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Frederick Capps

A New Direction

Eye movement desensitization and reprocessing (EMDR) is gaining acceptance as efficacious treatment for posttraumatic stress disorder for individuals but not for couples. This article reports three case studies of couples in which EMDR is combined with Gestalt therapy in a single session to resolve relational trauma effects, increase empathy and awareness in the supportive partner, and deepen intimacy within the couple. Case studies are described, and implications for research and clinical applications are discussed.

Keywords: EMDR; posttraumatic stress disorder; trauma; Gestalt therapy; couples therapy

The purpose of this article is to report the findings of three case studies of couples counseling in which eye movement desensitization and reprocessing (EMDR) is used to achieve three goals: (a) to resolve the effects of trauma for the traumatized partner (TP) that result from relational trauma previously inflicted by the supportive partner (SP) during the course of the relationship, (b) to increase empathy in the SP by increasing cognitive awareness of the other partner's trauma effects, and (c) to deepen intimacy within the couple. Furthermore, this article demonstrates that by combining EMDR with Gestalt techniques in an experiential couples counseling context, it is possible to achieve treatment goals in a single counseling session.

BACKGROUND

Following a brief but stormy history, EMDR is now accepted as an efficacious treatment for posttraumatic stress disorder (PTSD; American Psychiatric Association, 2004; Chambless et al., 1998; Chemtob, Tolin, van der Kolk, & Pitman, 2000; Foa, Keane, & Friedman, 2000; Foa &

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Rothbaum, 1998; Shapiro, 2001; Veterans Health Administration [VHA] & Department of Defense [DOD], 2004). Carole Alto (2001) selected 21 controlled research studies of EMDR for inclusion in her meta-analysis. A cursory perusal of the Digital Dissertations database via the Internet yielded 15 doctoral dissertations in which EMDR was the focus of controlled experiments. Although effect sizes varied among the 36 studies, all of them indicated efficacy in the use of EMDR.

The origin of EMDR (Shapiro, 1989a, 1989b) has been a source of controversy as has the role of eye movements (Acierno, Tremont, Last, & Montgomery, 1994; Levin, Lazrove, & van der Kolk, 1999; Rosen, 1995, 1997; Welch, 1996). In the first comprehensive text on EMDR, Shapiro (1995) claimed that more than 10,000 therapists had been trained in the method. Although Shapiro continued to advocate for her proprietary training, she published details on the protocol that could be followed by non-EMDR-trained researchers. Shapiro's early reluctance to divulge details of her method may have added to the controversy. Some early studies failed to adhere to the EMDR protocol (Devilley, Spence, & Rapee, 1998; Merckelbach, Hogervorst, Kampman, & de Jongh, 1994; Muris & Merckelbach, 1997; Muris, Merckelbach, Holdrinet, & Sijsenaar, 1998; Sanderson & Carpenter, 1992). These studies were less than enthusiastic about EMDR. Chastising Shapiro for making replication of her research difficult was a common theme among early EMDR investigators (Herbert & Mueser, 1992). Many of these authors live and work abroad, which may have created logistical problems in receiving EMDR training. In any case, it seems likely that methodological problems contributed to negative reports by these researchers.

Maxfield and Hyer (2002) found that methodological standards were highly correlated to effect size. McNally (1999) summarized the elements of the controversy in a particularly unflattering analysis of EMDR. However, a substantive majority of the more than 330 articles that have been pub-

lished on EMDR since 1989 (Baldwin, 2004) have supported EMDR for PTSD treatment and show promise for EMDR's efficacy in the treatment of other problems, as well (Maxfield & Hyer, 2002; Perkins & Rouanzoin, 2002; Shapiro, 2002; Shapiro & Forrest, 1997). In addition, physiological measures such as neuroimaging have aided in the understanding of the role of eye movements in EMDR (Levin et al., 1999; van der Kolk, 2002).

