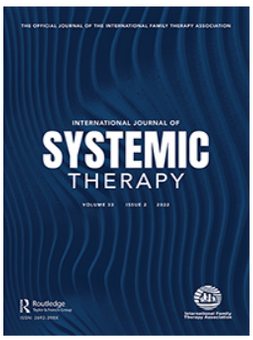

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Thematic Analysis of Therapists' Experiences Integrating EMDR and EFT in Couple Therapy: Conditions and Risks of Integration

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ABSTRACT

In this paper, we present and discuss partial findings of a thematic analysis on the experiences of 13 licensed clinicians who integrate Emotionally Focused Therapy (EFT) and Eye Movement Desensitization and Reprocessing (EMDR) in couple therapy. We cover five of the seven themes that emerged from the data. These themes refer to practical factors of implementation, such as identifying and assessing the conditions necessary for effective integration, risks of integrating, and timing of integration in couple therapy. One additional theme refers to the institutional and training factors that might hinder model integration. After presenting the findings, we contrast them with available literature. We conclude by discussing clinical and research implications.

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trauma; couple; EMDR; EFT; integration

The treatment of trauma and its effects, and the role of relationships in post-traumatic symptom development and treatment have become central in mental health. Yet, most trauma treatment modalities have been designed for individual therapy (Linder et al., 2021, 2022). Although helpful, these treatments do not directly address the relational effects of trauma on family or couple relationships. In addition, the healing potential of close relationships and family support is underutilized when therapy is conducted individually (Linder, 2020). To overcome these limitations, in their clinical practices, some therapists are venturing into "relationalizing" individual therapy modalities (e.g., using these modalities with couples or families) or integrating them with couple and family therapy models (Linder, 2020). Among them are therapists integrating Emotionally Focused Therapy (EFT) and Eye Movement Desensitization and Reprocessing (EMDR).

Both EMDR and EFT are evidenced-based therapies centered on experiential and emotional processes in present-moment, here-and-now awareness (Johnson, 2019; Shapiro, 2017). They aim to expand emotional intimacy in EFT and desensitize and reprocess traumatic memories in EMDR. Independently, the models

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may have limitations when treating trauma in conjoint couple therapy (Linder et al., 2021, 2022; McIntosh & Johnson, 2008; Moses, 2007). One limitation is that therapists usually treat the individual's trauma symptoms outside of the couple therapy context, thus missing opportunities to use the couple bond as a resource to heal (Linder et al., 2021, 2022; Negash et al., 2018). In addition, the integration of EFT and EMDR in couple therapy as an emerging practice is not well documented. Aside from the present study, current literature on the topic is limited to clinical case examples and scant research (i.e., one unpublished dissertation: Knox, 2016). In particular, information about how therapists decide to integrate EFT and EMDR and the skills and techniques needed to conduct this integration are not fully addressed.

In the present article, we describe the results of a thematic analysis conducted to understand the experiences of clinicians who integrate EFT and EMDR in their clinical practices with couples. Given the vastness of our study's findings and the focused nature of journal publications, we present in this article only five of the seven identified themes: (a) variables to consider when integrating the two models, (b) risks of integration, (c) integrating other models aside from EMDR and EFT, (d) integrating EMDR at any stage of EFT, and (e) integration as the exception, not the rule. The complete findings, including the remaining two themes (clinical and theoretical complementarity, and perceived therapeutic benefits of integration) can be found in the dissertation study by the first author (Linder, 2020) and in Linder et al. (2022). We start this paper by briefly introducing EFT and EMDR and presenting available information about using EMDR in conjoint couple therapy. Then, we present the partial findings of the study, focusing on practical aspects of implementation, with illustrative quotes from the participants. We conclude this article by discussing the findings and presenting clinical and research implications.

Emotionally focused therapy (EFT)

EFT, one of the most empirically validated couple therapy models (Dalgleish et al., 2015; Johnson, 2019; Lebow et al., 2012), emerged in the 1980s as a response to the paucity of research-supported couple therapy models (Johnson & Greenberg, 1985). Informed by attachment theory (Bowlby, 1979), Johnson (2004) found that what brought couples to therapy was their fear of disconnecting from their romantic partners, and their innate longing for securely attached relationships. Discord in intimate relationships is rooted in the emotional reactivity from partners feeling that their attachment bonds are threatened. EFT is also based on systems theory in its understanding of couples' relational cycles, and in experiential/humanistic therapies in their emphasis on transformative emotional experiences through enactments as the chief mechanism of change in therapy (Johnson, 2004). There are three stages in EFT: (a) assessment and de-escalation; (b) change of interactional patterns and creation of new bonds; and (c) consolidation (Johnson, 2004).

Eye movement desensitization and reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) emerged as a trauma treatment to decrease the intensity (desensitization) of disturbing memories, with sexual abuse victims and military service members as original target populations (Shapiro, 2018). EMDR is now used to treat various mental health issues related to traumatic memories and adverse life experiences (Marich, 2011; Parnell, 2010; Shapiro, 2012, 2018). EMDR therapy is based on the *adaptive information processing* (AIP) model (Shapiro, 1995, 2002a). According to the AIP, the brain and body have a natural capacity to process traumatic memories healthily and adaptively. However, significantly stressful experiences can overwhelm and thus obstruct this natural processing capacity. When the information related to a particularly stressful occurrence is poorly processed, it becomes stored as originally encoded, along with any distorted thoughts, images, sensations, or perceptions (Shapiro, 2007a, b). Through bilateral stimulation (presently known as dual attention stimulation) during EMDR, unprocessed information is linked with adaptive existing memory networks, which helps to qualify and contextualize these memories and lower their capacity to trigger emotional reactivity (Shapiro, 2007a, b).

EMDR in conjoint therapy

EMDR was developed primarily as an individual therapy, and initially the presence of significant others (client's partner or family members) was discouraged by Francine Shapiro, the model developer, because it could compromise the client's sense of safety needed for memory reprocessing. In the second edition of Shapiro's (2001) EMDR textbook, she adopted a more flexible stance affirming that the key factor in using EMDR in conjoint couple therapy was the degree of support and commitment of the client's partner. If it contributed to an environment of safety and support, a partner's presence could be considered acceptable and even therapeutically beneficial (Shapiro, 2001). The use of EMDR in conjoint therapy has mainly consisted of having one member of the couple follow the EMDR protocol (re*processing partner*) while in their partner's presence (*witnessing* or *observing partner*).

