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The Use of EMDR for Couples Going Through Divorce:

Theory and Practice

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Abstract

Eye Movement Desensitization and Reprocessing (EMDR), since its introduction in 1989 (Shapiro), has gained a solid body of evidence for its efficacious use in treating trauma and its effects. The process of divorce is likely to activate what is known as “small t” trauma reactions in each individual of the couple (Cvetek, 2008). “Small t” traumas are responses to common life difficulties like divorce or unemployment, and usually bring out irrational cognitions and inadequate ability to cope with the event (Laub & Weiner, 2013). In recent years, there has been a surge of interest in investigating how EMDR may be used for these more common traumas that can have a strong impact on individuals and couples. In particular, this paper outlines the use of EMDR with a composite case couple who are considering divorce. The paper reviews the history of trauma and Post Traumatic Stress Disorder (PTSD), and presents research support for EMDR as a psychotherapy model for both “capital T” and “small t” traumatic distress. The composite case of a couple is considered, and interventions that represent an EMDR-based approach are delineated. Finally, a discussion of the composite case and a call for future research are included.

**The Use of EMDR for Couples Going Through Divorce: Theory and Practice**

The therapeutic approach called Eye Movement Desensitization and Reprocessing (EMDR) has established a reputation over the past 25 years as being an evidence-based practice for trauma and cases involving Post-Traumatic Stress Disorder (PTSD) in particular. This article will outline how EMDR can be of use for counsellors addressing the traumatic response, though sub-clinical for PTSD criteria, which can be evoked for those experiencing relationship breakdown and subsequent divorce. First, the article will outline briefly the history of the concept of trauma and its diagnostic connotations. Next, there will be an overview of research regarding how EMDR is used for both “capital T” and “small t” traumatic responses. Following this, a link between how divorce can activate a “small t” traumatic response will be briefly explored. Then, the case of a composite couple considering divorce will be outlined. The case will demonstrate how EMDR can be used with couples considering divorce and how the therapist makes decisions within this framework throughout the couples counselling process. Lastly, a discussion of the composite case and the need for future research are considered.

Trauma and Its Evolution

**Response to war**. Freud was one of the first to write about responses that can arise from being in combat, as he treated returning soliders in World War I (WWI), and subsequently wrote about “war neurosis” (Ferenczi & Abraham, 2010). Psychiatrists treating soldiers on the battlefield in WWI used the term “shell shock” to describe how soldiers reacted to having been involved in combat and under constant threat of attack. At first, “shell shock” was conceived of as a physicalized brain response to being hit by or in proximity to exploding shells (Eagan Chamberlin, 2012). Towards the end of the war, “shell shock” came to refer to the psychological responses (such as nightmares, flashbacks, hyper-arousal, and feelings of anxiety and numbness about war events) to being in battle. Those who experienced the psychological side of shell shock were seen as “weak men” who were less morally strong compared to those who had a “legitimate” physical response (Eagan Chamberlin, 2012). The Second World War (WWII) saw a larger group of soldiers who had returned home after service and showed signs of shell shock. The terms “combat exhaustion” and “battle fatigue” began to gain prominence to describe the psychological responses that arose for many in the service after World War II (DiMauro, Carter, Folk, & Kashdan, 2014). After the Vietnam War, medical professionals began to see similarities in symptoms for those returning from Vietnam in the U.S., and soldiers’ symptoms from the First and Second World Wars.

**Other life events**. In the post-Vietnam era, the psychiatric community also began to consider that post-traumatic symptoms could arise from other life threatening events such as car accidents or sexual assault. The term and diagnosis of PTSD was included in the third Diagnostic and Statistical Manual (DSM-III) as a way to describe the experiences associated with coming back from combat (Crocq & Crocq, 2000). However, the criteria in the DSM-III were based solely on soldiers’ presentation and commonalities, and thus many who had experienced other types of trauma were excluded from the criteria and appropriate clinical treatment (DiMauro et al., 2014).

Although the DSM’s definition of traumatic events has expanded in the last several decades to include a wider range of perception and experience, its medical model emphasis remains on individual response to traumatic events being understood as dysfunctional reactions to significant abnormal events.

In addition to the impact of “capital T” traumas such as war combat, sexual assault, domestic violence and other life-threatening events, a group of researchers are exploring the impact of what they call “small t” traumas (Shapiro, 2012; Shapiro, 2014; Varese et al., 2012). This group of researchers explains that events such as physical punishment, losing one’s job, divorce and losing a close relationship can be understood as “small t” traumas and can activate the same post-trauma responses as “capital T” traumas. They argue that the psychological mechanisms of responding to an overwhelming event are the same, regardless of the magnitude of the event.

**Feminist and narrative perspectives**. In opposition to the dominant conceptions of trauma, there has been a groundswell of writers and therapists who have been troubled by the use of the word trauma and the way the term obscures systems or individuals who are initiating the traumatic reaction in the first place (e.g., Coates & Wade, 2005; Reynolds, 2010).

Feminists in the 1970s drew attention to the prevalence of events such as rape and domestic violence and the importance of considering the psychological impact of surviving these events (Burstow, 1992). Researchers such as Burgess and Holmstrom (1974) demonstrated that the symptoms associated with coping with sexual assault had many areas of cross-over with the symptoms associated with traumatized veterans. Feminists working with survivors of sexual assault and marital violence also stressed the need to consider how survivors’ “symptoms”, often pathologized, should be viewed as normal attempts to cope with abnormal events (Brown, 2004). Lastly, since the 1970s, feminist therapists have called for societal change so that blame for sexual assault and domestic violence lies with perpetrators and with unjust social structures, as opposed to those who have been the victims of these acts (Burstow, 1992; Moor, 2007).

