

Thematic analysis of therapists' experiences integrating EMDR and EFT in couple therapy: Theoretical and clinical complementarity, and benefits to client couples

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Abstract

In this article, we present partial findings from a thematic analysis study that examined integrating emotionally focused therapy (EFT) and eye-movement desensitization and reprocessing (EMDR) as clinical frameworks in couple therapy. The purpose of the study is to better understand how therapists integrate EFT and EMDR therapy in their clinical work. Thirteen licensed therapists ($n = 13$) trained in EFT and EMDR were interviewed about their experiences integrating these two models in their couple therapy practice. The findings included in this article are related to how these models complement each other as well as the clinical benefits associated with their integration. Findings provide preliminary evidence that there are benefits and challenges when integrating both models, although we emphasize complementarity in this article. Limitations and implications for future research on the integration and efficacy of these two models are also discussed.

KEYWORDS

clinical populations, couples, integrative, model, qualitative, research, theory

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1 | INTRODUCTION

Emotionally focused therapy (EFT) and eye-movement desensitization and reprocessing (EMDR) therapy are prominent and widely used psychotherapy modalities. Both EFT and EMDR have proven effective clinical models when implemented separately (Johnson, 2019; Shapiro, 2017). However, some therapists integrate these two models in their clinical work with couples to provide better services to their clients. That said, EFT and EMDR integration is highly complex and understudied. This article presents the partial findings of a thematic analysis on therapists' experiences integrating EFT and EMDR in couple therapy. Given the vastness of our study's findings and the focused nature of journal publications, we present only two of the seven themes in this thematic analysis. Specifically, this article highlights: (a) the theoretical and clinical complementarity of the two models and (b) the perceived clinical benefits of integration. The complete findings, including themes on the risks of integrating EFT and EMDR and factors to consider when integrating these two models, can be found in the dissertation study by the first author (Linder, 2020) and in upcoming journal publications by this team of authors. We start this article by briefly describing EFT and EMDR and reviewing available literature about their integration in therapy. After discussing these findings, we present the limitations of the study and suggest some areas for future research.

1.1 | EFT

EFT is one of the most common and empirically validated couples therapy models globally (Dalglish et al., 2015; Johnson, 2019). The model was developed by Sue Johnson and Leslie Greenberg in the mid-1980s, rooted in the need for a systemic perspective with couples that adequately addressed emotion (Johnson & Greenberg, 1985). Attachment theory is the foundation of EFT as it conceptualizes a couple's conflict as originating from a deep desire and basic survival need for a reliable connection with a significant other (Johnson, 2019). EFT is also influenced by experiential and humanistic theories which emphasize emotional processes (Johnson, 2004). The model advances in three stages (de-escalating negative interaction cycles, changing interactional positions, and consolidating and integrating relational gains; Johnson, 2004). EFT ultimately aims to challenge the negative cycle bringing couples to treatment and helps couples create new interactional cycles that promote healthy expressions of unmet attachment needs (Johnson, 2019).

1.2 | EMDR

EMDR was developed in the late 1980s to treat trauma symptoms such as hypervigilance, intrusive memories, and related disturbances (Shapiro, 2017). In the early 1990s, it grew from a modality of symptom desensitization into an integrative therapy based on the adaptive information processing (AIP) paradigm. This paradigm posits that traumatic symptoms develop when the normal brain information processing mechanisms are compromised during a traumatic event (Shapiro, 2017). Symptom reduction, positive affect, and shifts in core beliefs and related behaviors are, therefore, considered by-products to successful reprocessing of traumatic memories (Shapiro, 2002a). After approximately 33 years of research progress,

EMDR is now used to treat a variety of mental health issues (Shapiro, 2017) as well as the psychological consequences of adverse life experiences (Shapiro, 2012).

