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Integrating EMDR and EFT To Treat Trauma In Couple Therapy: A Literature Review

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ABSTRACT

In this paper, we present a literature review on integrating Eye Movement Desensitization and Reprocessing (EMDR) and Emotionally Focused Therapy (EFT) to treat trauma in couple therapy. Both are highly effective therapeutic models (one mainly used for individual trauma treatment and the other for strengthening attachment bonds in couples) that have gained significant traction and ample empirical support in the last three decades. Mental health therapists are increasingly experimenting with integrating these two models and have found that they can complement each other well; however, their integration is not well understood due to scant literature. Thus, we include research findings, clinical case examples, and theoretical discussions to provide readers with a comprehensive overview of the state of affairs on integrating these two models. We hope that this paper will highlight prior and existing practices and inspire clinicians to consider the clinical potential of integrating EFT and EMDR to increase effective therapy for couples affected by trauma.

KEYWORDS

EFT; EMDR; trauma;
integration; couple therapy

Introduction

Emotionally focused therapy (EFT) and eye movement desensitization and reprocessing (EMDR) are two prominent and widely used models in psychotherapy. EFT has been shown to work well with couples and EMDR with trauma, mainly in individual therapy. However, clinicians are often limited in their knowledge regarding compatible therapies that can help treat trauma at the couple level. The integration of EFT and EMDR could be considered to target trauma and address emotional processes in couples. However, research has been limited in regards to the combination of these models. This article will review relevant literature and recommendations for integrating EFT and EMDR and their application to working with couples.

Due to the limited research on EFT/EMDR integration, this paper will examine mainly clinical case examples, book chapters, a few peer-reviewed articles, and the three dissertations on this topic. Because of the increased interest in EMDR, clinicians would benefit from a deeper understanding of

compatible models and tools for difficult cases. This article is an effort to bring forth a consolidated view of pertinent literature on combining EFT and EMDR. The first author consulted Google Scholar and EBSCO to gather sources for this review using the following keywords: trauma, EMDR, EFT, couples, and couple(s) therapy. He also reviewed the references of works on the topic, such as Legg (2013), Linder (2020), and Knox (2016).

Trauma

Trauma is generally defined as any event that results in a negative long-term detrimental impact (Shapiro & Forrest, 2016). Herman (2015) referred to traumatic events as those that challenge our basic ideas of the world and others, and evoke powerlessness. Trauma can strip people of connection, purpose, control, and meaning (Herman, 2015; Johnson, 2002; Shapiro, 2017; Van der Kolk, 2015). Increasingly, researchers and clinicians are noting the major role contextual and relational factors, such as how one's community reacts to a traumatic event or the strength of one's social support network, play in symptom development following trauma (Herman, 2015; Johnson, 2002; Parnell, 2010; Shapiro, 2017). Trauma-related symptoms such as intrusion symptoms, avoidance, trouble concentrating, sleep disturbances, and hypervigilance can become so upsetting that they create major social, emotional, and occupational impairment for most sufferers (Herman, 2015). For these reasons, it is imperative to treat trauma relationally. Also, the quality of one's attachment relationships is one of the most significant factors in developing PTSD after a traumatic event (Mikulincer & Shaver, 2018). A secure attachment can serve as a safe haven when a person feels in danger, thus increasing their sense of safety. Not only do close relationships influence the outcomes of a traumatic event. Also, the effects of a traumatic experience can affect relationships.

Eye movement desensitization and reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) is a structured and empirically-based treatment designed to eliminate trauma symptoms and promote well-being and adaptive functioning (Shapiro, 2017). EMDR is not like traditional talk-therapy; it is a structured process involving addressing distinct trauma memories using awareness of body sensations, emotions, and core self beliefs during periods of bilateral stimulation (BLS), delivered periodically.

EMDR began as a single-incident trauma treatment to reduce symptoms such as hypervigilance and intrusive memories, and related disturbances. Shapiro (2017) transformed EMD (eye movement desensitization) from a modality of desensitization and symptom reduction to an integrative

information processing paradigm in 1990 (Shapiro, 2017). After approximately 33 years of research progress, EMDR is now used to treat a variety of trauma-related symptoms and mental health issues stemming from adverse life experiences (Marich, 2011; Parnell, 2010; Protinsky et al., 2001a, 2001b; Shapiro, 2017).

EMDR therapy is based on the *adaptive information processing* (AIP) model (Shapiro, 1995, 2002a). When the information related to a particularly stressful occurrence is ineffectually processed, it is stored as it was originally encoded, along with any distorted thoughts, images, sensations, or perceptions (Shapiro, F. 2007b). Through bilateral stimulation during EMDR, unprocessed information becomes linked with existing memory networks, which helps to qualify and contextualize these memories and lower their capacity to trigger emotional reactivity and promote empowerment and self-efficacy. A typical course of EMDR therapy is between three to fifteen 60 to 90-minute sessions (Shapiro, 2017).

