivor and the creation of new connections” (p. 133). She emphasized that recovery cannot occur in isolation and requires the context of relationships, stating that, with relation to trust, autonomy, initiative, competence, identity, and intimacy, “just as these capabilities are originally formed in relationships with other people, they must be reformed in such relationships” (p. 133). Research demonstrates not only that trauma impacts connection to others but that attachment increases resilience to trauma (Briere & Scott, 2006; Johnson, 2002, 2008; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012; Turner et al., 2007; van der Kolk & McFarlane, 2007). As noted above, a review of PTSD studies found that perceived lack of partner support before and after a traumatic event is one of the most important factors determining vulnerability to PTSD (Ein-Dor et al., 2010). Strong attachment increases one’s ability to seek out and provide support to others, be less reactive when hurt by partner, and be more flexible and tolerant of ambiguity. Furthermore, those who have more secure attachment demonstrate higher levels of differentiation (Johnson, 2002, 2008).

Though individual therapy is the most often used modality to treat issues such as depression, anxiety, substance use, and eating disorders, couples therapy has been incorporated as an adjunct to individual therapy in recent years and has also been utilized as the primary modality (Johnson, 2002). Barlow and colleagues (1984) observed a significant increase in the success rate for clients when the spouses were included in treatment for anxiety--from 46 % to 82% (Cerney et al., 1987). Female survivors of sexual assault in couples therapy have been found to experience more reduction in

depressive symptoms than those in individual treatment, while both treatment modality groups had comparable decreases in PTSD symptoms (Johnson, 2002).

As Gottman's (1994) research demonstrates, the negative interactions of pursue-withdraw and criticize-defend significantly increase couples' risk of separation. Such behaviors are familiar to trauma survivors, as their trust in the safety of the world and their own self-worth is severely impacted. Even previously secure relationships can experience significant distress when one or both members of the couple experience a trauma. For those who have suffered early childhood abuse or neglect, such trauma may interfere with the attachment security necessary as a foundation for the establishment of future intimate relationships. Thus, trauma and attachment security go hand in hand, and are mutually reinforcing, where partners may repeatedly engage in rigid interactional patterns that can exacerbate the effect of the trauma (Johnson, 2002). Furthermore, vicarious trauma for the partner may further complicate the dynamics within the relationship and interfere with the healing of both partners and the reestablishment of security.

Given the effects of traumatic exposure on one's interpersonal relationships, the use of an interpersonal approach to healing is particularly appropriate. Johnson (2002) noted that for such clients, even more powerful than the corrective emotional relationship with the therapist is that opportunity within the relationship with the client's intimate partner. The reports of participants in the current study demonstrates that addressing traumatic exposure in conjoint couples therapy involving EMDR serves the functions of attending to posttraumatic symptoms, increasing the intimacy and security of the

relationship, and addressing relationship dynamics that were created as a result of the PTSD.

Alexander (2003) noted the power of having one's partner present to hear and witness the telling of one's trauma story in the process of healing, recommending that telling one's story always be a part of couples therapy. Both witnessing and working partners in the current study pointed to the value of this conjoint process in increasing intimacy, empathy, differentiation, and understanding. Errebo and Sommers-Flanagan (2007) observed that combining EMDR and EFT for veterans and their spouses achieved the goal of obtaining the most comprehensive treatment effects within the shortest amount of time possible, while fostering stability within both the client and the client's system, a goal noted by Shapiro (2001).

Experiential couples therapy approaches such as EFT have been empirically validated and found to be effective in increasing attachment security and dyadic adjustment in couples (Errebo & Sommers-Flannagan, 2007; Makinen & Johnson, 2006). One of the demonstrated benefits of EFT as a couples therapy intervention is addressing the interactional patterns that tend to be self-reinforcing and difficult to extinguish such as blame/pursuit and withdrawal/distance (Johnson, 2002; Johnson et al., 1999). Emotionally focused couples therapy (EFT) has been shown to be one of the most effective treatments for reducing marital distress and to promote continued improvement even after the termination of treatment (Johnson et al., 1999; Schachner et al., 2003).

Emotionally focused couples therapy appears to have a higher success rate than other approaches with empirical support and lower rates of relapse (Johnson et al., 1999, 2001). Research on EFT has demonstrated a very large effect size of 1.3, and studies have

shown that between 70 and 75% of couples report that they are no longer distressed after 10 to 12 sessions, with 90% rating themselves as “significantly improved” (Johnson, 2003a, 2008; Makinen & Johnson, 2006). Research supports the premise that the expression of underlying needs and feelings as well as modifications of interaction patterns promote increased emotional accessibility and responsiveness (Johnson et al., 2001).

The changes demonstrated by couples who participated in EFT parallel those who engaged in conjoint EMDR, another experiential treatment that has been applied to trauma survivors, including deepening affect, increased empathy, enhanced intimacy, and increased differentiation (Capps, 2006; Capps et al., 2005; Flemke & Protitsky, 2003; Protitsky, Flemke et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996). Participants in the current study identified reduced interpersonal reactivity and increased stability within the relationship as outcomes of conjoint EMDR. Moses (2007) highlighted the value of conjoint EMDR in that each partner revisits past injuries, serves as a compassionate witness, vicariously experiences the partner’s pain, and becomes more attuned to the other, thereby modifying old narratives to become more loving. Participants in the present study repeatedly noted such changes within their relationships. It was evident from their reports that there was an increase in the perception of the relationships as a secure base. Conjoint EMDR seemed to allow the partner to serve as that secure base within the sessions rather than the therapist having that central attachment role, as in individual therapy.

An interesting pattern among the couples that emerged during this study involves the similar interpersonal dynamics that occurred during conjoint EMDR as within their

relationship as a whole. That is, partners who tended to be overly focused on their partner, to take on the “pursuer” role, to be overly controlled, to withdraw, or to engage in caretaking seemed to take on such roles within conjoint EMDR, behavior that suggests anxious attachment (Johnson, 2002; Schachner et al., 2003).

Within conjoint EMDR, such interpersonal dynamics also emerge during the therapy process and EMDR allows reprocessing of unresolved traumatic wounds that contribute to these patterns. This parallels Briere and Scott’s (2006) emphasis on “counterconditioning” in the treatment of trauma, such that clients reprocess material that is triggered within the session. Moses (2003, 2007) observed that when attachment injuries from within or outside of the current relationship are targeted during conjoint EMDR, interactional patterns move toward increased intimacy and healthy attachment processes, moving beyond impasses that often emerge during traditional couples therapy. In the current study, conjoint EMDR increased participants’ awareness of interpersonal patterns within the couple’s relationship, allowed the opportunity for vicarious healing, fostered increased intimacy and compassion, and facilitated softening of previously rigid interactional dynamics.

### **Benefits of Conjoint Eye Movement Desensitization and Reprocessing**

Many of the benefits reported by participants about their conjoint EMDR parallel what has been previously identified in the literature, either as potential benefits or actual benefits observed by couples (Capps, 2006; Capps et al., 2005; D’Antonio, 2010; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007). The changes observed by working partners consist of individual and relational

factors. The individual factors, including changes such as in trauma-related symptoms, are generally similar to those experienced in individual EMDR; however, many of the relational changes appear to be unique to conjoint EMDR. Furthermore, the witnessing partner's experience was identified by both partners as particularly powerful and meaningful to each of them, given the changes that followed the insight, empathy, and understanding gained by the witness.

**Working partner.** As expected, working partners reported relief from trauma-related symptoms, decreased anger, reduced self-blame and shame, decreased physical symptoms, reduced reactivity, and increased self-worth. These partners noted increased access and tolerance for previously disowned emotions and integration within their sense of self and interaction with the world. These findings are consistent with previous literature. Capps et al. (2005) and Capps (2006) noted the value of conjoint EMDR in reducing trauma-related symptoms, including decreased anger, and of increasing congruence between inner experience and outward behavior. Protinsky, Flemke et al. (2001) identified its effectiveness in reducing reactivity, stating that by targeting strong presenting emotion in order to access past traumatic material and the accompanying primary emotions, current negative interactional patterns are modified. Litt (2008) stated that conjoint EMDR can increase cooperation among and integration of ego states and Capps et al. (2005) observed an increase in growth and integrity resulting from this treatment. The accessing and tolerating of previously disowned emotion was noted by Flemke and Protinsky (2003) and Protinsky, Flemke et al. (2001) as a benefit to conjoint EMDR, which they facilitated in clients by targeting secondary emotions such as anger:

With the therapeutic alliance being a cornerstone, the therapist then works with one partner at a time (in the presence of the other) to evoke or activate deep

emotions that underlie the couple's dysfunctional interactional patterns. Partners in distressed relationships often present with intense secondary emotions such as anger. Their painful primary emotions such as shame, sadness, vulnerability, and fear may not be consciously experienced due to their association with some type of prior trauma experiences. The full recognition of these feelings of despair and vulnerability is hidden from the self because they are too painful and hidden from significant others because of fear of lack of acceptance. (Protinsky, Flemke et al., 2001, pp. 157-158)

**Witnessing partner.** Based on the reports of the participants, the value of conjoint EMDR is significant for the witnessing partner during the process and for both partners following the treatment process, as each of their understanding increases and their relational dynamics shift. Witnessing partners noted increased understanding, empathy, and compassion, which resulted in greater support, availability, and commitment to behavior change. The witnessing partners also emphasized the power of hearing the experience of their partners in a “compact manner” with its emotional impact as opposed to in a fragmented manner over time in a cognitive manner, as they had previously. This perspective offered by participants is unique to the current study. The context and process of conjoint EMDR facilitates the ability for the working partner to share their traumatic experience in such a way that their partner can more fully appreciate its meaning and impact. This understanding seems to be motivating for the witnessing partner to better support their partner and increases their likelihood of modifying their own behavior to that end.

The benefit of conjoint EMDR in terms of increasing empathy and support by the observing partner was identified in previous research (Capps, 2006; Flemke & Protinsky, 2003; Protinsky, Flemke et al., 2001; Reicherzer, 2011). Protinsky, Flemke et al. (2001) described those changes as follows: “As partners reveal their vulnerabilities during the EMDR process, empathy and support are often evoked from the observing partner. This

process may take the form of compassionate witnessing and often creates a ‘softening event’” (p. 160). Johnson and Greenberg (1995) describe “softenings” as bonding events during which an angry, blaming partner reaches out for and receives emotional responsiveness and availability from the other. Research has demonstrated that such interactions are correlated with decreases in marital distress (Schachner et al., 2003).

Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al. (2001) encourage witnessing partners to write in a journal about their reactions to their partner’s EMDR process in order to identify their own emotional responses that might serve to block empathy and compassion, blocks that can then be targets for EMDR for themselves. They noted that increased vulnerability and accessibility of the witnessing partner through memories that had been evoked for them from earlier traumatic experiences allowed them to be more fully present and responsive within the current relationship. Capps (2006) and participants from the pilot study also noted increased commitment to change their behavior and abstain from engaging in triggering behavior as a result of the understanding, insight, and compassion gained by witnessing partners during conjoint EMDR. Similarly, Reicherzer (2011) found that conjoint EMDR resulted in increased emotional responsiveness within the relationship.

**Relationship.** Conjoint EMDR underscores that the whole is greater than the sum of its parts in that during this treatment process, it is not solely the working partner who is gaining tools and reducing symptoms that result in a changed system; rather, each partner changes both in terms of behavior and in their degree of insight, understanding, compassion, and empathy. Such changes appear to have an even more powerful and more immediate impact on the relationship than does individual EMDR. Several participants



described conjoint EMDR as providing a “jump start” and “fast forwarding” healing and relational change. Participants in the current study also noted an increased ability to intervene in their cycle as a result of “unjamming the system” as well as increased commitment and hope for their relationship, findings that extend previous literature.

Furthermore, the intimacy described by participants is not only about the connection between members of couples; this intimacy also occurred within individual members as they became more compassionate and accepting of themselves. Several partners said that they initiated conjoint EMDR for the benefit to their partner, not anticipating the benefit they would receive themselves. It appears to be a process of opening oneself up, learning about oneself, and processing through issues that had never been explored or shared with their partner previously. Thus, the power of the EMDR process is partly in its revealing nature and partly in the intensity of being exposed and raw in such a manner with oneself and with one’s partner.

The reports by participants are consistent with the findings across the existing literature that conjoint EMDR leads to a deepening of affect (Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001), increases empathy and understanding (Capps, 2006; Capps et al., 2005; Litt, 2008, 2010; Moses, 2003, 2007; Reicherzer, 2011), and enhances intimacy and greater differentiation for both members of the couple (Capps, 2006; Flemke & Protinsky, 2003; Litt, 2008; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007). Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al. (2001) noted increased understanding by couples about the parallel between their current functioning and traumatic material as they reprocess trauma, stating that such connection is necessary

for both to modify their emotional responses. Flemke and Protinsky (2003) observed that EMDR incorporated into imago relationship therapy (IRT) facilitates movement through the obstacles of childhood traumas that had been preventing couples from establishing intimacy, given the projection that would otherwise occur during IRT techniques.

Moses (2003, 2007) identified increased trust and Capps (2006) observed increased relationship satisfaction as a result of conjoint EMDR. Reicherzer (2011) noted that conjoint EMDR increased understanding and intimacy within the relationship, emotional responsiveness to one another, greater ability and willingness to share vulnerability with the partner, and increased joy and commitment in their lives together. Talan (2007) also integrated EMDR with IRT and noted increased communication, differentiation, and intimacy that resulted from such treatment, findings consistent with reports by the participants within the current study:

Imago relationship therapy is used to organize the approach to therapy, identify unprocessed targets for EMDR processing, facilitate communication between the partners, and help couples become less reactive and more intentional, separate and ultimately more connected. (p. 192)

Talan (2007) also noted that conjoint EMDR modifies the couple “through the systemic effects of each partner’s personal growth and the shared experience within the session” (p. 199). Shapiro (2005) highlighted the benefits of increased differentiation and reduced reactivity toward a reactive spouse that frequently accompanies conjoint EMDR. Similarly, Litt (2008) said that contextualizing behaviors and negative cognitions:

When behaviors and negative cognitions are contextualized, often the couple’s relationship is relieved of the burden of being perceived as both the source of the problem and the means to its solution. Potentially, each client is more accepting of the need for individual growth and less reliant on trying to change the partner.

## **Assessment and Preparation**

Initial assessment of individual and relational functioning and dynamics, preparation, and ongoing assessment were important themes that recurred throughout participants' interviews, themes that extended beyond the literature on conjoint EMDR to date (Capps, 2006; Capps et al., 2005; D'Antonio, 2010; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007). Existing research has identified several necessary conditions to successfully integrate EMDR with couples therapy, including a therapeutic alliance in which trust and safety are established, both clients' and therapists' ability to tolerate intense emotions, each member's sincerity and commitment to working on the relationship, confidence that neither member would use disclosed material as a weapon, adequate differentiation and willingness to provide uninterrupted space to process, sufficient self-soothing skills, and informed consent (Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Shapiro, 2005).

Each of these factors was also noted by current participants in addition to multiple others related to the therapist, working partner, witnessing partner, and the relationship. The specifics of those elements identified to be important to successful integration of EMDR into couples therapy were noted in earlier sections. Those that extend previous literature (Capps, 2006; Capps et al., 2005; D'Antonio, 2010; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007) include the importance of specifically assessing for the following: attachment security, level of hostility, the role individual members take on within the relationship (e.g., pursuer),

specific relationship dynamics (e.g., withdrawal and pursuit), investment in personal change, and alignment of goals. The current research contributes to the existing literature (e.g., Capps et al., 2005; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001) in that these factors could provide valuable information in predicting specific dynamics that may occur during conjoint EMDR and these conditions may be related to positive outcomes.

In terms of preparation for conjoint EMDR, participants in the current study identified numerous steps to facilitate readiness for both members, several of which also extend previous research (e.g., Capps et al., 2005; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001). Moses (2003) pointed to the need for the therapist to determine whether both partners are sincere and well intentioned in terms of their investment in the relationship, given the significant risk of conjoint EMDR otherwise, and he noted the importance of sound clinical judgment in evaluating the risks and benefits for each couple. Several therapists responded to participant recruitment efforts for this study stating that they would not integrate EMDR within couples therapy or that they had attempted to do so but encountered reactivity during sessions that was an obstacle to its effectiveness. Thus, the assessment and preparation stages are particularly important for effectively integrating EMDR within a couples therapy context.

There was significant variation in the amount of preparation that was conducted by therapists within the current study, partly dependent on whether members of the couple had any previous experience with EMDR. Based on data from participants, it appears that it is beneficial to err on the side of providing more preparation for both

members of the couple rather than less, including when transitioning from individual to conjoint EMDR. This allows both partners to adequately anticipate and process each role, the expectations and requirements, and the impact of having one's partner present. The emphasis on preparation was unique to the current study.

Moses (2003) identified the following three principles to perform conjoint EMDR safely and appropriately: safety, balance, and containment. Safety involves client stability, fidelity to structure and protocol, and respect and adherence to boundaries between sessions. Though the structure of each therapist's approach to conjoint EMDR differed in several ways, each of these factors were addressed and identified by participants in the current study. Balance was a concept mentioned by several participants, including between individual and systemic dynamics and between members of the couple. Specific to the current study was the noted value of ensuring balance by adequately preparing a partner who had not previously engaged in EMDR when the other partner had previously participated in EMDR individually. Strategies in containing within and between sessions were also noted by participants, as was the importance of the assessment and development of appropriate resources prior to conducting EMDR.

The data from participants also highlight the importance of being attuned to the needs and dynamics of each couple and both members in order to provide the necessary preparation, particularly given the theme that individual and relational dynamics that occur outside of sessions are likely going to emerge during and related to the conjoint EMDR process. For example, several participants noted significant apprehension and nervousness in anticipation of engaging in EMDR when they were aware that they would be doing so in the next couples therapy session. Those individuals who seemed to have a

general tendency toward being overly controlled, inhibited, withdrawn, anxious, or reliant on external validation experienced anxiety related to exposing themselves in front of their partner, the possibility of “not being good enough,” potential outcomes of the process, how one’s partner might respond, or not being able to anticipate what might emerge during the session. As part of the assessment and preparation stages, it seems particularly important to be aware of members who may have a tendency toward caretaking or who might not feel safe or empowered enough to express their hesitation to engage in EMDR with their partner present. Discussing options regarding EMDR may be more appropriate to initiate individually, particularly in such cases.

Interestingly, several participants noted that some of the witnessing partners seemed to have an intuitive awareness of the importance of staying “out of the way” of their partner’s processing, of the power of the EMDR process, and appreciated being let in on such an intimate process between the therapist and their partner. This awareness may also be a function of these partners’ intra- and interpersonal dynamics such as their ability to self-soothe, level of differentiation, or attachment security. In contrast, partners were more reactive, focused on external validation, defensive, focused on the potential for “winners versus losers,” concerned about the potential outcome seemed to have more difficulty recognizing the importance of being a silent witness. Thus, the latter may benefit from more preparation and more direct instruction regarding the expectations and requirements of being a supportive witness. Moses (2007) said that when he integrates EMDR with couples therapy, the focus of the initial sessions are on joining, history taking, and identifying specific relational dynamics such as “distance” and “pursuer.”

A related theme that emerged in the data was the need to assess whether both members of the couple are in agreement about their goals and are open to self-reflect and personal change. Litt (2008) noted that clients with ego state conflicts may experience significant ambivalence about personal change, such that one or more ego states may be particularly invested in maintaining the status quo and current symptoms. In such cases, preparation would need to be tailored to addressing those conflicts, and engaging in individual EMDR prior to doing so conjointly may be appropriate. He said that relational work is more effective when clients' ego strength and integrative capacity are strengthened. Litt (2010) also identified the value in cultivating a therapeutic contract for each member and for the couple as a whole, based on their goals and level of motivation. He described "inviting a contract for change" as "more art than science" (p. 139). He developed a five-step protocol to guide therapists in developing such a contract and through this process, "each partner in turn is invited to examine how his or her own activation and subsequent defensive reaction is derailing constructive, caring dialogue" (p. 147).

The data from participants also suggest that choosing targets for EMDR related to events from outside of the relationship that parallel dynamics within the relationship, such as childhood trauma, may be particularly helpful in creating softening events for the witnessing partner, at least initially. Doing so appears to decrease the defensiveness and increase the availability of the witnessing partner, while decreasing the level of anxiety and preoccupation with the partner for the working member. It is possible that therapists who have not sufficiently assessed the readiness or prepared the couples, or who had members choose targets within the relationship that are highly charged without sufficient

assessment and preparation were the ones who experienced significant reactivity within conjoint EMDR sessions and as a result, determined that conjoint EMDR is not beneficial and never attempted again. Given the importance of therapists feeling confident and competent and of couples believing in the competence and confidence of their therapist, such experiences might also decrease the potential success of future attempts, if the therapist was more tentative and uncertain.

The participants emphasized the need for informed consent, such that members of couples were fully informed about their options regarding EMDR (whether to engage in this treatment at all or whether to do so individually or conjointly) and potential risks and benefits to each, and then empowered to determine the next steps in treatment. Given that the amount of trauma experienced by these participants and the sense of powerlessness inherent, the importance of such control and empowerment seems particularly salient. Similarly, the importance of sufficient preparation and assessment of the safety and comfort in engaging in conjoint EMDR for such clients is worth highlighting. As part of the preparation phase, therapists noted the benefit to familiarizing couples to EMDR language and emphasizing the connection between previous traumatic events and current relational dynamics, contextualizing the benefit to conjoint EMDR. Several therapists noted how much attention they give to the preparation stage, which may be a contributing factor to the success of these therapists and the positive response by these couples.

