

EMDR: An Approach to Healing Betrayal Wounds in Couples Counseling

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Since its introduction by Francine Shapiro in 1989, eye movement desensitization and reprocessing (EMDR) has gained wide acceptance as an efficacious clinical treatment. It is particularly useful in the treatment of posttraumatic stress disorder (PTSD) (Alto, 2001). Despite its relative novelty, EMDR has been used to treat survivors, emergency workers, and disaster relief counselors worldwide. EMDR therapists have successfully employed EMDR in Oklahoma City, Belfast, Zagreb, Rwanda, Dunblane, Sarajevo, Columbine, and Londonderry. EMDR has also been used in the treatment of PTSD for combat veterans from World War II, the Korean War, Beirut, and the Vietnam War (Silver & Rogers, 2002, p. xix). EMDR effects exceed those of nonspecific effects shared by all treatments and are independent of client expectations. Moreover, EMDR effects are at least equal to effects of cognitive behavioral therapy, and EMDR requires less time than other models with less client attrition (Silver & Rogers, p. 254). Importantly, the American Psychological Association has listed EMDR as an efficacious treatment for civilian PTSD (Alto, 2001).

Almost all research on EMDR has been conducted with individual subjects, with families and couples receiving short shrift. Thus, despite conjoint therapy being a time-honored clinical practice (Bowen, 1978; Satir, 1972), little is known about the effectiveness of EMDR in conjoint sessions. Shapiro mentioned a mixed result of the use of EMDR in couples work (1995, 2001). A study involving the use of EMDR in couples therapy found that EMDR fits within experientially based treatment and argued that it can increase therapeutic effectiveness (Protinsky, Sparks, & Flemke, 2001). More recently, Flemke and Protinsky have reported successfully integrating EMDR with imago relationship therapy (2003).

Maryhelen Snyder reported the effective use of EMDR within an experiential couples counseling context. Her techniques included the cultivation of intimacy through experiential techniques. Specifically, Snyder instructed the supportive partner to hold the other while the other experienced a catharsis involving

emotional pain stemming from childhood sexual abuse. Snyder utilized EMDR for remembering and processing traumatic material (Snyder, 1996). Both the Protinsky group and Snyder found that combining EMDR and experiential couples counseling strengthened emotional intimacy.

Experiential therapy has been shown to be effective in symptom reduction in depression (Greenberg & Watson, 1998). Experiential techniques have also been used effectively in dealing with trauma and with attachment injuries in couples counseling (Greenberg & Malcolm, 2002; Johnson, 2003; Johnson, Makinen, & Millikin, 2001). Combining EMDR with experiential therapy in couples counseling may provide the supportive partner the opportunity to experience the trauma and the trauma resolution of the traumatized partner at a deep level, thereby gaining awareness and empathy for the partner. The result of the relief of trauma/reframing by the traumatized partner together with the newfound awareness and empathy of the supporting partner is believed to encourage increased emotional intimacy that will lead to a stronger relationship (Hook, Gerstein, Deterich, & Gridley, 2003). In keeping with traditional experiential family therapy, the goal of integrating EMDR in couples counseling is growth and integrity, that is, congruence between inner experience and outward behavior (Nichols & Schwartz, 1991). A study using emotional focused couples therapy (EFT) found that emotional deepening is effective in increasing emotional intimacy in couples (Johnson, Hunsley, Greenberg, & Schindler, 1999).

In a case study article, Gestalt therapy combined with EMDR techniques appeared to be helpful in resolving trauma and in increasing emotional intimacy within the relationship in each of three trauma related scenarios: infidelity, domestic violence, and substance abuse related behavior (Capps, in press). Unlike couples counseling research that deals with attachment injuries or trauma from childhood, the focus in this research is on psychological injuries that have more recently occurred in the context of the primary relationship. The

current study attempted to replicate the clinical findings of Capps and his colleagues in the treatment of betrayal by way of sexual infidelity, and to examine the efficacy of EMDR in a single session treatment where the EMDR therapist has limited or no contact with the couple beyond the EMDR protocol.

Rationale

Betrayal by infidelity in a primary relationship is a common theme in couples counseling. The symptoms of posttraumatic stress disorder are typically noticed, albeit often at a subclinical level, in the presentation of the offended partner. The obstacle to relational intimacy posed by the vivid reprocessing of the betrayal material is experienced by the offended partner as a severe life stressor and often is cited as the cause of the demise of an otherwise viable primary relationship. Yet little is known about the efficacy of EMDR in resolving this issue (Whisman, 1999). If the infidelity is in the past and is unlikely to be repeated, conjoint counseling provides a context that could offer several benefits to the partners. The traumatized partner could experience relief from the betrayal related trauma through the application of the EMDR protocol that could lead to a revival of trust as closeness and support from the offending partner is offered. The offending partner could gain understanding of his or her partner's pain from experiencing the trauma resolution as an intimate witness to the EMDR protocol. This newfound awareness could lead to congruence for the offender and empathy toward the offended. These expected results could then lead to a deepening of intimacy between the partners and strengthen the resolve of both toward their respective commitment to the relationship.

Because of the rapid processing that is associated with the use of EMDR (Alto, 2001; Shapiro, 1995; Shapiro, 2001; Shapiro & Forrest, 1997), the researchers in this study hypothesized that EMDR could be applied in a single session of couples counseling. The EMDR therapist, in the role of consulting specialist, would be introduced and, with the couple's consent, treat the couple using the EMDR protocol for couples as presented in earlier research by Capps.