EMDR was one of the first therapies tailored to treat PTSD that was evaluated by controlled research (Shapiro, 2002b). Since its inception, robust evidence (Feske, 1998; Van Etten & Taylor, 1998; Wilson et al., 2018) suggested that EMDR is more time-efficient than many other trauma treatments. The most thorough EMDR research to date indicated that 77-90% of clients stop suffering from PTSD after three to ten hours of treatment (Shapiro, 2002a, 2017). This included large effect sizes, with no relapse at three to 15-month follow-ups, and over 30 randomized control trials (Stanbury, Drummond, Laugharne, Kullack, & Lee, 2020). At least seven meta-analyses of all peer-reviewed publications on psychological and pharmacological interventions for PTSD strongly suggested EMDR to be not only more effective or at least as effective, but also more efficient than other PTSD treatments (Van Etten & Taylor, 1998; Shapiro, 2002b, 2017; Van der Kolk, 2015; Van der Kolk et al., 2007)

Emotionally Focused Therapy (EFT)

EFT conceptualizes relationship conflict as a cycle of negative interactions rooted in emotional processes fueled by our need for close relationships. EFT privileges emotion because it communicates our needs, motives, and priorities and help us predict, interpret, and respond in significant relationships. Emotion is fundamental in orienting our perception, creating internal models of self (e.g., as a loved, worthy person) and other (e.g., as a dependable partner) (Johnson, 2009).

From this perspective, couples come to therapy not because of increased conflict but lack of connection, decreasing affection, and reduced emotional responsiveness due to partners being stuck in their 'negative cycle.' The EFT therapist collaborates with the couples to increase accessibility and

responsiveness. In doing so, emotions are the targets and vehicles of change. EFT is an opportunity to create new interactional patterns of emotionally-bonding experiences of vulnerability and closeness. A typical course of EFT is between eight to twenty sessions lasting 50 to 120-minutes each (Johnson, 2019).

Susan Johnson and Leslie Greenberg pioneered EFT in the 1980s in response to a shortage of empirically validated interventions for couples in therapy (Johnson & Greenberg, 1985). EFT stemmed from Johnson's doctoral dissertation, chaired by Greenberg, where she observed her couple therapy sessions to identify what worked well and what did not (Johnson & Greenberg, 1985). Informed by attachment theory (Bowlby, 1979, 1988), Johnson found that fear of isolation and abandonment, difficulties grappling with the threat of disconnection from attachment figures, and the longing for securely attached relationships were what brought couples to therapy (Johnson, 2004, 2009, 2019). Sustained connection with our loved ones is wired into our survival programming and gives life its meaning and purpose (Johnson, 2004). When there is conflict in our most important relationships, we become reactive emotionally because we perceive that our attachment bonds may be threatened. For example, when partners sense that the other is not accessible or responsive (Johnson, 2002, 2004, 2019), they become preoccupied with threats to their bond, rendering them unable to function effectively and be present (Johnson, 2002). In addition to attachment theory, EFT is also rooted in systems theory and addressing couples' relational patterns using experiential/humanistic techniques. The model is used to promote corrective emotional experiences as the mechanism of change in therapy (Johnson, 2004).

EFT has now become one of the most empirically validated couple therapy models (Dagleish et al., 2015; Hunsley et al., 1999; Johnson, 2019; Lebow et al., 2012), shown to be effective with many presenting issues, as long as therapists are sensitive to issues of addictions, betrayals or attachment injuries, infidelity, and abuse (Johnson, 2005). Recent research suggested that EFT is highly effective in 70-90% of couples in reducing conflict long-term (Dagleish et al., 2015; Johnson, 2005; Johnson et al., 1999). In addition, EFT has low drop-out rates (Dagleish et al., 2015), even for highly distressed couples.

Although there are many nuances to accommodate varying units of treatment and presenting problems, EFT always returns to the heart of the matter – attachment dilemmas (Johnson, 2004, 2019). Since EFT's inception in the mid-1980s, EFT has been adapted and used with a far-reaching scope of populations beyond couples, such as individuals, families, and groups (Johnson, 2004, 2009, 2019; Johnson et al., 2005), and presenting problems, such as eating disorders (Johnson & Williams-Keeler, 1998); trauma (Johnson, 2002, 2019), forgiveness (Johnson, 2005; Makinen & Johnson, 2006); and addiction (Fletcher, Nutton, & Brend, 2015; Johnson, 2005).

EFT as a treatment for the effects of trauma

Not only EMDR but also EFT can be considered a trauma treatment by nature. By strengthening secure bonds, EFT can heal the trauma of attachment disruption. For example, Hulchuk et al. (2010) found that EFT helped heal the trauma of infidelity. The benefits of the treatment continued three years after treatment. Also, clients affected by other forms of trauma can benefit from having a secure base in their partners (Johnson, 2002). EFT studies and clinical case descriptions suggest the model is useful for couples where one or both partners meet the criteria for PTSD (Greenman & Johnson, 2013; Johnson, 2002, 2004). The model is also helpful for couples affected by traumatic experiences such as grappling with terminal illnesses or childhood trauma (McLean & Hales, 2010; Naaman, 2008). Ultimately, EFT could be used prior to trauma to serve as a preventative buffer for the effects of trauma and to heal from the aftermath of trauma.