Since 1989, EMDR has been used to treat survivors and emergency workers, including disaster relief counselors, worldwide. EMDR has been used effectively in Oklahoma City, Belfast, Zagreb, Rwanda, Dunblane, Sarajevo, Columbine, and Londonderry; with veterans from World War II, the Korean War, Beirut, and the Vietnam War; and in many other applications (Shapiro, 2002; Silver & Rogers, 2002). EMDR effects exceed those of nonspecific effects shared by all treatments and are independent of client expectations (Perkins & Rouanzoin, 2002; Van Etten & Taylor, 1998). Moreover, EMDR effects are at least equal to effects of cognitive-behavioral therapy, and EMDR often requires less time than other models, with less client attrition (Silver & Rogers, 2002; VHA & DOD, 2004). Shapiro has continued to advocate for proprietary training. Tobin (2004) recently reported that more than 40,000 practitioners have been trained in Shapiro's model.

Couples Counseling

Conjoint therapy is a time-honored clinical practice (Bowen, 1978; Pessio, 1996; Roth & Chasin, 1994). However, EMDR was not widely studied in conjoint therapy prior to the 21st century. One reason for the dearth of early couples research may be because of Shapiro's caution to EMDR clinicians about using EMDR in the context of couples therapy (Shapiro, 1995, 2001). Shapiro noted mixed results and indicated the key in deciding whether to use EMDR in a conjoint session was the level of commitment to support by the SP. However, Shapiro did not cite the research on which her position was based. EMDR therapists have reported therapeutic gains with the use of EMDR in couples therapy (Flemke & Protinsky, 2003; Protinsky, Sparks, & Flemke, 2001; Snyder, 1996). Moses (2003) advocated for the use of EMDR in couples counseling in a model that promotes safety and balance. Protinsky et al. (2001) reported that EMDR fits within experientially based treatment and believe that it can increase therapeutic effectiveness. More recently, Flemke and Protinsky (2003) successfully integrated EMDR with Imago Relationship Therapy. Snyder (1996) reported therapeutic gains in increasing intimacy with a lesbian couple in conjoint sessions using EMDR with one partner, and the partner not receiving EMDR provided emotional support in alternate sessions.

Role of Gestalt Therapy

Experiential therapy has been shown to be effective in symptom reduction in depression (Greenberg & Watson, 1998). This factor is believed to play an important therapeutic

role in couples counseling because major depressive episodes and dysthymia are often associated with dyadic dissatisfaction (Whisman, 1999). Gestalt techniques in conjoint therapy afford the SP the opportunity to gain visceral awareness of the other's pain and to experience the trauma resolution of the TP at a deep level, thereby gaining awareness and empathy for the partner. Experiential techniques, borrowing heavily from Gestalt therapy in which "experiment is the cornerstone" (Zinker, 1977, p. 123), have been used effectively in dealing with both trauma and "attachment injuries" in couples counseling (Greenberg & Malcolm, 2002; S. M. Johnson, 2003; S. M. Johnson, Makinen, & Millikin, 2001). In keeping with traditional experiential family therapy, the goal of integrating EMDR in couples counseling with Gestalt techniques is growth and integrity, that is, congruence between inner experience and outward behavior (Nichols & Schwartz, 1991).

Definitions

Because of the novelty of EMDR therapy, many terms associated with the model may not be immediately clear to the reader. In addition, this article contains terms and acronyms that might be obscure. The following list of operational definitions and explanations is provided to assist the reader who is unfamiliar with EMDR.

Attachment injury. Attachment injury is a traumatic relational event that occurs early in life and tends to shape relatively enduring relational patterns. The traumatic event itself is typically one that is not outside the range of normal human experience and therefore is not usually associated with a diagnosis of PTSD. It can be a single incident or a series of similar events, described by Shapiro (2001) as "small *t* traumas."

Balance. This is a therapeutic technique in which both partners receive equivalent treatment to minimize the perception that one is "the patient" or has "more issues" than the other (Moses, 2003; Weeks & Treat, 2001).

Body scan. A body scan is a procedure in which the client is invited to notice any physiological sensations and to describe them to the counselor (Shapiro, 2001).

Containment. Containment refers to the handling of charged material within and between sessions. It includes assessment, development, and installation of internal and external resources of the partners; placement and coaching of the SP; and being reasonably available by telephone between sessions when necessary (Moses, 2003).

Desensitization. This refers to the implementation of sets of eye movements while focusing on the disturbing material. Between sets, the counselor instructs the client to breathe, to "let it go," and asks the client what he or she is experiencing. This procedure is the heart of the model of EMDR and is repeated until the disturbance is removed or minimized and the positive cognition is strongly endorsed by the client (Shapiro, 2001).