Several therapists highlighted the importance of timing in introducing and initiating EMDR. Similarly, several client participants noted that they would not have felt safe to engage in conjoint EMDR at the beginning of their couples therapy. This underscores the importance of trust, preparation, and availability of one's partner prior to



exposing oneself through conjoint EMDR. Doing so too soon and without sufficient preparation could be retraumatizing for the working partner, if the witnessing partner is not emotionally available to provide support or worse, interrupts the process due to his or her own reactivity.

A number of clients suggested the potential value of participating in individual EMDR prior to conjoint EMDR, particularly when one member of the couple had already had prior individual EMDR experience. This suggestion parallels Moses' (2003) guideline regarding balance. Engaging in a discussion about the pros and cons of participating in individual versus conjoint EMDR is valuable regardless of whether either member has engaged in EMDR previously but is particularly relevant when that is the case in terms of maintaining balance. Furthermore, a discussion about which partner will take on the working role is useful here. Moses (2007) noted the need for caution in treatment planning with respect to deciding the order of processing in the following circumstances:

- (a) one partner has more traumas or is more severely traumatized than the other;
- (b) one partner is more familiar or experienced with EMDR; (c) one partner has a more dramatic or "impressive" response; (d) one partner does not have much or any response; or (e) there is a rivalry as to who is the "better client." (p. 155)

These points parallel experiences identified by several participants in the current study.

Though authors have noted indications and contraindications for conjoint EMDR, and suggestions for assessment procedures, little research has referenced ongoing assessment. The importance of debriefing with both partners after reprocessing as well as in future sessions was apparent from participants' experiences. Moses (2003) presented a protocol for conjoint EMDR that did include a step during which the witnessing partner is presented with the opportunity to reflect upon how he or she was emotionally impacted

by serving as a witness to his or her partner, as well as to explore how the observing partner might unintentionally trigger the partner related to those issues within their relationship. Thus, Moses highlights the value of debriefing for the witnessing partner as well as for the working partner, an element that is inconsistent within the literature and that was also inconsistent among therapist participants within the current study.

As noted above, Protinsky, Flemke et al. (2001) encourage the witnessing partner to utilize a journal as an outlet for their internal reactions to their partner's reprocessing, which later become targets for EMDR. These notes can be shared with the partner during debriefing. Based on the experiences of the participants in the current study, encouraging witnessing partners to journal during their partner's EMDR is recommended. Doing so seems to allow them to remain present and attuned to their partner, while noticing their own reactions and possible triggers. Journal entries can then be useful in the debriefing process for both the witnessing and the working partner, providing insight and a different perspective to the working partner and allowing space for the witnessing partner to be active in the treatment process.

Beyond this debriefing that occurs by both partners at the end of the reprocessing and the re-evaluation of subjective units of distress (SUDs) and validity of cognition (VoC) levels by the working partner, the existing literature does not emphasize ongoing assessment. The importance of continued assessment emerged from several participants' experiences including the value of evaluating the effectiveness of a container if such a tool was used between sessions, exploring additional material and triggers that may have surfaced for either member between sessions related to the previous conjoint EMDR session, evaluating whether any verbal processing occurred about content that emerged

during EMDR between the partners since the last session and the impact of that discussion, and assessing ongoing safety that may have been affected by the disclosures. These factors may serve as important indicators for the potential need for further preparation prior to continuing conjoint EMDR.

### **Implications**

Based on the data from participants, several implications stand out as important for clinicians who may consider integrating eye movement desensitization and reprocessing (EMDR) with conjoint couples therapy; these implications apply across the stages of assessment, preparation, reprocessing, and re-evaluation. Much variation emerged from the current data related to specific conjoint EMDR protocol, the nature of the target for reprocessing, and frequency of conjoint EMDR sessions, based on the theoretical and philosophical approach of the therapists to conjoint EMDR and the presentation and needs of the couples. Benefits of conjoint EMDR were reported consistently across all participants, though several obstacles to the process were noted by a few.

Thus, based on current data, it does not appear that any specific protocol, beyond the standard EMDR protocol, is required in order for couples to benefit from the process; however, it may be that specific guidelines increase the likelihood of a successful change process. Specifically, this study highlights the value of therapists doing the following: (a) highlight the importance of relationships in healing from trauma and in promoting resilience with clients; (b) assess and remain attuned to attachment and relational dynamics, considering their impact on in-session processes and response to treatment; (c) foster trust and safety within the therapeutic relationship; (d) emphasize preparation and

ongoing assessment; (e) facilitate softening events prior to, during, and following engagement in the desensitization phase of conjoint EMDR; and (f) explore with clients the prospective benefits and obstacles of engaging in individual versus conjoint EMDR. Each of these is explored in detail below.

### **Importance of Relationship in Healing and in Promoting Resilience**

As noted in previous sections and in detail within the literature review chapter, much research highlights the importance of relationship in the creation of as well as in the healing from trauma (Alexander, 2003; Herman, 1997; Johnson, 2002, 2008; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). This was a central theme that linked all participants and was common among much of the data. The importance of a healing relationship in the creation of a corrective emotional experience for trauma survivors relates to the relationship between partners before and throughout the conjoint EMDR process. Such healing also necessitates a strong therapeutic alliance between the couple and the therapist. This theme was commonly noted by participants, and is consistent with the literature (Briere & Scott, 2006; Pearlman & Courtois, 2005). Regardless of the specific stages or principles set forth by trauma treatment models, authors consistently agree that treatment must begin with an establishment of safety and control within the therapeutic relationship, given the powerlessness and violation inherent in the experience of trauma (e.g., Alexander, 2003; Briere & Scott, 2006; Herman, 1997; Johnson, 2002; Pearlman & Courtois, 2005; Perry & Szalavitz, 2006; Rosenkranz & Muller, 2011; Tummala-Narra et al., 2012).

The following concepts relate to evaluating and strengthening the relationship between partners as well as with the therapist: safety, trust, empowerment of clients,

evaluation of stability and resources, and readiness and willingness to be exposed and vulnerable in the presence of the therapist and one's partner. Furthermore, these factors were also found to be important in the assessment process: strength and commitment of relationship, level of differentiation, security of attachment, extent of preparation, history of attachment wounds within and outside of the current relationship, opportunity for ongoing processing and re-evaluation of conjoint EMDR process. These elements should be emphasized by therapists considering integrating EMDR with conjoint couples therapy.

Based on the findings from the current study as well as existing literature (e.g., Capps et al., 2005; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001), conjoint EMDR is a treatment modality that promotes healing from trauma as well as the strengthening of intimate relationships. Research has highlighted the importance of partner support before and after a traumatic event in determining vulnerability to PTSD (Ein-Dor et al., 2010), the impact of military combat on both the veteran and the spouse (Calhoun et al., 2002; Ein-Dor et al., 2010; Johnson, 2002; Jordan et al., 1992; Kessler, 2000), and the positive outcomes for integrating conjoint EMDR with couples affected by war trauma (Errebo & Sommers-Flanagan, 2007). Each of these findings provides support for the potential benefit of the many military couples who are currently suffering the impact of post-traumatic symptoms.

Based on Gottman's (1994) research, empirical support for EFT (Johnson, 2002; Johnson et al., 1999, 2001; Schachner et al., 2003), and extensive studies validating EMDR as an individual treatment for trauma (e.g., Bisson & Andrew, 2007; Cvetek, 2008; Maxfield & Hyer, 2002; Turner et al., 2007), conjoint EMDR demonstrates the

potential for increasing relationship satisfaction and preventing divorce. Gottman (1994) found that negative interaction cycles involving criticism, stonewalling, defensiveness, and complaining predict relationship satisfaction and divorce. He demonstrated that when partners are able to remain emotionally engaged and responsive to one another, they are more likely to reconnect after conflict and are more satisfied in their relationships.

Emotionally focused couples therapy (EFT) has been applied to trauma survivors and their couples and has been found to reduce marital distress and promote continued improvement even after termination of treatment (Johnson et al., 1999; Schachner et al., 2003). The softening events that EFT promotes through the expression of underlying needs and feelings as well as changes in interaction patterns (Johnson et al., 2001) parallel the changes experienced by couples through conjoint EMDR (Capps, 2006; Capps et al., 2005; D'Antonio, 2010; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007), such as deepening affect, increasing empathy and understanding, enhancing intimacy, decreasing interpersonal reactivity, and promoting differentiation.

Beyond when couples present with a “couple’s issue,” conjoint EMDR is also likely to be beneficial when only one partner is experiencing symptoms, such as depression or anxiety. That is, including the asymptomatic partner in couples therapy to address what might be more traditionally treated in individual therapy may have benefits as an adjunct to individual treatment. Couples therapy has been incorporated as an adjunct to individual therapy in recent years and has also been utilized as the primary modality for issues such as depression, anxiety, substance use, and eating disorders

(Johnson, 2002). Research has demonstrated a significant increase in the success rate for clients when the spouses were included in treatment for anxiety, from 46 % to 82% (Barlow et al., 1984; Cerney et al., 1987). Bowling (2002) found that female survivors of sexual assault in couples therapy experienced more reduction in depressive symptoms than those in individual treatment, while both treatment modality groups had comparable decreases in PTSD symptoms.

Wesselman and Potter (2009) conducted research that demonstrated positive change in attachment security following individual EMDR. They pointed to the associations between secure attachment and sensitive caregiving toward children, stability in adult relationships, and mental health in proposing that EMDR may not only positively impact current intimate relationships, but also individuals' parenting and risk for mental illness. Similarly, conjoint EMDR has the potential to improve parenting skills and decrease the risk of mental illness, as partners increase their ability to self-soothe, become better differentiated, and are less reactive (e.g., Capps et al., 2005; Litt, 2008; 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001).

Furthermore, given that security and trust within a current relationship can increase resilience when coping with traumatic events (Herman, 1997; Johnson, 2002), conjoint EMDR also has implications in promoting resilience. Hundreds of studies demonstrate the protective nature of a loving connection with an intimate partner as well as its powerful role in increasing partners' ability to cope more effectively with trauma (Johnson, 2008). For example, Israeli researchers found that securely attached couples were better able to cope with dangers such as Scud missile attacks than were less securely attached couples, as indicated by less anxiety and fewer physical symptoms after the

attacks (Mikulincer et al., 1993). Thus, conjoint EMDR has implications in healing from trauma, strengthening relationships, decreasing the impact of war trauma (both in prevention and treatment), increasing relationship satisfaction, preventing divorce, treating individual symptoms (e.g., depression, eating disorders, substance use), increase sensitivity in parenting, and promoting resilience to stress.

### **Attunement to Attachment and Relational Dynamics**

Given the variation in the domain of attachment among participants and the importance of attachment dynamics and injuries within and outside of the relationship between partners, this area is a crucial one to evaluate and remain attuned to throughout conjoint EMDR, which should be explored further with research. The current study demonstrates that the importance of assessing individual and relational functioning; doing so allows clinicians to anticipate potential dynamics that may emerge related to conjoint EMDR. Furthermore, participants noted the importance of balancing individual and systemic dynamics throughout the process, allowing for the depth necessary to address individual issues while maintaining the focus on the couples issue.

Clinicians would benefit from being alert to the level of anxiety for each partner, common reactions to fears and particular needs, and roles taken on within the relationship in order to anticipate how such issues might play out within the treatment process. This should guide preparation for conjoint EMDR and be monitored throughout treatment. For example, if a member tends to take on a caretaker role or believes that he or she must not share vulnerable emotions with the other out of a fear of being a burden or of being abandoned, this partner may have more difficulty softening during conjoint EMDR. Given the value of vulnerability and emotional accessibility in decreasing distress



between partners (Johnson & Greenberg, 1998; Johnson et al., 2001; Schachner et al., 2003), therapists would benefit from conducting significant assessment and preparation to promote such conditions.

Furthermore, as noted previously, couples benefit most from conjoint EMDR when they have shared goals regarding self-reflection and personal change, letting go of an attachment to a particular outcome. When one member of a couple is invested in maintaining their mode of relating to one another as a way to reduce anxiety or reinforce a belief of deserving punishment (anxiously attached), that member is less likely to benefit from this treatment, unless an exploration of the pros and cons of pursuing such change is conducted. This is consistent with Moses (2003, 2007) who highlighted the importance of assessing each member's sincerity and commitment to working on the relationship prior to initiating conjoint EMDR. The conditions identified by current participants as facilitative of conjoint EMDR also parallel the questions Shapiro (2005) utilizes to assess couples' readiness for EMDR. Factors to consider in the assessment phase and specific suggestions are included below. It is important to individualize assessment, preparation, and treatment to the presenting issues, individual dynamics, and relational patterns that are unique to each couple.

### **Emphasis on Preparation and Ongoing Assessment**

As noted throughout this chapter, assessment of individual and relationship functioning must be a collaborative and ongoing process in order to adequately meet the needs of the system and maintain the attunement necessary to modify the treatment direction as needed. The data from this study have underscored the impact of such intrapersonal and interpersonal dynamics and history with EMDR and with the couples'

therapist on the amount and type of preparation that is required for each partner and each couple. It is important for therapists to explore with each member who has participated in EMDR previously in an individual context what potential obstacles and benefits might arise from doing so with their partner present. It is beneficial to discuss with the partners of such individuals what challenges and benefits they might experience as they witness their partner's process and as they begin EMDR themselves. Issues related to alliance and trust are essential to evaluate and explore when one partner has a history of individual work with the couples' therapist given the importance of balance and safety. Moses (2003) pointed to the need for safety, balance, and containment throughout conjoint EMDR. Similarly, Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al. (2001) stated that a therapeutic alliance in which trust and safety are established is essential prior to implementing conjoint EMDR. The remaining themes were unique to the current study.

Based on the data from participants, the initial assessment by clinicians should involve self-reflection about one's ability and comfort in balancing individual and systemic dynamics, one's experience and competence in managing reactivity and in integrating EMDR with couples therapy. Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al. (2001) pointed to the need for both clients and therapists to demonstrate the ability to tolerate intense emotions. Furthermore, the findings from the current study suggest that such an assessment should also include assessing the general intra- and interpersonal functioning of each member. For example, attachment security, hostility, role within the relationship, investment in personal change, level of differentiation, ego strength, attachment to a particular outcome, dynamics of interlocking trauma reactions,

engagement in therapy, alignment of goals, strength and commitment within the relationship, and level of safety. Moses (2003, 2007) highlighted the importance of assessing each member's sincerity and commitment to working on their relationship prior to initiating EMDR within the couples therapy context. He identified safety as ensuring client stability to cope with the emotional material that may emerge during sessions, following the EMDR protocol, and an agreement within the couple to limit deeper emotional processing to sessions rather than attempting to do so between sessions. The remaining themes were unique to the current study.

The following should also be evaluated for both partners: (a) trauma history, (b) stability and resources (including the ability to tolerate one's own and partner's affect for both partners, and ability to provide silent support and self-soothe for the witnessing partner), and (c) ability and willingness to be open and vulnerable should also be evaluated for both partners. Furthermore, the witnessing partner's ability and willingness to provide support and foster emotional safety with the partner must be explored, in that he or she will not use disclosures in retaliation or question the validity of material during or following EMDR. Moses (2003, 2007) emphasized the importance of containment for conjoint EMDR. Providing containment involves thoroughly assessing both members' internal and external resources, developing resources when appropriate, and supporting the witnessing partner to take on the role of a container for the working partner (e.g., holding the partner's hand, if mutually desired). It also includes providing the opportunity for closure at the end of each session, limiting each person's processing to two or three sessions at a time, and being accessible to clients between sessions if necessary (Moses, 2003, 2007).

Once the initial assessment has been conducted and if conjoint EMDR is indicated, clinicians should foster a respectful and collaborative decision making process with clients about their options regarding EMDR, such that they are fully informed prior to consenting to conjoint EMDR. Litt (2008, 2010) highlighted the value in developing a contract for EMDR therapy after the relational dynamics are contextualized in terms of prior attachment wounds. Shapiro (2005) also identified the importance of couples being fully informed about EMDR in order to provide consent.

This preparation should include the development of a strong therapeutic alliance, psychoeducation about the impact of trauma and about EMDR, and the installation and building of containment strategies and resources as appropriate. Preparation should also consist of helping clients understand how “the past is present,” orienting clients to EMDR concepts and language, and presentation of potential benefits and obstacles to conjoint EMDR. In addition, therapists should review expectations and requirements for both partners and discuss the option of individual versus conjoint EMDR (including beginning with individual EMDR, with the option to do so conjointly in the future). Finally, preparation should involve conjoint resource development and installation, and a discussion about the ongoing processing that will occur between sessions as well as expectations about verbal processing between partners outside of session versus container-ing material within the session. These specific recommendations are unique to the current research findings.

Meeting with each partner individually as well as together to obtain a thorough assessment and to discuss the option of conjoint EMDR is appropriate including exploring how their individual and relational dynamics may impact the benefits,

obstacles, and process of conjoint EMDR for each partner. Participants noted the benefit of journaling for the witnessing partner in order to maintain a sense of groundedness as well as to serve as an outlet for intense feelings that emerged; thus, clinicians may introduce this as part of the preparation for each partner's role and a discussion of what they can expect during EMDR. This is consistent with Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al.'s (2001) use of a journal to "discover their own painful emotional reactions that block the ability to feel empathy and to be compassionate" (p. 160).

Participants also noted the value of increasing the stability, safety, and commitment within the relationship prior to initiating conjoint EMDR; therefore, clinicians would benefit from ongoing monitoring and strengthening in these areas as part of the assessment and preparation phases. Given the importance of softening events in the success of couples therapy (Johnson & Greenberg, 1988; Schachner et al., 2003), strengthening the relationship such that members are more aligned and receptive to one another prior to engaging in conjoint EMDR is appropriate; however, it is clear from these participants' experiences that conjoint EMDR was helpful in fostering such softening events. An important factor in doing so relates to the choice of targets during conjoint sessions. Beginning with a target from an event outside of the relationship that parallels dynamics that occur within the relationship seems to be most appropriate in order to increase the level of comfort, safety, openness, and insight likely to be gained by both partners. Moses (2003) and Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al. (2001) highlighted the value of targeting earlier "feeder memories" that contribute to current relational impasses.

Ongoing evaluation appears to be a crucial component of increasing the benefit of conjoint EMDR. Thus, clinicians would do well to foster an open dialogue with both partners about their experience during and between sessions, continuing to revisit their reactions and any potential additional preparation that might be appropriate. Related to fostering safety is exploring how partners are doing in terms of following expectations outlined during the preparation stage, such as not using disclosures against one's partner in retaliation. As EMDR transitions from one partner to the other, it may also be useful to discuss any apprehension related to "performance anxiety," being exposed, providing adequate support to one's partner, or other issues. The theme related to over-focus on one's partner was unique to this research, but further research is needed to substantiate this finding (e.g., by examining the relation between level of differentiation and response to conjoint EMDR).

According to participants from this study, clinicians should be alert to both partners during conjoint EMDR, balancing the working partner's reprocessing as well as ensuring the safety and containment of the witnessing partner, shifting back to preparation and resource building as needed. Therapists should also ensure that sufficient time is allowed at the end of each session for both partners to verbally process their reactions. Similarly, time should be allotted in future sessions to revisit their reactions the previous session as well as between sessions.

Furthermore, if the clinician and couple determine that a container is an appropriate tool to use at the end of sessions and the couple agrees not to discuss the content of the session, this should be revisited in the next session to ensure that members followed this expectation, with the option to modify the agreement as appropriate.

Alternatively, if a container was not used, reactions and any discussion about the conjoint EMDR session should be explored, with the option to utilize a container in the future if deemed to be appropriate. Moses (2003) pointed to the value of containing material that is processed at the end of sessions and continuing processing the following session, if needed.

### **Limitations of the Study**

There are strengths and limitations to the research conducted through this qualitative study of the conjoint EMDR process. Though participants were asked to share documents about the conjoint EMDR process, there is a lack of validated objective outcome measures about EMDR (and certainly, about conjoint EMDR). Thus, data from such measures are not available to further triangulate the data obtained. Future research utilizing a mixed methods research design would be valuable to obtain more information about the efficacy of conjoint EMDR. One therapist in the current study did utilize validated outcome measures (Outcome Rating Scale, Session Rating Scale, Dissociative Experiences Scale, PTSD Checklist-Military Version, Beck Depression Inventory, Beck Anxiety Inventory) and data from these measures did provide support and corroboration for the benefits identified by that therapist as well as both members of the couple. Other means were utilized to obtain triangulation including the inclusion of all three members of the triad (both partners and the therapist) and the inclusion of other documents that included journal entries, notes, and ratings of SUDs and VoC prior to and following conjoint EMDR sessions. Furthermore, the focus of the current study was to develop a theory about conjoint EMDR rather than to assess its efficacy.

Another limitation of the current study was that participants were generally interviewed one time, with only two of the participants having done follow-up interviews and two others providing email updates. Thus, no data were available about the long-term impact of conjoint EMDR, the changing impact over time, or how their perceptions of the treatment experience might change. However, these were not included as research questions for the current study and participants in this study varied significantly in the length of time since participation in conjoint EMDR, providing useful information across a variety of contexts.

Finally, there was significant variability in the protocol and contextual factors across triads. The amount and type of assessment and preparation varied greatly as did the number of sessions, the nature of the targets chosen, and the degree of involvement of the witnessing partner. Furthermore, there was variation in terms of the familiarity and previous experience with EMDR within an individual therapy context across triads and between members of individual couples (including two individual clients who had participated in EMDR individually with the therapist who became their couples' therapist). The purpose of the study was to develop a grounded theory about conjoint EMDR rather than to obtain information about effectiveness of particular protocols; therefore, this variability is not seen as a weakness of the study.