From an attachment perspective, fostering a secure connection with a loved one can provide refuge during threatening situations and inoculation for future events (Johnson, 2002). Recuperating from devastating events is more likely in the context of securely attached relationships (Johnson, 2002, 2004). EFT's focus on strengthening secure bonds between partners produces a highly effective buffer from the aftermath of trauma and its effects (Johnson, 2002; Mikulincer & Shaver, 2018). Trauma sufferers with secure attachment are most likely to be open to new information and perspectives associated with recovery. Whereas trauma can lead to emotional and physiological dysregulation, a secure bond can foster regulation (Coan et al., 2006). Likewise, whereas trauma induces helplessness and fear, secure attachment eases and calms (Johnson, 2002). Traumatic events also tend to be experienced with a sense of intense aloneness, which secure attachment can powerfully mollify when activated.

A possible limitation of EMDR

EMDR has been utilized to treat attachment trauma and can lead to changes in attachment patterns (Parnell, 2013; Wesselmann et al., 2018, 2012; Wesselmann & Potter, 2009). For instance, Wesselmann and Potter (2009) conducted a qualitative case study of three clients who sought therapy to improve their mood, behavior, and relationships. These clients received two sessions of resource development and 10 to 15 sessions of EMDR and were administered the Adult Attachment Interview (AAI) before and after treatment. All patients reported positive changes in their relationships and the AAI after treatment. It is noteworthy that these clients reported relational and attachment changes, even though these were not the primary objectives of EMDR. Wesselmann et al. (2018) presented a quantitative study integrating

EMDR with the Attachment Trauma Protocol for Children with 24 families of children with histories of maltreatment, attachment trauma, and foster care. They showed significant improvements in attachment and trauma symptoms after an average of 12.7 months of treatment.

Despite the potential for relational change, most of the EMDR application and research has been conducted in individual therapy. This points to its possible limitation: not utilizing the relationships clients have to heal trauma. For example, one of the key symptoms of trauma is difficulty modulating one's affect (Johnson, 2002; Johnson et al., 2005; Parnell, 2010; Van der Kolk, 2015). Yet Coan et al. (2006) found that merely holding a loved one's hand resulted in significant physiological down-regulation. This suggests that contact with a loving partner can effectively safeguard against the stress and pain from upsetting traumatic memories (Johnson, 2002, 2004, 2019). Thus, the presence in EMDR therapy of a loved one could be an exceptional asset in the therapeutic process.

For clients, merely talking with a therapist about traumatic events they have experienced can be harmful (Marich, 2011) because of the risk of abreaction, dissociation, or emotional flooding. EMDR therapists could reduce these inherent risks by inviting a client's attachment figure in the therapy process to increase the client's emotional safety. Perhaps providing the client with immediate access to support and empathy from an attachment figure in the context of conjoint therapy can curb potential dysregulation inside or outside therapy. This has led clinicians and researchers to explore the implementation of EMDR in conjoint therapy.

Use of EMDR in conjoint therapy

EMDR was developed for individual therapy. Initially, the client's partner or family members' presence was discouraged by Francine Shapiro, the model developer, because it could compromise the client's sense of safety. In the second edition of Shapiro's (2001) EMDR textbook, she adopted a less cautious stance claiming that the key factor in using EMDR in conjoint couple therapy was the degree of support and commitment of the client's partner. However, she did not refer to any research that supports the conclusion above (Capps, 2006). In fact, in 2001, Shapiro included a case example of increased empathy and intimacy after conjoint EMDR with a couple. In 2007, Shapiro, Kaslow, and Maxfield published *EMDR and Family Therapy Processes*, further evidencing that Shapiro came to endorse the relational use of EMDR and considerably eased her previously more cautious stance. The use of EMDR in conjoint therapy has mainly consisted of having one client follow the EMDR protocol (*processing partner*) while the partner acts as a witness or observer (*witnessing or observing partner*).

Despite the growing use of EMDR in conjoint sessions, Shapiro (2017) still recommended that couple therapists separate partners for EMDR as a general rule. She proposed that lack of safety or intimacy in the couple may prevent the organic unfolding for the processing partner, for example, by worrying about the witnessing partner's reaction to their spontaneous associations during bilateral stimulation (Shapiro, 2017). Shapiro (2017) ultimately recommended that therapists rely on their clinical judgment regarding whether to have a client's partner present during processing.

Even before Shapiro's position on the use of EMDR in conjoint sessions became more flexible, clinicians and a few researchers had begun experimenting with conjoint EMDR. Except for Legg's (2013) doctoral dissertation, the use of EMDR in conjoint therapy has only been documented in clinical cases. In the following section, we will describe the findings of Legg's study in some detail, then summarize the findings and recommendations of clinicians who have provided conjoint EMDR in couple therapy and have shared their experiences in case descriptions. Legg's (2013) dissertation was a grounded theory on the application of EMDR in conjoint couple therapy. One particularity of this study is the inclusion of therapists' and clients' experiences through 21 interviews from seven cases (the therapist and each member of the couple).