Installation. Installation is the use of additional eye movement sets to reinforce the endorsement of the positive cognition (Shapiro, 2001).

Relational trauma. Relational trauma is operationally defined as any physical, psychological, or emotional insult that is perpetrated by one partner in a primary dyad toward the other partner.

Safety. In response to risks of increased vulnerability as the result of conjoint counseling, safety refers to assessing client stability and fidelity to a clear structure with both partners and the counselor committed to the process (Moses, 2003).

Supportive partner. SP is operationally defined as the former perpetrator of relational trauma whose aberrant behavior is in full remission and is seeking to mend the primary relationship.

Traumatized partner. TP is operationally defined as a survivor of relational trauma who is currently manifesting post-traumatic stress symptoms and is seeking to mend the primary relationship.

RATIONALE

The treatment method under discussion is believed to have wide applicability to diverse populations. EMDR has been effectively used in resolving trauma in the aftermath of wars, terrorist acts, and natural disasters worldwide for individuals from diverse populations (Silver & Rogers, 2002). An assumption of this study is that the diverse applicability for individuals will extend to couples. There is a fairly large degree of diversity of ethnicity, gender, and age in the three cases currently discussed (see "Methods").

At least one previous case study reports that conjoint couples EMDR therapy may be effective in increasing intimacy in a lesbian primary relationship (Snyder, 1996). However, the three cases in this study involve heterosexual couples in which the TPs are female. It is assumed, based on controlled research, that traumatized males and females benefit equally from EMDR in the treatment of trauma effects (VHA & DOD, 2004). However, females may be more likely to report trauma effects in couples counseling. This assumption is based on the wide body of literature that demonstrates that substance abuse is more common in males (Substance Abuse and Mental Health Services Administration, 2004) and that perpetrators of intimate partner violence are 5 times more likely to be male (Rennison & Welchans, 2000). In addition, at least one recent study indicates that females are more likely to be traumatized than males (Breslau, Wilcox, Storr, Lucia, & Anthony, 2004). Based on Snyder's (1996) methodology, the work of Flemke and Protinsky and their colleagues, and the universal applicability of EMDR (Silver & Rogers, 2002), it seems likely that attachment injuries and relational trauma

present barriers to intimacy in primary dyads without regard to gender or worldview of the couple.

Gestalt therapy has long been used with success in the treatment of substance abuse (V. Johnson, 1973; Ramey, 1998). Gestalt techniques, such as empty chair and making the rounds, have been shown to be useful in helping substance abusers attain visceral awareness that leads to congruence. Both Alcoholics Anonymous (AA) and Al-Anon Family Groups use the 12 steps, in which the 4th and 5th steps embrace experiential therapy techniques (Anonymous, 2001). Unfortunately, experiential techniques that are geared toward the substance abuser do not address the experiences of the family in relation to the substance abuse. Edwards (1990) stated that individual therapy techniques cannot address any systemic experience unless they are utilized in the context of couples or family therapy and approached systemically by the therapist. S. M. Johnson, Hunsley, Greenberg, and Schindler (1999) reported that experiential therapies, such as emotionally focused couples therapy (EFT), utilize Gestalt techniques in encouraging a visceral reaction that tends to resolve unfinished business (Greenberg & Malcolm, 2002). EFT utilizes techniques that lead to deepening of feelings to promote affinity (S. M. Johnson, 2003). It is believed that couples interventions that provide relief of trauma effects in the TP with a concomitant increase in awareness and empathy by the SP will deepen emotional intimacy. Increases in intimacy have been related to the strengthening of the dyadic relationship (Hook, Gerstein, Deterich, & Gridley, 2003).

Family members, especially primary partners of substance abusers in recovery, often report recurrent distressing recollections of their family member's abuse, distressing dreams of the abuse, a restricted range of feelings, irritability and outbursts of anger, heightened anxiety, and hypervigilance (Cermak, 1986; Finkelstein, 2004; Parrott, Drobos, Saladin, Coffey, & Dansky, 2003; Ranew & Serritella, 1992). These symptoms are consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; *DSM-IV-TR*; American Psychiatric Association, 2000) diagnostic criteria for PTSD. Whisman (1999) conducted covariance analyses controlling for comorbid disorders on associations between marital satisfaction and specific disorders and groups of disorders, using data on married respondents from the National Comorbidity Survey ($N = 2,538$). The results indicated that marital dissatisfaction was uniquely related to major depressive episodes and to PTSD in women and to dysthymia in men.