A 2007 publication of the book *EMDR and Family Therapy Processes* (Shapiro et al., 2007) provided further movement toward the relational application of EMDR. Despite this more accepting approach, Shapiro still recommended couple therapists to separate partners for EMDR because the presence of the observing partner could prevent the organic unfolding for the reprocessing partner, for example, by worrying about the witnessing partner's reaction to their spontaneous associations during bilateral stimulation (Shapiro, 2018). She ultimately recommended therapists to rely on their clinical judgment regarding whether to have a client's partner present during reprocessing.

As recommendations for and against the use of EMDR in conjoint couple therapy continue, clinicians and researchers have been experimenting with it and have documented their experiences in published clinical cases and exploratory studies (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Knox, 2016; Legg, 2013; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001; Moses, 2003, 2007; Reicherzer, 2011; Snyder, 1996; Linder et al., 2021, 2022; Negash et al., 2018; R. Shapiro, 2005). Snyder (1996) wrote the first published clinical case of conjoint couple EMDR, and found it helped foster intimacy for both partners in a lesbian couple with a history of sexual abuse and addiction. Clinical cases on the integration of EFT and EMDR also signal therapeutic potential. For example, Negash et al. (2018) suggested the benefits of using EMDR for couples struggling in EFT, particularly when attempting to facilitate corrective experiences in stage two of EFT.

Based on clinical experience, Protinsky, Flemke et al. (2001) and Protinsky, Sparks et al. (2001) developed a modality for using EMDR in conjoint couple sessions that incorporated EFT principles and interventions. They called this approach Eye Movement Relationship Enhancement (EMRE). EMRE enabled couples to be mindful and receptive after they took turns reprocessing traumatic events in each other's presence (Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001). The authors claimed this modality helped couples access their primary emotions when they were stuck in the reactivity of secondary emotions, and resulted in improved accessibility and vulnerability in the witnessing partner (Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001). They also posited that this therapeutic effect may work through enhanced access to earlier traumatic experiences (EMDR targets) relevant to the couples' presenting problems.

In terms of research findings, Legg (2013) conducted a grounded theory on the experiences of therapists and clients with using EMDR in conjoint couple therapy. Collecting information from seven cases (the therapist and each member of the couple), Legg (2013) identified clients' and therapists' conditions under which EMDR would be most appropriate. In relation to clients, conjoint EMDR seemed to work better when clients could empathize and be vulnerable with each other, discuss past attachment injuries, and not personalize or project feelings onto their partners. In the case of therapists, maintaining an integrative approach that balanced individual and relational elements, and an ability to explain to clients why each member may need extended individual attention periodically throughout treatment were characteristics of the therapists that made integrating EMDR more suitable (Legg, 2013).

Knox (2016) conducted a comparative (between-groups, quasi-experimental) quantitative study examining the effectiveness of combining EMDR and EFT for military couples. The study found that couples treated with EFT and EMDR experienced greater marital satisfaction, enhanced

attachment, and lower post-traumatic symptoms than those treated using each model separately (Knox, 2016). Until recently, said study was the only one to address EFT-EMDR integration. To contribute to the understanding of the integration of these two models, we now present the partial findings of a thematic analysis on the experiences of licensed therapists integrating EFT and EMDR in their clinical work with couples.

Methods

Thematic analysis ('TA') is a qualitative approach for identifying commonalities and patterns across participants' responses. Using 'TA,' researchers can identify, organize, analyze, and report patterns of meaning, or *themes*, in a data set (Braun & Clarke, 2006; Braun & Clarke, 2013). This study was conducted using 'TA' because of its inherent flexibility and compatibility with induction and deduction (Guest et al., 2011). For example, 'TA' enabled the first author to pose specific preliminary interview questions (Appendix B) related to integrating EFT and EMDR, while allowing the data to influence the direction of the study. These advantages also facilitated an exhaustive, rich, and multifaceted report of the data (Braun & Clarke, 2006).

In this 'TA' we explored how 13 therapists dually trained in EFT and EMDR integrated these models in conjoint couple therapy. Data were obtained through semi-structured interviews, lasting from 45-90 minutes. See Appendix B for the interview questionnaire.

Participants

The 13 participants were clinicians licensed in the U.S., trained in EFT and EMDR, practicing with couples, and integrating these two models in couple therapy. To be considered EFT trained, participants must have attended the 4-day EFT externship *and* the 4-day EFT core skills training. To be deemed trained in EMDR, participants met the minimum requirement of completing an EMDRIA-approved program (parts 1 and 2, each lasting 3 days) and to have received at least five consultation hours with an EMDRIA-approved EMDR consultant.

To recruit participants, details of this study were posted in the professional Facebook groups and list-serves of the International Center for Excellence in EFT (ICEEFT) and the EMDR International Association (EMDRIA). Snowball sampling was also used for recruitment (Creswell, 2007). This involved sharing the study information with EMDR and/or EFT certified or trained therapists, consultants, supervisors, trainers, and authors who had written on conjoint EMDR or integrating EMDR and EFT. Tables 1 and 2 present the participants' demographic and clinical information.

Table 1. Participants' demographic information.

Demographic variable	N (N = 13)	%	Demographic variable	N (N = 13)	%
Gender			**Relationship status**		
Female	9	69	Single	2	15
Male	4	31	Married	11	85
Race			**Education**		
White	11	85	Doctoral	5	38
Other	2	15	Masters	8	62
Type of License					
LMFT	5	30			
Psychologist	4	38			
LPC/LMHC	4	30			

aKey: LMFT: Licensed marriage and family therapist LPC: Licensed professional counselor LMHC: Licensed mental health counselor

Table 2. Participants' clinical information.