Grounded theory on conjoint EMDR

All therapists participating in the study were fully trained in EMDR and had a range of experience from 5 to over 30 years. Five of the seven couples experienced both roles (processing and witnessing), contributing to the richness of Legg's data. The length of the couples' relationships ranged from 2 to 47 years. The majority of the participants were White, two of the clients were Asian and one therapist identified as African-American. Legg's grounded theory proposed that conjoint EMDR is a relational treatment, following the premise that trauma is experienced and healed relationally. Legg's (2013) study revealed specific outcomes of conjoint EMDR as described by clients and underscored client- and therapist-related conditions for which conjoint EMDR would be most appropriate.

Client-related conditions regarding fit for conjoint EMDR

Emotional availability and other indicators of secure attachment, as well as readiness to change were characteristics that made conjoint EMDR more suitable for the couple. In addition, conjoint EMDR was especially helpful for couples whose trauma or reactivity was mutually triggering and those who did not tend to respond well to only talk-therapy (Legg, 2013). In contrast, those who were the angriest, highly fearful of their relationship ending,

particularly anxious about their partner's reaction during their EMDR, and needing external validation, reported the least amount of positive change from conjoint EMDR. Moreover, partners who depended on alcohol to self-soothe, distract, or numb their feelings showed less favorable responses to conjoint EMDR (Legg, 2013). Findings also showed conjoint EMDR to be less advisable when members have difficulty empathizing and being vulnerable with each other, are stuck in attachment injuries from the past, tend to personalize or project feelings onto their partners, and need support through structure and rapid processing of attachment issues (Legg, 2013). Legg (2013) pointed out that couples in which partners were ambivalent about change and reducing their dyadic reactivity benefited less from conjoint EMDR. By contrast, those who could effectively manage their reactivity and were committed to being part of the solution instead of changing their partner attained better results.

This study highlighted specific characteristics of the processing and witnessing partners that would facilitate conjoint EMDR. Legg found that the processing partner needs to be vulnerable in front of their partner and the therapist. This includes the knowledge that what they share cannot be 'unknown' or 'un-heard.' Several participants noted that in conjoint EMDR, their partner's witnessing presence became a 'non-issue' (p. 250). Others reported that it contributed to a sense of 'vicarious healing and shared journey' (p. 255), providing evidence that, under the right circumstances, a partner's presence not only does not disrupt, but can in fact aid, in the therapeutic process for the processing partner. For couples in which both partners processed traumatic material with EMDR, the partner processing needed to be prepared to witness their partner for a similar amount of time.

With observing partners, Legg (2013) found three key factors that contributed to positive outcomes: (a) openness to learning about their partner's process without interrupting or personalizing the information, (b) not becoming overwhelmed, and (c) not using processed material as a weapon for retaliation. The observing partner must avoid being triggered in the same session where their partner processes a memory. This includes being silently supportive and not judging or questioning the processing partner's material.

It is important that the observing partner also receive time to process their experience as a witness in the same session if possible (Legg, 2013). For example, the observing partner may be initially confused as to how childhood trauma affects their relationship until they are able to see its connection to their current relationship dynamics. This realization on the part of the observing partner merits processing. Therapists should outline a plan beforehand about how to proceed if a conjoint session has to end with the EMDR target still incompletely processed.

Areas of assessment in preparing clients for conjoint EMDR

Assessing relational dynamics is very important for successfully implementing EMDR in couple therapy (Legg, 2013). Although conjoint EMDR can help decrease partners' mutual emotional reactivity, volatile reactivity among partners was an obstacle to conjoint EMDR. Thus, therapists need to assess dyadic reactivity carefully prior to conjoint EMDR. For couples with an inclination toward hostility, mutual blaming, and disrespectful behavior, individual EMDR may be preferred (Legg, 2013). Other areas that need to be assessed are the couple's belief in couple therapy, and level of engagement in the process (e.g., regular attendance to sessions, completion of homework) (Legg, 2013).

According to the findings and the assessment of relational dynamics, it is important to assess both partners individually (Legg, 2013). Assessing each person's trauma history was found to be crucial to anticipate possible reactivity and be able to repair if necessary. Other areas that need to be individually assessed are each partner's familiarity with EMDR, the observing partner's capacity to witness their partner's processing, and the processing partner's comfort with being observed. Individual assessment consists of conversing with each partner and using validated outcome measures and scales. Scales such as the Beck Depression and Anxiety Inventories (Steer & Beck, 1997), Dissociative Experiences Scale (Carlson & Putnam, 1993), PTSD checklist (Weathers et al., 1993), and the Outcome and Session Rating Scales (Miller et al., 2003) were found to help with assessment and measure of treatment progress. In individual assessment, a therapist can also identify each partner's inclination to withhold information from each other, their willingness to share vulnerable emotions with their partner, and their capacity to follow the therapist's directions (Legg, 2013).

In addition to a thorough assessment, psychoeducation about EMDR is an important preliminary step for conjoint EMDR (Legg, 2013). This would involve educating clients on the potential benefits of conjoint compared to individual EMDR. In addition, Legg's (2013) findings suggest that therapists should discuss with clients how conjoint EMDR may influence their relational dynamic, for better or worse.

Therapist-related conditions

Legg's (2013) data revealed that successful conjoint EMDR requires that therapists aptly balance individual and systemic factors, carefully gauge the couple's attachment security before proceeding, and suitably explain why each member may need extended individual attention periodically throughout treatment. In addition, according to the findings, therapists need to carefully

evaluate relational dynamics, such as pursue-withdraw, before conjoint EMDR as these are likely to emerge in the couple interaction during processing.