Major effects of substance abuse include impaired judgment, cognitive distortion, emotional lability, and memory loss or even memory blackouts (American Psychiatric Association, 2000). Because of these effects, the substance abuser has limited or no recall of the aberrant behavior that has created trauma for the family. Thus, the abuser is, in effect, psychologically absent from the traumatic experiences of family members. Although most familial experiences involving the

behavior of a substance abuser fall short of the extraordinary events required for a diagnosis of PTSD, many experiences do qualify as those traumatic experiences that Shapiro and Forrest (1997) refer to as small *t* traumas and are identified as relational trauma. This investigator posited that the denial process common to substance abusers may also be manifested in the perpetrators of domestic violence and of betrayal. Therefore, relational trauma perpetrators could also benefit from witnessing the therapeutic EMDR process of their injured counterparts.

METHOD

Protinsky et al. (2001) focused on the use of eye movements to lead the client through childhood attachment injuries that had generalized to the current relational difficulties. In this article, three cases are discussed in which the emphasis is on relational trauma sustained within the context of the current relationship. The first case involves former substance abuse as a factor in the relational trauma. Two other cases are discussed in which substance abuse was not a factor. These cases involve other common relational complaints: domestic violence and a betrayal issue, specifically, the violation of physical intimacy boundaries.

In each of the three cases under discussion, a combination of EMDR and experiential couples counseling was used. In dealing with the trauma issues, treatment was accomplished using the first seven phases of the standard EMDR protocol in a single session. The phases included were (a) client history, (b) preparation, which includes creating a safe place, (c) assessment, which includes identifying negative and developing positive cognitions, (d) desensitization, (e) installation, (f) body scan, and (g) closure (Shapiro, 2001, pp. 70-75). The eighth phase of EMDR is reevaluation (Shapiro, 2001, p. 75). Because single-session results were observed in the cases under discussion, reevaluation as described by Shapiro was not done. Rather, general relational functioning was addressed in the follow-ups that were conducted in all three cases.

Sample

The illustrated cases comprise 3 males and 3 females in heterosexual primary relationships and represent diversity in ethnic and ancestral categories taken from Census 2000 (Brittingham & de la Cruz, 2004): In terms of ethnicity, three are Hispanic or Mexican and three are White (non-Hispanic and non-Latino). In terms of ancestry, one is of Spanish origin, two Mexican, two European, and one Arab. Ages range from 24 to 52, with a mean age of 31.5.

Procedure

Client history and preparation were completed in all cases. Except for the establishment of the "safe place," which is established by guided imagery in cases where the client cannot identify ideation of psychological respite, history and

preparation are identical to standard talk therapy. The EMDR assessment phase focused on the TP. A target issue was established that served as a descriptive for the trauma. The negative cognition was identified. The positive cognition was established, and its validity was rated on a 7-point Validity of Cognition Scale (VOC; Shapiro, 2001), where 1 is *completely false*, and 7 is *completely true*. Physical sensations were identified and located in the body. The severity of disturbance of the memory for the TP was measured with an 11-point Subjective Units of Disturbance Scale (SUD; Wolpe, 1990). The SUD was used to measure change of disturbance during the desensitization phase and as an outcome measure. The positive-cognition VOC was used during treatment to measure change in belief about the self. When there was no further movement, the positive cognition was installed during the installation phase. The VOC also served as an outcome measure.

The treatment model was experiential conjoint counseling using EMDR for the TP and Gestalt therapy for the SP. In the protocol that was used for both the case involving substance abuse and the case involving betrayal, the partners were situated in the same therapy room. This arrangement is consistent with the suggested protocol of Moses (2003). Moses proposed a treatment model focused on attachment injuries, which are characterized by abandonment or betrayal of trust (S. M. Johnson et al., 2001). Three principles are emphasized in the Moses model: safety, balance, and containment.

In working with substance-abusing couples, safety is maintained by applying treatment to couples who already have demonstrated a commitment to recovery, that is, are engaged in a recovery program such as Alcoholics Anonymous, Al-Anon Family Groups, or similar structured long-term programs. In addition, couples selected for treatment must espouse a firm commitment to enhancing their relationship. For cases involving extramarital affairs or related betrayal issues, the betrayal-related behavior must be in remission.