Building on feminist principles and narrative therapy, a group of Canadian researchers and practitioners have developed “Response-Based Practice” as a way to highlight how society uses language to imply that the victims of violence/trauma are somehow at fault for the perpetrators’ actions (Richardson & Wade, 2013). One of the central tenets of Response-Based Practice (RBP) is that “misrepresentation” of the reality of violence through language is integral to most forms of violence. Misrepresentation of violent acts in verbal descriptions and court documents can implicitly allow perpetrators to obscure their responsibility for attacking someone. Further, RBP assumes that victims always resist violence in some way, and that common traumatic responses such as going numb may be seen as ways in which survivors of violence cope with and keep themselves safe in the moment and from future violence (Reynolds, 2010). Both feminists and response-based practitioners have criticized psychology and psychiatry’s reliance on psychological/individual explanations for how responses to external traumatic events arise.

**Eye Movement Desensitization and Reprocessing Psychotherapy Model**

Evidence-based treatments for trauma and PTSD, for most of the latter half of the 20th century, have centred around behavioural strategies such as exposure (c.f., Bisson, 2007; Rothbaum, Astin, & Marsteller, 2005), and cognitive behavioural approaches (Devilly & Spence, 1999; Margolies, Rybarczyk, Vrana, Leszczyszyn, & Lynch, 2013). More recently, EMDR psychotherapy has gained a solid body of evidence for its efficacy in treating trauma and its effects, specifically in treating PTSD (see Schubert & Lee, 2009, for a comprehensive literature review).

Overview

Francine Shapiro (1989, 1995, 2001, 2014) developed EMDR as an approach to addressing trauma and its impact. She proposed the Adaptive Information Processing (AIP) model to explain how traumatic events affect people (Shapiro, 2001). The basis of the AIP model is that distress arises from information or memories that have not been processed. Shapiro proposes that in order to move past a distressing event or experience, the memory of that event must be sorted through the relevant neural networks. When this does not occur, memories and their associations (such as thoughts, images, and sensory reminders) become stored in their own negative network. Disturbing memories have not been processed and thus remain frozen in their own network. Researchers are beginning to show association between certain neurobiological structures such as impaired thalamic function and maladaptive memory networks (e.g., Bergmann, 2012). The individual cannot learn from the material (make sense of it), or integrate it into more adaptive networks. These dysfunctional networks are thought to give rise to maladaptive trauma symptoms. Schubert and Lee (2009) explain that EMDR helps to process the negatively stored memories through three mechanisms: (a) deconditioning that proceeds through a relaxation response; (b) neurological changes in the brain that activate and strengthen weak associations; and (c) factors that are involved with the client’s dual focus of attention on both the memory and a concurrent task, such as eye movements (EMs) (p. 126).

The “eye movement” component of EMDR is the mechanism through which the “D” (desensitization) and the “R” (reprocessing) are understood to operate (Shapiro, 2001). Using eye movements (whereby the therapist moves his/her hand back and forth in the client’s visual field as the client tracks movement) is meant to unlock the nervous system so that the client attends to both an initially distressing memory and an external stimulus, stimulating both sides of the brain, through bilateral stimulation (BLS). This essential quality of EMDR psychotherapy is known as “dual attention”.

Procedure

EMDR psychotherapy is comprised of eight phases. The length of each phase depends on the client(s)’ background, their current level of coping, and how many negative networks might exist and be interfering with functioning. During the first phase of *treatment planning/history taking*, like in other psychotherapeutic approaches, the clinician gathers information relevant to client history, develops the therapeutic relationship, and establishes mutual treatment goals. During the *preparation* phase, as with most other approaches, client(s) are taught skills of emotional regulation and their ability to tolerate distress is assessed and enhanced. During the *assessment* phase in EMDR, clinicians and clients identify what traumatic memories are activated by certain events and how they may be clustered together. This phase also consists of agreeing on which memories will be targeted for reprocessing first. The fourth phase of EMDR treatment, *desensitization*, is specific to memories identified during the *assessment* phase and may occur each session a memory is targeted to be reprocessed. During *desensitization*, the target memories are activated and through the process of dual attention via BLS, reprocessing, or accelerated learning occurs by clearing out the negative memory network. During the *installation* phase, previously negatively stored target memories are linked up to more positive cognitive networks, and generalizing positive effects can often be seen within new associative memory networks (Shapiro, 2001). During the *body scan* phase, the client thinks of the previously distressing memory and cognition, and reports what feelings are arising somatically. The theory underlying the necessity to have clients complete body scans is that dysfunctionally stored information often expresses itself through bodily sensations (e.g., Shapiro, 2014). The seventh phase, *closure*, involves ensuring the client is grounded and is not leaving the counselling office in distress. This phase is also essential at the end of a session in the majority of approaches to counselling and psychotherapy. The final phase of EMDR psychotherapy, *re-evaluation*, usually occurs in subsequent sessions to phases three through six as outlined above.

Empirical Support

As mentioned, EMDR has gained a solid body of evidence for its efficacious use in treating trauma and its effects (see Schubert & Lee, 2009). EMDR has been shown to be helpful for people who have PTSD diagnoses (Lake, 2015; Mevissen, Lievegoed, Seubert, & De Jongh, 2012), which according to the DSM V, means the person must have at least been exposed to or witnessed death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (American Psychiatric Association, 2013). In the U.S., the Department of Defence and the Veteran’s Administration have recently supported the use of EMDR as an effective therapy for veterans suffering from Post-Traumatic Stress Disorder (PTSD) (VA/DOD, 2010). EMDR treatment has also been demonstrated to be effective in reducing the symptoms of PTSD related to sexual assault, such as hyper-vigilance, flashbacks, and nightmares (Clayton, 2011; Parcesepe, Martin, Pollock, & García-Moreno, in press).