With regards to the therapist-client relationship, clients in the study noted the importance of factors such as believing in the therapist's clinical skills, therapist's level of confidence in their clinical ability, the appropriate fit between clients and therapists, and trust in their therapist and the therapeutic alliance (Legg, 2013).

Reported outcomes of conjoint EMDR

Promisingly, the client participants in Legg's study did not encounter major obstacles to conjoint EMDR. Said participants reported benefiting from the process despite experiencing some minor challenges. For example, one participant reported that conjoint EMDR had a 'voyeuristic aspect' and that their processing partner felt 'intruded upon' (Legg, 2013, p. 257). In general, the reported outcomes of conjoint EMDR were: (a) satisfaction with treatment, (b) increased differentiation and secure attachment, (c) reduced interpersonal reactivity, (d) increased compassion, empathy, and intimacy, (e) increased understanding, (f) increased ability to intervene in their cycle, (g) increased commitment, and hope, (h) increased communication, and (i) increased joy. Several client participants noted an 'increased sense of appropriate responsibility and clarity about each partner's role in current problems, resulting in a better capacity to interrupt unhealthy dynamics' (Legg, 2013, p. 265). According to some participants, the reduced reactivity originated from an increased range of responses when triggering material arose for the couple after conjoint work. Several participants reported that the material that came up in conjoint EMDR was 'grist for the mill' (Legg, 2013, p. 257). That said, the most mentioned obstacles for participants centered around: (a) concerns about their partner listening, (b) needing external validation (from both the therapist and the observing partner), and (c) overly focusing on the outcome of conjoint EMDR, instead of the process.

Clinical findings and recommendations on conjoint EMDR

EMDR developed in the late 1980s, and since the 1990s clinicians began to experiment with its boundaries, documenting their findings in published case examples. This included the use of EMDR in conjoint sessions and its integration with different models of couple therapy (e.g., Gestalt, Imago Therapy, EFT).

Snyder (1996) wrote the first published account of conjoint couple EMDR and found it fostered intimacy for both partners in a lesbian couple with a history of sexual abuse and addiction. A few years later, Protinsky et al.

(2001a) and Protinsky et al. (2001b) described the merits of conjoint EMDR when integrated with EFT and named their approach Eye Movement Relationship Enhancement (EMRE). This approach will be further explored below in the section focusing on the integration of EFT and EMDR. Two years later, Flemke and Protinsky (2003) found conjoint EMDR to help address a block in Imago couple therapy, promoting healing and reparation of childhood wounds. Talan (2007) similarly found conjoint EMDR worked well with Imago couple therapy. Capps (2006) presented a case study of three couples in which conjoint EMDR was used in a single session in the context of Gestalt couple therapy. He found that integrating EMDR healed the negative effects of trauma inflicted by the observing partner on the traumatized partner. The newfound awareness and empathy resulting from witnessing their partners during conjoint EMDR helped the couple strengthen their attachment, develop emotional closeness and intimacy, and increased their commitment to change their behavior and refrain from triggering their partner (Capps, 2006).

From her expertise and experience, Robin Shapiro (2005) recommended clinicians carefully appraise a couple's (a) ability to support each other; (b) level of emotional safety; (c) differentiation; (d) capacity to self-soothe and withstand intense emotions; (e) personality factors; and (f) therapeutic alliance, and then review the potential risks and benefits of conjoint EMDR before proceeding.

Also, Moses (2003, 2007) claimed that conjoint EMDR can facilitate emotional safety and clear treatment blocks in couple therapy. Prior to beginning conjoint work, this author recommended evaluating each member's internal and external resources (and strengthening or creating resources when needed), assessing the couple's commitment to their bond, and weighing the pros and cons of conjoint EMDR. Once conjoint EMDR starts has Moses (2003, 2007) recommended working with both partners on committing to only engaging in deep emotional processing during sessions and not outside of them, as well as ensuring partners take turns equally in EMDR processing so neither assumes the role of 'identified patient.' According to this clinician, a unique benefit of conjoint EMDR is that the observing partner can become a container for the processing partner (e.g., offering a soothing touch). The presence of the partner can provide emotional safety that may substitute the customary preparation activities in individual EMDR, such as calm safe/place or mastery resourcing (Moses, 2003, 2007).

Similar to Snyder (1996), Reicherzer (2011) found EMDR useful, especially in increasing relationship satisfaction in conjoint couple therapy with a gay couple. Moore (2016) published a case example on conjoint EMDR with a couple facing medical issues. She found that administering the ACE questionnaire (Felitti et al., 1998) was useful in identifying childhood trauma to target in conjoint EMDR. Moore (2016) also recommended treating both

partners for individual trauma before any conjoint couple work while giving the couple the option to treat the individuals together or separately.