1.3 | EMDR and couple therapy

With a few exceptions (Capps, 2006; Linder, 2020; Legg, 2013; Moses, 2007; Shapiro, 2005), there is little research about the use of EMDR in couple therapy. In the early 2000s, Protinsky, Flemke, et al. (2001) developed eye movement relationship enhancement (EMRE). EMRE enabled couples to be more mindful and receptive after each took turns reprocessing traumatic events using EMDR in front of the other (Protinsky, Flemke, et al., 2001; Protinsky, Sparks, et al., 2001). Legg (2013) conducted a grounded-theory study focusing on EMDR in conjoint couple therapy. While EMRE has an EFT couple therapy focus in its integration with EMDR, Legg's study underscored nonmodel specific, therapist-based, and client-based conditions in which conjoint couple EMDR would be most appropriate, such as the level of empathy and vulnerability couple members can have with each other, or the presence of attachment injuries from the past.

1.4 | Integrating EFT and EMDR

Both EMDR and EFT are evidenced-based therapies centered on experiential and emotional processes in present-moment, here-and-now awareness (Johnson, 2019; Shapiro, 2017). They aim to expand emotional intimacy in EFT and desensitize traumatic memories in EMDR. Independently, the models may have limitations when treating trauma in conjoint therapy (Linder et al., 2021; MacIntosh & Johnson, 2008; Moses, 2007). One limitation is that therapists usually treat individual trauma symptoms outside of the couple therapy context, thus missing opportunities to use the couple bond as a resource to heal (Linder et al., 2021; Negash et al., 2018).

To date, only one study has explored the effectiveness of integrating EFT and EMDR. Knox (2016) conducted a comparative (between-groups and quasi-experimental) quantitative study examining the effectiveness of combining EMDR and EFT for military couples. The study found that couples treated with a combination of EFT and EMDR experienced greater marital satisfaction, enhanced attachment, and lower posttraumatic symptoms than those treated using each model separately. With a clinical case, Negash et al. (2018) suggested the benefits of using EMDR for couples struggling in EFT, particularly when attempting to facilitate corrective experiences in Stage 2 of EFT. Despite the similarities of EMDR and EFT, integration of these models has remained underexplored and potentially untapped (Linder, 2020). This study aimed to add to the literature focused on integrating these two models.

2 | METHODS

A thematic analytic approach (Braun & Clarke, 2006) was used in this study to highlight commonalities in qualitative data regarding patterns across participants' responses. The approach was also used to identify, organize, analyze, and report patterns of meaning, or *themes*, in a data set. Data for this study were obtained through semistructured interviews. The descriptive themes that emerged from the data were not intended or used to prove or confirm any preconceived notions about integrating EMDR and EFT.

2.1 | Participants

Participants for this study were 13 EFT and EMDR-trained clinicians, licensed in the United States, and who integrated both models in conjoint couple therapy. For this study, the minimal requirements to be considered trained in EMDR were to have completed an EMDR International Association (EMDRIA)-approved training program (Parts 1 and 2) and received at least five consultation hours with an EMDRIA-approved EMDR consultant. To be considered as EFT trained, participants at a minimum must have attended the 4-day EFT Externship and the 4-day Core Skills training.

Participants were recruited by sharing the details of this study in the list-serves of the International Center for Excellence in EFT (ICEEFT) and the EMDRIA. Snowball sampling was also used for recruitment (Creswell, 2007; Ghaljaie et al., 2017). This involved contacting EMDR and EFT-certified therapists, consultants, supervisors, and trainers for eligible participants. Lastly, authors on conjoint EMDR or integrating EMDR and EFT were contacted. Tables 1 and 2 present the participants' demographic and clinical information.

2.2 | Procedure

After institutional review board (IRB) approval from the authors' university, participant recruitment started. Potential participants were briefed regarding the nature of the study and the potential risks. Then, they were screened telephonically or via email to ensure they meet eligibility criteria. After consenting for participation and before the interview, participants filled out a demographic form. Pseudonyms were used during the interviews to protect participants' identities. Also, participants were reminded to use pseudonyms if they referred to clients. Participants received a \$50 gift card after the interview as a token of appreciation. Compensation for participation came from the first author's scholarship from the California Association of Marriage and Family Therapy.

TABLE 1 Participants' demographic information

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

Abbreviations: LMFT, licensed marriage and family therapist; LMHC, licensed mental health counselor; LPC, licensed professional counselor.

TABLE 2 Participants' clinical information

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

Abbreviations: EFT, emotionally focused therapy; EMDR, eye-movement desensitization and reprocessing.