There has been growing interest by EMDR researchers and clinicians alike for establishing the same level of research support and understanding of psychological processes associated with those events that might not be classified as “capital T” traumas or responses to stressors that may not meet traditional criteria for PTSD (e.g., Cvetek, 2008; Pillai-Friedman, 2010; Shapiro, Kaslo, & Maxfield, 2007; Shapiro, Hofmann, & Grey, 2013). “Small t” traumas involve more common life difficulties like divorce or unemployment and usually bring out irrational cognitions and a decreased coping ability (Laub & Weiner, 2013). Perry (2002) claimed that the impact of prolonged “small t” trauma events such as neglect can negatively impact a child even more than surviving a “capital T” trauma event. Shapiro has been instrumental in illuminating how reactions to negative life experiences are essentially traumatic responses, that everyone experiences some type and level of difficulty in encountering them (e.g., Shapiro 2012, 2014), and that EMDR can help with the “sequelae of psychological trauma and other negative life experiences” (2014, p.71) – what Epstein (2014) calls “the trauma of everyday life.”

EMDR is gaining a modicum of research support for problems that are the result of a distressing negative life experiences. Mental health problems, commonly understood as originating in an individual, are being viewed within the AIP model as responses to distressing events whereby processing the event causes it to get stuck (Shapiro, 2014). There have been studies examining the use of EMDR for various types of anxiety (Capezzani et al., 2013; Gauvreau & Bouchard, 2008; Maxwell, 2003), including separation anxiety disorder (Morrissey, 2013). Further, EMDR is gaining support as a “promising practice” for people with chronic pain (Tesarz et al., 2013), those experiencing grief (Murray, 2012; Solomon & Rando, 2012), those with phantom limb pain (Schneider, Hofmann, Rost, & Shapiro, 2007; Wilensky, 2006), and (in combination with pharmacotherapy) those diagnosed with psychosis (van den Berg, Van der Vleugel, Staring, De Bont, & De Jongh, 2013).

**Divorce and Couples Therapy – State of the Problem**

Divorce rates are currently at staggering heights in Canada. The percentage of marriages that are projected to end within the next thirty years is between 35 and 42 percent (Statistics Canada, 2011). There is less societal stigma about the act of divorcing in North America than in past years, and it follows that in general, and both men and women are more willing to seek support when they are considering or going through a divorce (Canham, Mahmood, Stott, Sixsmith, & O’Rourke, 2014; Roy, Tremblay & Robertson, 2014). Counsellors and psychotherapists are thus seeing more and more couples who enter couples therapy knowing divorce is a possible outcome (Lebow, 2008). Obviously, some couples enter couples therapy and are able to remain together. Others enter couples counselling and the process morphs into counselling for divorce for the best possible outcome as one or more of the partners decide to formally end the relationship. Other couples may come to counselling having made up their minds to end the relationship and who are seeking assistance with this process (Lebow, 2008).

It is generally acknowledged that those who undergo divorce generally have poorer outcomes for their mental health compared to those who do not undergo divorce (Symoens, Van de Velde, Colman, & Bracke, 2014). Divorced couples report higher levels of depression, lower self-esteem, and more general health problems (Wood, Goesling, & Avillar, 2007). Ongoing conflict with an ex-spouse is linked to higher levels of anxiety and emotional stress (Symoens, Colman, & Bracke, 2014).

**Divorce as small t trauma response activator.** As aforementioned in the discussion of “small t” traumas, the process of divorce often activates a response consistent with “small t” traumatic events. This means that for each individual member of the relationship, the process can activate a negative memory network of thoughts, feelings, and sensations associated with the divorce (Cvetek, 2008). Further, the decision to divorce can touch on other dormant memory networks where dysfunctional and irrational cognitions and affect are stored, based on past personal history with both small t and capital T experiences (Laub & Weiner, 2013).

**EMDR as a way to help.** EMDR can be a helpful way to deal with the distress of marital conflict and to help enhance individual and couple functional patterns, regardless of outcome. Most researchers and clinicians writing about EMDR for family and couples psychotherapy highlight that EMDR is best employed as an integrative approach along with the therapist’s theoretical approach to marriage and family therapy (e.g., D’Antonio, 2010). However, there is also agreement that adherence to stages 3-6 of the EMDR protocol in terms of traumatic memory activation, desensitization through trauma processing, installation of positive memory network, and body scan must be included in treatment of “small t” traumatic experiences in order to claim that EMDR has been a part of the overall therapeutic model.

**Case Example**

A case example of a couple considering divorce is outlined below. The presentation of the case study outlines the background information, presenting issue, assessment process, case conceptualization, treatment progression, and treatment outcome for the case. EMDR psychotherapy will serve as a primary focus to conceptualize the case with several other approaches used to form an integrative theoretical structure to guide case analysis and related interventions (Corey, 2011). In addition to EMDR as the primary foundation, some elements of Integrative Body Psychotherapy (IBP) (Rosenberg, Rand, & Asay, 1985) will be implemented as needed. The rationale for a primarily EMDR-focused assessment and intervention, and how this guides therapist decision-making will be interspersed with transcripts from the therapy sessions.