Moore (2016) also asserted that conjoint EMDR is preferable to individual EMDR because the healing process should ultimately be associated with one's partner instead of the therapist. Healing is a relational process, Moore emphasized, and conjoint EMDR may fortify the partners' connection to each other and their ability to support each other in the future. Consequently, Johnson and Moore (2012) recommended the witnessing partner to administer BLS (instead of the therapist, as is customary) while the processing partner receives EMDR, stating it produces a calming effect. Related, conjoint EMDR is only suggested when both partners show a capacity to self-regulate and an unwavering commitment to working on the relationship (Moore, 2016).

The cited case examples and Legg's (2013) study have consistently suggested that, in addition to helping clients process specific traumas, conjoint EMDR can expand intimacy between partners and improve their relational dynamics. Furthermore, when integrated with other modalities of couple therapy, EMDR seems to help overcome impasses and blocks in the therapy process rooted in traumatic experiences. Finally, the cited researchers and clinicians agree on the importance of a thorough assessment to decide whether the use of conjoint EMDR would be suitable for a specific client couple.

Combining EFT and EMDR

EFT and EMDR coincidentally emerged in the late 1980s (EFT in 1985 and EMDR in 1988) and have garnered more than 33 years of clinical and research support and development. Although dissimilar, EFT and EMDR are commonly utilized to heal the consequences of trauma; in the case of EFT, especially the trauma of attachment or relational origin (Johnson, 2002, 2008, 2005, 2019; Parnell, 1999, 2013; Wesselmann et al., 2018, 2012; Wesselmann & Potter, 2009). In addition, both EMDR and EFT help clients access and process the deeper emotions associated with hurtful experiences and rewrite their narratives in ways that revamp clients' sense of resilience, self-agency, and self-worth (Negash et al., 2018).

An EFT and EMDR combined approach may help treat trauma and promote connection for survivors for whom isolation and self-protection have become deep-rooted strategies to buffer against the effects of trauma. In addition to being beneficial for clients, the integration of EFT and EMDR may also be useful for therapists. Johnson (2002, 2005) has claimed that EFT is effective in treating both relationship trauma (e.g., attachment injuries like infidelity) and individual trauma that may have occurred outside of or before the intimate relationship (Johnson & Williams-Keeler, 1998). However, in social media groups, numerous EFT therapists have reported feeling stuck with certain cases in which clients have endured substantial trauma. Thus, EMDR may

attract EFT therapists who are seeking to increase their specialized knowledge in trauma treatment. For example, the self-denigration common to trauma sufferers can become a barrier to completing stage one of EFT, de-escalation. It can also be a barrier to facilitating corrective experiences in stage two of EFT (McIntosh & Johnson, 2008; Karris & Caldwell, 2018). EMDR can be especially helpful in this area by lowering the client's reactivity through desensitization and promoting more positive self-thoughts through installation (Capps, 2006; Capps et al., 2005; Negash et al., 2018; Protinsky et al., 2001a, 2001b; Shapiro, 2017; Shapiro et al., 2007). In addition, EMDR seems to complement other therapies well (Shapiro, 2002a). For example, Shapiro (2002a) and Protinsky et al. (2001a) highlighted that the experiential focus in EMDR, including attention to body sensations and 'whatever comes up now,' naturally complements experiential therapies, such as EFT. In this section, we will explore the literature on the integration of EFT and EMDR. It primarily consists of integrating EMDR throughout EFT to desensitize and reprocess the charged emotions driving the couple's negative cycle and stuckness.

Eye Movement Relationship Enhancement (EMRE)

Protinsky et al. (2001b) stated that EMDR-based interventions could help couples access, activate, tolerate and reprocess the intense emotions that underlie a couple's dysfunctional dynamics, their negative cycle in EFT terms. Months later, Protinsky et al. (2001a) named their integrated EFT-EMDR approach Eye Movement Relationship Enhancement (EMRE). EMRE does not incorporate the standard EMDR protocol, yet it includes many of its features, such as psycho-education, creating safety, and reprocessing. EMRE's primary purpose is accessing and working with formerly unacknowledged emotions to strengthen couple intimacy.

A central assumption in EMRE is that couples come to therapy in high distress because of the disowned primary emotions underlying their secondary emotional responses to each other (Johnson, 2004, 2008, 2019; Protinsky et al., 2001a, 2001b). Disowned emotions can distance partners from each other and exacerbate their negative cycle. These negative cycles shield clients from accessing their vulnerable primary emotions, which then remain hidden and unacknowledged. In EMRE, these disowned emotions are believed to be rooted in previous traumatic experiences. Thus, a person may experience an 'over-reaction' to their partner's behavior because it has activated a primary emotion from past trauma (Protinsky et al., 2001b, p. 156). To break this dynamic, Protinsky et al. (2001a) recommended targeting each partner's secondary emotions in conjoint EMDR because it allows them to access and reprocess the primary emotions and traumatic memories from earlier trauma in a dyadic context.

In EMRE, the therapist works with each partner at a time, as the other witnesses. The witnessing partner may be encouraged to comfort the processing partner if it does not occur naturally (Protinsky et al., 2001b). Also, Protinsky et al. (2001a) recommended that witnessing partners record their reactions to their partner's EMDR process to detect any blocks that may impede couple understanding. These could become future targets for EMDR when the witnessing partners switch roles. Protinsky et al. (2001a) noticed that the relaxation response resulting from the bilaterally stimulating eye movements was helpful to decrease elevated emotional reactivity during the couple's negative cycle. This finding is consistent with the role of eye movements, and bilateral stimulation in general, in the EMDR standard protocol (see Shapiro, 2017). After EMDR processing, the therapist reviews with the couple how their processed material has fueled their negative cycle and how they can use their renewed sense of connection to create new, healthier dynamics. As reported by the authors, EMRE enabled couples to be more attuned and mutually receptive after taking turns processing their traumas in front of each other (Protinsky et al., 2001a, 2001b).