Data collection and analysis were primarily conducted by the first author. The second author acted as a research auditor. The third and fourth authors were consultants during data collection and analysis. All authors reviewed and audited the final study report. Interviews were conducted via video-conferencing, audio-recorded, and then transcribed. Participants were asked to review the accuracy of their transcriptions via email, in the first round of member checking (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). Transcriptions were then subject to thematic analysis with the aid of the MaxQDA. The software allowed the first author to code text segments, organize codes in hierarchies, and access coded segments across research participants for further analysis.

Data analysis was comprised of four phases. First, the transcriptions were coded by applying brief labels to portions of the text using data segmentation. Data segmentation is a technique for bordering data and exploring semantic elements, similarity, dissimilarity, and relationships (Guest et al., 2011). For example, we grouped together comments of participants with similar traits (e.g., suggesting that integrating EMDR helps EFT work better, especially with severe, escalated cases). To systematically locate meaning, a “keyword in context” or KWIC approach was used to identify words as loci of themes without predefining the text or boundaries of the focus (Guest et al., 2011). For example, if a keyword or expression such as “benefit of integration” or “clinical effectiveness” was found in the transcripts, it was labeled as a locus, and the context in which the word or expression was embedded was further considered and, if appropriate, coded. These codes were then grouped into larger themes and subthemes based on formations of meaning, leading to thematic networks (Attride-Stirling, 2001). A record of preliminary codes, subthemes, and themes was then created (Hsieh & Shannon, 2005; Manning, 1997). This record included succinct descriptions for each theme and subtheme, classifications of the codes, and exemplary quotes from the transcripts. This preliminary list was shared with the second author for auditing (Lincoln & Guba, 1985). Auditing consisted of verifying that the codes were based on what participants said and not on inferences by the first author. The coded segments supported the emergent themes and subthemes.

The second phase included discussing the preliminary codes, themes, and subthemes between the first and second authors to define a final list. Factors such as frequency (how often a code was mentioned and by how many participants), saliency (how important the code was in the description provided by the participant), and relevance (whether the code was pertinent to answer the research question) were considered in the decision. For example, when a code was endorsed by seven participants, but most of the endorsements came from only one or two of them, it was excluded. The second phase was audited by the second author and ended with an updated list of codes, themes, and subthemes with illustrative quotes.

The third step consisted of re-examining the interview transcripts with the updated list. Themes and subthemes mentioned by more than seven participants (more than half of the sample) were considered major themes and used to outline the findings (Hsieh & Shannon, 2005). The themes that were mentioned by less than seven participants were discarded. The fourth phase included asking participants to review the final list of major themes, subthemes, and codes for a second round of *member checking* (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). In addition to member checking and auditing, other methods to ensure trustworthiness included maintaining an audit trail (Shenton, 2004), and written and verbal memos of every step of the process. This included the first author recording his thought process and reactions to put aside any preconceived notions or assumptions that could affect the coding or the building of thematic networks. Also, the second, third, and fourth authors

reviewed the final report to verify that it was written in descriptive language to minimize the risk of biases. For a more detailed description of the study procedures, please see Linder (2020).

3 | RESULTS

To put the following findings in context, it is important to mention that most of the interviewed participants reported integrating EFT and EMDR with only a fraction of their clients, when they felt it was clinically necessary, and when certain conditions of emotional safety were met. Seven themes emerged from the data analysis: (a) complementarity between EFT and EMDR; (b) clinical benefits of integrating these two models; (c) variables to consider when integrating EFT and EMDR; (d) risks of integration; (e) integrating other models; (f) integrating EMDR at any EFT stage; and (g) integration as the exception, not the rule. The present article focuses on the first two themes because they were most frequently mentioned by participants and because of space limitations. For a comprehensive description of the study's seven themes, please see Linder (2020) and future publications by this team of authors. Table 3 lists the themes and subthemes that will be described in this article, with their corresponding frequency. These themes and their subthemes will be presented below with illustrative quotes from participants. Pseudonyms were assigned to participants to protect their identity.