### **Future Directions for Research**

The current study has led to a better understanding about factors and conditions that are perceived to be beneficial by couples and therapists during conjoint EMDR. This study also resulted in determining useful steps in the assessment and assessment phases. It has extended past research that was primarily from the perspective of clinicians to



include the voices of clients. Several areas for future directions emerged as a result of the data provided by participants. Specifically, an examination of the following areas of study would extend the current research and the topic of conjoint EMDR further: (a) research to develop assessment tools to help determine couples' readiness to engage in conjoint EMDR, (b) randomized controlled trials to obtain more outcome information, (c) interviews with clinicians and/or couples who report having had what they would consider "unsuccessful" experiences of conjoint EMDR, (d) investigating the variables of attachment security and dyadic adjustment with conjoint EMDR (such as the Revised Experiences in Close Relationships measure of romantic attachment, ECR-R and the Dyadic Adjustment Scale, RDAS) and (e) comparing the experiences of couples and therapists as well as the outcomes among varying conjoint EMDR protocols. Each is discussed below.

### **Assessment Tools for Readiness**

The current study corroborates the recommendations as well as the indications and contraindications presented in the existing literature in terms of assessment and preparation procedures. It may be useful to clinicians considering integrating EMDR with couples therapy to have access to concrete tools, such as an interview or questionnaire to aid in determining their appropriateness or readiness to pursue this treatment as well as areas that may require further attention (e.g., resource development and installation or increasing the level of trust between partners). Previous research as well as the current study provide a useful guide for assessment and preparation that may be helpful in creating such a scale or interview. Quantitative research to develop and test a self-report

assessment's efficacy through factor analysis would be a valuable contribution to the fields of couples therapy and of EMDR treatment.

### **Randomized Controlled Trials**

Literature about the integration of EMDR with couples therapy has included a variety of theoretical and clinical approaches to couples work including contextual therapy, imago relationship therapy, and emotionally focused couples therapy (Capps, 2006; Capps et al., 2005; Errebo & Sommers-Flanagan, 2007; Litt, 2008, 2010; Talan, 2007). Rationales have been provided for the way in which adding conjoint EMDR to these clinical approaches augments treatment and serves to move through impasses. The clinicians interviewed in the current study presented with a variety of theoretical approaches and utilized different frameworks to conceptualize their work with couples. Dozens of randomized controlled studies have been conducted to compare the efficacy of various individual trauma treatments, including EMDR (e.g., van der Kolk, Spinazzola et al., 2007). Similarly, it may be useful to examine the outcomes of conjoint EMDR in conjunction with each of these theoretical approaches to determine whether there is equivalence across frameworks, thereby extending the efficacy research to conjoint couples therapy. Comparing treatment outcomes within these approaches between couples who participate in conjoint EMDR and those who do not may also be informative. Furthermore, investigating outcomes between individual versus conjoint EMDR and exploring the factors that impact the effectiveness of one over the other (e.g., attachment security) would provide important information to aid in treatment planning.

### **Investigating Unsuccessful Conjoint Eye Movement Desensitization and Reprocessing Treatment**

Participation was voluntary and involved a self-selected sample of participants. In order to participate in the study, clinicians needed to be willing to approach current or past clients who had participated in EMDR within couples therapy. Both therapists and those clients needed to consent to participate in the study in order for any member of the triad to be included. Therefore, this self-selection process limited the sample. There is no way of knowing how the sample of participants might differ from those clinicians who had conducted conjoint EMDR but chose not to volunteer or those couples where both members chose not to participate in spite of the clinician's willingness to do so.

Given that the clinicians and couples who participated in the current study unanimously reported benefit from their conjoint EMDR experience (though some encountered more obstacles than others during the process), it may be interesting to hear from therapists and couples whose experience was negative or who perceive no benefit from their conjoint EMDR treatment. This perspective would be valuable in obtaining further information about when conjoint EMDR may be contraindicated or provide more guidelines regarding preparation procedures. Furthermore, including both clinicians and couples in such research would be valuable to explore whether individual client factors, relational functioning, and/or therapist factors contributed to those less successful experiences.

### **Attachment, Dyadic Adjustment, and Differentiation as Predictors**

Research validates the effectiveness of experiential couples therapy approaches in terms of increasing attachment security and dyadic adjustment in couples (Errebo &

Sommers-Flannagan, 2007; Makinen & Johnson, 2006). Incorporating an experiential trauma focused treatment such as EMDR into couples therapy may result in positive changes not only in PTSD symptoms but also within dyadic adjustment and attachment security. Future research might include pre- and post- measures of these variables to investigate the impact of conjoint EMDR on those factors (such as the Revised Experiences in Close Relationships measure of romantic attachment, ECR-R and the Dyadic Adjustment Scale, RDAS). This would extend Wesselman and Potter (2009)'s research that examined the impact of individual EMDR on attachment security to include conjoint EMDR.

Given the impact of early trauma on attachment security, the importance of attachment style on relational dynamics (including differentiation), and the themes related to attachment and differentiation that emerged within this research, it would also be useful to conduct quantitative research using attachment security, dyadic adjustment, and differentiation as predictors for outcomes of conjoint EMDR treatment. Such an investigation might suggest varying preparation is appropriate dependent on the attachment style of individual members of couples and the dynamic between their respective attachment styles. Individual EMDR may be found to be indicated more with individuals who have particular attachment styles or when attachment security is low. Such information would also be valuable in treatment planning and preparation for EMDR.

### **Comparison Across Protocols**

Though clinicians followed the standard eight-phase eye movement desensitization and reprocessing (EMDR) protocol in most respects, each clinician

reported variations in their approach to conjoint EMDR, from the introduction of conjoint EMDR through the reprocessing and re-evaluation stages. Several authors have presented conjoint EMDR protocols (Litt, 2010; Moses, 2003; Talan, 2007) and clinicians within the current study included aspects of each but did not specifically follow any of these protocols. Given that variation, quantitative research such as outcome efficacy studies examining several protocols, including those of Litt (2010), Moses (2003), and Talan (2007) as predictors for conjoint EMDR may prove useful in guiding future clinicians and to provide a standardized conjoint EMDR treatment protocol.

### **Conclusion**

The participants' stories provide support for the notion that having another stand beside you to face the "dragon" of trauma does, in fact, serve as a source of strength and comfort (Johnson, 2002, p. 3). Much research exists to inform us about the extensive impact of trauma on survivors' relationships. The current study about conjoint EMDR includes many stories of rebuilding, recovery, and reconnection. Anthony described the changes he and Bonnie experienced:

It's opened something in me and in her that allows us to touch each other's heart and soul in a much more real way than we ever did before...Seeing somebody else being honest with their feelings and how they're being impacted by events...makes it easier for you to look at your feelings...I think couples therapy and doing EMDR together is a marvelous thing...I think it just breaks the ice to be able to talk about things in a much more real way, once you see somebody struggling with the big events of their life.

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**APPENDIX A**


**INSTITUTIONAL REVIEW BOARD APPROVAL**

UNIVERSITY of  
NORTHERN COLORADO  
Institutional Review Board (IRB)



November 28, 2011

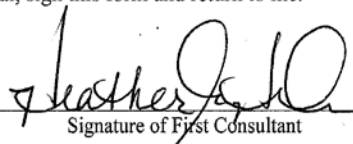
TO: Heather Helm  
APCE

FROM: Maria Lahman, Co-Chair   
UNC Institutional Review Board

RE: Expedited Review of Proposal, *Eye Movement Desensitization and Reprocessing in Conjoint Couples Therapy: A Grounded Theory Study*, submitted by Elizabeth Legg (Research Advisor: Mary Sean O'Halloran)

First Consultant: The above proposal is being submitted to you for an expedited review. Please review the proposal in light of the Committee's charge and direct requests for changes directly to the researcher or researcher's advisor. If you have any unresolved concerns, please contact Maria Lahman, Applied Statistics and Research Methods, Campus Box 124, (x1603). When you are ready to recommend approval, sign this form and return to me.

I recommend approval as is.

 1/18/12  
Signature of First Consultant Date

The above referenced prospectus has been reviewed for compliance with HHS guidelines for ethical principles in human subjects research. The decision of the Institutional Review Board is that the project is approved as proposed for a period of one year: 1-23-12 to 1-23-13.

 1-23-12  
Maria Lahman, Co-Chair Date

Comments:

## **APPENDIX B**

### **DEFINITION OF KEY TERMS**

*Trauma* will include one or more events subjectively experienced as distressing that negatively impacts current functioning. These traumas may include small “t” traumatic events such as attachment injuries by a partner, parental neglect, or public humiliation, that do not meet the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for PTSD and/or big “T” traumatic events such as sexual or physical abuse, that do meet criteria for PTSD (Shapiro, 2001).

*Posttraumatic Stress Disorder (PTSD)* is a condition in which the following criteria are met:

- A. The person has been exposed to a traumatic event in which:
  - 1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - 2. The person’s response involved intense fear, helplessness, or horror
- B. The traumatic event is reexperienced in one or more of the following ways:
  - 1. Recurrent & intrusive distressing recollections of the event (e.g., thoughts, perceptions, and images)
  - 2. Recurrent distressing dreams of the event
  - 3. Acting or feeling as if the traumatic event were recurring
  - 4. Intense psychological distress at exposure to internal or external cues that symbolize the trauma
  - 5. Physiological reactivity on exposure to internal or external cues that symbolize the trauma
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by three (or more) of the following:
  - 1. Attempts to avoid thoughts, feelings, or conversations associated with the trauma
  - 2. Attempts to avoid activities, places, or people that arouse recollections of the trauma
  - 3. Inability to recall an important aspect of trauma
  - 4. Diminished interest/participation in activities
  - 5. Feelings of detachment/estrangement from others
  - 6. Restricted range of affect
  - 7. Sense of foreshortened future
- D. Persistent symptoms of increased arousal, as indicated by two (or more) of the following:
  - 1. Difficulty falling or staying asleep
  - 2. Irritability or outbursts of anger
  - 3. Difficulty concentrating
  - 4. Hypervigilance
  - 5. Exaggerated startle response
- E. Causes clinically significant distress or impairment (adapted from the American Psychiatric Association; APA, 2000)

*Attachment* was described by Bowlby (1969) as an emotional bond that is unique to the relationship between parent and child. He asserted that it is motivated by an innate force that serves the four functions of 1) proximity seeking, 2) the creation of a secure base, 3) the creation of a safe haven, and 4) the initiation of separation protest.

*Attachment Style* is “an enduring, trait-like characteristic of an individual that influences functioning in close relationships” (Feeney, 1999, p. 373). The three patterns of child attachment (secure, ambivalent, and avoidant; Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969) have been applied to adults and romantic relationships (Bartholomew & Horowitz, 1991; Hazan

& Shaver, 1987; Maine & Hesse, 1990), and have been found to influence individuals' processing of information, emotional regulation, and social interactions (Johnson et al., 2001).

*Eye Movement Desensitization and Reprocessing (EMDR)* is a comprehensive and evidence-based method of psychotherapy, which follows an eight phase protocol guided by an information processing model that views pathology as the product of perceptual information that has been maladaptively stored (Shapiro, 2001). It follows a three-pronged approach in which past trauma (including small "t" and big "T" trauma; Shapiro, 2001), current triggers, and future events are targeted for reprocessing.

## **APPENDIX C**

### **SAMPLE REFLEXIVE JOURNAL ENTRIES**

6/28/12: I was very impressed with this therapist's ability to speak very succinctly and clearly about his assessment and preparation procedures as well as the changes that he observed with this couple. His perspective will add a valuable contribution to the assessment/preparation process. I also appreciate his inclusion of pre- and post- measures and his collaborative approach to assessing the ongoing satisfaction of clients in terms of the treatment process. He is clearly very thorough and skilled, and is confident in his ability to appropriately assess a couple's appropriateness for conjoint EMDR. I'm also happy to include his perspective, given his active involvement in the EMDR community. Given how many EMDR clinicians bristled at the prospect of doing EMDR conjointly, I'm glad to include his thoughtful and competent perspective as well as the outcome measures to support the value of this work.

8/24/12: I feel so incredibly grateful to this couple and therapist for sharing their stories with me—this interview was very moving and is really the ultimate success story about personal growth and transformation within a relationship. I am very excited about this interview, given the power of his experience and the richness of his descriptions. He is also a huge proponent of conjoint EMDR and his unsolicited statements are very powerful. I am excited to include several of his quotes, particularly given the poetic nature of the analogies he used. Again, no new themes emerged from this interview, confirming saturation.



## **APPENDIX D**

### **SAMPLE ANALYTIC MEMOS**

1<sup>st</sup> Triad: I'm struck by the potential benefits that are discussed and how what one might perceive as a benefit (reduce interpersonal reactivity or intensity of emotions) might be perceived by another as a threat to attachment or invalidation of that person's feelings—like in the case of Rita, if I feel less intensely, does that mean I don't matter? Does that mean that I'm less likely to be heard and validated by my spouse? Does that mean that I will always be a victim—that I'm resigning myself to being a doormat?

Rita preferred to be the witness—she was less vulnerable in this role—she was observing him rather than being raw and exposed herself. However, it potentially reinforced her role as victim—I'm learning about all this information for the first time in this way. Bill talks about the value in having the “acting out partner” be the first one to engage in EMDR—that makes sense in terms of softening that person's reactivity and fostering an emphasis on that personal responsibility. Did he do this with Rita? She would have to want this...

3<sup>rd</sup> Triad: Huck's initial concern re: NyxRN's potential boredom reminds me of some of the other couples in terms of the potential for being distracted by the other member, particularly when there is an external need for validation as well as the idea that whatever roles the members take on and whatever their general relational dynamic is will likely play out during conjoint EMDR—e.g., if Huck tends to be the caretaker, he is likely going to be assessing whether his wife is ok and whether he needs to take care of her or whether it's truly ok for him to let go and be vulnerable—again, this is valuable to anticipate as a therapist and to discuss with the couple. Here, I suspect, my IPT orientation is playing out and this might not fit for others as well as it does for me. This also applies in terms of his not wanting her to see him in his “weak moments” and being concerned that she might lose respect or admiration for him due to the behavior he engaged in.

4<sup>th</sup> Triad: I wonder whether this couple would have recognized how much the accident was connected to their relationship without doing EMDR—the way in which they shifted from the accident and the death of the person in the other car to the near death of Beth. This would be a great quote and dimension to include under the core category re: healing occurring within relationships. Similarly, the descriptions of Beth actively becoming involved in facilitating the EMDR sessions would be great as subcategories of this core themes. Here, their experience touches on what I wrote about in the introduction chapter in terms of the partner serving as that secure base for the working partner rather than the therapist having that central attachment role. It would be valuable to write about the cognitive/relational interweaves Beth did with him.

## **APPENDIX E**

### **LETTER OF INTRODUCTION**

My name is Elizabeth Legg and I am a Ph.D. student at the University of Northern Colorado. I am contacting you because I am completing a study for my dissertation on clients' and therapists' experience of Eye Movement Desensitization and Reprocessing (EMDR) within couples counseling, where one or both members of a couple participated in EMDR with his/her partner present.

If you are:

- 1) an EMDR trained therapist who provided EMDR within couples therapy (with both members of the couple present) and completed this course of treatment within the past six months; or
  - 2) an adult client who is in a committed relationship and who completed EMDR within couples therapy (with you and your partner present) within the past six months,
- I would appreciate your help with this study!

I am interested in speaking with clients (and both their partners and therapists) who participated in EMDR after having experienced upsetting events that had a negative impact on themselves and/or their relationship, including various types of traumas (for example, sexual assault, physical abuse, or car accident, as well as those such as divorce, unfaithfulness by a partner, or abandonment/neglect as a child or adult).

If you agree to participate in this study, each person will be interviewed separately for 60-90 minutes about your experience (as a client or therapist) of the EMDR process within couples therapy, what you found to be helpful or unhelpful about the EMDR process, and any changes that you experienced or observed individually and/or as a couple.

Each person who chooses to participate will be entered into a raffle to win a \$25 Visa gift card.

If you are interested in participating, please read the attached consent form and respond by email: [legg4874@unco.edu](mailto:legg4874@unco.edu) or phone: 720-244-1468.

Thank you for your time. Please forward this information to anyone who you think would be interested and would qualify to participate in this study.

Sincerely,

Elizabeth Legg, MA, LPC, NCC  
EMDR Certified Therapist  
Doctoral Candidate,  
Counseling Psychology PhD Program,  
University of Northern Colorado

**APPENDIX F**

**INFORMED CONSENT FOR THERAPIST  
PARTICIPANTS**

UNIVERSITY of  
NORTHERN COLORADO



**CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH  
UNIVERSITY OF NORTHERN COLORADO**

**Dissertation Title:** Eye Movement Desensitization and Reprocessing in Conjoint Couples Therapy:

A Grounded Theory Study

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**Dissertation Chair:** Mary Sean O'Halloran, PhD, Licensed Psychologist, Counseling Psychology Program

**Phone:** 970-351-1640

**E-mail:**

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**Consent Form for Therapist Participants**

**Purpose and Description of the Study:**

I am studying the experience of clients and therapists during Eye Movement Desensitization and Reprocessing (EMDR) within conjoint couples therapy. I will interview EMDR trained therapists who conducted EMDR with one or both members during couples therapy (with both members present) as well as each member of these couples. Through these interviews, I will develop a theory to explain the factors and conditions that contribute to the change process and those that decrease or interfere with the usefulness of EMDR within couples therapy. I am interested in hearing from your experience with clients (and their partners) who participated in EMDR after having experienced upsetting events that had a negative impact on themselves and/or their relationship, including various types of traumas (for example, sexual assault, physical abuse, or car accident, as well as those such as divorce, unfaithfulness by a partner, or abandonment/neglect as a child or adult).

**To Qualify for the Study:**

If you meet the following criteria, I would be interested in hearing about your experience:

- You are an EMDR trained therapist.
- You provided EMDR with one or both members as part of couples therapy (with both members of the couple present) to clients in a committed relationship.
- You completed this course of treatment within the past six months.
- You believe that both members of the couple are stable and appropriate to be interviewed for this study.
- You are willing to contact the couple, provide each member with information about the study, and request that each member sign an Authorization to Release Information form to obtain permission to share their contact information with me.

**Therapist Participants' Role:**

If you and members of the couple(s) you conducted EMDR with agree to participate in this study,

- I will interview you individually in a quiet area (e.g., your office, my office, or a local library), if possible. If not possible due to location or scheduling, interviews may be conducted by Skype or phone. I will ask you open-ended questions that will last an hour to an hour and a half. Questions will focus on describing your experience as a therapist providing EMDR treatment to clients within couples therapy, what you saw as valuable

and helpful about the EMDR process, what you believe may have interfered with the process, and observations of clients' status individually and in terms of their relationship both before and after the EMDR process.

- I may also ask you follow-up questions to develop a better understanding of your unique experience as a therapist who provided EMDR treatment to one or both members of a couple, with their partner present.
- Interviews will be audio recorded and transcribed (typed in written form).
- You are invited to provide copies of documents such as questionnaires, measures, or other written information that provide information about clients' functioning before, during, and/or after their EMDR therapy experience.
- You will have the opportunity to review your transcription and codes from your interview to determine whether these capture your experience, and to review the theory that is developed from all interviews to evaluate whether it fits with your experience.

#### **Your Information:**

- Every precaution will be taken to protect your confidentiality.
- You will be given the opportunity to choose your own pseudonym (fake name) that will be included with your information. Only I will know your identity.
- All information will be stored in a locked cabinet or electronic file and will only be accessible to me, research assistants, and my dissertation chair. No specific information that could be identifying (e.g., job title, employer, school, etc.) will be included with the data.
- I will keep your information for three years after the completion of this study and then identifying information such as consent forms will be destroyed.
- I will report the findings as part of my doctoral dissertation and I may present the results at a professional conference and/or submit a manuscript for professional publication.
- You may request a copy of the final paper to review before I submit it for publication or professional presentation.

#### **Risks and Benefits:**

- No risks are anticipated from your participation in this study.
- You will be entered into a raffle to win one of four \$25 gift cards for your participation.
- Possible benefits may also include increased awareness or understanding about the therapeutic process of EMDR within couples counseling, about your clients, or about yourself as a therapist. You may also experience a sense of satisfaction about contributing to the field of therapy and potentially benefiting other clients in the future.

Participation is voluntary. You may decide not to participate in this study and if you begin participation, you may still decide to stop and withdraw at any time. If you decide to withdraw, you will still be eligible for the gift card drawing. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research study. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

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Participant's Signature

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Date

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Researcher's Signature

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Date

**APPENDIX G**

**INFORMED CONSENT FOR CLIENT  
PARTICIPANTS**



UNIVERSITY of  
NORTHERN COLORADO



**CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH  
UNIVERSITY OF NORTHERN COLORADO**

**Dissertation Title:** Eye Movement Desensitization and Reprocessing in Conjoint Couples Therapy:

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**Researcher:** Elizabeth Legg, MA, Student in Counseling Psychology PhD Program

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**Consent Form for Client Participants**

**Purpose of the Study:**

I am studying the experience of clients and therapists during Eye Movement Desensitization and Reprocessing (EMDR) within couples therapy (with both members of the couple in the room). I will interview therapists who provided EMDR therapy as part of couples therapy and each member of these couples. Through these interviews, I will develop a theory to explain the factors and conditions that contribute to the change process and those that decrease or interfere with the usefulness of EMDR within couples therapy. I am interested in speaking with clients (and their partners) who participated in EMDR after having experienced upsetting events that had a negative impact on themselves and/or their relationship, including various types of traumas (for example, sexual assault, physical abuse, or car accident, as well as those such as divorce, unfaithfulness by a partner, or abandonment/neglect as a child or adult).