Using EMDR Within Specific Stages of EFT Protinsky et al. (2001a) and Protinsky et al. (2001b) did not specify when in the EFT process could EMDR be integrated. In contrast, Negash et al. (2018) recommended clinicians use the combined EFT-EMDR approach by integrating EMDR into the second stage of EFT. Negash and collaborators' article is the only one in the current literature that specified how conjoint EMDR fits into the corresponding steps and stages of EFT.

According to Negash et al. (2018) clinicians who combine the approaches should start couple therapy with EFT; this consists of implementing the first two steps of the model with the clinical focus on the dyad (Negash et al., 2018). Yet, at step three of EFT, all phases of EMDR, one to eight, can be incorporated to heal trauma that may be blocking the emotional safety necessary for vulnerability and clinical success in EFT (Negash et al., 2018). The ability to engage in repair is also an important requisite to conjoint EMDR (Negash et al., 2018). The therapist should be reasonably sure that the observing partner will not interrupt the processing partner during EMDR. Although the inclusion of EMDR could focus on different sources of trauma, ultimately, the couple's attachment needs should be the priority throughout the therapy using the combined approach (Negash et al., 2018).

Combined EFT and EMDR for military couples

Based on the literature search done for this literature review, Knox's (2016) dissertation is the only study that specifically evaluated the clinical outcomes of the EFT-EMDR combined approach. Knox (2016) compared four different groups of 20 participants (i.e., received EFT only, EMDR only, combined EFT

and EMDR, and no treatment control). Clients in the study completed a battery of self-report measures pre-treatment and after six to eight weeks of treatment. The self-report measures included the Revised Dyadic Adjustment Scale, PTSD checklist, the Posttraumatic Growth Inventory, and the Experiences in Close Relationships scale to appraise and measure participants' adult attachment, marital satisfaction, trauma symptoms, and posttraumatic growth.

Knox (2016) found that there was 'overall greater improvement in those that received the combined treatment' (Knox, 2016, p. 81), and this finding was statistically significant. The military couples receiving the combined approach showed the strongest decrease in relationship anxiety, suggesting that this approach may work particularly well with couples with anxious attachment (Knox, 2016). The EFT only group, however, yielded the greatest decrease in relationship avoidance, followed by the combined approach. The combined approach also yielded the highest increase in relationship satisfaction. In contrast, the group that received only EMDR had no change in relationship satisfaction.

Couples who received only EMDR, as well as those receiving the combined approach, experienced a greater decrease in PTSD symptoms compared to the group that received only EFT (Knox, 2016). However, Knox surmised that longer EFT treatment (opposed to the study's six to eight-week timeframe) may be necessary to decrease PTSD symptoms. The group that received EMDR only had a greater decrease in PTSD symptoms than the group receiving the combined approach. Knox (2016) posited that this may be merely because the EMDR only group may have received more EMDR sessions than the group receiving the combined approach. In retrospect, Knox stated he would have liked to ensure that the combined and the EMDR only group had the same number of EMDR sessions. In summary, Knox (2016) found that the combined approach was most effective in increasing relationship satisfaction and attachment security, and the EMDR only modality was more effective than the combined approach in reducing posttraumatic symptoms.

It is important to underscore that Knox's study had some limitations. The portion of treatment that was evaluated was short, only six to eight weeks, and the requirements for therapists were minimal training in EMDR and having completed the EFT externship. In contrast with Legg's (2013) research, clinicians in this study were not required to be licensed, be certified in either model, or have received additional training. Lastly, his study only included 80 participants, four groups of 20, which may be a low sample for quantitative research. It also remains unclear if Knox's study included conjoint sessions. Knox did not specify if the 20 individuals in each of the four groups consisted of couples. The last limitation is that what applies to military individuals and couples may not generalize to nonmilitary couples.

Therapists' experiences integrating EMDR and EFT in conjoint therapy

Linder's (2020) thematic analysis study explored how therapists dually trained in EFT and EMDR integrate both therapies when working with couples. Linder (2020) conducted 13 qualitative interviews in which participants described how and why they combine these two models, what they believed makes them clinically useful, and the pitfalls, complexities, and risks of integration. Seven themes emerged from his data.

This first, most robust theme in Linder's (2020) study refers to reports from participants that the theoretical premises and clinical practices of both models work well together in an integrated fashion. More specifically, Linder found that EMDR and EFT address the individual and relational realms, respectively. According to his participants, healing memory networks in EMDR are complements moving toward secure attachment in EFT; both are adaptive processes strongly associated with relational and emotional health. The more memory networks a client heals in EMDR, the more secure attachment they should have. EFT aims to form secure bonds between the members of the couple, which often addresses trauma as well.