Clinical variable	N (N = 13)	%	Clinical variable	N (N = 13)	%
Experience as couple therapist			**Cases treated – EMDR**		
1-10 years	6	46	15-20 cases	1	8
11-20 years	6	46	20-50 cases	1	8
21 or more	1	8	50-100 cases	3	22
EFT training			100-200 cases	2	15
Trained (externship & core skills)	10	77	200-300 cases	4	32
Certified	3	23	Over 300 cases	1	8
Experience as EFT therapist			Unsure	1	8
1-5 years	5	38	**Years integrating EFT/EMDR**		
6-10 years	7	54	1-2 years	3	22
20 or more	1	8	3-4 years	4	32
EMDR training			5-6 years	1	8
Fully trained and consultations	4	32	7-8 years	2	15
Certified	5	38	9-10 years	2	15
Approved Consultant	3	22	11-13 years	1	8
Approved Trainer	1	8			

Procedure

After IRB approval, participant recruitment started. Potential participants were briefed regarding the nature of the study and were screened telephonically or via e-mail to ensure eligibility. Afterward, participants signed an informed consent, filled out a demographic form (Appendix A), and participated in a semi-structured interview (Appendix B). Pseudonyms were used during the interviews to protect participants' confidentiality as well as their clients'. Participants received a $50 gift card after the interview as a token of appreciation. Compensation for participation came from funds from the first author's 2018 Ronald E. Lunceford Scholarship of the California Association of Marriage and Family Therapy (CAMFT).

Interviews were audio-recorded, transcribed by using transcription services (Rev.com), and shared with the interviewee via email to verify their accuracy. Transcriptions were then subject to 'TA' using the qualitative data analysis software MaxQDA. Regarding our roles in the research team, the first author was the main coder, the second author acted as a research auditor, and the two remaining

authors reviewed the final report. In relation to social location, the first author is a cisgender, able-bodied, middle-class, and Jewish male, the second author is a mixed-race, cisgender, middle-class, able-bodied, and immigrant Latina, the third author is a Black immigrant, cisgender, and middle class female, and the fourth author is a female cisgender, middle class, able-bodied, and second generation Mexican-American.

Data analysis comprised four phases. First, the first author coded the transcriptions by applying brief labels to categories of meaning using data segmentation. Then, codes were grouped into subthemes and overarching themes, leading to thematic networks. The first author created a list of preliminary codes, subthemes, themes, and exemplary quotes and shared them with the second author. In the second phase, the first and second authors discussed the preliminary lists. When a code, theme, or subtheme was questionable, the authors deliberated the pros and cons of its inclusion into the final list. Factors such as saliency (how central the code was in the description provided by the participant) and frequency (e.g., how often a code was mentioned and by how many participants) were considered in the decision. The second phase ended with a revised list of codes, themes, subthemes, and illustrative quotes. The third step consisted in reexamining the interview transcripts with the updated list. Themes and subthemes that were mentioned by more than seven participants (more than half of the total 13 participants) were considered major themes and remained, while other themes that were mentioned less frequently were discarded. The final list of the major themes and subthemes was used to outline the findings. The fourth phase included asking participants to review the final list of major themes, subthemes, and codes for member checking (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). In addition to member-checking, other methods to ensure trustworthiness included maintaining an audit trail (Shenton, 2004) and memos of every step of the process.

Results: themes and subthemes

Seven themes emerged from the data, but only the five that are related to the practical aspects of integrating EFT and EMDR in couple therapy are presented in this article. The remaining two themes (theoretical and clinical complementarity between EFT and EMDR, and benefits of integration to client couples) are presented and discussed elsewhere (Linder, 2020; Linder et al., 2022). The themes and subthemes to be described in this paper are listed in Table 3, with their respective salience. Participants' quotes are included to exemplify the themes and subthemes.

In general, participants spoke of viewing high distress and discord in the couple as rooted in relational and attachment-based traumatic memories. For participants, this was especially evident when partners' reactions to each other seemed out of proportion to what was discussed in session. They reported

Table 3. Frequency of themes and subthemes reported by participants.

Themes and subthemes reported by participants	Frequency	Participants (N = 13)	%
Variables to consider when integrating			
Integrate when relationship is safe	50	11	77
Severity of trauma dictated integration choice	32	10	77
Decisions based on collaborating with couple	35	7	54
Psychoeducation	22	8	62
Individual EMDR sessions to serve couple	22	8	62
Individual assessment before conjoint EMDR	11	7	54
Risks of integration			
Integration is risky	56	10	77
Going rogue	20	11	85
Integration is clinically complex	32	8	62
Integration is not always advisable	18	7	54
Balancing individual and couple work	17	7	54
Integrating other models	40	8	62
Integrating EMDR at any EFT stage	19	8	62
Integration is the exception not the rule	11	7	54

using EMDR to heal these unresolved memories to keep them from fueling the couple's negative cycle. Participants also reported using EMDR self-regulation and self-soothing strategies to help couples deescalate and be more emotionally ready for EFT interventions. When integrating EMDR and EFT, participants described mainly two modalities: (a) using EMDR in conjoint sessions with couples engaged in EFT, in which one partner at a time was reprocessing traumatic memories while the other took the role of supportive witness; and (b) doing individual sessions of EMDR with one or both members of the couple and then resuming conjoint sessions. The former seemed to be the most popular modality as nine of the thirteen participants reported using it.

Theme one: variables to consider when deciding whether to integrate both models

As much as participants recognized the clinical value of integrating EMDR and EFT, they identified certain conditions that needed to be in place for it to work smoothly. This theme refers to key markers participants reported using when deciding whether and how to proceed with the integration.

Integrating both models when the couple relationship was assessed to be safe

Safety between partners was seen as a vital prerequisite for integration. As participant Montana stated, when there is not enough safety and security in the bond, it is preferable to refer the clients to individual therapists before integrating EMDR into their EFT couple work. Participants identified five individual and relational elements that served as indicators of safety. First, integration was seen as likely to succeed when both the reprocessing and the observing partners could tolerate EMDR psychologically without abreacting. Participant Rachael stated, "I only integrate after they've deescalated." A second marker of safety was the degree of

emotional supportiveness between partners. Participant Lisa reported paying attention to the couple's mutual responsiveness, care, respect, and capacity to hold space for each other rather than interrupting or being intrusive, when considering integrating EMDR and EFT. A third way safety was assessed was each partner's level of vindictiveness, evidenced by, for example, the possibility they may use what they hear during a trauma reprocessing session against each other. For example, Lisa mentioned, "high vindictiveness would mean less safety and therefore less likelihood of effective EFT-EMDR integration." A fourth marker of safety mentioned by participants was each partner's level of self-regulation. Participant Kevin stated that both clients needed to be "well-resourced" (which in EMDR refers to having tools for affect regulation) to tolerate trauma reprocessing and achieve a positive outcome. A fifth safety gauge was each partner's openness and honesty in couple therapy. Kevin noted that suspecting that clients were keeping information from him or each other decreased the sense of felt safety, which made him less comfortable with integration. Participant Lisa mentioned,

> I'm feeling out how open is this partner with me versus with their partner, and so if my sense is that a partner is sort of defended, withholding info, there's something that's holding them back, even if I'm not really clear about what that is, my gut's going to tell me that this isn't the place to be doing this EMDR work together.