**To Qualify for the Study:**

If the following apply to you, I would be interested in hearing about your experience:

- You are an adult in a committed relationship.
- You and/or your partner completed EMDR within couples therapy (both you and your partner were in the room during EMDR) within the past six months.
- You are willing to allow your therapist and your partner to be interviewed about this process of EMDR within couples therapy.

**Client Participants' Role:**

If you, your partner, and your therapist agree to participate in this study,

- I will interview you individually in a quiet area (e.g., a local library or my office), if possible. If not possible due to location or scheduling, interviews may be done by Skype or phone. I will ask you open-ended questions that will last an hour to an hour and a half. Questions will focus on describing your experience as a client who participated in EMDR within couples therapy, what you saw as valuable about the EMDR process, what you believe may have interfered with the process, and your status individually and in terms of your relationship before and after the EMDR process.
- I may also ask you follow-up questions to better understand your unique experience as a client who participated in or witnessed EMDR, with your partner present.
- Interviews will be audio recorded and transcribed (typed in written form).

- You are invited to provide copies of personal writings (e.g., journal entries, letters, or poems) or artwork that reflects your experience individually or in terms of your relationship before, during or after the therapy process.
- You will have the opportunity to review your transcription and codes of your interview to decide whether these capture your experience, and to review the theory that is developed from all interviews to assess whether it fits with your experience.

#### **Your Information:**

- Every step will be taken to protect your confidentiality.
- You will be able to choose your own pseudonym (fake name) that will be included with your information. Only I will know your identity.
- All information will be stored in a locked cabinet or electronic file that can only be accessed by me, research assistants, and my dissertation chair. No specific information that could be identifying (e.g., job title, employer, school, etc.) will be included with the interview data.
- I will keep your information for three years after the completion of this study and then identifying information such as consent forms will be destroyed.
- I will report my findings as part of my doctoral dissertation and I may present the results at a professional conference and/or submit a manuscript for professional publication.
- You may request a copy of the final paper to review before I submit it for publication or professional presentation.

#### **Risks and Benefits:**

- Potential risks in this project are minimal. Because you will be interviewed about your experience as a client who participated in couples therapy involving EMDR, there may be some degree of emotional discomfort during your interview. Your interview will involve thinking about your experience in couples therapy. Describing your experience of therapy may include thinking and talking about upsetting experiences from your past or related to your relationship.
- You may choose how much you would like to share about those experiences.
- You will be provided with mental health resources.
- You will be entered into a raffle to win one of four \$25 gift cards for your involvement in this study.
- Possible benefits may also include increased insight or understanding about your therapy process, yourself, or your partner, and an increased sense of closeness with your partner. You may also experience a sense of satisfaction about contributing to the field of therapy and possibly helping other clients in the future.

Participation is voluntary. You may decide not to participate in this study and if you begin, you may still decide to stop and withdraw at any time. If you decide to withdraw, you will still be eligible for the gift card drawing. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research study. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

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Participant's Signature

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Date

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Researcher's Signature

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Date

## **APPENDIX H**

### **AUTHORIZATION TO RELEASE INFORMATION**

**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_, authorize **Elizabeth Legg, MA, LPC, NCC** to obtain from, and share information with:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Regarding: \_\_\_\_\_

	Client's name	Client's DOB	Client Signature	Date
Information may include:				
<input checked="" type="checkbox"/>	Social History			Dental
<input checked="" type="checkbox"/>	Psychological Testing/Reports			Immunizations
	Hospitalizations			Medical Records
<input checked="" type="checkbox"/>	Progress in therapy			Transcripts
	Court Reports/Investigative Reports	<input checked="" type="checkbox"/>		Test Data
	Academic progress	<input checked="" type="checkbox"/>		Attendance Data
	Placement History			Health Records
	Other _____			

Information to be used for:				
	Assessment			Leaving School.
	Service Planning			Entering School
	Continuity of Care			College Admission
<input checked="" type="checkbox"/>	Other Research Purposes			Employment

I understand that I may revoke this authorization to release/request information at any time by giving written notice to **Elizabeth Legg, MA, LPC, NCC**. Without such revocation, this authorization shall expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date). (If left blank, one (1) year from the date of my signature). I also herewith release **Elizabeth Legg, MA, LPC, NCC** from all liability for releasing such information.

**NOTICE TO WHOM THIS INFORMATION IS GIVEN:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

I hereby revoke this Authorization to Release/Request for Information:

Client: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

A copy of this Authorization is as valid as the original.

**APPENDIX I**  
**MENTAL HEALTH RESOURCES**

## MENTAL HEALTH RESOURCES

**Call these numbers below, or go to your nearest hospital's emergency room.**

**Emergency for Denver County Residents** (psychiatric, drug/alcohol):

Denver Health Medical Center (formerly Denver General)

777 Bannock St.----- 303 602-7221

303 602-7236

Mobile Crisis (for Denver Medicaid clients only) ----- 303 602-7220

**Emergency for non-Denver County Residents:**

**Call Crisis Lines for Community Mental Health Centers**

Adams County Mental Health Center ----- 303 853-3500

Arapahoe Mental Health Center ----- 303 730-3303

Aurora Community Mental Health Center (North office) ----- 303 617-2400

Jefferson Center for Mental Health ----- 303 425-0300

Note: This line rolls over to Inpatient Pavilion for University of

Colorado Health Sciences Center at night (12605 E. 16<sup>th</sup> Ave –

Colfax & Ursula) ----- 720 848-5197

**Child Mental Health Emergency**

Children's Hospital ----- 720 777-6200

1-800-624-6553

**Domestic Violence**

Alternatives to Family Violence (Adams County) ----- 303 289-4441

Boulder County Safehouse (Crisis Line) ----- 303 444-2424

Gateway Battered Women's Shelter (Arapahoe County/North) - 303 343-1851

Gateway Battered Women's Shelter (Arapahoe County/South)

(Not Crisis Line) ----- 303 761-7721

Safehouse (Denver County) ----- 303 830-2660

Brandon Center (Denver County) ----- 303 620-9190

Women in Crisis (Jefferson County) ----- 303 420-6752

Women's Crisis Center of Douglas County ----- 303 688-8484

Rape/Sexual Assault

Rape Awareness and Assistance Program (RAAP) ----- 303 322-7273

303 329-0031 (Spanish)

303 729-0023 (TTY)

Suicide Hotline

COMITIS Helpline ----- 303 343-9890

National Suicide Prevention Lifeline ----- 1-800-273-TALK (8255)

1-888-628-9454 (Spanish)

[www.myspace.com/suicidepreventionlifeline](http://www.myspace.com/suicidepreventionlifeline)

## MENTAL HEALTH RESOURCES

**Call these numbers below, or go to your nearest hospital's emergency room.**

<ul style="list-style-type: none"> <li>• <b>Adolescent Suicide Hotline</b> 800-621-4000</li> <li>• <b>Adolescent Crisis Intervention &amp; Counseling Nineline</b> 1-800-999-9999</li> <li>• <b>AIDS National Hotline</b> 1-800-342-2437</li> <li>• <b>CHADD-Children &amp; Adults with Attention Deficit/Hyperactivity Disorder</b> 1-800-233-4050</li> <li>• <b>Child Abuse Hotline</b> 800-4-A-CHILD</li> <li>• <b>Cocaine Help Line</b> 1-800-COCAINE (1-800-262-2463)</li> <li>• <b>Domestic Violence Hotline</b> 800-799-7233</li> <li>• <b>Domestic Violence Hotline/Child Abuse</b> 1-800-4-A-CHILD (800 422 4453)</li> <li>• <b>Drug &amp; Alcohol Treatment Hotline</b> 800-662-HELP</li> <li>• <b>Ecstasy Addiction</b> 1-800-468-6933</li> <li>• <b>Eating Disorders Center</b> 1-888-236-1188</li> <li>• <b>Family Violence Prevention Center</b> 1-800-313-1310</li> <li>• <b>Gay &amp; Lesbian National Hotline</b> 1-888-THE-GLNH (1-888-843-4564)</li> <li>• <b>Gay &amp; Lesbian Trevor HelpLine Suicide Prevention</b> 1-800-850-8078</li> <li>• <b>Healing Woman Foundation (Abuse)</b> 1-800-477-4111</li> <li>• <b>Help Finding a Therapist</b> 1-800-THERAPIST (1-800-843-7274)</li> <li>• <b>Incest Awareness Foundation</b> 1-888 -547-3222</li> <li>• <b>Learning Disabilities - (National Center For)</b> 1-888-575-7373</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Missing &amp; Exploited Children Hotline</b> 1-800-843-5678</li> <li>• <b>National Alliance on Mental Illness (NAMI)</b> 1-800-950-NAMI (6264)</li> <li>• <b>Panic Disorder Information Hotline</b> 800- 64-PANIC</li> <li>• <b>Post Abortion Trauma</b> 1-800-593-2273</li> <li>• <b>Project Inform HIV/AIDS Treatment Hotline</b> 800-822-7422</li> <li>• <b>Rape (People Against Rape)</b> 1-800-877-7252</li> <li>• <b>Rape, Abuse, Incest, National Network (RAINN)</b> 1-800-656-HOPE (1-800-656-4673)</li> <li>• <b>Runaway Hotline</b> 800-621-4000</li> <li>• <b>Self-Injury Hotline SAFE</b> (Self Abuse Finally Ends) 1-800-DONT CUT (1-800-366-8288)</li> <li>• <b>Sexual Assault Hotline</b> 1-800-656-4673</li> <li>• <b>Sexual Abuse - Stop It Now!</b> 1-888-PREVENT</li> <li>• <b>STD Hotline</b> 1-800-227-8922</li> <li>• <b>Suicide Prevention Lifeline</b> 1-800-273-TALK</li> <li>• <b>Suicide &amp; Crisis Hotline</b> 1-800-999-9999</li> <li>• <b>Suicide Prevention - The Trevor HelpLine</b> (Specializing in gay and lesbian youth suicide prevention) 1-800-850-8078</li> <li>• <b>Teen Helpline</b> 1-800-400-0900</li> <li>• <b>Victim Center</b> 1-800-FYI-CALL (1-800-394-2255)</li> <li>• <b>Youth Crisis Hotline</b> 800-HIT-HOME</li> </ul>
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**APPENDIX J**

**DEMOGRAPHIC INFORMATION SHEET**



## Demographic Information Sheet

1. Pseudonym: \_\_\_\_\_
2. Age: \_\_\_\_\_
3. Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Transgender \_\_\_\_\_
4. Relationship status (e.g., married, common-law): \_\_\_\_\_
5. Highest level of education completed: \_\_\_\_\_
6. Ethnicity/Race: \_\_\_\_\_
7. Religious Affiliation, if any: \_\_\_\_\_
8. Approximate Annual Income: \_\_ \$25,000 or less \_\_ 26,000-\$40,000 \_\_ \$41,000 to \$55,000  
\_\_ \$56,000-\$70,000 \_\_ \$71,000-\$85,000 \_\_ \$86,000-\$100,000 \_\_ Above \$100,000
9. Occupation: \_\_\_\_\_
10. Previous therapy experience, including time period and approximate number of sessions: \_\_\_\_\_  
\_\_\_\_\_
11. Is this your first committed relationship or marriage? Yes \_\_\_\_\_ No \_\_\_\_\_  
If no,
  - please explain (e.g., divorce/separation from previous partner, death of partner/spouse): \_\_\_\_\_  
\_\_\_\_\_
  - how many times have you previously been involved in a committed relationship or been married?: \_\_\_\_\_
12. How long have you been involved with or married to your current partner/spouse?  
\_\_\_\_\_
13. Do you or your spouse/partner have children: Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please provide their ages, whether they live with you, and their relationship to you and your partner/spouse: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Please include any other demographic information that you believe would be important for us to know about you for the purposes of this study:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPENDIX K**  
**INTERVIEW QUESTIONS**

### Sample Research Interview Questions for Client Participants

- Demographic information: age, gender, ethnicity, occupation, relationship status, length in current relationship (if applicable), etc.
- What, if any, previous therapy experience did you have, before entering into couples therapy?
- What brought you into therapy (in the past, if applicable, and for this specific couples therapy)?
- Please describe your own personal status and the status of your relationship at the beginning of couples therapy.
- How did you come to participate in EMDR treatment (either directly or indirectly) as part of couples therapy?
- Describe your experience of EMDR treatment (during and any changes that you believe to be related to that treatment, both individually and as a couple).
- Please describe your own personal status and the status of your relationship at the end of couples therapy.
- Subsequent follow-up, probing and clarifying questions.
- Please select a pseudonym, or name for yourself, to be used for this research study.

### Sample Research Interview Questions for Therapist Participants

- Demographic information: age, gender, ethnicity, title (e.g., Licensed Professional Counselor, Psychologist, etc.), level of EMDR training and experience, professional specializations/expertise and preferred populations/treatment issues, theoretical orientation, etc.
- What brought this couple into therapy with you?
- Please describe the status of each individual and their relationship at the beginning of couples therapy.
- How did the member(s) of the couple come to participate in EMDR treatment as part of couples therapy?
- Describe your experience of providing EMDR treatment with this couple, including during the treatment itself and in terms of any changes that you believe to be related to that treatment—individually and as a couple.
- Please describe the status of each individual and their relationship at the end of couples therapy.
- Subsequent follow-up, probing and clarifying questions.
- Please select a pseudonym, or name for yourself, to be used for this research study.

## **APPENDIX L**

### **CONJOINT EYE MOVEMENT DESENSITIZATION AND REPROCESSING CASE FLOW**

## CONJOINT EMDR CASE FLOW

**Assessment** (Parallels phase 1 of standard EMDR protocol, client history and treatment planning):

### **Therapist:**

- Does the therapist have an integrated approach, with a balance of individual and systemic dynamics within a theoretical framework with a focus on personal responsibility (vs. blaming or changing one's partner)?
- Does the therapist have sufficient competence and confidence in conducting conjoint EMDR? Does the couple have confidence, trust, safety, and alignment with the therapist?

### **Working Partner:**

- Does the intra- and inter-personal functioning of the working partner (attachment security, anger, investment in personal change, degree of differentiation, etc.) suggest readiness?
- Has a trauma history been obtained?
- Does the working partner have sufficient stability and resources?
- Is the working partner willing to be vulnerable in front of the therapist and the witnessing partner?

### **Witnessing Partner:**

- Does the intra- and inter-personal functioning of the witnessing partner (attachment security, anger, investment in personal change, degree of differentiation, etc.) suggest readiness?
- Does the witnessing partner have sufficient stability and resources?
- Has the witnessing partner's trauma history been obtained? Is the witnessing partner aware of the working partner's trauma history?
- Does the witnessing partner demonstrate the ability to provide sufficient support and safety to the working partner?

### **Relationship**

- Does the couple experience interpersonal reactivity/interlocking trauma reactions? Has adequate assessment been done to identify the negative interaction patterns and the needs each partner is attempting to meet through such behavior? Is there sufficient safety and trust within the relationship?
- Is there sufficient engagement in therapy and cooperation by both members?
- Are both members' goals in alignment with one another in terms of personal accountability and growth?
- Is there sufficient strength and commitment within the relationship?

If **YES** to all and **sufficient stability**, proceed to preparation phase below.  
 If **NO** to a few, but **relative stability**, build resources to strengthen individual(s) and/or relationship functioning prior to moving forward  
 If **NO** to several and there is evidence of **instability or high-risk re: safety**, stabilize and consider hospitalization, medication evaluation, safety planning, crisis intervention, etc.

**Preparation** (parallels phases 2 and 3, preparation and assessment, of standard EMDR protocol):

consider contextual factors, such as previous familiarity with EMDR, history of individual EMDR (with or without the conjoint therapist individually), whether both partners will take on one or both roles (witnessing and working partner), and reason for referral; provide sufficient preparation for both partners:

- Introduce EMDR during alliance building, while highlighting "past is present"; introduce EMDR language and concepts; identifying negative and positive cognitions relevant to significant events in each partner's history
- Provide psycho-education (impact of trauma, role of EMDR in trauma resolution, description of EMDR, research about EMDR and conjoint EMDR, provide resources for further research, etc.)
- Present potential benefits (e.g., symptom relief, reduce interpersonal reactivity, increase awareness re: self/partner/relationship dynamics, etc.) and obstacles (emotional exposure,

learn difficult material about partner, inability to “un-know” material, intrusion/distraction by partner, etc.) to conjoint EMDR and when compared to individual EMDR

- Review the requirements of both partners (e.g., focus on increasing own awareness and on personal change vs. changing one’s partner, need for alignment of goals, needs for support from witnessing partner, instruct witnessing partner to journal about reactions during EMDR to remain present, working partner to identify “stop signal,” etc.)
- Empower the couple in decision making (individual vs. conjoint, who will take on working role first, choice of target, type of bilateral stimulation, timing re: initiation of conjoint EMDR, whether to participate in individual EMDR first, etc.)
- Provide conjoint resource development and installation (e.g., safe place and/or light stream)
- Review of ongoing processing outside of session (including planning for self-care and rules re: limiting/containing material between sessions)

**Desensitization** (parallels phase 4 of standard EMDR protocol):

- One partner engages in bilateral stimulation while recalling a disturbing memory (e.g., floating back to an earlier memory from outside of the current relationship that parallels a recurring negative interaction pattern that occurs within the relationship) and the other serves as a supportive witness
- Witnessing partner keeps journal to note reactions
- Assess conjoint EMDR process during initial and ongoing sessions (e.g., affect tolerance, distraction, safety, intrusion, use of material as weapon against partner, etc.)

**Installation** (parallels phase 5 of standard EMDR protocol):

- Skip this step if session is incomplete (disturbance remains)
- If PC continues to be relevant, assess VoC and link PC with image and memory, while engaging in BLS (or new PC is obtained and installed), with partner present as witness
- Continue installation until it no longer strengthens
- If VoC is 6 or less, address any blocking beliefs, if relevant, with BLS

**Body Scan** (parallels phase 6 of standard EMDR protocol):

- Skip this step if session is incomplete (disturbance remains)
- Assess for bodily disturbance/tension and engage in BLS to target disturbance/tension, if relevant, or to strengthen positive body sensations with BLS

**Closure** (parallels phase 7 of standard EMDR protocol):

- Provide opportunity for debriefing with both partners, beginning with working partner (witnessing partner may share observations from journal)
- If session is incomplete, skip installation and body scan steps, and provide containment (e.g., safe place exercise)
- Discuss ongoing processing that may continue after session
- Plan for containment and/or limits to verbal processing between partners until following session, discuss use of safe place exercise or other techniques/resources to cope with material that surfaces, and ask partners to note any material that emerges between sessions (and provide other homework that may be relevant)

**Re-Evaluation** (parallels phase 8 of standard EMDR protocol): this step determines need for any further preparation:

- Assess conjoint EMDR process during initial and ongoing sessions (e.g., safety, affect tolerance, distraction, intrusion, use of material as weapon against partner, etc.)
- Review material that surfaced between sessions and revisit last conjoint EMDR session to further debrief with each partner (re-assess SUDs and VoC levels and discuss any concerns about moving forward with conjoint EMDR, evaluate use of container and/or compliance with agreements made—e.g., not using material as weapon)
- Attend to needs in the moment (attune to body language, explore triggers between sessions, watch for in-session reactivity) and/or continue unfinished conjoint EMDR for unfinished target, move to new target of three-pronged plan, or move to EMDR for other partner

**APPENDIX M**  
**DRAFT OF ARTICLE**

Eye Movement Desensitization and Reprocessing in Conjoint Couples Therapy:

Relational Trauma Treatment Theory

Elizabeth Legg & M. Sean O'Halloran

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trltcounseling@gmail.com

720-244-1468 (phone), 303-455-0661 (fax)

M. Sean O'Halloran:

Professor, Department of Counseling Psychology and Director, Psychological Services

Clinic, Counseling Psychology PhD Program, University of Northern Colorado:

248 McKee Hall, Box 131, 501 20<sup>th</sup> St. Greeley, CO 80639

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970-351-1640 (phone), 970-351-2625 (fax)



### **Abstract**

Eye movement desensitization and reprocessing (EMDR) is an evidence-based trauma treatment primarily conducted within individual therapy. Though it has been incorporated into couples and family therapy in recent years, limited research has examined its use within conjoint couples therapy and none has systematically investigated the experience of both clients and therapists. The purpose of this grounded theory study was to explore the experiences of couples and therapists during conjoint EMDR. Interviews were conducted with 21 participants including seven couples and their therapists. Interviews were analyzed using Strauss and Corbin's (1998) grounded theory data analysis. The theory developed from the data about conjoint EMDR as a relational trauma treatment provides perspectives not captured in previous research and offers guidance about assessment and preparation procedures.