Even though EFT is already a model that addresses trauma, ten of the thirteen participants in the present study found EFT insufficient in treating trauma. According to Linder's participants, the emphasis on present processes in EFT may overlook the influence of past traumatic events on current couple dynamics, which EMDR addresses more comprehensively and systemically. In the context of EFT, participants spoke of the need for more therapeutic tools to help individual partners who were significantly affected by past trauma connect and progress in EFT. So, participants agreed EFT therapists need more specialized training in individual and trauma therapy approaches such as EMDR. Integrating EMDR into EFT may meet this need.

The second theme highlighted the benefits of integrating EMDR and EFT. Undoubtedly this second theme builds on the first theme of the study. If EFT and EMDR complement each other well (the first theme), logically, both models integrated may benefit couples too (this second theme).

Linder's third theme reviewed several variables germane to the effective integration of both models in couple therapy. His fourth reviewed the clinical risks of integrating. The fifth covered the penchant for participants to mention integrating other models into their clinical work with couples. The sixth was integrating EMDR at any of the three stages of EFT couple therapy. The seventh and last theme was that integration was more the exception than the rule given its complexities (Linder, 2020). This was the first author's doctoral dissertation and more detailed findings will be published in the next months.

Summary of the literature on integrating EMDR and couple EFT

Humans are innately interdependent beings, bonding mammals that count on each other for survival and fulfillment (Johnson, 2005). However, despite the relational nature of trauma, EMDR is traditionally conceptualized and used in individual contexts. Consistent with this, the literature on EMDR in couple therapy is scarce but growing. According to Negash et al. (2018), when a couple therapist reaches an impasse, they always have the option of providing outside referrals for individual EMDR, yet this could delay progress in couple therapy. For instance, an individual EMDR referral can block opportunities for the non-processing partner to observe and comprehend the processing partner's deeper intrapsychic and emotional process and to naturally comfort the processing partner (Legg, 2013; Linder, 2020; Capps, 2006; Moses, 2003, 2007; Negash et al., 2018), and others, an individual.

Several authors (Capps, 2006; Capps et al., 2005; Flemke & Protinsky, 2003; Johnson & Moore, 2012; Moore, 2016; Moses, 2003, 2007; Negash et al., 2018; Protinsky et al., 2001a, 2001b; Snyder, 1996) found that couples had positive experiences witnessing their partner receive EMDR. Conjoint EMDR also opens opportunities for dyadic comforting and bonding as the EMDR processing unfolds, unlike individually administered EMDR. As Protinsky et al. (2001a) and Protinsky et al. (2001b) illustrated, witnessing EMDR can clinically benefit the witnessing partner. The witnessing partner transitioning from a negative or defensive position to a softer, more empathic one was common in conjoint EMDR.

The benefits of using EMDR with couples call for more research linking EMDR to couple therapy models such as EFT. Combining EFT and EMDR may be sensible in several ways. The combined approach may foster opportunities for attunement, empathy, mutual support understanding, and other pro-attachment behaviors (Negash et al., 2018; Protinsky et al., 2001a, 2001b).

Several recommendations have emerged when integrating EFT with EMDR in conjoint therapy. First, when one partner receives EMDR, the other partner would ideally function as a witness-like support in silence (Moses, 2003, 2007; Negash et al., 2018; Protinsky et al., 2001a, 2001b). The processing partner must decide how they would like to receive this support, open to therapist recommendation (Legg, 2013; Negash et al., 2018). The witnessing partner should remain highly engaged emotionally, so they can appreciate the profundity and complexity of the processing partner's psychological and somatic process in EMDR (Moses, 2003, 2007; Negash et al., 2018). Moreover, the witness is also encouraged to reflect on how the processing partner's disturbing memory may influence their relationship (Legg, 2013; Negash et al., 2018).

Although of high clinical value and integrity, the body of literature linking EMDR to EFT consists of primarily case examples, instead of systematic and

rigorous research, except for the three dissertations cited above (Knox, 2016; Legg, 2013; Linder, 2020). More empirical research is needed and recommended to better understand the benefits and limitations of integrating EMDR and EFT in couple therapy.

Research implications

We recommend future empirical research focus on the contexts in which integration would be practical and useful. Given some of the inherent risks associated with treating trauma relationally, future research should identify potential barriers and pathways for integrating EFT and EMDR with vulnerable and diverse clinical communities. Further, research should focus on the training needs of integrative EFT/EMDR therapists. There is also a need to develop an integrative model with more detail, such as delineating specific steps regarding when and how to integrate EMDR and EFT, given its complexity. Lastly, rigorous experimental research comparing the benefits of an integrated approach compared to using only EMDR or EFT is needed.

Conclusion

The integration of EFT and EMDR is an emerging area of clinical practice and research. This article aimed to provide therapists with a review of existing literature that might aid them in their implementation and research of EFT with EMDR to treat trauma, as well as the potential benefits of combining these two models. EMDR can provide fast relief to couples who are suffering from trauma, while EFT can help couples gain individual support and connection for long-term relational health. In light of its complexities, if clinicians are intending to provide a trauma-focused treatment that provides healing at the relational and individual level, the combination of EFT and EMDR is worth considering.

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