Severity of the trauma symptoms couples displayed dictated integration decisions

Participants were less likely to integrate models with clients who displayed higher severity of trauma symptoms, as this was seen as associated with less capacity for self-regulation which, as seen before, can compromise the safety in the relationship. Also, higher symptom severity could also indicate the need for more sessions focused on reprocessing the trauma of *one* member of the couple, which can affect the *couple* therapy process. Participant Max believed that integration works best when a limited number of EMDR sessions is required with each partner. He also stated,

> When there is a Big T-trauma, that is going to take a lot of time. It's going to be more than a couple of sessions. It's going to be more than a brief treatment [. . .] a serious multiple trauma residual, it could be a 20-session treatment or so, and that just doesn't work within this conjoint model, unless it's meeting with them individually every week, as well as a couple. It's too cumbersome and, in my opinion, too risky because of all the list of pitfalls that come, mixing individual and couples work.

Integration decisions were based on collaboration with the couple

This subtheme refers to participants presenting clients the option of integrating EFT and EMDR, and making this decision collaboratively. Participants emphasized the importance of clarity and openness in this discussion for clients to make an informed decision. Rachael mentioned telling clients, "here's this model, here's a bunch of things that come with my toolbox, and here's why I would think that this might be helpful. Would they be willing or experiment or try it, or do they see any benefit? I let clients lead." Tyra noted the importance of consensus between partners, "I specifically talk to the couple and I'm really big on that, making sure they're both going to be okay. They both need to opt in." Emily provided several examples of how discussing EFT-EMDR integration with clients can lead to different outcomes,

> Usually, the couple's quite clear, like, 'Oh yeah, this would be great to do together. I would totally love to have my husband here with me while I'm processing this.' Or like, 'You know, I do need to process this, but I just cannot imagine doing it with her here because I'm not ready for her to witness this part of me yet.' Or, 'I would love to be here to support her, but I can't because I know that the person who sexually assaulted her is somebody who's still in our lives, and if I hear more about it, I'm going to get too triggered and hate that person.'

Lastly, participant Ali mentioned giving couples the option to integrate EMDR with her in the context of EFT therapy, or individually with another therapist.

Importance of psychoeducation about EMDR and EFT, and potential benefits and risks of integration

As described by participants, providing clients with appropriate information about EMDR, EFT, and their integration enables them to collaborate with their therapist more effectively in decision-making. Emily stated, "for clients, of course introducing them to the different models and getting them familiar enough with it to be able to make an informed decision about whether or not it's something they're interested in doing, that's definitely important." Most participants spoke of telling clients the "pros and cons of integration" as part of psychoeducation. The pros of integration discussed with clients included the possibility of accessing the root of their relational problems or facilitating insight, and the cons included the risks, which are reviewed in a subtheme further below.

Individual EMDR sessions are indicated if they serve the couple's treatment goals

In some cases, participants concluded that it was clinically helpful to conduct limited individual EMDR sessions with each partner, as long as it aligned with the couple's therapeutic goals. As Emily said, individual EMDR sessions "must always be in service of the couple." More specifically, participants spoke about

considering including EMDR to help couples reach EFT therapeutic goals. Tyra stated "EMDR must serve the couple's bond in EFT," whereas Mel spoke of using individual EMDR sessions primarily to help partners maintain emotional stability during the EFT work.

Individual assessment with each partner before conjoint EMDR

When participants considered integrating EMDR and EFT through conjoint sessions, they spoke about the need to assess each partner's capacity to engage in it. Lisa captured it well,

> So, when they need to rescue or defend themselves, or if they have a hard time self-soothing or self-regulating, that's going to show up in the conjoint EMDR. So, I want to be assessing all those pieces together and individually, and I wouldn't propose it [EMDR-EFT integration] unless the signs are suggesting to me that they might be appropriate.

This assessment included looking into each partner's capacity for self-soothing as well as their "ability to tolerate their partner's process" as Kelly stated. Also, Bella mentioned assessing "the commitment level of each partner." Participants reported preferring to meet individually with each partner before venturing into conjoint EMDR. For some participants, individual assessment was part of their couple therapy protocol, independent of whether they considered EFT-EMDR integration. In other cases, individual assessment meetings were only conducted when they were deemed clinically necessary. For example, Kevin reported using individual meetings when he felt clients were not being completely open and forthcoming in the couple context. Kevin stated, "If I feel like somebody is not giving me the truth here, I want to check on them individually, or I am getting a sense that they are not fully safe being vulnerable in front of their partner, I want to find out why, especially before using the EMDR."

Theme two: risks of integration

Most participants mentioned that integrating both models may not always work as hoped, and could readily think of potential risks of EMDR-EFT integration. Participants thus wanted to make sure that the benefits of integrating EMDR and EFT outweighed the risks. Participants' emphasis on caution and awareness of possible pitfalls led this topic to be considered a theme in its own right.

Integrating both models is risky

Participants mentioned several possible risks that could come with integration. Among them was deciding the best time to integrate. As Max commented "it can be hard to tell it is too soon to integrate before it's too late." Emily spoke to

the possibility that jumping too quickly to EMDR can compromise what makes EFT work, such as the bonding moments, the quality of enactments, or the overall focus on restructuring the couple's dynamic. Another risk mentioned by Max was underestimating the extent of each partner's trauma. Bella described how including EMDR in couple therapy can "open partners to even more rawness and vulnerability," which naturally translates into the possibility of partners getting hurt.

Many examples of the risks of integration involved conjoint EMDR. Lisa spoke of the possibility of integration "backfiring," and provided an example of observing partners' comments interrupting the reprocessing partner during EMDR, creating an attachment injury. However, Lisa also mentioned that conjoint EMDR provides partners with the opportunity to repair those injuries. Ali spoke to the risk of partners using the content of each other's conjoint EMDR sessions as ammunition in future arguments. To minimize this risk, Kelly mentioned implementing the blind-to-therapist (B2T) protocol (Blore et al., 2013) to help facilitate emotional safety in conjoint EMDR. The B2T protocol mirrors the standard EMDR protocol, except that clients do not need to disclose the content of their spontaneous associations during EMDR reprocessing, so they do not feel pressured to report what they may not want their partner to hear. Even when participants stated they coached the observing partner and appropriately prepared both partners for conjoint work, they acknowledged the impossibility of knowing how the couple would respond.