*Keywords:* couple, EMDR, Eye Movement Desensitization and Reprocessing, grounded theory

## **EYE MOVEMENT DESENSITIZATION AND REPROCESSING IN CONJOINT COUPLES THERAPY: RELATIONAL TRAUMA TREATMENT THEORY**

### **Introduction**

It was amazing...how...the things that our minds would dwell on during the EMDR were...symbolic of how we processed life, how our temperaments work, and then down the line, how we interacted in our relationship.... When I started with the EMDR,...one of the huge things I was focusing on that I couldn't get past was that a salad that I had been making before the accident was all over the sofa.... I kept looking at it after the accident and thinking that I have to clean this up, people are going to think I'm a messy person, and in the state I was in [after having been knocked unconscious],...I was there cleaning up the mess. And later on, we were able to tie that to how I have, almost my whole life, had to please other people, had to clean up messes and had take care of everybody, had to make sure everything was perfect.... It was a huge aha moment. (Beth, client participant)

We learn about trust and safety through our earliest relationships, namely those with our primary caretakers. When a traumatic experience causes a disruption in our sense of safety in the world, this event inevitably impacts our perception of ourselves, others, and the world as a whole. Thus, in order to recover from such trauma, it is essential that safety and trust be re-established, and that healing occur within the context of a supportive relationship.

Several treatment approaches are effective in reducing posttraumatic stress disorder (PTSD) symptoms; those that target the trauma-related symptoms through exposure and trauma processing (including in vivo as well as imaginal exposure) within a safe and supportive relationship seem to be most effective (van der Kolk, McFarlane, & van der Hart, 2007). Exposure treatments are effective in reducing re-experiencing symptoms, while group therapy for survivors is helpful in addressing the interpersonal effects of traumatic exposure such as the numbing and detachment symptoms (Herman, 1997; van der Kolk et al., 2007). Eye movement desensitization and reprocessing

(EMDR) is a comprehensive and evidence-based method of psychotherapy for trauma, which is primarily conducted within individual therapy (Shapiro, 2001). Eye movement desensitization and reprocessing is an experiential treatment that allows for imaginal exposure, reprocessing, and integration of traumatic material into a coherent narrative.

Research demonstrates increased success rates for anxiety, depression, and PTSD when couples therapy is incorporated into treatment (Barlow et al., 1984; Bowling, 2002; Cerney, Barlow, Craske, & Himadi, 1987). Couples therapy provides a context in which healing from trauma can occur and where the traumatized partner can re-establish a safe haven and secure base within the relationship, when both partners are invested and committed to this process (Johnson, 2002). Alexander (2003) noted the power for partners to witness their spouse's trauma narrative as survivors work toward developing an integrated and coherent story. Furthermore, rather than the therapist serving as the corrective attachment figure as with individual therapy, a couples therapy context allows the opportunity for one's intimate partner to contribute to that corrective experience.

Though EMDR has been incorporated into couples and family therapy in recent years (Capps, 2006; Capps, Andrade, & Cade, 2005; D'Antonio, 2010; Errebo & Sommers-Flanagan, 2007; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke, & Sparks, 2001; Protinsky, Sparks, & Flemke, 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007), researchers are only just beginning to examine its use within a conjoint couples therapy context (see Capps et al., 2005; Protinsky, Flemke, & Sparks, 2001; Protinsky, Sparks, & Flemke, 2001; Litt, 2008, 2010; Moses, 2003, 2007; Reicherzer, 2011; Talan, 2007 for examples of those who have). Furthermore, none have included interviews to explore the *experience* of couples

and therapists. The existing literature related to conjoint EMDR is primarily from the perspective of therapists and is generally in the form of case illustrations and proposed protocols for integration of EMDR within couples therapy, without systematic research of the conjoint EMDR process.

Johnson, Hunsley, Greenberg, and Schindler (1999) noted that within couples and family therapy research, the client's perspective on the change process has been generally neglected and recommended that this perspective should be explored in future research. Since that time, researchers have argued that there is a gap between research and practice in that it is still not understood how conjoint therapy works and what factors lead to therapeutic outcomes (Heatherington, Friedlander, & Greenberg, 2005). Thus, it is worthwhile to understand the clients' perspective about the therapeutic process of conjoint EMDR to inform both research and practice in the fields of couples therapy and trauma treatment.

One of the most powerful observed effects of integrating EMDR into couples therapy is the revelation of each partner's vulnerabilities which in turn, evokes empathy and support from the observing or witnessing partner (Capps, 2006; Capps et al., 2005; Litt, 2008, 2010; Moses, 2003, 2007). Traumatic experiences not only impact individuals' view of themselves, others, and the world, but they also impact their relational and attachment patterns (Alexander, 2003; Herman, 1997; Turner, McFarlane, & van der Kolk, 2007). For example, individuals who experienced emotional neglect as children will likely be impacted in their attachment style as adults (Johnson, 2002; Perry, 2009; Schachner, Shaver, & Mikulincer, 2003; Wesselmann & Potter, 2009), which may contribute to difficulties within intimate relationships. Therefore, incorporating a trauma-

focused treatment such as EMDR into couples therapy may contribute to positive changes within interpersonal factors such as communication, trust, empathy, and intimacy. In fact, Wesselmann and Potter (2009) demonstrated that clients' attachment status did change following EMDR therapy. However, their study involved EMDR applied individually and not within the context of conjoint couple sessions.

Eye movement desensitization and reprocessing's protocol incorporates clients' assessment of personal change through rating their Subjective Unit of Distress (SUDs) and their Validity of Cognition (VoC); however, these number ratings provide a numerical baseline and a follow-up measure but not a descriptive narrative of their experienced change. The current study examined how addressing past trauma through EMDR treatment within conjoint therapy was experienced by both members of the couple as well as by the therapist facilitating the sessions. By interviewing members of the couple and the therapist, more can be learned about the differences between EMDR therapy within the modalities of individual versus couples therapy and factors that contribute to the efficacy of EMDR treatment in conjoint therapy. These data could provide valuable information regarding appropriate preparatory steps and assessment procedures prior to deciding how EMDR might be incorporated into the treatment plan. The more that is understood about the process of EMDR from clients' perspectives as well as from that of the therapist, the more effectively individual and relational issues impacted by trauma can be addressed and resolved.

The purpose of the current study was to explore the experience of clients and therapists during EMDR treatment within the context of conjoint couples therapy and, through interviews and document review, to develop a theory grounded in the data. This

theory provides a preliminary understanding of the process of conjoint EMDR, including the related meanings and conditions that play a role for participants, and provides a theoretical explanation for how various factors and conditions contribute to the change process as well as those that decrease or interfere with its usefulness as a treatment modality. Specifically, the research questions were:

- Q1     How do members of couples describe their experience of conjoint couples therapy involving EMDR treatment?
- Q2     How do therapists describe their experience of providing EMDR treatment within the context of conjoint couples therapy?
- Q3     What do participants perceive as valuable or meaningful about the process?
- Q4     What do they perceive as impeding the process or not valuable? 5) How does each participant describe the status of the couple prior to and following EMDR, both individually and relationally?

### **Methodology**

Grounded theory was chosen as the methodology, given the limited research conducted within this area of study. According to Stern (1995), “the strongest case for the use of grounded theory is in investigations of relatively uncharted water, or to gain a fresh perspective in a familiar situation” (p. 30). Grounded theory is a systematic methodology that involves both inductive and deductive methods, which results in the development of a theory about a particular phenomenon or process through the analysis of participant data (Charmaz, 2005, 2006; Creswell, 2007; Strauss & Corbin, 1998). Grounded theory methods include the following: (a) simultaneous data collection and analysis, (b) a process for coding data, (c) comparative methods, (d) memo writing as a means of creating conceptual analyses, (e) theoretical sampling, and (f) development of a theoretical model (Charmaz, 2005).

Currently, the two most common approaches to grounded theory research are the systematic methodological procedures of Strauss and Corbin (1998) and the constructivist perspective of Charmaz (Creswell, 2007). Strauss and Corbin's grounded theory data analysis method includes (a) open coding--to identify and develop categories, (b) axial coding--to identify the relationships among categories, and (c) selective coding-- to synthesize the categories into a theoretical model. In the current study, the classic method of data analysis outlined by Strauss and Corbin is utilized, informed by Charmaz's (2006) constructivist epistemological and theoretical approach, which highlights multiple realities based on each individual's unique constructed meanings, shaped by one's culture and interactions with the world (Creswell, 2007).

### **The Researcher**

In qualitative research, the researcher is the primary instrument of data collection and analysis (Creswell, 2007). I assume Charmaz's (2006) perspective that "neither data nor theories are discovered," but rather "we are part of the world we study and the data we collect. We *construct* our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices" (p. 10, emphasis in original). Thus, throughout this research, I recognized that I would be offering an interpretation of participants' experience rather than an objective reflection. Given my primary role in collecting and analyzing data as well as my own background that served as a starting point, it was important for me to be reflexive and endeavor to be aware of my biases as well as remain open to participants' experience throughout the process in order to allow their voices to guide the research.

My personal interest in this topic came from my experience as a Licensed Professional Counselor over the eight years prior to this research and as an emerging Counseling Psychologist. Much of the clinical work that I had conducted was with individuals who had experienced trauma, and whose behavior and interpersonal dynamics had been significantly impacted by that experience. I had witnessed the devastating impact of trauma on clients' perception of themselves and the world, just as I had had the privilege of witnessing powerful healing and transformation through clinical intervention and loving relationships.

I had been trained in EMDR six years prior to the current study and obtained certification through EMDR International Association (EMDRIA) as an EMDRIA Certified Therapist. I incorporated this modality into much of my therapeutic work with clients. Through this work, I had observed powerful shifts in clients' view of themselves, others, and the world as a result of reprocessing past traumatic material. Over the four years prior to the current study, I had begun integrating EMDR into couples therapy. I was inspired to further explore the experience of EMDR within couples therapy as a topic for my dissertation, after being deeply touched by the increased empathy, trust, understanding, and intimacy that I witnessed in clients who participated in this treatment with their partner.

### **Participants**

Participants for this study included seven triads (see Table 1 for demographic information), composed of individuals who had participated in conjoint couples therapy in which EMDR was utilized with one or both members of the couple, as well as the therapists who had provided the therapy to each couple, resulting in a total of 21



participants. Purposive sampling (Merriam, 1998) was initially utilized to identify participants, followed by theoretical sampling (Strauss & Corbin, 1998) in order to modify the sample as appropriate, based on the emerging data. Follow-up interviews were conducted with two participants to provide further information in the theory development.

The participant recruitment process lasted five months, involved hundreds of emails, dozens of recruitment letters and consent forms through the mail, and many phone calls, and the process continued until the point of saturation. This intensive recruitment included the following: contacting personally known EMDR therapists, posting information about the study on the EMDR Institute listserv on two occasions, contacting the Research Special Interest Group for the EMDR International Association (EMDRIA), posting information about the research on the EMDRIA General listserv, sending emails to all consultants as well as all certified therapists listed on the EMDRIA directory who work with couples, posting a discussion thread twice on the LinkedIn EMDR discussion group, contacting authors and researchers who had studied and presented on the topic of EMDR with couples, contacting Division 56 (Division of Trauma Psychology) of the American Psychological Association about distributing information on their listserv, reaching out to therapists who provide EMDR therapy and work with couples through various psychotherapy directories, contacting a number of trauma centers and institutes, holding a workshop about EMDR within couples therapy in my private practice, presenting a poster at state wide conference about conjoint EMDR, contacting psychotherapy centers and institutes, emailing psychotherapy networking groups, contacting Emotionally Focused Therapy trained practitioners from the

International Centre for Excellence in Emotionally Focused Therapy (ICEEFT) web site, contacting the EMDRIA Board of Directors, emailing the editor for the Journal of EMDR Practice and Research, reaching out to the EMDR Research Foundation, as well as contacting former presenters at the EMDRIA annual conference. These initial recruitment efforts resulted in a snowball sampling strategy, such that those I contacted shared information about the study with colleagues, friends, and trainees; distributed information about this research in newsletters and local listservs; and shared with me contact information for colleagues, whom I then contacted. The result of these efforts was the inclusion of the current sample of 21 participants.

Table 1

*Participant Demographic Information*

Participant	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	Triad 6	Triad 7
Therapist	Bill	Cat	Rich	Fred	Nancy	Michelle	Doris
Age	52	56	43	58	54	54	66
Gender	Male	Female	Male	Male	Female	Female	Female
Ethnicity	White	Eastern European/ Jewish	Caucasian	Anglo, Caucasian	Caucasian	African American	English/Irish
Title	MFT, Consultant, Trainer, AAMFT Approved Supervisor	MSW, LICSW, Consultant, Writer	LMFT, Supervisory Advocacy Clinical Counselor	Licensed Psychologist	LPC	LMFT, Owner of Private Practice	Licensed Psychologist
EMDR Training	EMDRIA Approved Consultant	EMDRIA Approved Consultant, Former Trainer, HAP Board	EMDRIA Approved Consultant, Facilitator, Working toward becoming a Trainer	Basic levels 1 and 2, Consultation group	EMDRIA Approved Consultant	Basic levels 1 and 2, Working toward Certification, Advanced trainings, Consultation groups, regional EMDRIA meetings	EMDRIA Certified Clinician

Table 1, continued

Participant	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	Triad 6	Triad 7
Partner 1	Rita	Nesse	NyxRN	Beth	Ursula	Bonnie	Louisa
Age	59	47	39	66	62	66	64
Gender	Female	Female	Female	Female	Female	Female	Female
Relationship Status	Married	Divorced	Married	Married	Married	Married	Married
Length of Relationship	36 years	2 years	3 years	47 years	42 years	47 years	34 years
Education	MSW	Bachelor's	Master's	BA	12 <sup>th</sup> grade	1 year college	MA
Ethnicity	French Canadian/ Caucasian	Asian	Asian	Caucasian	Irish/German	Caucasian	White
Religion	*	Buddhist	Lutheran	Protestant	Methodist	Episcopalian	"Not really"
Occupation	State Legislator	IT Manager	Registered Nurse	Retired	Retired	Retired	Homemaker

Table 1, continued

Participant	Triad 1	Triad 2	Triad 3	Triad 4	Triad 5	Triad 6	Triad 7
Partner 2	Matt	Richard	Huck	Sam	Algernon	Anthony	Roger
Age	59	37	34	70	68	68	59
Gender	Male	Male	Male	Male	Male	Male	Male
Relationship Status	Married	Single/In Relationship	Married	Married	Married	Married	Married
Length of Relationship	37 years	2 years, 2 months	3 years	47 years	42.5 years	47 years	34 years
Education	MD	*	Some College	BA	MBA	14 years	MA
Ethnicity	Caucasian	White/British	Caucasian	Caucasian	Caucasian	White	Caucasian
Religion	*	N/A	Catholic	Protestant	None	Episcopalian	*
Occupation	*	IT Manager	Military Police	Retired	Retired	Retired	University Professor

*\*Information not provided*

## **Data Collection**

After approval from the Institutional Review Board (IRB) and consent was obtained by the therapist and both members of each couple, clients and therapists participated in separate 90 minute semi-structured interviews (Charmaz, 2006; Merriam, 1998) about their experience of conjoint couples therapy that included EMDR with at least one member of the couple. These interviews were audio recorded and transcribed. Follow-up interviews were conducted for two participants (one client and one therapist) in order to fill in gaps within the data, in line with theoretical sampling (Charmaz, 2006). Participants also shared documents (including journal entries by clients, a client poem, emails, therapist notes, and pre- and post-treatment measures), which served as supplemental sources of data (Charmaz, 2006).

## **Data Analysis**

Interviews were transcribed, after which both transcriptions and therapeutic documents were analyzed through Strauss and Corbin's (1998) grounded theory data analysis procedures. Themes that emerged during the interviews were coded, categorized, and analyzed for frequency. Throughout the analysis of the data from interviews and documents, the "constant comparative method" was used (Glaser & Strauss, 1967). That is, comparisons were made at each phase of the process, observing similarities and distinctions among data in order to refine the theory.

The grounded theory approach involves generating an abstract analytical schema or theory regarding a particular phenomenon that serves to explain the process and results in the development of a substantive or context-specific theory (Strauss & Corbin, 1998). Coding is the first step in the analysis and involves sorting and labeling the data to

develop theoretical categories (Charmaz, 2006). The three-step coding process identified by Strauss and Corbin (1998) was utilized; it includes open, axial, and selective coding.

Open or substantive coding involves studying and categorizing fragments of data including words, lines, or sections, and providing labels to those segments based on themes. Axial coding is “the process of relating categories to their subcategories, termed ‘axial’ because coding occurs around the axis of a category, linking categories at the level of properties and dimensions” (Strauss and Corbin 1998, p. 123). Finally, selective coding involves the refinement and integration of the theory that is grounded in the collected data. During this process, data were organized into the six components of grounded theory: influential conditions, phenomenon, contextual factors, intervening conditions, actions/interactions, and consequences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Integrating the various categories provided a theoretical picture that illustrates participants’ experience of EMDR within conjoint couples therapy.

### **Trustworthiness**

Several methods were incorporated into the research process to increase the rigor and trustworthiness of the study. Member checks were included at two points during this study. First, participants were provided with copies of the transcription and initial coding of the interviews and were asked to provide feedback about whether the transcript and emerging categories accurately reflected their perspective. In response to this first check, eight of the 21 participants shared their feedback, all confirming that the content was accurate, one asking for a follow-up interview to provide an update and clarification, and another two participants providing email updates since their interviews. Second, participants were provided with a copy of the theory that was grounded in all of the

participant data and were encouraged to provide feedback. Five participants responded to this second check, all expressing appreciation for being provided with the theory and confirming that their experience fit with the final theory.

Peer debriefing included consulting with a fellow doctoral student to discuss the data analysis process, emerging themes, theoretical constructs and relationships, and any concerns or questions that arose throughout the process. She read each of the transcriptions and developed categories for each, which we compared to those I had developed. When there were discrepancies in our categories, we discussed them until we reached agreement. She reviewed my reflexive journal after each interview in order to be aware of my personal reactions and biases as an additional means of accountability. She also reviewed and provided feedback about the developing theory.

Triangulation refers to seeking out “corroborating evidence from different sources to shed light on a theme or perspective” (Creswell, 2007, p. 208). I incorporated triangulation into the research by interviewing both members of each couple as well as the therapist and by the inclusion of multiple triads, in order to obtain a variety of perspectives that provide credibility to the themes that emerged. Triangulation was also incorporated into the study through peer debriefing, which resulted in two sets of eyes looking at the data to assess the accuracy and appropriateness of the categories. Furthermore, the use of multiple data collection sources, including interviews and document review, provided additional triangulation.

I provided rich detail in the descriptions of participants’ experiences, including personal quotes, in order to accurately capture their perspectives. Modal comparisons were utilized through the inclusion of multiple participants and perspectives in order to



enhance the transferability of the study. Thorough memos (Charmaz, 2005; Creswell, 2007) were maintained throughout the research process detailing the process of data collection and analysis, including ideas regarding codes, categories, and relationships among categories. These notes served as an audit trail to provide information about how the research was conducted and to authenticate the findings (Merriam, 1998). A comprehensive review of the literature and a pilot study further contributed to the trustworthiness of the current study.

Finally, attempts were made to maintain a reflexive approach throughout the study, seeking to be aware of any biases and assumptions. Memo writing served as an outlet to note those as they surfaced in order to reduce the likelihood that they would interfere with the process of allowing the data to guide the process. Peer debriefing also provided an additional measure of accountability to increase that self-awareness.

## **Findings**

### **Conjoint EMDR: Relational Trauma Treatment Theory**

The theory developed from client and therapist participant data, “EMDR in Conjoint Couples Therapy: Relational Trauma Treatment Theory,” illustrates the phenomenon of conjoint EMDR among couples and therapists who participated in this treatment process (see Table 2 for a summary of the theory). The theory highlights that trauma is experienced relationally and that healing from trauma also occurs relationally. It suggests that conjoint EMDR can provide a corrective experience for both members of couples, resulting in numerous positive changes on both individual and relational levels.

Beth’s (pseudonym) words at the beginning of this article highlight the relational nature of her conjoint EMDR experience. Though she and her husband, Sam, pursued

treatment to address posttraumatic stress symptoms that resulted from a motor vehicle accident, the focus of treatment shifted to patterns within their relationship that were symbolized by various images, cognitions, and feelings related to the accident. Their therapist, Fred, said:

This isn't just about desensitizing an accident. It really is far more about the two of them using this as a catalyst for having the kind of relationship they have really needed.... Much of the work...was related around...the dynamics of the marriage. The picture was being in the motor home, and waking up from being unconscious and seeing salad strewn all over the place. That was kind of imprinted for her. Her negative cognition was that "I have to take care of everybody". So, it wasn't so much about losing her life...She said the accident was symbolic of their whole marriage, her pattern of not taking care of herself.

The theory of conjoint EMDR as a relational trauma treatment incorporates specific assessment and preparation guidelines, based on several contextual factors. The theory is presented here, organized into the six components of grounded theory: influential conditions, phenomenon, contextual factors, intervening conditions, actions/interactions, and consequences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Table 2 below presents those six components.

Table 2

*Components of Conjoint EMDR: Relational Trauma Treatment Theory*

Influential Conditions	Contextual Factors	Phenomenon	Intervening Conditions	Actions / Interactions	Consequences
Assessment:	1. Previous familiarity with EMDR	Core Category: Trauma is Experienced Relationally and is Healed Relationally	1. Preparation	1. Length/speed/ amount of conjoint EMDR	1. Working partner
1. Therapist	2. Roles		2. Re-Evaluation	2. Roles	2. Witnessing partner
2. Working partner	3. Reasons for referral			3. Targets: present vs. float back	3. Relationship and common themes between partners
3. Witnessing partner				4. Unexpected directions and insights	
4. Relationship				5. Indirect Communication	
				6. Power of conjoint EMDR vs. verbal processing	
				7. Working partner	
				8. Witnessing partner	
				9. Obstacles	

**Influential Conditions: Assessment**

Influential conditions are factors that led to the occurrence of the phenomenon under study, namely conjoint EMDR. The influential conditions in the current study related to the assessment of clients' appropriateness and readiness for conjoint EMDR. Participants identified three therapist factors, four factors related to each member of the couple, and four related to the relationship. These influential conditions parallel phase one of the standard EMDR protocol: client history and treatment planning, during which information is gathered about clients' history, clients are assessed to determine whether

they are good candidates for EMDR, and targets are identified for reprocessing.