**Background Information**

Jaswinder (Jas), a 44-year-old man, and Sarah, a 41-year-old woman, have been married for 13 years. They have one 10-year-old son, Rajiv. Both Jaswinder and Sarah were born in Canada. Jas is dark-skinned and was born to parents who emigrated to Canada several years after they were married in Southern India. Sarah has white skin and was born to parents who were born in Canada to Norwegian immigrants. Sarah and Jas (and their respective parents) live in a major urban centre in Western Canada. Both Sarah and Jas are on adequate terms with their parents, although there were some initial tensions between the two sets of in-laws. Sarah’s parents divorced when she was 14 years old; Jas’s parents are still together. Sarah suspected that Jas’s parents wanted him to marry an Indian woman, possibly arrange a marriage for him, discussed this with Jas before they married. He said that they had brought it up with him at one point and respected that he told them he was not interested in an arranged marriage. Jas has never indicated to Sarah that he has any issues with her parents and he is always polite and friendly with them. Neither Sarah nor Jas currently attend organized religious events but both grew up attending Christian Presbyterian church and Sikh temple, respectively. They are both working professionals in their community.

**Presenting Issue**

Sarah and Jas sought counselling, as it recently came to light that Sarah had an affair with another man for the past six months. Jas was very upset and upon initial intake, refused to consider the option of getting a divorce. At intake, Sarah was unsure about being at the point for divorce but was amenable to counselling in order to further explore what might be the best option. She stated that she became nervous about the affair and decided to tell Jas when her male lover began to call her at home. She was adamant that she had ended things with this man and that she had no intention of becoming involved with him again.

**Case Assessment Process and EMDR**

From an EMDR psychotherapeutic perspective, we can conceptualize of most relational difficulties as “small t” traumas for one or both members of the couple; although the presenting issue will be filtered through one’s historical memory networks (Litt, 2010). Further, the therapist needs to consider the impact of an affair on both parties; especially the person who identifies the affair as a betrayal of trust against them (Croitoru, 2014).

**First couple’s session**. In the initial session with a couple in which one has had an affair, the EMDR-focused counsellor is looking for the degree of distress associated with the affair. After going through standard confidentiality and safety policy discussions, the counsellor began by asking why each one is there. This is not unique to EMDR, but EMDR-focused therapists still need to understand the presenting issue from clients’ perspectives (Litt, 2010).

Jas: I can’t believe that she would have an affair and disgrace our family in this way.

Sarah: (weeping for 30 seconds). “You don’t understand why I did it” (said softly).

J: (shakes his head and clenches his fist in response). Long silence for two minutes….

At this point, the counsellor sensed that Jas was not ready to talk openly about the effect the affair has had on him. He made the decision to probe further with Sarah regarding the situation. This is general counselling assessment in terms of understanding the presenting problem. However, from an EMDR-focused perspective, it speaks to the *treatment planning* phase to get a sense of both her level of distress overall with regard to the marriage, as well as to judge her ability to handle strong emotions, which is one of the pre-requisites necessary for successful EMDR treatment and part of the *preparation* phase (Shapiro, 2001). He asked Sarah to tell him more about what led up to having an affair.

S: I’ve been unhappy for several years. It just has crept up on us…I tried to talk to Jas about it…but it’s hard for me.

C : How did that go for you, trying to talk to him?

S: Well, I thought he might have figured it out because I was “not in the mood” a lot more than before. I also mentioned that I was worried about Rajiv, because, you know, the tension. .

C: Thank you for telling me about that. How do you think these messages were received?

S: Probably not very well. (weeping for 30 seconds)..

C: What are you feeling right now?

S: I don’t know…just feel bad. Maybe ashamed of what I’ve done.

At this point in the assessment process, the counsellor decided to do some history and genogram work based on IBP (Rosenberg, Rand, & Asay, 1985), with a view to establishing what he thinks may be a goal of the couple – to possibly improve their communication. From an EMDR perspective and the model’s *history taking* phase, he wanted to see how distressing family of origin issues are for Sarah, to see if it may warrant some individual reprocessing sessions.

C: I’d like you to talk to me about how people communicated in your family of origin and what stands out for you. I’ll be jotting down some notes and asking you more questions as you go.

S: Well, growing up, no one ever talked about any kinds of problems. A lot of times I thought my mom and dad might be fighting but they never did in front of me and sometimes had these fake smiles on their faces. I guess what stands out for me…I remember this one family meeting and they were trying to make sure there were enough times that my brother and sister were around to look after me. I remember I was about eight or so and I said, “Mommy, I don’t like it when you are away from us all the time”. Then her face turned red, and she got really quiet. My dad then said “don’t you dare talk to your mother like that”. He sent me to my room, and I was really upset. (cries off and on throughout this disclosure).

At this point, the counsellor decided to do some psycho-education focused around some of the principles of EMDR; specifically early memories feeding current negative reactions, which he calls “brick by brick” (Croitoru, 2014). He then turned his attention to Jas to assess his level of emotional distress – again with a view to assessing how he might handle strong emotions (a prerequisite for EMDR treatment) as well as what types of triggers there might be for thinking about the affair (see transcript below). Further, the counsellor wanted to explore Jas’s communication style and family of origin history to determine what type of work might be needed for improving communication between the couple. These aims are consistent with IBP principles; connecting intergenerational themes regarding communication and relational and intimacy difficulties (Rosenberg, Rand, & Asay, 1985). They also comprise the *history-taking/treatment planning* phase of EMDR.

C: What was that like for you to hear? Can you tell Sarah?

J (long silence; glances only at therapist): I understand a little bit more now but…(voice getting louder; fists clenched, face contorted)…but I still don’t understand why she would choose to humiliate me like this.

C: Just like I asked Sarah, I’d like you to talk to me about how people communicated in your family of origin and what stands out for you. I’ll be jotting down some notes and asking you more questions as you go.