This subtheme complements preceding ones in that participants reported that a thorough assessment, collaborating with clients, discussion of pros and cons, and psychoeducation were ways of reducing these risks. For example, Rachael shared, "sometimes the partner wants to jump in and save the reprocessing client in the middle of reprocessing, so I do a lot of front-end work, again, about what their role is, how EMDR works, and how we might use them"

Going rogue

Among participants, there was a sense of "going rogue," when they integrated both models. They reported having to figure things out by themselves, and shared a sense of going against expectations and mandates received during their training. Emily referred to "feeling like she was flying by the seat of my pants," whereas Montana mentioned feeling like a "rebel," and Max described the process as learning by trial and error.

As mentioned by participants, "going rogue" was related to the tendency of the models' developers, clinical communities, and training institutions to promote a rigid implementation of the models and to discourage integration with other models, often to promote fidelity to the model and the research supporting it. Tyra mentioned receiving integration "pushback" from

colleagues at EFT conferences, and having to defend her approach by saying "Really, I'm on your side. I'm not downing EFT just because I'm saying I'm using something else, too." In relation to EMDR, Bella noted, "I think there's a reason to be cautious from Francine's [Shapiro] perspective about using EMDR relationally, but I do think that we need to be doing it because as systemic thinkers, how could we not want to do it?"

Maintaining the cohesion of models that have demonstrated clinical effectiveness), they also highlighted the limitations they have found in applying each model in isolation. Peter captured it succinctly, "what I see sometimes with these founders, it's almost like a territorial war, like 'oh, I have this therapy and it's a cure-all.' But humans aren't that simplistic, and I think we need a ultifaceted approach." Max zoomed out implying this issue is "bigger than Sue Johnson and Francine Shapiro," stating that most model originators "talk about their models as if they're all therapists need." When faced with the limitations of each model to address the clinical needs of their clients, combined with the opposition to integrate coming from model developers and training institutions, the participants' option was to "go rogue."

Integration is clinically complex

There was no clinical map or choice-point guide when integrating both models, making it difficult for participants to navigate the "integration terrain." Lisa mentioned, that after assessing the suitability of integrating EMDR and EFT with specific couples "in my mind it feels like it could be 'EFT on steroids' too, sometimes, and other times just be messy." When describing conjoint EMDR in the context of EFT, participants spoke about the complexity of working with the reprocessing partner while paying attention to the responses of the observing partner. Emily stated,

> If they hear something that sounds bad from their partner and in my mind, I'm thinking, "Oh, this is an abstraction, or this is a symbol of how scary this is for this person," I'm not going to get phased by that. But if the partner is hearing it and they interpret it in a certain way, then they're going to have their own reaction, and now the EMDR partner is vulnerable and so is the observing partner, and now it's like, "Okay, crap."

Nancy spoke to the observing partner needing to be "contained" so that she could focus primarily on the reprocessing partner. Mel used the metaphor of catching an "atom bomb," instead of a "bullet," when describing handling partners' unexpected reactions in conjoint EMDR. In sum, participants recognized the complexity of integration and its demands on the therapists.

Integration is not always advisable

Because integration is complex, risky, and is not guaranteed to go well, participants emphasized that it is not always advisable. Even if the therapist integrates both models as carefully as possible, the possibility that it does not work well or falls flat is always lurking. Max captured this subtheme concisely, stating, "even if we do our best, it is cumbersome. It can always go wrong and that could be beyond our control." Emily likewise stated that "sometimes it's helpful but integrating both models is unfortunately not as successful as I may have wished."

Balancing individual work in the context of couple therapy

This subtheme refers to the challenges participants faced when including individual sessions of trauma reprocessing in couple therapy. A consensus was that doing too many sessions of individual EMDR could get "too messy" for the therapeutic alliance, and too taxing on the therapist, compromising the therapeutic process. For example, Max mentioned breaches of confidentiality or rivalry as possible challenges. He said,

> They're coming in already with issues. Why complicate it by their having some rivalry about who's the preferred patient or some accidental breach of confidentiality of something that comes up individually or whatever other imagined – no matter how careful the therapist is – complication that comes up? Because, God knows, there are many other therapists out there, as long as there's a good collaborative relationship. So, I would refer to someone that I know and someone that I've worked with before, and so the work could be bridged to the couples' work, especially if there is a deeper trauma.

Similar to Max, Ali and Nancy also preferred to refer members of their couples to individual sessions with a colleague to mitigate the risks. Some participants opted for doing conjoint EMDR to keep the focus on the couple, whereas others preferred doing a limited number of individual EMDR sessions with each partner between conjoint EFT sessions. Montana spoke of feeling conflicted when integrating individual sessions of EMDR in EFT work because she was playing the role of the reprocessing partner's individual therapist at least temporarily, which could alter the therapeutic alliance. She shared that playing all three roles (couple therapist, and individual therapist for each member of the couple) once got particularly "messy when one partner started talking about non-EMDR related content" in their individual sessions. To mitigate this risk, Montana now offers a limited number of individual EMDR sessions. Participants spoke about learning to navigate the tensions of individual and couple work by trial and error, as they did not find much in the literature that could be of guidance. In sum, most participants were cautious about the implications of adding individual sessions to their

couple work, but were in favor of occasional individual or conjoint EMDR sessions if directly relevant to shifting the couple's negative cycle and meeting their treatment goals.

Theme three: integrating other therapy models besides EMDR and EFT

Participants generally expressed pro-integration views, and cautioned against model developers' purism and reluctance to integrate. Participants believed no one model is sufficient for every couple case, and seemed to prioritize helping their clients over loyalty to a specific model. This meant using all the germane tools at their disposal, and integrating other therapy models into their EFT or EMDR work. Mel stated, "I'm all for bringing on as many tools and my biggest guns, so to speak, to make the work effective." Among the models participants reported integrating are the Gottman Method, Internal Family Systems (IFS), and Accelerated Experiential Dynamic Psychotherapy (AEDP).