3.1 | EFT and EMDR complement each other well

"The information about what's going on with the brain, and everything with EMDR and then the emotional component of the EFT was this perfect dance." -Peter

Participants reported that both models' theoretical premises and practices fit well together; EMDR addresses the individual factors and EFT the relational realm. According to participants, healing memory networks with EMDR complements moving toward secure attachment in EFT. Below, the four subthemes from this theme are reviewed.

3.2 | Integrating EMDR helps self-regulation in EFT

This subtheme highlights the need for partners to reach for each other with self-regulation and flexibility for EFT to progress adequately and how EMDR can aid partners reach that point. Ali spoke of the futility of attempting to help partners understand each other if they were bogged down by their trauma-based emotional arousal, stating, "why have them together if they are not regulated enough to self-calm and hear their partner in a helpful way?" Participants offered multiple examples of how EMDR would help each client self-regulate sufficiently to succeed in EFT. Max described separating partners from each other for EMDR work so they could come back together with more "emotional stability" and thus progress in EFT. Other therapists, however, preferred to conduct EMDR with one client while the partner observed the process.

In Montana's words, the consensus was that Phase 2 of EMDR (preparation, stabilization, and resource building) helped couples directly engage with each other in a more "heartfelt" way. In Phase 2 of EMDR, the clinician helps the client develop self-regulation and distress tolerance skills as well as learn techniques to access sensations of calm and safety in preparation to target traumatic memories (Shapiro, 2017). Emily referred to EMDR phase-two tools as helping

TABLE 3 Reported frequency of themes and subthemes

Themes and subthemes reported by participants	Frequency	Participants (N = 13)	%
EFT and EMDR complement each other well	87	13	100
EMDR helps self-regulation in EFT	28	10	77
The AIP model in EMDR and attachment theory of EFT are complementary	36	9	69
EFT and EMDR both heal attachment trauma at their core	44	8	62
Both models are similar in practice	23	9	69
Integration benefits couples	77	13	100
Integrating EMDR accesses the root of the EFT negative cycle	79	13	100
Integration helps clients develop insight	57	11	85
Integrating EMDR helps EFT work more efficiently	60	10	77
Benefits from using the EMDR floatback procedure when couples are stuck	36	12	92
Integration shows past affects present	40	10	77
Advantage of knowing both models well	20	10	77
Conjoint EMDR helps develop intimacy	22	9	69
Relational-izing EMDR boosts effectiveness	20	7	54

Abbreviations: EFT, emotionally focused therapy; EMDR, eye-movement desensitization and reprocessing.

partners foster a “working distance” from their reactivity. Mel noted that the self-regulation skills in Phase 2 of EMDR strengthen a couple's ability to be “empathic and present with each other” in EFT. Nancy spoke of Phase 2 work of EMDR helping pursuing partners self-regulate more effectively instead of depending on their partner for self-regulation. These tools and skills helped partners make more intentional choices instead of resorting to the automatic trauma-based responsiveness fueling their negative cycle. Overall, participants believed integrating these two models promoted the self-regulation needed to create new bonding patterns in their clients' relationships and get to the heart of their negative cycle in EFT.

3.2.1 | AIP model in EMDR and attachment theory of EFT are complementary

This subtheme refers to the theoretical complementarity of both therapeutic models. Participants reported noting similarities between the AIP model and the attachment frame of EFT in how they conceptualize the origins of dysfunction and how to help clients move toward healthier intra- and interpersonal functioning. Participants noted that theoretically, both models are strength-based, experiential, and nonpathologizing, leading to similar treatment goals. Kelly commented,

Connected-wise, AIP says that the body wants to heal, the mind wants to heal, and all it needs is a little bit of help to get there because it already knows everything it needs. We just have to be able to access it. If you think about development and attachment, everything that happens, the seeds for all of our negative beliefs and maladaptation occur during development, during the first six years. So, your attachment is very integral in your ability to develop appropriately, and for you to be able to adaptively perceive information in your environment. So, I think they're the same.

Participants often spoke of EFT and EMDR as if they were focusing on similar issues; the traumatic events a therapist would target in EMDR using the AIP model are similar to the attachment events in the past that get activated during a couple's negative cycle in EFT.