Domestic violence cases must be evaluated carefully to assess partner safety. Violence must be historical and must have been addressed prior to couples sessions. In the case under discussion involving historical domestic violence, the decision to place the partners in separate rooms with different counselors was made because of lack of evidence that the abusive partner had acquired adequate anger management skills prior to couples counseling.

Balance was achieved by expanding the preparation and assessment phases of the EMDR protocol to address the willingness of the SP to participate as requested by the TP and directed by the counselor and by the counselor's addressing issues of commitment to recovery and to the relationship and exploring what the SP hoped to gain from treatment. The SUD levels for the SP were recorded at baseline if the SP reported disturbance. Awareness and empathy were measured pre- and posttreatment by clinical interview, and value

of experience was measured posttreatment by a 7-point Likert-type scale. The counselor also set expectations of participation levels and monitored the nonverbal cues of the SP. Containment was achieved by monitoring nonverbal cues throughout the session and through the establishment of a safe place for both partners prior to the onset of eye movements.

The variant model was used in the domestic violence case because safety and containment concerns outweighed the potential benefit of immediacy, meaning the TP would not have the *in vivo* experience of witnessing the change of empathy and understanding in the SP. The SP was paired with a counselor who utilized a Gestalt technique of modified empty chair, in which the SP viewed the EMDR session on closed-circuit television. Balance was achieved by a debriefing that followed the concurrent EMDR and Gestalt sessions, in which both counselors and the couple met as a consulting team to process the parallel experiences. Because consulting teams have been used in a variety of contexts and have shown promise as a tool in both family counseling and in counseling education (Alexander & Parsons, 1982; Kinoy, 2001; Papp, 1980; Sieppert, Hudson, & Unrau, 2000; Smith, 1994; Williams, Riley, Risch, & Van Dyke, 1999; Wren, 2000), it was believed that use of consultation posttreatment would increase intimacy in a similar manner as the conjoint model that was used in the other cases.

VOC and SUD ratings are used in the EMDR protocol. These scales were used in this study to evaluate the treatment experience for the TP. To evaluate the experience for the SP, a value of experience scale (VOE) was developed. The VOE is a 7-point Likert-type scale, with 1 representing *no value at all* and 7 representing *the most valuable experience possible*. This measure is consistent with the 7-point VOC that is used as both a process and an outcome measure for the TP. The SUD is also an outcome measure for the TP. SP qualitative reports were taken to supplement and balance the qualitative data that are routinely reported by the TP in the EMDR process.

Case Illustration 1

Fred and Ethel have been in a committed monogamous relationship for 2 years. Fred is 28 years old, is employed as an executive recruiter, and has been diagnosed from the *DSM-IV-TR* with 304.20 cocaine dependence in early full remission (American Psychiatric Association, 2000, p. 242). He has 9 months of continuous sobriety. Ethel is a 24-year-old teacher diagnosed with posttraumatic stress features at a subclinical level. Both are diagnosed with V61.10 relational problem (American Psychiatric Association, 2000, p. 737). Fred's complaint is that Ethel "is not in recovery. She doesn't know how it works. If only she would go to Al-Anon . . ." Ethel complains, "When he goes to meetings, sometimes he doesn't come home until midnight. I'm terrified he's out there using again." Ethel states that she is sure that if they marry immedi-

ately, she will feel more secure. Fred states that he is in favor of delaying plans to marry until their relationship is more stable. Both are hopeful that counseling will help them.

The assessment of the couple reveals that both are committed to enhancing their relationship. Fred is also committed to his recovery program and views Ethel's complaints as a lack of understanding and support. Ethel exhibits posttraumatic symptoms of anxiety, hypervigilance, and distressing recollections of events such as Fred's use of crack cocaine, stealing her money, and ignoring important social obligations. Fred is insensitive to Ethel's trauma. He has difficulty understanding Ethel's perspective of their relationship. He is unable to empathize with her painful feelings about his past behavior and believes that continued recovery is sufficient to make amends. He believes that Ethel should be accepting of his efforts and that she should forgive him. Fred believes that he would know that Ethel has forgiven him when she is able to manifest a reduction of symptoms.