Method

EMDR and experiential couples therapy is utilized to treat the couple in this case. In a previous session, the primary counselor utilized experiential techniques to help the couple examine the process of the relationship and to deepen the couple's understanding of the impact of non-verbal behavior. In the second session, a mask-making exercise was used with both

partners and the 9-year-old daughter of the female partner. The purpose of the exercise was to illustrate each person's perceived outer presentation on one side of the mask and their inner feelings on the other. On the third therapy session, in which only the couple and the primary counselor were present, the EMDR therapist was introduced as a consultant, who interacted with the couple to provide treatment utilizing the EMDR protocol. The EMDR therapist and the primary counselor had consulted before the session for approximately 1 hour, discussing specifics of the case and deciding if EMDR might be a helpful technique. The primary counselor consulted with the couple, explaining the EMDR protocol and securing the couple's consent to bring the EMDR consultant into the counseling session.

The standard EMDR protocol includes seven phases: (a) client history; (b) preparation, which includes creating a safe place; (c) assessment, which includes identifying negative and developing positive cognitions and establishing a baseline self-estimate of validity of the positive cognition (VoC) on a seven-point Likert scale and a baseline of self-estimate of disturbance as reported by the subjective units of disturbance (SUDs) scale (Wolpe, 1990) where 0 indicates neutral or no disturbance and 10 indicates the most disturbance imaginable; (d) desensitization; (e) installation; (f) body scan; and (g) closure (Shapiro, 1995, p. xiii-xiv).

In the case presented, the offending partner had admitted to a sexual liaison with a third party some 3 years prior to the therapy session. The repetitive intrusive memories and feelings of the offended partner had become an obstacle to reconciliation. She repeatedly stated, "I can't get over it."

After explaining the EMDR protocol and proposing the couples counseling context for treatment, both partners agreed to the treatment. In keeping with Mark Moses' recommendations concerning safety, balance, and containment (2003), the male partner was instructed to be present and to sit close to the female partner, but not to interrupt or touch his partner in any way unless invited to do so by the female partner or by the counselor. After taking the history, preparing the couple, and assessing the positive and negative cognitions, saccades of eye movements were initiated in the desensitization phase of treatment. From an initial validity of cognition of 1 (completely false) for the positive cognition, "I'm really worth it," the treatment resulted in a VoC of 7 (completely true). The subjective units of disturbance (SUDs) level moved from a 10 (as disturbed as could possibly be) to a 0 (neutral or no disturbance). The female partner stated, "It's still there. I can see it (the target image), but it's not important."

The male partner indicated that he felt overwhelmed at how hurt his wife was, and rated the value of the treatment (on a Likert scale of 1 to 7 where 1 is “no value at all” and 7 is “the best experience you could imagine”) at 7. A 30 day follow-up revealed that the couple had ended their separation and felt closer than ever before. The couple was contacted by telephone again at 90 days. They reported sustained relief from trauma-related memories and feelings and a sense of deepened intimacy. The couple declined further counseling, stating that they felt, “We’re doing fine. We’ll call if we ever need help again.”

Discussion

The research on EMDR has often been criticized, and rightly so, for the abundance of anecdotal evidence and the paucity of empirical data. The current study is most certainly a candidate for that type of criticism. Instrumentation is virtually nonexistent in EMDR technology, which relies heavily on self-reported VoC and SUDs measurements. At the same time, it is precisely the self-reported resolution of an issue that is the gold standard in measuring clinical success. One might argue that objective observation of symptom abatement is a better empirical measure. Objective laboratory results as the measure of a cure of a medical condition would serve as an illustration. However, a closer examination might reveal that it is the interpretation of well-being by the patient as evidenced by the laboratory report that makes the patient feel better, as suggested by numerous placebo studies. However, like the current study, EMDR studies often utilize a case study approach that prevents generalizability. To overcome this shortcoming, empirical research needs to be conducted.

Generalizability is one of the many questions that linger in EMDR studies. While shown to be useful in PTSD, what is not known is how often EMDR does not work and what consequences that produces. Does EMDR, if ineffective, create a larger problem? Could it exacerbate depression if it does not work? Although the consensus of EMDR therapists seems to suggest that EMDR is not harmful when it is not effective, what empirical evidence exists that validates this opinion? One of the apparent dangers of case study research is that when a clinical technique does not work, the client simply does not return for further sessions. Lacking thorough follow-up leaves the question of consequence relatively unexamined.

Another issue related to generalizability could be addressed through more empirical studies. Candidates for EMDR are, for the most part, drawn from a criterion specific population, as was the couple for this study.

When deciding to whom the EMDR therapist administers treatment, does the inherent bias of the therapist influence selection? Perhaps the EMDR therapist intuitively selects candidates who are more likely to benefit from EMDR, while consciously citing symptom presentation as the ostensible deciding factor.

There are many unknown and unexplored issues regarding the effectiveness of EMDR technology that will provide researchers a wealth of topics for the foreseeable future. One recurring theme stands out, nonetheless. The apparent promise of EMDR as an efficacious treatment for the relief of human suffering is as exciting as its explanation is mysterious.

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