J (takes a breath, calms down somewhat): I guess the way people got their point across was to raise their voices. I guess I learned that I better yell so that people can get my point. It’s probably not the best way. I just really wanted Sarah to understand how upset I was.

C: Is there anything that stands out for you in your family as a time when you felt really upset about people yelling?

J (taking a minute to think): No, nothing is coming right to mind. .

From this interchange, the therapist was able to see that Jas could handle his strong emotional response in some ways, enough to focus on describing his family of origin. Further, it seemed that his reaction to Sarah’s affair was not concretely linked to a memory network that has to do with family of origin communication styles. Based on this input, the therapist decided that he would like to do further assessment about how much the affair is impacting on Jas’s functioning. He sensed that perhaps it was not comfortable for Jas to reveal exactly how distressed he is in front of Sarah at this time.

The therapist used clinical judgment to begin to talk about the treatment plan and to set some mutual goals for continued therapy. Both EMDR and IBP approaches to therapy advocate the use of goal setting (Ben-Shahar, 2014; Litt, 2010). He eventually got agreement from both Sarah and Jas that they would like to improve their communication with one another, no matter what the outcome of their relationship. They agreed that for the time being, they will not address topics that are laden with emotion or distress pertaining to their relationship. The therapist explained to them that from an EMDR-based perspective, their current communication patterns are likely the result of negative networks being activated. He explained that they each likely have reactive networks being touched on when they try to communicate. They established that at the end of their counselling treatment, they would like to be able to communicate with much less distress and emotional reactivity. They also agreed that they would like to make decisions about whether they may or may not stay together with clear, rational discussions in which they do not bring up each other’s perceived faults. At the end of the session, Jas became teary. Without prompting from the therapist, he blurted out,

Jas: I can’t sleep! I keep seeing them together. Can’t we just fix this now?

Sarah (weeping): I never wanted to hurt you – I was so unhappy…please forgive me.

Jas (eyes fill with tears): I just can’t hear that right now. I need to put it out of my mind.

Based on the above interchange, and his assessment that Jas can handle strong emotions, the therapist recommended an individual EMDR-focused session for Jas. He decided to see Jas individually as he not convinced that Jas would feel free to emote and share his thoughts as freely in Sarah’s presence at this time. This is one of the contraindications for doing conjoint EMDR couples work (Litt, 2010). For these individual sessions, his intent is to continue to assess Jas’s level of distress in response to Sarah revealing the affair to him and to engage in some EMDR to bring down the distress. The therapist believed that Sarah is upset but is not currently having the same level of subjective distress as Jas is to the situation. Both are agreeable to this initial treatment plan. Before they left the extended initial session, the counsellor outlined that he would like to teach them an EMDR-based skill of being able to put things that are triggers for them and their relationships stress into a container (Murray, 2011). This ability to regulate emotions via a container speaks to the “preparation” phase of EMDR. He went through the script and they both appeared to understand the skill and agreed to use it individually before they meet again as a couple. The counsellor asked Jas to fill out an Impact of Events Scale (IES) (Weiss & Marmar, 1997) over the next week before they meet for individual therapy. He clarified that Jas should fill it out with respect to the intrusive images Jas reported regarding the affair. Jas took the document but does not look it over in front of Sarah. The IES is used to for the *treatment planning* phase of EMDR, as it helps provide both a way to measure level of distress about events, as well as a way to identify what associated images are the most distressing.

**Individual session (Jas)**. The counsellor noticed at the beginning of this session that Jas was much more vocal and seemed less angry about Sarah’s affair compared to a week prior. The counsellor at this point continued the *treatment planning* phase and the target identification part of the *assessment* phase of EMDR treatment by ascertaining Jas’s current level of distress associated with thinking about the affair. He used the formalized assessment tool (IES) as well as questions to do this. Further, he asked Jas some questions about which visual(s) are the most disturbing. Identification of the most distressing visuals will allow the therapist to move along to the remainder of the *assessment* phase and to begin the *desensitization* part of treatment, targeting a mutually agreed upon visual. Within an EMDR-based framework, it was important for the counsellor to touch base regarding how the container exercise practice has been going for Jas. This provided input regarding how Jas might handle strong emotional content during and after the EMDR desensitization work:

Counsellor: So, how has it been going to practice putting things away, to be dealt with later, like we talked about with the container exercise?

Jas: Well, to be honest, it works okay when I am just mildly upset. We can be civil talking about Rajiv’s schedule. Then when I start thinking about the affair, well, it doesn’t work so well. Then I can’t really talk to her at all.

C: I am glad to hear that you have been using it for mildly annoying things. I don’t know if you remember me saying while explaining it last time, that it is like running a marathon-you have to train up for using the skill for the big race, which are things like thinking about what happened with Sarah. We also plan to use the eye treatment that I also mentioned last time so that eventually, some of those memories or visuals won’t be so overwhelming anymore.

J: I am willing to try anything. It feels pretty crappy right now, so I think it won’t be worse?

C: That is the reasoning behind the EMDR treatment; we want to be able to bring your bad feelings and thoughts down to a more manageable level so you can get through your days. I am going to give you a video that shows the eye movements in action, as well as some websites so you can do your own research.

J: That’d be good. I’d like having some time to check things out.

C: So in looking at the scores of the survey, it looks like you’ve got some troubling things going on with regard to thinking about Sarah’s affair. Tell me more about the items you rated really high: “you tried to stay away from it”, and “pictures of it popped into my mind”.