3.2.2 | EFT and EMDR both heal attachment trauma at their core

Participants referred to the common goal in both models of healing attachment injuries. Attachment injuries occur when an attachment figure does not respond in a time of serious need (Wallin, 2007). As Montana noted, "many of the traumas [addressed with EMDR] happened within the family and so trauma, I mean, the definition of trauma is an attachment injury." Peter likewise said, "I look at it as more that they blend really well together, because a lot of times what we're looking at with the AIP model when we're going back to the touchstone, or the first memory, a lot of it is their attachment style." Lisa agreed, stating, "the attachment piece is so tied into the AIP model in the sense of it really being about the internal working models of self and other, and where those early templates, messages, beliefs about self, really first got formed, and then how do they show up now." This subtheme mirrors the previous one in that a key focus in both therapies is healing and transforming the attachment traumas/wounds responsible for the present dysfunction, which is often the relationship issue that brought the couple to therapy.

3.2.3 | Both models are similar in practice

In addition to noticing theoretical similarities, participants reported how EMDR and EFT are alike in their execution, which is connected to their theoretical overlap. Max noted,

What I like around the integration with EFT is that it's an experiential therapy. I mean, there's cognitive components in it. There's behavioral pieces. But, mostly, it's an experience. I work a lot in using active techniques, but that's been the pull from EFT because, when it's effective, people have a visceral experience, where they have that emotional attunement with one another and so forth. Also, when EMDR is effective, it's also an experience. The common ground area is that EMDR can enhance the attachment, enhance the connection in the relationship, which is what EFT is all about, through this deep emotional experience that both of them are experiencing, somewhat in a different way.

Participants stated seeing similarities between models in their agendas, tasks, procedures, and goals. Moreover, the present trauma triggers (when a present situation prompts feelings

from a traumatic event, like hearing a phrase or tone the perpetrator had used) a clinician addresses with an individual in EMDR often show up the negative cycle between partners in EFT in the context of couple therapy.

3.3 | Integration benefits couples

All participants shared examples of how integrating EFT and EMDR benefited their clients in couple therapy. Although participants reported benefits, it is important to remind the reader that participants also reported integrating EFT and EMDR cautiously, assessing couples' emotional safety, and discussing the possibility of integration with the couples before proceeding. For more detailed information on the factors participants considered before integrating, please consult Linder (2020).

3.3.1 | Integrating EMDR accesses the root of the negative EFT cycle

This subtheme refers to therapists identifying the “root” of a couple's negative cycle in unresolved attachment events, generally occurring before the couple met. In Tyra's words, “people come in saying they have one problem and then you find out that there's this vast array of history and connected dots that, often, lead to trauma. They don't even realize it's trauma.” The overarching idea was that unprocessed experiences from clients' families of origin (memories still stored in their state-dependent, traumatic form with accompanying maladaptive beliefs, emotions, images, and body sensations from the original event [Shapiro, 2017]), especially those in which clients felt like they did not matter or were not good enough, were instrumental in fueling the current disturbance or negative cycle with their partners. Integrating EMDR, or “going to the root,” according to Emily, was indicated when a client's emotional reactivity arising in the couple's negative cycle felt “out of portion to the current dynamic or their partner's current behavior.”

3.3.2 | Integration helps clients develop insight into their own and their partner's behavior

There appeared to be a consensus among participants that integrating EMDR and EFT helps clients understand, on a deeper level, what is driving their problematic reactivity on both sides. According to participants, developing this awareness helped clients make progress in EFT because partners could de-personalize the source of their discord, from personal inadequacies in the present to unresolved attachment traumas in the past. As Lisa stated,

I think, oftentimes, there's this incredible understanding and clarity that happens for the individual who's working in EMDR and also for their partner. It's like, “Oh, now I get it. Now I get what happens between us. Now I get why you react to me the way that you do. You see me as that person.” And then this clarity around, “Now I understand myself and why it's so scary when my partner does this thing.” So there's a sort of click that happens for couples when you bring in EMDR.