However, many of the conditions identified by participants are specific to conjoint EMDR, given the needs and factors that are unique to this modality. Based on data from participants, these influential conditions are useful to predict potential obstacles, guide preparation, and provide information that is necessary in determining whether conjoint EMDR is appropriate for a particular couple.

Three primary therapist factors are considered important to effectively conduct EMDR within a couples therapy context: (a) an integrative approach that balances individual and systemic dynamics and that emphasizes personal responsibility, (b) sufficient experience and competence in EMDR and couples treatment, and (c) confidence in the therapist's abilities and alliance between clients and therapist. The importance of clinical judgment and the ability to provide a rationale to couples for differential attention to one member of the couple at various times were emphasized. Bill noted that incorporating EMDR within couples therapy "emphasizes personal responsibility in a context that otherwise lends itself to reliance on blame." He described EMDR as being about "healing intra-psychoic wounds and increasing interpersonal resilience of the individual" and that it maintains the focus on personal responsibility such that each individual is encouraged to become part of the solution rather than trying to change the other.

Participants noted the following critical conditions to consider for the working partner: (a) general intra- and interpersonal functioning, including such factors as attachment security, hostility, anger, role within the relationship, and investment in change; (b) trauma history; (c) stability and resources; and (d) willingness to be

vulnerable. Therapist participants noted the need to evaluate partners both individually and together to gather background information and observe functioning. They stated that identifying the negative cognitions that impact relational dynamic and assessing each partner's ability to follow the expectations were important. They also valued the exploration of attachment security, level of hostility and anger, investment in personal change, and degree of differentiation in anticipating the progress of conjoint EMDR. All participants reported positive outcomes from conjoint EMDR; however, the working partners of couples who were most angry, invested in their partner's change rather than personal growth, highly fearful about the dissolution of their marriage, overly anxious about their partner's reaction, or dependent on external validation demonstrated the least amount of positive change.

Similarly to individual EMDR, therapists highlighted the importance of evaluating the stability and resources of both partners. Specifically, therapists noted the need for working partners to be able to tolerate their own and their partner's affect and to be sufficiently differentiated to not be overly preoccupied by their partner or the outcome of the EMDR process. Clients who relied on alcohol or on their partner to soothe, distract, or numb their emotions benefited the least from conjoint EMDR, though still reported positive change.

One of the most commonly identified necessary criteria for working partners was their willingness to be forthcoming in front of their partner, not censoring themselves or downplaying their experience to protect themselves or their partner. Willingness to be vulnerable in front of the therapist as well as one's partner requires sufficient differentiation to face the reaction of others and an uncertain outcome. Several client

participants noted a heightened awareness about the presence of their partner initially, often followed by an immersion in the EMDR process that allowed them to trust that it was safe to be exposed. In her follow-up interview, Rita, said that her resistance prevented her from being as open and willing as was necessary and served as a barrier to the process. She became more willing to be vulnerable over time, which allowed her to gain more benefit from treatment.

The areas of assessment for the witnessing partner included (a) general intra- and interpersonal functioning; (b) trauma history; (c) stability and resources, including the ability to provide silent support to one's partner, capacity to self-soothe, sufficient differentiation to not personalize material, tolerance for intense affect, and ability to inhibit any desire to interrupt the partner's process; (d) knowledge of partner's trauma history; and (e) support and safety, including not using the partner's disclosures in retaliation and not challenging the validity of the partner's experience. As with the working partner, a general assessment of the witnessing partner's intra- and interpersonal functioning appears to be crucial in obtaining a preliminary picture of potential obstacles and benefits of conjoint EMDR. In particular, it is useful to evaluate the degree of attachment security for the witnessing partner to anticipate what might emerge during conjoint EMDR. As noted for the working partner, the level of hostility, investment in personal change, and degree of differentiation impacted the witnessing partner's ability to be fully present in a supportive role.

When asked what advice clients would give to couples considering participating in conjoint EMDR, several client participants noted the need to be prepared to hear potentially distressing material and to remain present for themselves and their partner.

NyxRN said: “I think that they have to have a very open mind about each other. And not to take everything that happens personally...You have to be prepared...If you’re going to secretly look into somebody’s closet, you have to be prepared for what you might see.”

Therapist participants in this study emphasized the importance of being familiar with the witnessing partners’ trauma history in order to anticipate how witnessing their partner’s processing of traumatic material may impact them and to prevent the witness from being triggered by learning new information. Participants noted the need for the witnessing partner to be silent, respectful, and supportive, without judging or questioning the validity of the material being disclosed. A common theme was the importance of trusting that a partner will not use disclosures as weapons of retaliation in the future.

Finally, relationship variables identified as important to the assessment process included (a) general relational functioning, including safety and respect, interlocking trauma reactions and interpersonal reactivity, level of differentiation, and relational dynamics (e.g., withdrawer/ pursuer); (b) ability and willingness to follow expectations; (c) level of engagement in therapy; (d) alignment of goals; and (e) strength and commitment within the relationship. Participants noted that conjoint EMDR is helpful for couples who experience interpersonal reactivity and interlocking trauma reactions, such that one person’s trauma-related reactivity triggers that of his or her partner. Though such interpersonal reactivity may be an indication for the potential benefit of conjoint EMDR, volatile reactivity may also serve as an obstacle to conjoint EMDR. For example, if partners are so hostile with one another that there is insufficient respect, trust, and safety to engage in EMDR together, therapist participants noted that individual EMDR may be more appropriate.

Furthermore, the current study pointed to the value of assessing the repeating patterns and roles that occur within the relationship. For example, if there is a withdrawer-pursuer dynamic that recurs within the couple, the therapist may anticipate that such a dynamic is likely to occur within the therapy room and during the conjoint EMDR process. Similarly, the data from the current study suggest that it is also worth noting the value of dysfunctional interpersonal dynamics for members of the couple in order to anticipate potential resistance to changing such dynamics. Those who gained less benefit from conjoint EMDR within the current study were those ambivalent about change and about reducing the intensity of their emotional reactivity, likely because it served them in some way. Thus, assessing the way in which their patterns are purposeful and the potential resistance to changing them may be valuable in anticipating obstacles to the conjoint EMDR process. Thus, the assessment procedures guide the next steps in terms of the degree and type of preparation that is necessary for each member and the couple as a whole prior to engaging in conjoint EMDR, if determined to be indicated.

Participants also highlighted the importance of both members being in agreement about their goals for conjoint EMDR. If both partners are not invested in personal growth, insight, or increased awareness into their own role within the relational dynamics, it is unlikely that they will obtain the same degree of benefit from treatment. Rita discussed her desire to change her husband, Matt, and her reluctance to soften the intensity of her anger toward him, apparently fearing that letting go of her anger might result in less change on his part. Furthermore, her pattern of engaging him through pursuit and attack served to maintain her connection to Matt. To let go of that anger or of her reactivity would likely be threatening, as it would mean risking that attachment.



## **Contextual Factors**

Context consists of a particular set of properties or circumstances within which the phenomenon being studied (in this case, EMDR within conjoint couples therapy) occurs. In the current study, contextual factors for the participants included their previous familiarity with EMDR, the roles taken on during the conjoint EMDR process by each member, and the reasons for referral that resulted in their initiating couples therapy. Previous familiarity with EMDR varied among participants; several participants had previously engaged in individual EMDR, others had participated in EMDR individually with the therapist who subsequently became the couples' therapist, and the remaining participants had no previous experience with EMDR.

The current study suggests that when one partner is less familiar with EMDR (e.g., his or her partner previously engaged in individual EMDR with their couples' therapist), he or she may benefit from more preparation (e.g., psycho-education about EMDR, each partner's role, and what to expect during the process) and from taking on the witnessing role first as methods of promoting balance. Furthermore, preparation should include anticipating the benefits and the potential challenges of engaging in conjoint EMDR for each partner as well as how doing so conjointly might be different than individually. It may also be beneficial for the partner who has more familiarity with EMDR to share his or her experience with the partner who has not engaged in EMDR as part of preparation. Several partners with no previous familiarity with EMDR wished they had had more preparation and better understanding of what to expect from EMDR prior to taking on the working role themselves.

Most participants took on both the working and the witnessing roles during conjoint EMDR; however, for one couple, only one of the partners engaged in EMDR. Furthermore, one other couple had consisted of only one working partner, but they were intending to change roles in future sessions. One participant noted the importance of balancing individual and couples dynamics when only one partner engaged in EMDR, given the increased focus on the working partner. That is, ensuring that the witnessing partner has sufficient time to share his or her experience after the partner's EMDR is helpful in engaging both partners throughout the process. Two participants noted their preference for the witnessing role, while the others did not note a preference either way. Those who preferred the witnessing role seemed to have benefited less than their partner and were preoccupied by external factors, including their partner's reactions and the outcome of treatment.

Finally, the reasons for referral varied for participants within this study. Three couples sought treatment due to infidelity by one member of the couple and the resulting sense of betrayal, anger, hurt, and confusion for the partner. Two other couples sought therapy due to volatile conflicts. One couple was on the verge of divorce as a result of intense anger and reactivity within the relationship. The sixth couple had experienced a motor vehicle accident that had resulted in the death of an individual in the other car. The final couple sought counseling for the male partner, who had participated in individual therapy initially to address military combat and then transitioned to couples therapy. Several of the participants were noted to have met criteria for PTSD at the beginning of treatment. The present findings provide support for the value of conjoint EMDR for a broad range of small "t" and big "T" traumatic events.

The targets for EMDR occasionally were directly related to their reason for referral; however, for several couples, it became clear that earlier life events had exacerbated their current response to stressors and those events became the targets. Common themes among these couples included interpersonal reactivity, impasses that resulted from interlocking trauma reactions, attachment or relational trauma (either within the current relationship or a prior one, often related to family of origin), and a lack of differentiation.

### **Phenomenon: Conjoint EMDR**

The phenomenon within grounded theory is the central process or phenomenon under study related to a set of actions or interactions. In this study, the phenomenon was conjoint EMDR. The core category is the main theme of the research that links together the other categories to create a structure to the theory (Strauss & Corbin, 2008). The primary theme that emerged from the data is that traumatic experiences occur within relationship to others and that the impact of such trauma is also healed within relationship. Nesse observed the value of conjoint EMDR in that having Richard present in the room allowed her to face a primary trigger to her attachment trauma experientially, which she could then reprocess through EMDR, while providing Richard the opportunity to witness that process and better understand her fears and needs:

Being in a relationship brings out a lot of old fears and past trauma for me and because of the couples EMDR it has allowed me to work through it in front of my partner...and because he pushed my buttons, I was able to move through them. So there's a benefit that all of the issues arise now so we can work through it.

Though EMDR includes an eight phase protocol, the first three (client history and treatment planning, client preparation, assessment) are addressed under “influential conditions” above and “intervening conditions” below. The phenomenon of conjoint

EMDR discussed in this section consists of phases four through seven: desensitization, installation, body scan, and closure. Thus, it includes (a) one partner engaging in bilateral stimulation (BLS) while recalling a traumatic or disturbing memory, (b) installing a positive cognition related to that event, and (c) processing any remaining discomfort with BLS after resolution of a target with his or her partner serving as a witness. It also includes the closure phase, which may incorporate (a) a safe place exercise or another means of increasing stabilization when a target is not fully processed; (b) education about ongoing processing between sessions; (c) instructions to either partner to note any observations related to the target; (d) safety planning; (e) the imagining of a “container” to store images, feelings, thoughts, and sensations related to an unfinished target between sessions; and (f) a discussion with the couple about whether to engage in verbal processing of the conjoint EMDR session outside of the therapy room.

### **Intervening Conditions: Preparation and Re-Evaluation**

Intervening conditions are structural circumstances that influence the actions and interactions that occur within a particular phenomenon. Within the current study, intervening conditions related to preparatory and re-evaluation procedures that participants identified as beneficial to their conjoint EMDR treatment. Bill said:

I see a lot of therapeutic impasses or errors made because of inadequate attention to the preparation phase, meaning the therapist was too quick to jump in...and wants to move into phase four...They may be in too much of a rush to plow ahead at the expense of being where the client is at.

Participants identified seven conditions for effective preparation. The first involves introducing EMDR early while building an alliance and emphasizing the ongoing impact of the past on clients' current functioning. Thus, clients are exposed to EMDR language and concepts from the beginning. Furthermore, both the therapist and

the couples recognize the negative cognition(s) related to past trauma that continue(s) to play a role. Nancy discussed EMDR from the very beginning of counseling and noted the value of linking the past to the present:

I start to really help them to see the link between what is happening today in their relationship and how they are responding to the other based on core beliefs and experiences from way back...How the past is present, basically....

The second preparation condition is providing psycho-education to couples. This education includes the impact of trauma, the role of EMDR in trauma resolution, the EMDR process, and research on EMDR. It also involves sharing material with clients to do further research. The third condition includes presenting the potential benefits and obstacles to engaging in conjoint EMDR. Doris stated that she frequently explains to couples the value of conjoint EMDR in overcoming impasses:

I said "it's often helpful in really getting where your partner is, to see what this place is where they're caught. So if you're a witness, you get to know them better. And when they're a witness, they get to know you better. And meanwhile, the point is turning down the volume in this reactivity. And probably the reactivity is at least partly from an ancient source, a young source."...I often explain to couples that if we can just break the impasse, which is probably the intersection of these two stories, that probably they'd be in a much different place.

The fourth condition is a review of expectations and requirements for both partners, including those identified in the assessment section, above. Participants also noted that preparation should include providing the witnessing partner with information about what to expect during the process for the working partner and with instructions about how to manage emotions that might arise. Two of the couples discussed the witnessing partner having written in a journal their thoughts, feelings, and impressions that came up for them while observing their partner. Algernon noted the value of the journal as an outlet for intense feelings and helped him to feel more engaged rather than a

passive witness to the process. Informing the couple about what to expect also included asking the working partner to pay attention to his or her feelings, thoughts, and body sensations and to allow whatever happens during EMDR to happen. Preparation also involved developing a stop signal for the working partner and providing information to the witnessing partner about what he or she might observe during the process.

The fifth intervening condition related to preparation is empowering couples in decision making, such that couples are provided with choices regarding (a) whether to engage in EMDR or not and whether to do so individually or conjointly, (b) the type of bilateral stimulation, (c) the timing of EMDR, (d) which partner will take on the working role first, and (e) the target. A few participants noted the value of being offered the opportunity to engage in EMDR individually prior to doing so conjointly, particularly for those whose partner had prior EMDR experience but they had not.

The sixth preparation condition identified by participants included conjoint resource development and installation, depending on the stability and previous experience of the clients. Several participants engaged in a safe place exercise conjointly prior to trauma reprocessing with bilateral stimulation. Nancy incorporated resource development and installation (RDI) conjointly, including both safe place and light stream and said that RDI can serve as both part of assessment for safety and readiness for conjoint EMDR as well as preparation.

The final condition for preparation is a discussion of ongoing processing outside of sessions. This includes informing the working partner about processing that continues after EMDR as well as decision making about whether members will engage in verbal processing about the conjoint EMDR process or container the material in session.

Michelle noted her use of “container-ing” material for the working partner when targets were incomplete. Anthony described this: “we locked it up and put it in a box and put it away until next time.” Anthony said that he and Bonnie would often verbally process their experience after sessions but that such processing was limited to their subjective experience rather than the content, which he found valuable.

The re-evaluation stage described by participants parallels phase eight of the standard protocol but factors related to this phase are integrated in unique ways within the couples therapy modality. Participants identified three re-evaluation conditions. First, the EMDR process is assessed during initial and ongoing sessions, with the option of returning to the preparation stage, if needed. Participants noted that it is the therapist’s job to observe how EMDR proceeds in session and whether both members are demonstrating an ability to tolerate the affect and material that emerges, to self-soothe, and to maintain a level of safety and respect throughout the process. The way in which sessions proceeds will determine whether more preparation is needed.

Second, therapists must be attuned to the needs of partners in the moment. This includes body language, in-session reactivity, and triggers between sessions. This process involves revisiting the previous session (and re-assessing the SUDs and VoC levels) and exploring any reactions or new material that surfaced, discussing any apprehensions about moving forward, evaluating the helpfulness of the container as a tool (if it was used), and assessing the current safety and stability of both partners and the relationship (including whether material was used as a weapon).

Finally, therapists should facilitate post-EMDR debriefing by each partner. Verbal processing of the conjoint EMDR experience at the end of each session and in future

sessions provided a balance between individual and systemic dynamics. This might include discussing their conjoint EMDR experience, what it was like to be witnessed or to be the witness, exploring any apprehensions about moving forward, and reviewing journal entries by the witnessing partner. Nancy said that debriefing often looks as follows:

When we are finished, I take time to talk with the person who processed. “How was that for you? How was it to have this person in the room?” And then I always take some time with the observing person. “Tell me what that was like for you?” So that they are able to verbalize it....I find that often times, they have a lot to say because the experience was so profound for them.

### **Actions and Interactions**

Actions and interactions relate to strategies and experiences for the phenomenon under study, impacted by influential and intervening conditions, and resulting in consequences (presented below). The process of conjoint EMDR varied significantly across participants, depending on a number of factors. The variability was primarily in the length, speed, amount, and frequency of EMDR, as well as in the targets that were reprocessed for each participant.

Generally, the witnessing partners’ role consisted of silently witnessing their partner’s EMDR in the background. However, in the case of Sam and Beth, Fred encouraged Beth to take on a more active role during Sam’s reprocessing, particularly as they prepared for in vivo exposure to significant triggers: test driving a motor home and returning to the location of the accident itself. In anticipation of those events, Sam participated in conjoint EMDR in sessions with Fred but they also planned during sessions for Beth to later deliver bilateral stimulation to Sam during those in vivo experiences. Fred described his rationale for Beth’s active involvement:



Beth has a lot more resources around the accident itself and so while she certainly qualified for PTSD, her reactivity to the different triggers were much milder than Sam's. His were much more debilitating....I basically taught her to do EMDR with him...I did a protocol...to assess his SUDs level beforehand and identify the negative cognition and then basically for him to process through it with her doing the tapping. And they found that very calming and very reassuring, that they would have this tool and could process it in vivo...What I did not want to happen is for them to...get into the motor home and all of sudden, he's having these flashbacks and they don't have any tools for dealing with it.

Thus, her level of involvement as the witnessing partner was more active than that of other participants.

Though naturally the targets themselves varied from client to client, the common theme regarding the nature of those targets for all but Huck (whose focus of EMDR related to his military combat experience) was previous--often childhood--experiences that played out within the current relationship and in the roles that each took on within that relationship in an attempt to meet early attachment needs. Current reactivity would occasionally be targeted with EMDR. However even in that instance, frequently that reactivity would link back to a previous attachment injury that would be reprocessed during EMDR.

Several client participants noted that choosing a target from the past that paralleled current dynamics was useful for both the working and the witnessing partners. The reprocessing of that target helped the working partner gain insights into how the past impacted the present and how to change current dynamics. Simultaneously, the witnessing partner was able to remain more present and open rather than becoming defensive as he or she might otherwise, were the target to be related to their current relationship. Louisa stated:

I think the helpful thing was we were each able to take on a core issue related to our childhood...so it wasn't threatening for the other person because it didn't link

specifically with our relationship...I think if we had just came in and said we are going to do EMDR about our relationship, that could be very intimidating and defensive making.

Beyond these individual differences, participants identified several common themes related to their experience of conjoint EMDR. Those shared actions and interactions included the following for both members of the couples: (a) unexpected directions and insights; (b) indirect communication; and (c) power of EMDR versus verbal processing. Participants repeatedly noted the unique value of conjoint EMDR as a method of indirect communication between members of the couple and as a way to communicate “beyond words.” NyxRN stated that she learned things during conjoint EMDR that she would never have known otherwise. Huck described its value: “She does hear.... It’s like you told her but you didn’t have to go through the hard part of telling her.” Bill highlighted the role of EMDR in moderating the intimacy within the partners’ exchange:

EMDR served to mitigate the intensity of an intimate encounter while providing the benefits of intimacy: shared knowing, mutual understanding, and disclosure...These are issues that [Matt] locked away for decades and hadn’t ever addressed....EMDR opened him up to experiencing his own intense affect in a safe and secure environment that emboldened him...He’s opening himself up vis-a-vis his wife.

Many participants noted the power of conjoint EMDR in comparison to verbal processing, with several noting the physical exhaustion they experienced and others observing the power of the insights, emotions, and understandings that emerged. Beth noted:

We both commented on...the way the brain and the body work. Like, there would be times where, especially in the beginning, when his body would just be shaking from the trauma of what he was dealing with ...it’s just an amazing thing to observe afterwards what your mind had done....We were completely exhausted physically and mentally.

The following themes were noted for working partners about their conjoint EMDR experience: (a) initial skepticism; (b) powerful and meaningful process; and (c) building a bigger picture. Participants reported skepticism about EMDR prior to experiencing it firsthand. Huck said:

Just me and Rich were talking for quite some time and eventually he said “Let’s try some EMDR and see if that will help.” And I’m like “Yeah what is it?” Well there were a bunch of flashing lights and I’m thinking “Are you crazy? Who does this guy think he is?” I was like “You’re crazy. This isn’t going to do any good.”