In making the decision to use EMDR, counseling goals for each individual and for the couple were considered. The goal for the couple was to increase harmony and emotional intimacy. To achieve that goal, it was necessary to relieve trauma for Ethel while increasing Fred's awareness of his former behavior and increasing his empathy for Ethel. These factors were the respective individual counseling goals for Ethel and for Fred. After thoroughly explaining the procedure and providing a safe place for both Ethel and Fred, the counselor established a target image for Ethel, which was "seeing him high from cocaine." Her negative cognition was "I'm not worth it." Her positive cognition was "I am worth it." The initial VOC was 3. Her feelings were identified as anger, and the SUD level of disturbance was reported at 9. The counselor established a baseline feelings level for Fred. His feelings were identified as anxiety, guilt, and frustration, with an SUD level of 9.

The protocol was completed with an installation of Ethel's positive cognition at a VOC of 7, the highest level, and an SUD level of 0. Fred's SUD level was also reduced to 0. At the outset, when the topic of Fred's using cocaine was mentioned, Ethel had a marked reaction consistent with anxiety. Her eyes darted about the room, she clenched her fists, her breathing became rapid and shallow, and she indicated that his relapse would mean that he did not love her and indicated that the relationship would be in jeopardy. Following the EMDR protocol, Ethel was able to talk about the possibility of Fred's relapsing calmly, stating, "Oh well, [stuff] happens." Fred's final VOE rating was 6. Fred reported being more aware of Ethel's concerns than prior to the session and stated that knowing that Ethel's suffering was because of his substance abuse reinforced his resolve to remain abstinent.

A 30-day follow-up was completed. At that time, both partners reported feeling closer to each other than ever and had made plans to marry in the near future. At a 1-year follow-up, Fred and Ethel had been married for 1 month, and

both stated that they were very happy. Ethel reported that she had been free from trauma-related symptoms for the entire year. Fred had maintained chemical-free status. His *DSM-IV-TR* diagnosis was upgraded to cocaine dependence in sustained full remission (American Psychiatric Association, 2000, p. 196).

Case Illustration 2

Raul and Rosa have been married for 1 year and have been in a committed relationship for 4 years. Raul is 30 years old and is employed as a waiter at a private club. Rosa is 52 years old and performs child care in her home. Raul has a history of alcohol abuse but currently has no Axis I diagnosis. Rosa displays *DSM-IV-TR* symptoms of 309.81 PTSD at a subclinical level (American Psychiatric Association, 2000, p. 467). Her distress stems from a traumatic incident in which a female sibling of Raul forced her way into Rosa's apartment prior to her marriage to Raul. The woman physically assaulted Rosa in an attempt to prevent Rosa from marrying Raul. Rosa is terrified that the incident will be repeated. When she becomes anxious and rails at Raul about his family of origin, Raul becomes frustrated and rages, as manifested by raising his voice, slamming doors, and hitting walls with his fist. Rosa contends, however, that Raul does not physically abuse her, although he did hit her once "a long time ago." Raul admits a family history of violence and has alienated himself from his family of origin.

The clinical analysis of this case is complex. The decision to employ EMDR to deal with Rosa's trauma with Raul as the SP was made based on the need for trauma relief for Rosa, which was a primary goal for the couple. For Raul, the family history of violence had attenuated his ability to experience alarm regarding his sibling's attack on Rosa. His lack of empathy was viewed as very similar to that of the previous described case in which the SP was a former substance abuser. Because of the familial and relational history of violence attending this case, a model of treatment in which one counselor executed the EMDR protocol with Rosa in one room, while a second counselor worked with Raul experientially while viewing the EMDR session on closed circuit television, was preferred.

The EMDR protocol was executed in a manner similar to that in the first case. At several points during the EMDR sessions, the counselor used a "cognitive interweave" (see Shapiro, 2001, pp. 249-276) to help Rosa unblock material being processed. The positive cognition "I am powerful" was installed with a VOC of 7. The SUD level was reduced from a pretreatment level of 10 to a posttreatment level of 1. Because of the possibility that violence could recur, it seemed unlikely that the SUD level would be reduced further. The decision was made to end the protocol at that time.