This de-personalization (sourcing the couple's issue as located outside each other) is also part of EFT. EFT externalizes the couples' issues into their negative cycle (Johnson, 2004). With the integration of EMDR, past attachment trauma before partners met emerged as a source of the couple's distress and negative interactions. Participants reported these insights to be empowering for clients because when they realize that, essentially, their child-self takes over during the negative cycle, they can be more empowered to respond in the future from a mature and adaptive place, and not their wounded past-self.

3.3.3 | Integrating EMDR helps EFT work more efficiently

According to participants, integrating EMDR essentially makes EFT work faster. Ali and Rachael referred to this as “EFT on steroids.” Participants offered clinical examples and plausible explanations for this. Some participants mentioned that the integration helps resolve issues based on the couple's past, which other EFT clinicians focusing solely on the present may overlook. Several participants described this as EMDR filling in the “trauma gap” in EFT. Montana mentioned that integrating EMDR helped partners out of their “trauma vortex” significantly more than EFT alone. Peter mentioned clients having fast revelations in session, accelerating the progress of therapy when he integrates EMDR and EFT. He also spoke of EMDR tools as readily useful and available in de-escalating a negative cycle in EFT, and literally “stop it in its tracks.” Bella shared that EMDR tools helped the withdrawing and the pursuing partner become less rigid in their positions in the negative cycle. In addition to their observations, participants shared that their clients have also seen these benefits. Montana stated, “Per report from two of the clients with whom I've been the couple therapist, and I've done individual EMDR work, they reported to me that they're not getting stuck, triggered, or drawn in the same aspects of their cycle in which they were before the EMDR.”

3.3.4 | Benefits from using the EMDR floatback procedure when couples are stuck

Participants spoke of utilizing the EMDR floatback procedure (Shapiro, 2017), which is essentially exploring the “touchstone” memory (the first time a traumatic event occurred) at the moment partners are the most escalated in their negative cycle. The procedure entails pausing partners during their reactivity and inquiring about the first time they remember feeling the way they do in the present. Participants reported that clients benefited from the EMDR floatback procedure to decrease and de-personalize their reactivity in their negative cycle. Bella captured this subtheme in detail,

When she would feel that rage in session, I did a floatback with her and she came up with this memory of her dad abusing her when she was a child. We targeted that memory [with EMDR] and it helped turn the emotional volume down in the room from an eight to a two. When they're the most activated, I ask them to access the reactive part of themselves, like in a physiological sense. I then do a floatback in that moment, like what comes to mind as you access this part of yourself, and if it's just with their partner, then it's just their partner. If it's a specific time with their partner, then I'm making note, like is this a memory? Then we can get to,

usually, an earlier touchstone memory behind their reaction. It's in the moments where they're the most escalated that I access that.

3.3.5 | Integration shows how the past affects the present EFT cycle

In their responses, participants implied both models work well together because EFT may be too focused on present dynamics when the past is relevant, and EMDR may be too focused on the past and self-soothing, missing the role of a client's present dynamic with their partner. They suggested that partners often revert to functioning as their previous selves during the negative cycle, when an attachment-based traumatic event originally occurred, instead of the mature adults they are in the present. As Ali and Max mentioned, a marker to integrate EMDR to address how the past keeps them stuck in their negative cycle is when the couple's block appears repeatedly across multiple sessions, and EFT interventions alone have been insufficient to address it. Participants are consequently integrating EFT and EMDR when it is apparent that unresolved past issues play out in the couple's current distress.

3.3.6 | Advantage of knowing both models well

Participants spoke of feeling they had a clinical advantage from knowing both models well compared with clinicians who practice each model in isolation. For example, Kevin noted having two "power drills" that work well in tandem, in a way that is greater than the sum of using each separately. He also mentioned conceptualizing cases and informing his clinical choices from a "hybrid" knowledge. Kelly correspondingly noted, "with both, I can help them [clients] see the other part of the couple as whatever wounded part is showing up in the moment." Ali also noted that knowing both models well helps her "see the bigger picture."