Participants also expressed that, despite different packaging, most therapeutic models, especially those meant to treat couples and emotional or attachment trauma, have a great deal of overlap, which facilitates integration. Rachael stated, "all models have something great to say, and I don't think they are too different. I think that there's just a little tweak here and there and a little benefit." The pro-integration stance may be unique to this sample of therapists as one of the requirements for participation was to have integrated EFT and EMDR.

Theme four: integrating EMDR at any EFT stage

This theme refers to reports from participants that EMDR could be integrated during any of the three stages of EFT. Thus, some noted that conjoint EMDR could help couples deescalate in stage one by increasing empathy and addressing relational traumas that fuel the negative cycle. Others mentioned it is safer to do conjoint EMDR only in stage two of EFT, after more emotional safety between partners has been established. Yet others stated it can be integrated at any stage of EFT. For Lisa, integrating EMDR is about clearing the blocks in EFT, no matter where they arise in the process, stating, "It's not necessarily when they're at a stage one or stage two. It's not necessarily about a couple not being able to get to stage two."

Participants mentioned being creative regarding how they incorporated EMDR across the EFT stages. Kelly found a way to make the common EMDR preparation exercise *calm/safe place* (now called *calm/safe state* in the updated 2021 EMDR manual) more relational by having a "shared calm/safe-place" for the couple to envision in their minds together. Tyra mentioned going back and forth between the two models, "We can do EFT after the EMDR, coming back to the couple focus to do an enactment for that." The consensus was that there is no surefire way to integrate EMDR into EFT, and that it is unique to each client couple.

Theme five: integration is more the exception than the rule

Mostly participants reported that they do not usually integrate EMDR into EFT, and they seldom do conjoint EMDR. Lisa stated,

> Honestly it's the rare, probably less than 25%, the couples that I can integrate EMDR with, unfortunately, because of readiness, because of safety, because of partners being maybe one foot out or not being able to be responsive or there's not that personal accountability.

Tyra likewise stated, "I've done it a few times" explaining that "logistics sometimes rules that" referring to office space availability. Max spoke of the importance of keeping the EMDR work "time-limited" in order to keep the focus on the EFT couple work. While participants reported integrating models infrequently, integration appears to be more inherent to how they conceptualize their couple cases.

Discussion

This article presents partial findings of a thematic analysis on the experiences of licensed clinicians integrating EFT and EMDR in couple therapy, with a focus on its practical aspects. In agreement with other authors (e.g., Negash et al., 2018; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001), participants recognized that integrating EMDR and EFT could be helpful for couples as it not only aligned with, but also facilitated, the goals of creating secure bonds and helping partners meet each other's attachment needs (Johnson, 2019, 2002). However, participants stated integration is not always recommended, were rightly cautious about possible pitfalls, and mentioned strategies they have used to reduce risks. For these reasons, participants reported integrating both models in couple therapy sparingly.

Participants indicated a limited number of individual or conjoint EMDR sessions to maintain the focus of therapy on the couple relationship. In conjoint EMDR, the literature recommends the observing partner function as a witness and silent supporting presence (Linder et al., 2021, 2022; Moses, 2003, 2007; Negash et al., 2018; Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001). Congruent with this recommendation, participants reported coaching their clients for their role of observing partners, and mentioned being vigilant of both partners' reactions to prevent interruptions for the processing partner.

Similar to Protinsky, Sparks et al. (2001), Protinsky, Flemke et al. (2001), and Robin R. Shapiro (2005), participants expressed awareness of the risks of integrating EMDR and EFT. Some possible risks and measures to mitigate them have also been mentioned in available literature. Moses (2007) pointed out that the main risk of EFT-EMDR integration was "unbalancing the system" (p. 164), as it can become challenging to all three parties to alternate evenly between the couple and each member of the couple. Individual EMDR with both or either partner can strengthen the therapist's alliance with one

partner, clouding the therapist's neutrality and dedication to the couple unit. Likewise, participants mentioned difficulties in managing the expectations of conducting individual and couple therapy sessions with the same clients. Moses (2003, 2007) emphasized the importance of clinicians ensuring both partners take turns equally in EMDR reprocessing so that neither assumes the role of identified patient. Other recommendations to reduce risks include advising partners to only engage in deep emotional processing during sessions and not outside of them (Moses, 2003, 2007), and warning the reprocessing partner that everything they share aloud during EMDR cannot be unheard by their partner (Legg, 2013).

There was a sense among participants that as helpful as it was, certain conditions needed to be in place for the EFT-EMDR integration to work, especially if implemented in conjoint sessions. Safety was deemed crucial. Participants reported five factors to assess for safety individually and in the relationship: each partner's level of psychological tolerance, emotional support between partners, possibility of vindictiveness, capacity for self-regulation, and openness and honesty when in the partner's presence. These factors have some support in the literature. For example, Robin R. Shapiro (2005) recommended clinicians carefully appraise a couple's ability to support each other, level of emotional safety, level of differentiation, capacity to self-soothe and withstand intense emotions, personality factors, therapeutic alliance, and the potential risks and benefits of conjoint EMDR before proceeding. In her study on the experiences of therapists and clients using EMDR in couple therapy, Legg (2013) found that conjoint EMDR did not go well when partners were extremely angry at each other, or when they were more invested in having their partners change than in their own development. Also, conjoint EMDR was not recommended when partners were highly fearful of their relationship ending, particularly anxious about their partner's reaction during EMDR, and if they needed external validation (Legg, 2013; Moses, 2007). Moses (2003, 2007) underscored the importance of both partners' sincerity and commitment to their bond before beginning EMDR in couple therapy, and mentioned intense conflict or hostility as a contraindication to conjoint EMDR. In sum, the results of the present study align with the extant literature in considering safety in the couple relationship as a central factor to EFT-EMDR integration.

Participants were less likely to integrate models with clients who displayed severe trauma symptoms as this could indicate lower capacity for self-regulation and difficulties listening to, and making space for, one's partner's experience. This finding is supported by the trauma treatment literature in general, where it is considered that a certain level of emotional regulation and distress tolerance is necessary for trauma reprocessing (e.g., Briere & Scott, 2015). Specifically, in EMDR, therapists can proceed with memory reprocessing (phases 3 to 7) only when the client is "psychologically ready to tolerate it" (Shapiro, 2018, p. 56) and has developed some emotional resources (phase

two). Moses (2007) recommended therapists attempting conjoint EMDR to be cautious when one or both partners display acute trauma symptoms. The present study found that trauma symptom severity directly influences clinicians' integration decisions.