Several participants said that while engaged in EMDR, they were so deeply involved that their partner’s presence became a non-issue. Anthony shared his gratitude for the opportunity to have Bonnie present to allow her to truly see him, as if for the first time: “I was happy that I had given her a window to really see me, you know in an honest way...A lot of the stuff I was saying I was admitting to myself for the first time really. She was hearing it with me.”

The final theme that emerged from the working partners’ descriptions was that EMDR provided the opportunity to understand the impact of past experiences and to observe the parallel between those experiences and current relationship triggers. Richard noted his surprise in recognizing the impact of a childhood experience on his current functioning:

Emotions would automatically pop up and I would feel angry or sad or something would really just get to me...At a younger age, a lot of my friends were just taking the mick out of me and I didn't realize it or even remember it until we went through the sessions...Some of my younger years, I was challenged with learning...People would call me names and I would find school very hard. So when people say to me even now, “you can't do that,”...I will prove that I can do it...I found out afterwards part of that quick reaction for me was because of my past, a past that I'd completely forgotten about.

The following categories were identified for the witnessing partners: (a) providing support and grounding to partner; (b) intuitive awareness of partner's needs; (c) initial skepticism and bewilderment; (d) impact of witnessing emotional expression in session; (e) admiration, respect, and empathy for partner; (f) vicarious healing and shared journey; and (g) "eye opening." Every couple noted some element of the first theme including the respectful, quiet, attentive, accepting, and non-reactive support demonstrated by the witnessing partner that provided comfort and grounding. Several participants observed an apparent intuitive understanding of the importance of being an unobtrusive observer, such that little instruction or redirection were provided to the witnessing partner about their role. Doris attributed the tendency of clients to treat EMDR with respect to the fact that it is out of the ordinary:

There's something about the protocol for EMDR that it seems so unusual and special and out of the ordinary that it seems like people do treat it with a lot of respect and so...they use care. That it feels like it's something precious and that they shouldn't be messing with it.

Similarly to the working partners, witnessing partners observed their initial skepticism about EMDR and their sense of bewilderment about the process. Richard said that even as he witnessed Nesse's EMDR process, he doubted that it could be as impactful for him. He went on to express his shock at the intensity of her emotions:

Seeing Nesse go through it and seeing how all of a sudden, she'd have really strong emotions and reactions was one, kind of shocking. I was like "what just happened there? How can she have that reaction so quickly?" And for Cat to work through with her and pick out what the issue is...I would sit there and think "I don't know what she just did, how she just got that."

Several participants noted the value of witnessing their partner's EMDR in that they were able to hear material that they might have heard previously in segments and on a cognitive level, but never as meaningfully in its entirety and with the emotional impact

on their partner. Michelle noted the power for Anthony to see the impact of Bonnie's past experiences through conjoint EMDR: "To be able to just, not in fragments over a period of years knowing these instances, but just compact in the room. And not just hearing it in a cognitive way but seeing her emotional response with it and how strong that was for him."

Participants were deeply moved by witnessing their partner's EMDR process, and experienced significant empathy, admiration, and love. Louisa was grateful to witness the healing that Roger experienced through EMDR: "What I gained in being a witness to him, I would never trade. I think it was so worth it just for that experience of seeing how effective it was. If it hadn't been effective, I don't know....But it was clear it had made a difference right then for him." Anthony shared his compassion for Bonnie during her processing: "The only obstacle...is that I knew I just couldn't go up and put my arms around her.... I really wanted to."

Participants said that conjoint EMDR allowed the opportunity for a shared journey, in that the witnessing partners experienced such empathy for their partner that it was as though they were experiencing the events with them and vicariously healing through their partner's EMDR. Algernon found it powerful to experience Ursula's emotions with her:

My feelings were really in concert and attuned to Ursula's because as she was relating something, I shared her emotion....It wasn't just because I could relate to that...that I have my own story...I was feeling *her* story...It was very much special because I was *with* Ursula....feeling her and not feeling me...I became emotionally involved in listening...I was swept into the moment.

Witnessing partners also described the process as "eye opening" to learn the parallels between their partner's past and their current dynamics and to learn information for the

first time. Michelle noted how moving it was for Anthony to see the parallels between Bonnie's childhood experiences and the dynamics that occurred within their relationship.

She read statements he had made during conjoint EMDR sessions from her notes:

For him to see the parallels in her reactivity, the parallels between her previous trauma to the betrayal in the affair in the present relationship...He was able to...have a greater understanding of how some of his behavior triggers these old wounds...[Reading from notes:] "It was eye-opening the things that she had said about our situation..."What she was saying about the molestation was the same things at another time she had told him about their relationship and the affair that he had. And it says, "I feel worse about what I did. It created a deeper understanding of her."

Finally, when participants were asked about obstacles they experienced during conjoint EMDR, overwhelmingly clients and therapists directly denied having encountered any obstacles that interfered with the benefits to the process and stated that any material that came up served as "grist for the mill." However, a few participants did identify obstacles, particularly initially during the conjoint EMDR process, though they still were grateful for and benefited from conjoint EMDR. Thus, any obstacles that were identified did not seem to interfere with the benefits of the process, though they may have decreased the potential degree of benefit that might have been obtained with further assessment or preparation. The following obstacles were noted: (a) over-focus on partner and external factors (e.g., performance anxiety, distracted by the partner, and preoccupation with the outcome); (b) initial reluctance to experience and share vulnerability; and (c) initial reactivity by witnessing partner during or directly following conjoint EMDR.

The most mentioned obstacle for participants related to preoccupation with their partner, desire for external validation, and focus on the potential outcome of EMDR and the therapy process as a whole. This focus on external factors seemed to be a distraction

for some participants from full engagement in their own EMDR process. Rita demonstrated a strong need for external validation from both her husband, Matt, and from their therapist, Bill, which appeared to be an obstacle to her ability to fully trust the EMDR process. She shared her desire to change Matt and concern that her feelings might be “minimized” through EMDR. She observed some “resistance,” which she believed did prevent her from gaining as much from EMDR initially as she might have otherwise.

A second theme regarding obstacles that relates to the first is participants’ initial apprehension about experiencing and sharing the vulnerability involved in conjoint EMDR. Huck noted his hesitation to share vulnerable emotions but his resulting gratitude and relief when he did share vulnerability with NyxRN:

I always put my guys first and I always was the stronger one...as a leader, you got to be a strong leader - physically, mentally, and emotionally...In a lot of aspects, I think that’s who she fell in love with. But now that I have to break down and show a little bit of the weakness, it is kind of frustrating.... You can’t help tears. It just comes, it just flows...And if you have the confidence enough to let yourself open up like that, that’s when EMDR starts to help more and more and more.

Several participants noted initial reactivity or intrusiveness by the witnessing partner, either during or following the first conjoint EMDR sessions, though each said that they were able to effectively overcome this obstacle through various means. Michelle stated that Bonnie was initially intrusive during Anthony’s first EMDR session: “If she didn’t agree, she wanted to correct it.” Michelle said:

A lot of times, I’ll kind of physically contain her.... Sometimes I’ve gone over and sat on the floor and put my hand on her knee or sat next to her and just kind of helped regulate her. That was enough.... Just reminding her of the importance of staying in the moment with the processing.... The notebook seemed to help her contain and regulate herself and I guess putting it down satisfied where she didn’t have to express it verbally in the moment.

## Consequences

Consequences are the outcomes of the phenomenon under study, namely conjoint eye movement desensitization and reprocessing (EMDR). Participants identified numerous benefits from their conjoint EMDR experience, both individually and relationally, and no negative consequences were noted. All clients expressed appreciation for conjoint EMDR, stated that they would encourage others to participate in this treatment, and noted gratitude and respect for their therapist. Working partners observed the following outcomes of the conjoint EMDR process: healing trauma, increased self-worth, and decreased self-blame. Many participants who had served in the working partner role during conjoint EMDR reported significant decrease in trauma symptoms overall and healing of relational trauma. Nesse noted that after her experience of EMDR, when she thought about her childhood trauma, “I can’t even see the details anymore.” NyxRN noted that Huck no longer blames himself for events during his military combat experience.

Participants identified several significant relationship changes experienced through conjoint EMDR and common themes for both witnessing and working partners.: (a) high levels of satisfaction and changes on outcome measures; (b) increased differentiation; (c) reduced interpersonal reactivity; (d) increased empathy, compassion, and depth of intimacy; (e) increased understanding of self, partner, and relational dynamics; (f) increased ability to intervene in cycle; (g) increased commitment and hope; (h) increased communication; and (i) increased happiness and enjoyment. All therapists noted improvements in the SUDs and VoC scales for EMDR clients.



A theme across both the witnessing and the working partners was an increase in their levels of differentiation and of secure attachment within their relationship. Several participants noted an ability to better recognize where their personal responsibility lies and to let go of inappropriate responsibility they had been carrying, whether related to their partner or to events from their past. Bonnie shared a change in her level of shame and responsibility for events that had happened during her childhood that she recognized are not hers to carry, and a similar compassion for the burden Anthony had been carrying for years:

I can see those things with a different perspective now and not take responsibility for things that happened to me when I was two years old or seven years old. You know, where kids feel like they have a part in those choices that they don't. They really don't and the same with Anthony.

One of the most commonly observed changes by all participants was the reduction in interpersonal reactivity, both within their romantic relationship and beyond. Doris observed that Louisa became increasingly able to “look beyond her own reactivity and really see [Roger] instead of just her projection of who he might be or she's afraid he is.” Similarly, Michelle noted the decreased projection, triggering, and reactivity between Anthony and Bonnie that has allowed them to be more tolerant and present for one another: “She has developed an understanding that she also triggers him. It's not just him having the responsibility for her. So that has decreased, thereby allowing him to remain present for longer periods of time when they're having challenging moments.”

Participants also noted increased levels of empathy, compassion, and intimacy within their relationship following conjoint EMDR. Anthony was moved when he witnessed Bonnie process through childhood trauma, recognizing how much it had continued to impact her:

I didn't realize all those years that she was suffering from PTSD...Even though she would put a pretty hardened face on it... that she had dealt with it and stuff, it was really quite evident how raw the wounds still were...It's really been helpful for me to keep that picture of the seven year old in my mind...I think the key word in all the sessions would be empathy. I have not been a very empathetic person most of my life...It was really hard...to see the woman you love as a seven year old suffering... I just felt like my heart was being ripped out.

Another common change through conjoint EMDR was an increased understanding of themselves, of their partner, and of the dynamics within their relationship. They described an increased awareness of their triggers, of their environment, and of their own emotional experience. They shared greater understanding of how their past influences the present, the impact of their own behavior on others, and a resulting increase in understanding of how to better support their partner and motivation to change their own behavior. Witnessing partners reported that learning more about the impact of their partner's past helped them to better understand their partner's reaction to current events, helping them to be less reactive themselves, and increasing their level of confidence in terms of their ability to support their partner. Michelle noted:

As an individual, [Anthony] has grown so much in developing just a deeper understanding and a more compassionate understanding of himself...And that is increasing his ability to be genuine, not just with himself but with others, like his wife...He's been peeling back layers of who he really is rather than the facade that he's put up for others.

Participants reported that their increased understanding of themselves and one another, their greater level of differentiation, and their decreased reactivity allowed them to respond deliberately with one another, thereby intervening in or bypassing their negative relationship cycle. Nesse said that she and Richard used to escalate to the point of "no return," and that now, they argue more often, but the arguments are bickering

about little things rather than explosive as in the past. Richard observed their ability to circumvent their previous cycle:

I truly believe that the sessions have helped in the way I react. And that's the biggest issue we had was our very strong reactions that would end up in big arguments to the point where Nesse would be hysterical and want to get away from me, get rid of me, whereas now it's just an argument. We speak about it and then we're done.

Participants noted a greater sense of hope in general and specifically, hope in the future of their relationship. Though they seemed more aware of the uncertainty of the outcome, there was an increased trust in their ability to cope with difficulties and a commitment to continuing the work they had started. Ursula shared her increased sense of safety with Algernon:

I think that this has just enhanced that journey...it's not just that individual trip...I have definitely been enjoying the results of the growth that Algernon and I have made in the real intimacy of our relationship. The hurts and false/wrong messages that we encountered in the past don't hold much sway with us now. We are, indeed, on the right path this time and we don't need to leave a trail of bread crumbs because we are not going back that way anymore.

Participants reported a significant change in their openness, noting increased depth and honesty in their communication. Anthony shared:

I started to see things and feel things differently and became very open to expanding that side of me. I like the feeling of not hiding things. I like the feeling of being able to tell somebody what I feel...Sometimes I feel like a toddler in a lot of ways because I just had never experienced them...I can't tell you the difference in being able to talk to somebody on a real level and not the superficial level like conversations used to be on.

The final theme shared by participants was their increased happiness and enjoyment of life. Many used the term "light" and referred to laughter and humor, as they spoke about the changes in their relationship and life as a whole. Sam mentioned having slowed down, that "things have really come into focus a lot better," a softening of his personality,

and more enjoyment of life. Doris noted that Roger and Louisa have been traveling together, that they are both “more content in their lives,” and that “they’re playful with each other.”

## **Discussion**

### **Trauma is Relational**

One of the primary themes from the participants’ interviews is the relational nature of their traumatic experience and the ongoing impact of that trauma on current relationships. Perry and Szalavitz (2006) highlighted the power of human relationships in both harming and healing one another: “Fire can warm or consume, water can quench or drown, wind can caress or cut. And so it is with human relationships: we can both create and destroy, nurture and terrorize, traumatize and heal each other” (p. 5). Similarly, Flemke and Protinsky (2003) state, “We are born into relationship, we become wounded in relationship, and we heal within relationship” (p. 32).

**Attachment and intimacy.** At least nine of the 14 client participants in the current study had suffered the impact of attachment wounds early in life, which were repeatedly triggered within their current relationships, both by daily interactions and by more significant traumatic events such as infidelity. Though no attachment interviews or questionnaires were completed by participants, therapists identified several of the client participants as having an insecure attachment that impacted their tolerance of and response toward intimacy.

Research has demonstrated that individuals who experienced emotional neglect during childhood are often impacted in terms of their attachment style as adults (Johnson, 2002; Perry, 2009; Schachner et al., 2003; Wesselmann & Potter, 2009), which may

negatively affect later intimate relationships. To re-establish a sense of security within relationships, healing from early attachment injuries must occur within a nurturing relationship (Alexander, 2003; Herman, 1997; Johnson et al., 2001). Eye movement desensitization and reprocessing to address attachment-related trauma has demonstrated the capacity to increase attachment security (Moses, 2007; Protinsky, Sparks et al., 2001; Wesselmann & Potter, 2009). The current study extends the findings from Wesselmann and Potter's (2009) study examining the impact of individual EMDR on attachment to the couples therapy context.

Individuals' capacity to tolerate intimacy can be impacted by traumatic experiences as well as mediate their response to trauma (Pearlman & Courtois, 2005; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Turner et al., 2007). Turner et al. (2007) noted the varying levels of tolerance for intimacy within trauma survivors and stated that this ability is a crucial determinant of treatment success as well as of the survivor's response to the trauma. The importance of one's ability to tolerate intimacy in the success of couples therapy highlights the distinct value of conjoint EMDR for clients whose trauma history results in difficulty tolerating intimacy.

Bill noted that conjoint EMDR "mitigates the intensity of an intimate encounter;" thus, it seems to provide an advantage as a couples therapy intervention in that it both increases the intimacy experienced between partners while simultaneously serving to increase partners' tolerance of the intimacy experienced during the process. Bilateral stimulation is a method of grounding or maintaining "one foot in and one foot out" of the traumatic event, such that it is not overwhelming (Shapiro, 1989, 2001). Eye movement

desensitization and reprocessing within couples therapy seems to offer a similar benefit to couples who would otherwise be overwhelmed by the intimacy of couples therapy.

Several of the current participants noted the value of targeting a childhood traumatic event that paralleled issues within their intimate relationship. Choosing a target that is external but related to their relationship seems to reduce the intimacy and the reactivity that might otherwise accompany such processing. This distance appears to increase the likelihood that the witnessing partner will remain present and gain the resulting awareness, insight, and empathy that participants reported to have achieved. The current study suggests that one unique benefit of conjoint EMDR is the balance of deepening intimacy, understanding, and compassion along with the mitigation factor and indirect communication that serve to increase the safety in such a vulnerable encounter, particularly for those with insecure attachment.

Several factors increase the resiliency of individuals to the impact of trauma, including a strong social network, a thoughtful and active coping style, and an internal locus of control (Herman, 1997; Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Research has demonstrated that individuals with secure attachment have higher self-efficacy (Johnson, 2002). Many participants within the current study endorsed feelings of inadequacy and shame at the beginning of therapy and reported increased self-worth as well as decreased shame following conjoint EMDR. Alexander (2003) pointed to the connection between shame and attachment insecurity, such that “the self is considered unlovable and unentitled, making it very difficult to either express needs or to accept the nurturing of others” (p. 349).

Alexander's (2003) observations are consistent with the current findings that following conjoint EMDR, individuals are more emotionally available and differentiated, allowing them to give and receive care more freely. Research supports the premise that the expression of underlying needs and feelings as well as modification of interactional patterns promote emotional accessibility and responsiveness (Johnson, Makinen, & Millikin, 2001). According to studies on adult romantic relationships and attachment styles, partners who are securely attached have longer, more stable, and more satisfying relationships with high commitment, interdependence, trust, and friendship, and describe relatively selfless style of love without game playing (Makinen & Johnson, 2006; Schachner et al., 2003). They are happier and are more likely to seek out and provide support to others, are better able to articulate their needs, and are less likely to become verbally aggressive or to withdraw during problem solving activities (Johnson, 2002). These findings support the value of conjoint EMDR in increasing differentiation through positive changes in attachment security within one's intimate relationship.

Individual differences in attachment exacerbate or attenuate PTSD symptoms in traumatized individuals and their spouses (Ein-Dor, Doron, Solomon, Mikulincer, & Shaver, 2010). A review of PTSD studies found that perceived lack of partner support before and after a traumatic event is one of the most important factors determining vulnerability to PTSD (Ein-Dor et al., 2010). Ein-Dor et al. (2010) examined the role of ex-POWs' and their wives' attachment insecurities in the long-term repercussions of war captivity, and found associations among attachment-related dyadic processes, posttraumatic stress disorder in war veterans, and secondary traumatic stress (STS) in their wives. Specifically, they noted that anxious attachment is implicated in both PTSD

and STS. Though intimate relationships appear to be highly influenced by one's early attachment experiences, adult intimate relationships can also provide a corrective experience and thereby attenuate the impact of such early experience.

This finding supports the theory that differences in response to conjoint EMDR may be at least partly related to differences in attachment. In spite of improved relationship satisfaction and security within the relationship, several participants within the current study who had high levels of initial attachment insecurity continued to experience anger and betrayal toward their partner after conjoint EMDR. Research shows that adult attachment impacts how individuals process attachment information, regulate their emotions, and communicate with others, as well as what is accessible to memory (Alexander, 2003; Johnson, 2002; Johnson et al., 2001; Pearlman & Courtois, 2005; Tummala-Nara et al., 2012). These are also areas of functioning impacted by EMDR (Shapiro, 2001). Consistent with these findings, the current study found that for individuals who had experienced trauma as well as those with attachment injuries, conjoint EMDR resulted in decreased reactivity, improved communication, greater relationship satisfaction, and deeper intimacy.

**Over-focus on partner and external factors.** All client participants shared their appreciation for conjoint EMDR and noted both individual and relational benefits. However, those who seemed to have the most ongoing reactivity within their relationship were those who were overly focused on their partner or on other external factors, such as the potential outcome of the conjoint EMDR process. These findings are consistent with research about attachment insecurity. Individuals with high anxiety and low avoidance are hypervigilant toward and preoccupied with their partners, describe low relationship



satisfaction, and have higher relationship dissolution rates (Schachner et al., 2003). They tend to worry about abandonment and are more jealous than their secure counterparts (Johnson, 2002). Individuals who are high on both the avoidance and the anxiety dimensions tend to demonstrate similar emotional vulnerability and preoccupation as anxious partners while behaviorally exhibiting more avoidance, tending to withdraw from closeness. Research has demonstrated that this fearful avoidant style is related to parental alcoholism and abuse (Pearlman & Courtois, 2005; Schachner et al., 2003).

Using EFT with trauma survivors and their partners has been found to be effective for increasing affect tolerance and regulation, as well as increasing intimacy among partners and rebuilding a sense of self among survivors (Alexander, 2003; Johnson, 2002). Research on the effectiveness of EFT is consistent with findings about the benefits of conjoint EMDR in existing literature (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Reicherzer, 2011; Snyder, 1996) and within the current study in deepening affect, increasing empathy and understanding, reducing interpersonal reactivity, enhancing intimacy, and increasing differentiation among both partners, as well as healing trauma, increasing self-worth and decreasing self-blame for the working partner. The current study extends past literature (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Reicherzer, 2011; Snyder, 1996) by providing information about the factors and conditions related to positive outcomes within conjoint EMDR, including sufficient attachment security, investment in personal change, and differentiation to remain open during EMDR with one's partner present.

According to findings from this study, participants strongly invested in changing their partners and who were ambivalent about decreasing the intensity of their own feelings (particularly anger) related to partner betrayal perceived such a decrease as a potential threat to their attachment. Participants who relied on external validation and who had an external locus of control were likely fearful that decreasing the intensity of their own emotional response could reduce the likelihood that their partner would be available and responsive.