Meanwhile, Raul received experiential counseling while viewing his spouse's EMDR session on closed circuit televi-

sion. He was asked to move his spouse from the television screen to the empty chair and to tell her how her experience made him feel. The counselor deepened the session by inviting Raul to focus on his visceral awareness and by allowing Raul to verbalize his experience. His level of awareness and empathy was markedly increased, as indicated by self-report during the consultation with his spouse and her counselor posttreatment. Raul reported a VOE of 7. The couple continued experiential couples counseling for four more sessions. They terminated counseling at that time, having met their counseling goals of increased intimacy, trauma resolution in Rosa, and decreased raging by Raul. At a 30-day follow-up, both partners reported increased satisfaction in their relationship, and Rosa reported no recurrence of trauma-related symptoms. In a 6-month follow-up, Rosa reported a decrease in marital satisfaction, citing Raul's renewal of contact with his family of origin as a source of anxiety for her and a source of argument for the couple. Although additional counseling was offered, Raul and Rosa declined. Rosa and Raul did request additional counseling after 1 year posttreatment.

Case Illustration 3

Naomi and Jihad presented for couples counseling with the goal of reestablishing the affinity they felt when they were first married. Both are in military service. Naomi is 25 years old and Jihad is 30 years old. The couple had been married for 4 months following a 2-month courtship, which Naomi characterizes as a "whirlwind romance." Both partners agree that they are committed to their marriage and both agree that they are "very much in love." Assessment of conflict resolution, decision making, range of feeling, and sexual activity place the current *DSM-IV-TR* global assessment of relational functioning (GARF) estimate at 70 (American Psychiatric Association, 2000, p. 814). The couple self-reports a history of a nearly ideal intimate relationship. The highest GARF during the past year is estimated at 95.

Shortly after Naomi and Jihad married, they visited Jihad's family of origin for a holiday weekend. Jihad's family consists of his mother and three sisters, two older and one younger than Jihad. Jihad reports a very close relationship with his family that is characterized by abundant physical demonstrations of affection. Naomi is an only child and has experienced the level of affection she witnessed with Jihad's family only with a significant other. The incident that Naomi states "I just can't get over" involves Jihad and his younger sister. Naomi, on entering the room designated as her and Jihad's makeshift bedroom, discovered Jihad lying on the pallet. His sister was also lying on the pallet with her head on Jihad's stomach. The two were engaged in conversation. Naomi sat on a nearby chair and reports noticing that she was clearly uncomfortable with the scene she was witnessing. She expected Jihad to end the conversation and to ask his sister to move. Naomi states, "She was where I was supposed to be."

When, after a period of time that Naomi believes to be “too long” without her expectation being met, she left the room in anger. The remainder of their visit was strained. Both Naomi and Jihad agree that “nothing has been the same” in their relationship since that incident.

Jihad has attempted to convince Naomi that he is loyal to her. He has agreed to set boundaries with his sisters, restricting physical contact in an effort to appease Naomi. Naomi exhibits PTSD symptomatology, including recurrent and intrusive recollections of the event, intense psychological distress, and physiological reactivity on exposure to cues that symbolize the event, such as seeing Jihad hug his sister or hearing him express affection or terms of endearment to his sister in a telephone conversation. She feels somewhat detached and estranged from Jihad and states she has diminished interest in sex. She also reports experiencing outbursts of anger and has difficulty concentrating. These symptoms are consistent with a subclinical level of PTSD (American Psychiatric Association, 2000).

The decision to utilize EMDR for Naomi with Jihad present as the SP was made based on the following: (a) the expectation of efficacy treatment using EMDR for Naomi’s post-traumatic symptoms, (b) Naomi’s and Jihad’s eagerness to help each other work through this issue and return to their former level of intimacy, and (c) that both partners presented with neither signs nor self-reported history of additional pathology. These factors elicited a clinical opinion that the requirement of safety was met (Moses, 2003). Balance, as in the case described earlier in this article, was achieved in the preparation and assessment phases of the EMDR protocol by addressing the willingness of the SP to participate as requested by the TP and as directed by the counselor. The counselor also set expectations of participation and prepared to monitor the nonverbal cues of the SP. Containment was achieved by monitoring nonverbal cues and through the establishment of a safe place for both partners prior to the onset of eye movements.