Participants spoke of deciding collaboratively with their clients whether and how to integrate EMDR and EFT. They also mentioned providing psychoeducation to their clients, especially on the risks and benefits of integration, to help them make an informed decision. The value of collaboration in goals and tasks is well supported in psychotherapy literature (see, Duncan et al., 2010) and has been also important in conjoint EMDR. Moses (2007) recommended weighing the pros and cons of conjoint EMDR with the couple and ensuring both partners "mutually consent" before proceeding with integrating EMDR in couple therapy (p. 163). The importance of providing clients with adequate information was also highlighted in Legg's (2013) findings. In her study, some clients stated they would have wanted more education about the benefits of conjoint vis-à-vis individual EMDR before engaging in treatment.

There were diverse experiences regarding the stage of EFT in which they would integrate EMDR. For example, some participants stated EMDR was an aid during de-escalation (Stage 1 of EFT), whereas others included EMDR in Stage 2 of EFT, after the negative cycle had been deescalated and there was more emotional safety in the couple relationship. Others reported using EMDR at different stages of EFT, depending on the clients' needs. In the scant literature on EMDR-EFT integration, there seems to be some support for using EMDR therapy to reduce the intensity of the negative cycle. For example, in EMRE (Protinsky, Flemke et al., 2001; Protinsky, Sparks et al., 2001), EMDR is used to help partners deescalate with self-regulation strategies, so they are less entangled in negative interactional patterns. Similarly, Negash et al. (2018) stated that clinicians who combine these two approaches should start with the first two steps of EFT, and then conduct the eight phases of EMDR in step three of EFT, to heal the traumas blocking the emotional safety necessary for vulnerability during stage two (Negash et al., 2018). EMDR can help and be helped by the establishment of the couple's secure attachment bond, which would support the usefulness of trauma reprocessing through EMDR in either Stages 1, 2 or 3 of EFT.

The needs of clients propelled participants to venture into exploring an EMDR-EFT integration. These needs were related to the impact of trauma in the current couple dynamics and tapping into the healing potential of the couple's attachment relationship. However, for participants, there was a sense of "going rogue" as there was no clinical map when integrating. It appears they were experimenting successfully and finding ways to handle the complexities effectively, as reflected in examples where participants reported therapeutic benefits, such as reprocessing the attachment traumas fueling the couples' negative relational cycles. Yet, a number of participants stated feeling that their integrative efforts were not supported by the EFT or EMDR clinical

communities and training systems, as their procedures were out of the traditional and research-sanctioned use of these models. EFT and EMDR are groundbreaking models that shifted the treatment of couples and trauma. Consequently, in both cases, training programs and certification processes have been developed to guarantee that therapists faithfully follow these models. This rigor, although important to preserve the integrity and effectiveness of the models, was experienced by most participants as restrictive.

It is important to clarify that in the case of EMDR, there is not an opposition to integrating it with other models. In fact, EMDR as a trauma treatment is expected to be used in tandem with the therapists' preferred approaches to therapy. However, the audacity of this study's participants consisted in integrating EMDR with a couple therapy model (EFT) and, in many cases, conducting conjoint EMDR sessions. In the first two editions of the book "Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures" (Shapiro, 1995, 2001), Shapiro discussed EMDR as an individual treatment and affirmed that using it with couples and families is often "too complicated" (p. 75). Process and outcomes research supporting EMDR has been conducted in individual therapy, and conjoint EMDR has only been reported in clinical cases and in one exploratory study (Legg, 2013). The integration of EFT and EMDR has received even less research attention, except for Knox's (2016) comparative study on combined EFT and EMDR for military couples and the present study.

The interest in implementing EMDR in relational modalities of therapy, and in the integration of EFT and EMDR seems to be gaining traction. In fact, it was reported to the first author that in a recent EFT training, Susan Johnson stated that EMDR can be a helpful addition to EFT as long as the individual self-regulation part of EMDR supports aids the co-regulation and secure attachment between the members of the couple (L. Palmer-Olsen, personal communication, 25 March 2020). As the participants of this study stated, the integration of EFT and EMDR should only occur if it serves the couple's treatment goals.

Limitations and recommendations for future research

This is the first study that has investigated the experiences of therapists integrating EMDR and EFT in their work with couples. With the findings of this study as a starting point, further research can focus on specific areas that have been identified here. For example, studies can further elucidate procedures to assess the appropriateness of integrating EMDR and EFT, especially in relation to safety and protection of therapeutic alliances (e.g., assessment of traumatic symptoms severity, distress tolerances skills, risk of vindictiveness, etc.) Given that the integration of these models happened in two modalities (EMDR reprocessing in conjoint sessions, individual sessions of EMDR in the context of EFT), further studies can focus on each of these modalities, their

advantages and risks, and the best way to conduct them. This could help develop a clinical map of choice-points for EFT-EMDR integration and a detailed integration manual.

There was a disproportionately large number of White participants in this study (eleven of the thirteen), which may impact the transferability of the findings to more diverse clinicians. The racial makeup of the sample might speak to the economic and logistical nuances associated with becoming EFT and EMDR trained and certified. These processes are often expensive and lengthy, and therefore not always accessible to therapists from different socio-economic backgrounds. Improving accessibility to both EMDR and EFT trainings to more diverse populations would allow to eventually find a more racially diverse group of therapists who are integrating these models.

The study did not focus on participants' or clients' contextual realities such as nationality, language, race, ethnicity, ability, gender identity, sexual orientation, size, or height among others. During the interviews, topics such as how the clients' social locations were related to their experiences of trauma or their couple dynamics were not mentioned. Insufficient attention to social location continues to be a major issue in marriage and family therapy and mental health. Not all couples and clients are equal. Clients' social locations have enormous impact on their access to healthcare (e.g., ability to pay for treatment, transportation, availability of qualified providers) and overall therapy outcome (Linder et al., 2019). The fact that no participant spoke of these issues strengthens already marginalizing dominant discourses, and reflects major blind spots among participants and the field. We as researchers also should have also more proactively solicited this contextual information about clients from participants as well. Future studies on the integration of EFT and EMDR should specifically inquire about the influence of contextual factors in clients' realities and trauma histories, and the therapeutic process. Demographic characteristics of therapists' clients can also be included as part of the data collected.