Participants who were overly focused on their partner (and whose preoccupation suggests anxious attachment) tended to prefer the role of witnessing partner, which makes sense, given the reduced exposure and vulnerability within this position. Litt (2008), who proposed a treatment model to apply EMDR within couples therapy with an ego state and contextual therapy approach, noted the value in engaging the “acting out” partner first when both are good candidates for conjoint EMDR. That is, he suggested that the partner who tends to destabilize the relationship be the first to participate in EMDR; thus, the “acting out” (and anxiously attached) partner is encouraged to experience a “softening event” (Johnson & Greenberg, 1988). Johnson and Greenberg (1988) describe “softenings” as bonding events during which an angry, blaming partner reaches out for and receives emotional responsiveness and availability from the other. Research has demonstrated that such interactions are correlated with decreases in marital distress (Schachner et al., 2003).

Thus, it may be that in spite of the tendency of certain clients to prefer the witnessing role, there is benefit to increase their participation within the working role in order to soften such individuals’ reactivity, increase their differentiation, and foster a

more internal locus of control. Several authors have pointed to the benefit of conjoint EMDR for those who are highly reactive, have strong negative affect (D'Antonio, 2010), lack empathy or sensitivity toward the other, struggle with obtaining a “softening event,” are “stuck” in past attachment wounds, and personalize or project feelings onto their partner (Moses, 2003, 2007). Furthermore, research has demonstrated the value of conjoint EMDR in targeting secondary emotions, such as anger, that are triggered within current interactional patterns in order to allow primary emotions (such as hurt and fear) and previous traumatic memories to surface and be reprocessed (Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001).

However, engaging in conjoint EMDR as the working partner requires a willingness to relinquish former unhealthy ways of relating to oneself and one's partner. These issues relate to the importance of both partners having compatible goals for the therapy process, a criterion identified by several participants as essential to obtaining benefit from this treatment process. Participants also noted the importance of entering into conjoint EMDR with an open mind and a focus on their own change and healing process, irrespective of the outcome. This state seemed to differentiate those who obtained the greatest benefit from the conjoint EMDR process.

Protinsky, Flemke et al. (2001) highlighted the relation between acceptance and intimacy: “The paradox of acceptance is an important aspect of increasing intimacy. Letting go of attempts to change our partners paradoxically creates a context for change” (p. 160). This is consistent with findings that those with an internal locus of control are more resilient to the impact of trauma than those with an external locus (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). The current study highlights the paradox

that conjoint EMDR facilitates increased differentiation that fosters intimacy and relationship satisfaction, but engaging in such treatment requires willingness to risk an uncertain outcome. This finding is unique to the present study, extending existing literature related to conjoint EMDR.

**Simultaneous activation and corrective experience.** Several participants noted being activated by having their partner present during EMDR, given that the partner was often a trigger related to trauma. Participants also pointed to the value of having that “trigger” present during EMDR, while reprocessing traumatic experiences. Briere and Scott (2006) emphasized the importance of “counterconditioning” in the healing of attachment wounds and relational trauma, which they described as the simultaneous presence of both (a) activated trauma-related distressing memories and (b) the comfort and connection produced by the supportive therapeutic environment.

Briere and Scott (2006) propose that counterconditioning may provide a corrective emotional experience, which can increase one’s ability to modify existing cognitive schemas. Eye movement desensitization and reprocessing serves these purposes; however, conjoint EMDR does so on multiple levels, such that clients are not only activating memories as they identify their target but they are also being activated by their partner’s presence. None of the current participants reported having felt overwhelmed by the presence of their partner; thus, it appears that the level of activation experienced was in proportion to the sense of safety within the relationship and within their window of tolerance. This theme was unique to the current study, extending previous findings (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Protinsky, Flemke et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996).

**Relational trauma treatment.** To date, EMDR as an individual treatment modality with trauma survivors has been empirically validated in over 20 randomized controlled trials. For example, van der Kolk, Spinazzola et al. (2007) conducted a randomized clinical trial of EMDR, Fluoxetine, and a pill placebo to compare their efficacy in the treatment of PTSD and the maintenance of those effects. The authors found that EMDR was more effective than both the medication and placebo to produce substantial and sustained reduction in PTSD symptoms. Furthermore, at least six meta-analyses have demonstrated the effectiveness of EMDR in the treatment of post-traumatic symptoms.

Maxfield and Hyer (2002) discovered that effect size was highly correlated with the methodological standards in EMDR efficacy studies, such that higher effect sizes emerged for studies that were more rigorously designed. Bisson and Andrew (2007) conducted a systematic review of 38 randomized controlled trials of psychological treatments for chronic PTSD. They found that TFEBT and EMDR showed benefits over waiting list or “usual care” therapies on most outcome measures of PTSD symptoms. They reported limited evidence for stress management and group CBT, but “other therapies” (supportive/non-directive, psychodynamic, and hypnotherapies) appeared to be least effective, resulting in no clinically meaningful decrease in PTSD symptoms. They found that direct comparison of TFEBT and EMDR did not result in significantly different treatment outcome or speed of therapeutic change.

Posttraumatic stress disorder (PTSD) has significant effects on intimate relationships. For example, Kessler (2000) found that combat veterans experience higher rates of marital instability. Similarly, Jordan and colleagues (1992) discovered that

Vietnam veterans with PTSD had marriages twice as likely to end in divorce and they were three times more likely to have more than one divorce (Jordan et al., 1992). Cook Riggs, Thompson, Coyne, and Sheikh (2004) found that former prisoners of war from World War II with PTSD experienced chronic problems such as poorer relationship adjustment and communication with significant others, and higher levels of difficulties with intimacy than those without PTSD.

Furthermore, partners of those with PTSD also report lower levels of relationship satisfaction. For example, Jordan et al. (1992) discovered that female partners of patients with PTSD were more likely to be unhappy with the relationship and to report relationship distress. Calhoun, Beckham, and Bosworth (2002) similarly found that the partners of veterans with PTSD reported lower satisfaction, increased caregiver burden, and poorer psychological adjustment than did the significant others of veterans without PTSD. Furthermore, partners of trauma survivors may develop secondary traumatic stress (Figley, 1986), experiencing symptoms that mimic PTSD such as vivid mental images of their partner's trauma and avoidance of reminders (Ein-Dor et al., 2010). Thus, significant research demonstrates the impact of trauma on the survivor as well as the survivor's intimate partner.

Though individual therapy is the most often used modality to treat issues such as depression, anxiety, substance use, and eating disorders, couples therapy has been incorporated as an adjunct to individual therapy in recent years and has also been utilized as the primary modality (Johnson, 2002). Research has demonstrated a significant increase in the success rate for clients when the spouses were included in treatment for anxiety, from 46 % to 82% (Barlow et al., 1984; Cerney et al., 1987). Bowling (2002)

found that female survivors of sexual assault in couples therapy experienced more reduction in depressive symptoms than those in individual treatment, while both treatment modality groups had comparable decreases in PTSD symptoms.

Given the effects of traumatic exposure on one's interpersonal relationships, the use of an interpersonal approach to healing is particularly appropriate. Johnson (2002) noted that for such clients, even more powerful than the corrective emotional relationship with the therapist is that opportunity within the relationship with the client's intimate partner. The reports of participants in the current study demonstrates that addressing traumatic exposure in conjoint couples therapy involving EMDR serves the functions of attending to posttraumatic symptoms, increasing the intimacy and security of the relationship, and addressing relationship dynamics that were created as a result of the PTSD.

An interesting pattern among the couples that emerged during this study involves the similar interpersonal dynamics that occurred during conjoint EMDR as within their relationship as a whole. That is, partners who tended to be overly focused on their partner, to take on the "pursuer" role, to be overly controlled, to withdraw, or to engage in caretaking seemed to take on such roles within conjoint EMDR, behavior that suggests anxious attachment (Johnson, 2002; Schachner et al., 2003). When such interpersonal dynamics emerge during conjoint EMDR, EMDR allows reprocessing of unresolved traumatic wounds that contribute to these patterns. This parallels Briere and Scott's (2006) emphasis on "counterconditioning" in the treatment of trauma, such that clients reprocess material that is triggered within the session. In the current study, conjoint EMDR increased participants' awareness of interpersonal patterns within the couple's

relationship, allowed the opportunity for vicarious healing, fostered increased intimacy and compassion, and facilitated softening of previously rigid interactional dynamics.

The reports by participants are consistent with the findings across the existing literature that conjoint EMDR leads to a deepening of affect (Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001), increases empathy and understanding (Capps, 2006; Capps et al., 2005; Litt, 2008, 2010; Moses, 2003; 2007; Reicherzer, 2011), and enhances intimacy and greater differentiation for both members of the couple (Capps, 2006; Flemke & Protinsky, 2003; Litt, 2008; Moses, 2003; 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks, et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007). Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al. (2001) noted increased understanding by couples about the parallel between their current functioning and traumatic material as they reprocess trauma, stating that such connection is necessary for both to modify their emotional responses. Flemke and Protinsky (2003) observed that EMDR incorporated into Imago Relationship Therapy (IRT) facilitates movement through the obstacles of childhood traumas that had been preventing couples from establishing intimacy, given the projection that would otherwise occur during IRT techniques.

Moses (2003, 2007) identified increased trust and Capps (2006) observed increased relationship satisfaction as a result of conjoint EMDR. Reicherzer (2011) noted that conjoint EMDR increased understanding and intimacy within the relationship, emotional responsiveness to one another, greater ability and willingness to share vulnerability with the partner, and increased joy and commitment in their lives together. Talan (2007) also integrated EMDR with IRT and noted increased communication,



differentiation, and intimacy that resulted from such treatment, findings consistent with reports by the participants within the current study.

### **Assessment and Preparation**

Initial assessment of individual and relational functioning and dynamics, preparation, and ongoing assessment were important themes that recurred throughout participants' interviews, themes that extended beyond the literature on conjoint EMDR to date (Capps, 2006; Capps et al., 2005; D'Antonio, 2010; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks, et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007). Existing research has identified several necessary conditions to successfully integrate EMDR with couples therapy, including a therapeutic alliance in which trust and safety are established, both clients' and therapists' ability to tolerate intense emotions, each member's sincerity and commitment to working on the relationship, confidence that neither member would use disclosed material as a weapon, adequate differentiation and willingness to provide uninterrupted space to process, sufficient self-soothing skills, and informed consent (Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Shapiro, 2005).

Each of these factors was also noted by current participants, in addition to multiple others related to the therapist, working partner, witnessing partner, and the relationship. Those that extend previous literature (Capps, 2006; Capps et al., 2005; D'Antonio, 2010; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks, et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007) include the importance of specifically assessing for the following: attachment security, level of hostility, the role individual members take on

within the relationship (e.g., pursuer), specific relationship dynamics (e.g., withdrawal and pursuit), investment in personal change, and alignment of goals. The current research contributes to the existing literature in that these factors could provide valuable information in predicting specific dynamics that may occur during conjoint EMDR and these conditions may be related to positive outcomes.

In terms of preparation for conjoint EMDR, participants in the current study identified numerous steps to facilitate readiness for both members, several of which also extend previous research. Moses (2003) pointed to the need for the therapist to determine whether both partners are sincere and well intentioned in terms of their investment in the relationship, given the significant risk of conjoint EMDR otherwise, and he noted the importance of sound clinical judgment in evaluating the risks and benefits for each couple. Thus, the assessment and preparation stages are particularly important for effectively integrating EMDR within a couples therapy context.

There was significant variation in the amount of preparation that was conducted by therapists within the current study, partly dependent on whether members of the couple had any previous experience with EMDR. Based on data from participants, it appears that it is beneficial to err on the side of providing more preparation for both members of the couple rather than less, including when transitioning from individual to conjoint EMDR. This allows both partners to adequately anticipate and process each role, the expectations and requirements, and the impact of having one's partner present. The emphasis on preparation was unique to the current study.

Moses (2003) identified the following three principles to perform conjoint EMDR safely and appropriately: safety, balance, and containment. Though the structure of each

therapist's approach to conjoint EMDR differed in several ways, each of these factors was addressed and identified by participants in the current study. Balance was a concept mentioned by several participants, including between individual and systemic dynamics and between members of the couple. Specific to the current study was the noted value of ensuring balance by adequately preparing a partner who had not previously engaged in EMDR when the other partner had previously participated in EMDR individually. Strategies in containing within and between sessions were also noted by participants, as was the importance of the assessment and development of appropriate resources prior to conducting EMDR.

The data from participants also highlight the importance of being attuned to the needs and dynamics of each couple and both members in order to provide the necessary preparation, particularly given the theme that individual and relational dynamics that occur outside of sessions are likely going to emerge during and related to the conjoint EMDR process. For example, several participants noted significant apprehension and nervousness in anticipation of engaging in EMDR when they were aware that they would be doing so in the next couples therapy session. Those individuals who seemed to have a general tendency toward being overly controlled, inhibited, withdrawn, anxious, or reliant on external validation experienced anxiety related to exposing themselves in front of their partner, the possibility of "not being good enough," potential outcomes of the process, how one's partner might respond, or not being able to anticipate what might emerge during the session. As part of the assessment and preparation stages, it seems particularly important to be aware of members who may have a tendency toward caretaking or who might not feel safe or empowered enough to express their hesitation to engage in EMDR

with their partner present. Discussing options regarding EMDR may be more appropriate to initiate individually, particularly in such cases.

Interestingly, several participants noted that some of the witnessing partners seemed to have an intuitive awareness of the importance of staying “out of the way” of their partner’s processing, of the power of the EMDR process, and appreciated being let in on such an intimate process between the therapist and their partner. This awareness may also be a function of these partners’ intra- and interpersonal dynamics, such as their ability to self-soothe, level of differentiation, or attachment security. In contrast, partners were more reactive, focused on external validation, defensive, focused on the potential for “winners versus losers,” concerned about the potential outcome seemed to have more difficulty recognizing the importance of being a silent witness. Thus, the latter may benefit from more preparation and more direct instruction regarding the expectations and requirements of being a supportive witness.

### **Implications**

Based on the data from participants, several implications stand out as important for clinicians who may consider integrating EMDR with conjoint couples therapy. Based on current data, it does not appear that any specific protocol, beyond the standard EMDR protocol, is required in order for couples to benefit from the process; however, it may be that specific guidelines increase the likelihood of a successful change process.

Specifically, this study highlights the value of therapists doing the following: (a1) highlight the importance of relationships in healing from trauma and in promoting resilience with clients; (b) assess and remain attuned to attachment and relational dynamics, considering their impact on in-session processes and response to treatment; (c)

foster trust and safety within the therapeutic relationship; (d) emphasize preparation and ongoing assessment; (e) facilitate softening events prior to, during, and following engagement in the desensitization phase of conjoint EMDR; and (f) explore with clients the prospective benefits and obstacles of engaging in individual versus conjoint EMDR.

Conjoint EMDR may be particularly helpful in the treatment of military couples. Research has highlighted the importance of partner support before and after a traumatic event in determining vulnerability to PTSD (Ein-Dor et al., 2010), the impact of military combat on both the veteran and the spouse (Calhoun et al., 2002; Ein-Dor et al., 2010; Johnson, 2002; Jordan et al., 1992; Kessler, 2000), and the positive outcomes for integrating conjoint EMDR with couples affected by war trauma (Errebo & Sommers-Flanagan, 2007). Each of these findings provides support for the potential benefit of conjoint EMDR to the many military couples who are currently suffering the impact of post-traumatic symptoms.

Gottman (1994) found that negative interaction cycles involving criticism, stonewalling, defensiveness, and complaining predict relationship satisfaction and divorce. He demonstrated that when partners are able to remain emotionally engaged and responsive to one another, they are more likely to reconnect after conflict and are more satisfied in their relationships. Based on Gottman's (1994) research, empirical support for EFT (Johnson, 2002; Johnson et al., 1999, 2001; Schachner et al., 2003) and extensive studies validating EMDR as an individual treatment for trauma (e.g., Bisson & Andrew, 2007; Cvetek, 2008; Maxfield & Hyer, 2002; Turner et al., 2007), conjoint EMDR demonstrates the potential for increasing relationship satisfaction and preventing divorce.

Beyond when couples present with a “couple’s issue,” conjoint EMDR is also likely to be beneficial when only one partner is experiencing symptoms, such as depression or anxiety. That is, including the asymptomatic partner in couples therapy to address what might be more traditionally treated in individual therapy may have benefits as an adjunct to individual treatment. Couples therapy has been incorporated as an adjunct to individual therapy in recent years and has also been utilized as the primary modality for issues such as depression, anxiety, substance use, and eating disorders (Barlow et al., 1984; Bowling, 2002; Cerney et al., 1987; Johnson, 2002).

Wesselman and Potter (2009) conducted research that demonstrated positive change in attachment security following individual EMDR. They pointed to the associations between secure attachment and sensitive caregiving toward children, stability in adult relationships, and mental health in proposing that EMDR may not only positively impact current intimate relationships, but also individuals’ parenting and risk for mental illness. Similarly, conjoint EMDR has the potential to improve parenting skills and decrease the risk of mental illness, as partners increase their ability to self-soothe, become better differentiated, and are less reactive (Capps, 2006; Capps et al., 2005; D’Antonio, 2010; Flemke & Protinsky, 2003; Litt, 2008, 2010; Moses, 2003, 2007; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Reicherzer, 2011; Shapiro, 2005; Snyder, 1996; Talan, 2007).

Furthermore, given that security and trust within a current relationship can increase resilience when coping with traumatic events (Herman, 1997; Johnson, 2002), conjoint EMDR also has implications in promoting resilience. Hundreds of studies demonstrate the protective nature of a loving connection with an intimate partner as well

as its powerful role in increasing partners' ability to cope more effectively with trauma (Johnson, 2008). For example, Israeli researchers found that securely attached couples were better able to cope with dangers such as Scud missile attacks than were less securely attached couples, as indicated by less anxiety and fewer physical symptoms after the attacks (Mikulincer, Florian, & Weller, 1993). Thus, conjoint EMDR has implications in healing from trauma, strengthening relationships, decreasing the impact of war trauma (both in prevention and treatment), increasing relationship satisfaction, preventing divorce, treating individual symptoms (e.g., depression, eating disorders, substance use), increase sensitivity in parenting, and promoting resilience to stress.

### **Limitations**

There are strengths and limitations to the research conducted through this qualitative study of the conjoint EMDR process. Though participants were asked to share documents about the conjoint EMDR process, there is a lack of validated objective outcome measures about EMDR (and certainly, about conjoint EMDR). Thus, data from such measures are not available to further triangulate the data obtained. Future research utilizing a mixed methods research design would be valuable to obtain more information about the efficacy of conjoint EMDR. One therapist in the current study did utilize validated outcome measures (Outcome Rating Scale, Session Rating Scale, Dissociative Experiences Scale, PTSD Checklist-Military Version, Beck Depression Inventory, Beck Anxiety Inventory) and data from these measures did provide support and corroboration for the benefits identified by that therapist as well as both members of the couple. Other means were utilized to obtain triangulation, however, and the focus of the current study was to develop a theory about conjoint EMDR rather than to assess its efficacy.

Another limitation of the current study was that participants were generally interviewed one time, with only two of the participants having done follow-up interviews and two others providing email updates. Thus, no data were available about the long-term impact of conjoint EMDR, the changing impact over time, or how their perceptions of the treatment experience might change. However, these were not included as research questions for the current study and participants in this study varied significantly in the length of time since participation in conjoint EMDR, providing useful information across a variety of contexts.

Finally, there was significant variability in the protocol and contextual factors across triads. The amount and type of assessment and preparation varied greatly as did the number of sessions, the nature of the targets chosen, and the degree of involvement of the witnessing partner. Furthermore, there was variation in terms of the familiarity and previous experience with EMDR within an individual therapy context across triads and between members of individual couples. The purpose of the study was to develop a grounded theory about conjoint EMDR rather than to obtain information about effectiveness of particular protocols; therefore, this variability is not seen as a weakness of the study.

### **Future Directions for Research**

The current study has led to a better understanding about factors and conditions that are perceived to be beneficial by couples and therapists during conjoint EMDR. This study also resulted in determining useful steps in the assessment and assessment phases. It has extended past research that was primarily from the perspective of clinicians to include the voices of clients. Several areas for future directions emerged as a result of the



data provided by participants. Specifically, an examination of the following areas of study would extend the current research and the topic of conjoint EMDR further: (a) research to develop assessment tools to help determine couples' readiness to engage in conjoint EMDR, (b) randomized controlled trials to obtain more outcome information, (c) interviews with clinicians and/or couples who report having had what they would consider "unsuccessful" experiences of conjoint EMDR, (d) investigating the variables of attachment security and dyadic adjustment with conjoint EMDR (such as the Revised Experiences in Close Relationships measure of romantic attachment, ECR-R and the Dyadic Adjustment Scale, RDAS) and (e) comparing the experiences of couples and therapists as well as the outcomes among varying conjoint EMDR protocols.

### **Conclusion**

The participants' stories provide support for the notion that having another stand beside you to face the impact of trauma does, in fact, serve as a source of strength and comfort. Much research exists to inform us about the extensive impact of trauma on survivors' relationships. The current study about conjoint EMDR includes many stories of rebuilding, recovery, and reconnection. Beth observed the depth of intimacy that she experienced as a result of EMDR with Sam:

I can't imagine having done it alone because way down deep inside, you get to the heart when you're doing EMDR and when you can see and feel each other's heart when you're in a different state of consciousness almost, it b brings you together on a deeper level.

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