From here, the counsellor continued with the *treatment planning* phase of EMDR treatment, working within the model that each member of the couple can be treated individually for various relational reactions that are distressing before coming back together for a couple’s session (c.f., Croitoru, 2014; D’Antonio, 2010). For the remainder of the session with Jas, they ranked other events in Jas’s life at present, with regard to a Subjective Unit of Distress Scale (SUDS) (Wolpe, 1969). It became apparent that the reaction to Sarah having an affair was the most subjectively disturbing event for Jas at this time. In addition to some concerning symptoms as reported on the IES, he also cried several times when describing his reactions to the affair in session.

The counsellor explained that he would like to proceed with at least one EMDR session following this one and that he would like to target Jas’s imagery of Sarah’s affair. Overall, the counsellor was fairly confident in proceeding to the *desensitization* phase of EMDR treatment using BLS with Jas for their next session as he seems to have some decent ability to feel strong emotions and is learning how to regulate them better (*preparation* phase). They agreed to meet for an extended session (two hours) to target the images of infidelity that are intrusive and very distressing for Jas. This session will take place several days before the next couple’s session scheduled with Sarah.

**Individual session (Sarah)**. Before the next individual session scheduled with Jas, Sarah called the marriage counsellor in tears. She requested an individual meeting as she has “not been doing well” over the past week. She described that she has been haunted by feelings of guilt and is remembering seeing Jas’s face fill with anger and disappointment the day she told him about the affair. She told the counsellor she has been holding it together but for some reason, she is starting to “fall apart”. The counsellor suggested an individual session and indicated Sarah could write Jas a note to let him know she is attending. He suggested this so that Sarah practices her open communication with Jas (one of their goals as a couple) and also so that Jas is re-assured that she is not going to meet her ex-lover.

When Sarah met with the therapist for the individual session, she appeared more distressed than during the first couple’s session. The counsellor engaged in the EMDR model’s *assessment* phase (see transcript below) by asking some questions about what is most troubling to Sarah.

Counsellor: I am glad you came in. It sounded like you were very upset on the phone. Can you tell me what is going on?

Sarah: I am having trouble sleeping lately. I just keep picturing…the look on his face. When I told him what had happened. When I try to fall asleep, I see Jas’s face, and he looks so disappointed, I just can’t stand it.

C: You sound really troubled by that image. How is that affecting your communication together?

S: I kinda avoid eye contact with him. Cause when I see his face, it just reminds me, you know? That container thing isn’t working too well right now. But before some of my overwhelming thoughts kicked in, early last week, it was working okay when we would just talk about who was picking up our son or making lunch, that kind of thing.

C: Remember how we talked about things that trouble you now being like a brick that is connected to other earlier bricks? (She affirms she does). Well, I’m thinking that this seeing Jas’s face and feeling upset is probably connected to something to some other earlier bricks for you. I’d like to see if you are open to me using a technique that we talked about in the first couple session so that we connect to that earliest brick and turn it from a negative association into a neutral one. Overall, this is you can get some relief from the distressing feelings and get some sleep. I also wonder if you are open to having Jas present for a session where we use the EMDR approach. I think it would help both of you – I think it would allow you to express some things about how you’re feeling about the affair and not wanting to hurt him, and overall I think that would be beneficial to him to hear these things. I can give you some websites and materials to check things out further.

S: I’m a little scared, but I think it would be good to have a neutral place like here so that things don’t fall off the rails. And I really am sorry and I don’t think he’s been able to hear that so far.

The therapist in the above interchange used clinical judgment to determine that it would be beneficial to all involved (Sarah, Jas, and the couple as a unit) for Jas to witness a session with Sarah. He also believed that Sarah has some decent ability to manage strong emotions, and he asks her to continue to practice some deep breathing and the container so she can continue in the *preparation* phase. Further, they worked together to identify a “calm place” (Shapiro, 2001) to enhance the *preparation* phase.

**Conjoint EMDR-focused couple’s session**. After the counsellor contacted Jas and he agreed to attend, the counsellor explained to the couple his rationale for having Jas witness a session where the focus is on resolving Sarah’s overwhelming feelings regarding the affair. The transcript below outlines the remainder of the *assessment* phase, as well as some of the *desensitization* phase. Each of the EMDR standard protocol steps is italicized below (Shapiro, 2001).

Counsellor: Just to check in, Sarah, I want to double check that we are going to target your visual of Jas’s face when you told him about the affair. (Sarah affirms she still wants to work with this; *target identification*). (to Jas); So, Jas, your job is just to act as a witness at this point and we can debrief both of your reactions afterwards. (Jas nods). Let’s get started with a focus on the target for Sarah.

Sarah, when you think about Jas’s face and his expression when you told him, which words go best with that picture? (He shows Sarah a list of potential negative cognitions).

Sarah: Hmmm, I think it’s “I am a bad person”. (*Identification of negative cognition*).

C: Okay. And what would you like to believe about yourself now? (shows her list).

S: Do you mean in general?

C: No, I mean when you think of his face in that moment, what would you like to believe now?

S: Okay, well, I think I’d like to believe that I am a decent person, even though I messed up. (*Identification of Positive Cognition*).

C: When you think of his face now, how true do the words ‘I am a decent person’ feel, on a scale of one to seven, where one feels completely false and seven feels completely true?

S: About a two. (*Validity of Cognition, VOC*).

C: When you think about his face when you told him, what emotions do you feel?

S: I feel…sad, and angry at myself. (*Identification of Emotions*)

C: On a scale of zero to ten, where zero is no distress, and ten is the highest level of distress you can imagine, how distressing does the image seem to you now? (shows a visual of this scale).

S: It’s about a seven and a half. (*Subjective Units of Disturbance -SUDS*).

C: And where do you feel the reaction in your body?

S: In the pit of my stomach. (*Location of Body Sensation*).