Naomi chose the target of the husband and sister on the bed and reported the negative cognition “I’m unlovable.” The positive cognition “I am lovable” was established. Naomi reported an initial VOC for the positive cognition as 1 on the 1-to-7 scale. Naomi’s initial SUD level was reported at an 8, with feelings of anger, hopelessness, and despair. Post-treatment, the VOC for Naomi’s positive cognition “I am lovable” was installed at 7. Naomi’s posttreatment SUD level was 0. Jihad reported that he was somewhat aware of Naomi’s feelings and had moderate empathy for Naomi. At post-treatment, Jihad reported increased awareness and empathy by stating that the treatment made him see that Naomi really had felt betrayed by his behavior. Jihad rated the counseling experience at 7 on the VOE. When Jihad was asked what the experience was like for him, he stated, “When we came in here, it was like the Grand Canyon was between us. Now, I

feel like I’m in a Mel Blanc Looney Tunes cartoon, where somebody throws a lasso across the canyon and drags the other side over here.”

Follow-Up

Routine follow-ups have been conducted with the couples. At 30 days posttreatment, both partners in each of the three cases report that gains in intimacy have been maintained or have increased; that attitudinal changes regarding continued abstinence, awareness, and empathy by the SP have been sustained; and that both partners believe that the treatment is beneficial to them individually and corporately. In two cases, gains in intimacy are reported to be sustained at the 1-year interval. The couple in the case involving a history of domestic violence self-reported decreased marital satisfaction at 6 months, and the couple has returned to counseling.

DISCUSSION

In the three cases studied, the SPs witnessed the rapid processing of the trauma material by the nonabusing TPs. In each case, the SP gained awareness of the impact of the relational trauma. It is hypothesized that this awareness led to a deepened sense of empathy for the TP, which was also reported by each of the three SPs. The SPs also reported strengthened resolve to abstain from the behavior that precipitated their partner’s trauma. The former substance abuser resolved to remain in recovery. The physical abuser vowed to refrain from resorting to violence and committed to getting more counseling to learn better coping skills. The SP in the betrayal case averred his commitment to fidelity and boundary setting within his family of origin.

The TPs in all three cases reported relief from the trauma as treatment effect of EMDR in a single session of EMDR therapy. It is expected that the EMDR treatment effect will be reinforced as the SP is able to display increased empathy and understanding for the TP. All 6 participants have reported an increase of empathy toward their partner at posttreatment and at 30-day follow-up. Self-reports of value of the treatment experience have ranged from 6 to 7 on the VOE. The combination of trauma effect reduction, awareness, empathy, support, and value of experience may all be factors in the increase of emotional intimacy that is subjectively reported by treatment participants.

Limitations

Although this process appears to be effective, caution must be used in interpreting case results. Rigorous controlled research is indicated to ascertain that change is occurring because of the application of treatment and not as a result of extraneous variables. Certainly, expectancy effects can be assumed. No one would seek counseling if they did not expect positive results. Similarly, counselors would be unlikely to continue in their profession if they were not at least occasion-

ally validated by a treatment success. Validated objective outcome measures are needed to measure therapeutic gains for the individuals and intimacy gains for the couple. Longitudinal research will explore treatment decay issues and the impact of conjoint EMDR on long-term marital satisfaction. Comparative research is needed to determine if attachment injuries occurring in childhood require different treatment than relational trauma sustained in current relationships. It is possible that the antecedent will dictate a specific application or that childhood trauma and its sequelae will require longer term therapy than the single session discussed in this article.

The model in discussion addresses cases involving relation-specific trauma and is limited to relationships in which the aberrant behavior is in remission. Although this description describes a large number of troubled primary relationships, it is far from inclusive. Moreover, although seemingly efficacious with the defined population, this treatment model requires skilled clinicians. Assessment, dealing with abreactions, and simultaneously attending to both partners in the session, could prove to be daunting tasks for relatively inexperienced counselors, despite the fact that the EMDR protocol is standardized. In the split-therapy version of the model, two clinicians are required to work with the couple. Factored together with the idiosyncratic EMDR model, the split-therapy version is resource intensive. However, the efficacy of this model of couples therapy in either version may lead to the reduction of recidivism to addictive behaviors, to reduced trauma-related pathology, and to the strengthening of the primary relationship. These gains could lead to lower divorce rates, particularly in the substance-abusing population, which could in turn lead to fewer problems with the children of this population. Like ripples in a pond, the impact of combined EMDR and experiential couples counseling could be far reaching, indeed.

NOTE

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