Empirical research on integrating EMDR and EFT is in its infancy, which calls for a careful interpretation of the findings of this study. Because this study focused on therapists' experiences, no assertions can be made based on these findings about the actual effectiveness of this integration. It is important to examine clients' experiences and measure therapeutic outcomes to assess the clinical effectiveness of the EMDR-EFT integration.

Clinical implications

Couple therapists are encouraged to proceed carefully and intentionally when using an integrated EMDR-EFT approach. Context matters, particularly as it pertains to safety. Therapists should first assess to determine if a partner's presence may cause emotional harm when appraising for and reprocessing trauma. Next, therapists must determine a partner's ability to

show empathy, distress tolerance, and willingness to support a partner through their trauma narrative. Therapists should also evaluate the severity and complexity of a traumatic experience and the extent to which clients have processed their trauma to determine if it is appropriate to use the integrated approach. Transparency is also important. Empowering clients to decide if their past trauma experiences could be discussed in conjunct therapy should be a collaborative decision that both the couple and therapist should support. Therapists are encouraged to avoid therapeutic jargon when explaining the potential benefits and risks of using the integrated approach. Finally, it is not clear from the current study at what point in treatment the therapist should integrate EMDR and EFT. With that in mind, we recommend therapists use EMDR as a pathway through whatever stage in EFT the therapist and couple may feel stuck.

Conclusion

Clients' trauma experiences can pose considerable barriers to couple therapy. This article describes therapists' experiences integrating EMDR and EFT to address these barriers. Findings highlight some pathways for integration to simultaneously help clients reprocess traumatic experiences that inhibit individual and relational functioning, and promote an intimate connection between partners in conjunct treatment. Schwarzbaum (2022) stated that couple therapists need to be nimble and use all tools at their disposal when helping our clients, including integrating different theories and therapeutic modalities. The clinicians who participated in this study are already answering this call in their clinical practices.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Appendix A: Demographic form

Demographics

(1) Today's date:
(2) Pseudonym:
(3) Gender (circle):
  (a) Cisgender female
  (b) Cisgender male
  (c) Transgender female
  (d) Transgender male
  (e) Intersex
  (f) non-binary
  (g) Other (please specify): _____
(4) Relationship status (circle):
  (a) single
  (b) separated
  (c) married
  (d) widow
  (e) divorced
  (f) other (please specify):_____
(5) Race/Ethnicity (select all that apply): a) Hispanic
  (a) Asian
  (b) White
  (c) Black
  (d) American Indian or Alaskan Native
  (e) Native Hawaiian or Pacific Islander
  (f) Mixed
  (g) Other (please specify): _____
(6) Age (circle):
  (a) 21-30
  (b) 31-40
  (c) 41-50
  (d) 51-60
  (e) 61-70
  (f) 71-100
  (g) Other (please specify): _____

Education

(7) Highest level of education:
  (a) Master's

(b) Doctorate

(8) Graduation year:

(a) 1971-1980
(b) 1981-1990
(c) 1991-2000
(d) 2001-2010
(e) 2011- 2020

Clinical qualifications

(9) What's your license (circle)?

(a) LCSW
(b) LPC
(c) Psychologist
(d) Psychiatrist

(10) Which professional associations do you belong to?

(a) ICEEFT
(b) EMDRIA
(c) AAMFT
(d) ACA
(e) Other (please specify): _____

Clinical experience: EFT

(12) How long have you been working in mental health?

(a) 1-5 years
(b) 6-10 years
(c) 11-15 years
(d) 16-20 years
(e) 21-25 years
(f) 26-30 years
(g) Other (please specify):

(13) How long have you been doing couple therapy?

(a) 1-5 years
(b) 6-10 years
(c) 11-15 years
(d) 16-20 years
(e) 21-25 years
(f) 26-39 years
(g) 40+ years

(14) How long have you been specializing in EFT as your main couple therapy modality?

(a) 1-5 years
(b) 6-10 years
(c) 11-15 years
(d) 16-20 years
(e) 21-25 years
(f) 26-30 years

(g) Other (please specify):_____

(15) Approximately how many couples have you worked with using EFT?
(a) 1-10 cases
(b) 11-20 cases
(c) 21-30 cases
(d) 31-40 cases
(e) 41-50 cases
(f) 26-30 cases
(g) Other please (specify):_____

(16) What is your training in EFT?
(a) ICEEFT trained
(b) ICEEFT certified
(c) ICEEFT certified supervisor
(d) ICEEFT certified trainer

(17) When was your training in EFT (i.e. finishing the externship and core skills)?
(a) 1 year ago
(b) 2-3 years ago
(c) 4-6 years ago
(d) 6-10 years ago
(e) 11-20 years ago
(f) More (please specify):_____

Clinical experience: EMDR

(17) What is your level of EMDR training?
(a) EMDRIA certified
(b) EMDRIA approved consultant-in-training
(c) EMDRIA approved consultant
(d) EMDRIA approved training provider

(18) Approximately how many clients have you treated using EMDR?
(a) 1-10 cases
(b) 1-20 cases
(c) 21-30 cases
(d) 31-40 cases
(e) 41-50 cases
(f) 51-60 cases
(g) Other (please specify):)_____

(19) Where did you get trained in EMDR?
(a) Humanitarian assistance program (HAP)
(b) EMDR Institute
(c) EMDRIA
(d) Other (please specify):_____

Your therapy experiences

(20) What kind of trauma do you treat when using EMDR and EFT?
(follow-up with relational or individual)

Appendix B: Preliminary Interview Questions

(1) What originally interested you in EFT? EMDR?
(2) Which model did you learn first and why?
(3) How do you integrate EFT and EMDR in conjoint couple therapy?
(4) What prompts you to integrate them?
(5) How do you decide if integrating both approaches is suitable for a particular couple?
(6) What is different about integrating EFT and EMDR to treat couples versus using them individually in couple therapy?
(7) What has been your experience integrating EMDR and EFT in couple therapy? (follow up on a positive and negative experience, if possible)
(8) What are the pros and cons of being trained in both?
(9) In your therapeutic work, how do you see EMDR and EFT as theoretically related? How do you think they are theoretically different?
(10) How do you perceive your clients' experience when you integrate EFT and EMDR in conjoint couple therapy?
(11) Debrief: Is there anything else you would like to mention that I did not ask? Do you have any follow-up questions?