C (after reiterating the protocol for the BLS/EM in the *desensitization* phase): I’d like you to bring up the picture of Jas’s face, the words “I’m a bad person”, and sadness and anger in the pit of your stomach. I will get you to follow my hands with your eyes for a while and then we’ll talk briefly. (Counsellor does about a minute of EM). What is there for you now?

S: I’m remembering being young, maybe four or five. I can tell my parents are fighting. My mind thinks they are fighting about me.

C: Focus on that. (Continues with EM for another minute). What is there for you now?

S: Huh. Well, remember that I told you my dad told me to go to my room back when we first came to counselling? That’s what memory came up for me.

C: Focus on that.

The therapist continued with the EM and the *desensitization* phase for another fifteen minutes. Eventually, as per EMDR protocol, the SUD rating associated with the target came down to zero, and he moved on with the *installation* of the positive cognition identified at the beginning of the session. He finished with a *body scan* and ensured that Sarah felt grounded as they moved into the *closure* phase of the EMDR treatment. Sarah indicated at the end of the session that she wants to take responsibility for making amends with Jas and knows she has hurt him. She also reported feeling free of taking on all of “the blame” for other things that have transpired in their relationship. The counsellor invoked a “future template” (Hensley, 2009) during the EMDR session where she saw herself communicating effectively while being clear of all the guilt that’s not hers so she can focus on making amends for “the stuff that is hers”. The counsellor invited Jas to comment how the session was for him. He appeared calm and said that he really appreciated Sarah being willing to take the risk of saying how she’s feeling with him there. The EMDR-focused session for Sarah seemed to be a success for the couple in that Jas was able to have empathy for Sarah’s suffering; and Sarah was able to move past some of the distress that was preventing her from moving towards their goal as a couple to communicate better.

**Individual session (Jas)**. Jas arrived the next day for his second individual session with the counsellor. He indicated that things have been a “little bit better” over the past few days as he’s been able to get some sleep. He also reported that although he appreciated witnessing the session with Sarah, he still had some thoughts and images about her affair last night after the session. They began an EMDR-focused treatment session that proceeded with the same protocol as outlined in Sarah’s session above. During the *assessment* phase of the session, Jas identified the *target* image as seeing Sarah in bed with her lover and a “mocking smile” on her face. The associated *negative cognition* for that image was “I am unlovable”. Jas identified his preferred positive cognition as “I am lovable”. He reported his SUDS regarding the image of Sarah and her lover as being at an “8 or 9” out of 10. After some reprocessing, he appeared much less distressed and reported much less anger in his feelings and bodily experience. He continued to report his SUDS at a 2, despite being much less disturbed overall. The counsellor probed further to ascertain what might be happening:

C: Sometimes people are afraid of their ratings going lower, because it might mean that the other person’s behavior was okay somehow. I just want to clarify that rating things lower does not automatically equate to forgiveness.

J: Yeah, I’m worried that it means she doesn’t have to take responsibility like she said she would-but what you say makes sense. I can feel better and we can still work on making repairs.

C: Okay, think about that. (Does a set of EMs).

After several more minutes of processing, Jas identified that his SUDS went to zero (a “complete” EMDR session) (Shapiro, 2001). The therapist then went through another EMDR intervention, the future template (Hensley, 2009), with Jas:

C: When you see yourself knowing you are lovable in the future, with Sarah and with others, what does that look like?

J: Well, I just see myself being okay with myself and my quirks, you know; being able to stand my ground with Sarah or my family and not try and please them too much. I can see that I know myself better.

C: Great. Focus on that type of scene—maybe with Sarah. See yourself being okay with yourself, so to speak. See the two of you interacting. See yourself standing your ground, if need be. Got it? (Jas nods). Now I will do some eye movements with you.

(After 80 seconds of EMs): C: Reflecting on that scene in your mind, what do you feel right now?

J: I think the closest word is….peaceful.

C: Okay, where do you feel that?

J: In my chest. And hands.

C: Focus on the peaceful feelings there. (Counsellor does a set of EMs to enhance good affect).

**Remainder of couple sessions**. Over the next month, Jas and Sarah came back after their individual appointments for several more marital sessions. During these sessions, the focus was on their goal of working towards healthy communication and Sarah making sincere apologies for her actions. After the EMDR-focused sessions, they both said they have been less reactive with each other and are able to “put away the past” when they need to have tough conversations, both in session and at home. Sarah was able to apologize to Jas in session and Jas seemed to be capable of hearing her and receiving her apology.

The counsellor used more general and IBP couple-focused strategies in these sessions, including practicing assertive communication and listening and receiving in session (e.g., D’Antonio, 2010; Rosenberg, Rand & Asay, 1985). At the beginning of each joint session, the counsellor engaged in the *re-evaluation* phase of EMDR by checking each target worked on to ensure that the level of distress remained low. Each affirmed that they are only mildly distressed regarding the distress they once experienced and are relieved that things are at this phase. Both reported feeling much less triggered in their normal everyday interactions. From an EMDR theoretical base, this can be conceived as evidence that maladaptive networks related to the relationship and the affair have been cleared out and linked up with more adaptive networks.

At the time of the fourth couple’s appointment, Jas announced that he has made a decision about their relationship that he would like to communicate with the counsellor present. Sarah was amenable to hearing what Jas has to say in session. He became quite emotional and declared that while he is on the road to forgiving Sarah for her actions, he has discovered that he does not truly know what he wants to do in life. He explained that he feels like a disappointment to everyone around him – Sarah, his family of origin, even himself. He stated he has always felt pressure to go into a lucrative job field, even though his current area does not bring him any joy or passion.

J: I’ve really been thinking about it over the past month, and though I feel much better about what happened, I still think it would be best if we get divorced. I hope we can do this in the best way possible for us and Rajiv.

S: (appears shocked). (several minutes of silence) I need to leave.

The next day Sarah phoned the counsellor and explained what happened for her at the end of the session. She told the counsellor that she just felt devastated; “like the bottom fell out from under me; it’s like I was watching my parents leaving each other again in slow motion”. The counsellor considered this reaction from an EMDR perspective as a signal that another negative network was being activated for Sarah. He explained this briefly to Sarah and asked if she and Jas could attend another couple’s session. They were both agreeable.

When the couple arrived several days later, they both agreed that for the remainder of their work with the therapist, they would like to work on resolving themselves to having as “healthy a divorce process as possible”. Sarah outlined that some of her past patterns were re-activated and she had an irrational sense that “she is not good enough” that came into play whenever she contemplated the process of divorce. She is worried about what she will tell her parents and her friends. The therapist decided it would be beneficial for Sarah to reprocess some of her distress using EMDR protocol in Jas’s presence. This time, he enlisted Jas to provide some of the BLS by tapping gently on Sarah’s back. Sarah chose the “disappointed look” on her father’s face as the *target* image that represents the highest SUDS for her (7 out of 10). She chose “I am not good enough” as her *negative cognition* and “I am good enough no matter what other people think” as her preferred *positive cognition*. About half an hour was then spent helping Sarah in the *desensitization* phase using EMDR to alleviate the distress associated with the upcoming divorce. After the session, both Jas and Sarah reported feeling a sense of peace. Jas said directly to Sarah, “I’m glad I got a chance to actually do something practical to help you”.

The couple came back several more times and made practical decisions about how to tell their son about their decision, making shared custody arrangements. The counsellor provided information for another therapist who specializing in helping children and teens through divorce in their family. Both parties expressed some sadness and regret but they affirmed that they are not totally overwhelmed anymore by the situation. It appeared that they needed to clear out some of the negative networks/associations in order to learn some important skills. The counsellor observed that they communicated much more effectively by the last several sessions, and were clearer about what they wanted for themselves and their family, even though they made a potentially stigmatized choice to divorce.

**Discussion of Composite Couples Case**

As shown above, in many ways, marital therapy that incorporates EMDR as part of the treatment process, proceeds in similar fashion to traditional effective marital therapy. The couple’s communication style and skill is assessed, agreement about the goals of counselling is obtained, and practice of different strategies learned in session is encouraged in real life settings (Dattilio, Kazantzis, Shinkfield, & Carr, 2011). Areas of emotional vulnerability are identified (McKinnon & Greenberg, 2013) and the impact of the affair and the need for forgiveness is explored openly (Fife, Weeks, & Stellberg-Filbert, 2013). As per effective counselling from any theoretical model, the therapist is aware of multicultural factors such as gender, socioeconomic factors, religious and cultural norms and how these impact on the couple’s development as well as on the counselling process (DuPree, Bhakta, Patel, & DuPree, 2013).

The manner in which distress is sorted out is perhaps the key difference. The most popular approaches to working with couples are currently Cognitive-Behavioural Therapy (CBT), traditional behaviourism, insight-oriented, emotionally focused, and integrative approaches (Abbott & Snyder, 2012). There is thus an emphasis in current approaches, with the exception of integrative approaches, to talk about problems, set goals to change the problems, understand interaction patterns systemically, and integrate emotional awareness to help resolve distress. The EMDR psychotherapy model may be seen as an integrative approach to couples’ counselling, as it focuses on reducing distress through emotional expression and cognitive change. In the EMDR approach, the concept of dual attention to reprocess irrational cognitions, distressing body memories, and related body feelings is a unique factor to traditional marital approaches named above. The EMDR model advocates emotional containment and self-regulation but does not directly teach skills such as communication or assertiveness; these must be augmented by the therapist’s own style and technical repertoire.

The composite case presented here illustrates how including EMDR with a couple is a different process than using it with individuals. The couple is seen as “the client” and the therapist makes clinical decisions and treatment plans with the best outcome for the couple as a whole in mind. As above, the counsellor may decide that couple’s witnessing each other’s traumatic responses related to a recent disclosure may be contra-indicated, as the therapist did above for the individual sessions with Jas. The therapist also has the responsibility to decide if it would be healing to have one witness another’s pain, as he chose to do several times where Sarah was the focus. Compared to individual approaches, there is a much greater emphasis on teaching communication skills with one another in couples’ therapy that incorporates EMDR. The counsellor remains aware that poor communication without requisite emotional regulation can trigger a trauma response in one or both of the partners that could be detrimental to the couple as a whole. In individual therapy, the skill of communication is not as much of an issue unless the person presents with wanting to improve on this.

**Call for more research.** The use of EMDR in couples’ counselling is currently not considered an evidence-based approach for working with couples. There is thus a need for more research evidence to support its use. A literature search for EMDR being used with couples who are divorcing reveals only conference presentations (e.g., Kannan, 2008; Omaha, 2004) or a theoretical exploration of its use for treating trauma and stress in divorce (e.g., Taylor, 2004). There is some literature regarding the use of EMDR in couples’ therapy, but the main source of research base for many of these claims is case studies or theoretical explorations (c.f., MacKinnon, 2014; Schneider & Brimhall, 2014; Wesselmann et al., 2012). Of course there are ethical considerations to take to heart regarding recruiting people who are in distress as research participants. However, if the research design can compare EMDR-focused couples’ treatment with a more established treatment such as CBT, it may be possible to ethically gain some support for the integration of EMDR into couples’ counselling in a more systemic way.

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