3.3.7 | Conjoint EMDR helps couples develop intimacy

Participants reported that conjoint EMDR (when one partner is observing while the other is undergoing EMDR) in the context of EFT helps build emotional closeness between partners and provides them an opportunity to empathize and connect with each other's pain. Ali provided an example of how a previous session of conjoint EMDR was used to facilitate a bonding moment in an EFT enactment,

We did an enactment after working on a memory [using EMDR] where he didn't have a safe childhood and only knew how to fight and hide. Those were his adaptations in the relationship, and as he walked through not feeling safe, and how vulnerable it was for him to stay in the room and share it with his wife. He was visibly shaken, and his wife reached over and grabbed his hand so this is something, like when the wife is looking at me with tears in her eyes, is like 'this is what I want, thank you.'

As reported by participants, conjoint EMDR could catalyze intimate bonding moments in EFT. Peter spoke of the advantage of the partner's presence during EMDR, "having an attachment figure present in EMDR can help their bond," because as Mel put it, "one of the most harmful parts of the trauma is that the person was alone, so conjoint EMDR reminds them they're not alone anymore." Kelly also spoke of how useful a client's partner can be during EMDR reprocessing to produce moments of connection. For example, if a client's negative belief in EMDR is "I'm not lovable," their partner showing love and acceptance toward them during the EMDR session can create bonding and healing moments that the individual EMDR would not. Kelly shared that after using conjoint EMDR, one couple decided to keep photos of each other when they were children and were traumatized to remind themselves to be sensitive to each other's wounds, providing evidence of this newfound intimacy.

3.3.8 | "Relational-izing EMDR" can improve its effectiveness

Participants stated that integrating clients' partners into EMDR can make it more effective. Bella stated that a shortcoming of EMDR is focusing on grieving bonds, whereas EFT helps repair them. Mel spoke of bringing in a client's partner to deepen the EMDR work, even if the person did not originally come in with their partner. He stated,

I apply EFT to EMDR sessions, even if I'm not necessarily treating the couple, in terms of just using the attachment lens, and helping the individuals recognize their triggers. And, rather than the empathic attunement, the compassion, and the therapist working individually with that partner, why not have that be experienced also by their life partner who could be sensitized to it? That's where I saw it being a unique way of working.

4 | DISCUSSION

In this thematic analysis of interviews with 13 licensed therapists trained in EFT and EMDR who integrate these models in their clinical work with couples, participants found the models to be theoretically and practically complementary and reported that their integration benefited their client couples. Similarities between EFT and EMDR can also be found elsewhere in the literature. Developers of these models describe them as integrative, de-pathologizing, evidence-based, brief therapies that rely on built-in healing processes that humans share (Johnson, 2004; Shapiro, 2017). In addition, both models have been used to heal the aftermath of traumatic events (Greenman & Johnson, 2013; Johnson, 2002, 2004, 2019; MacIntosh & Johnson, 2008; Shapiro, 2017).

Even though EFT has been implemented to treat trauma in couple therapy, 10 participants found it insufficient when treating some of their clients. According to participants, the emphasis on present processes in EFT may overlook the influence of past traumatic events on current couple dynamics, which EMDR addresses more directly. Participants implied EFT and EMDR could work best in tandem, with EMDR addressing individual traumas and EFT enhancing the couple relationship. According to participants, healing memory networks with

EMDR complements moving toward a secure bond in EFT; both of which are adaptive processes associated with emotional and relational health (Moses, 2007).

Participants in the present study alluded to the theoretical complementarity between AIP and attachment theory but did not elaborate. They spoke of EFT and EMDR as if they were focusing on the same processes: the traumatic events a therapist targets in EMDR using the AIP model align with the attachment events in the past that get activated during a couple's negative cycle in EFT. Although participants did not fully explain the theoretical overlap between these models, it is possible to extrapolate the conceptual complementarity based on the literature.

According to attachment theory, humans are emotionally, socially, and physiologically wired to create close connections with special others (attachment figures) who are expected to be trustworthy and offer support and protection in times of need (Bowlby, 1988; Johnson, 2019; Wallin, 2007). The benefits of a secure attachment have been identified in many areas, including brain development and functioning. For example, a context of safety and calm mediated by the presence of a secure attachment can regulate the limbic system's fear response, which helps the outer layers of the neocortex work properly to facilitate optimal learning, executive functioning, and adaptive responding (Perry, 2009). Thus, following the AIP model of EMDR (Shapiro, 2017), it can be expected that in a brain that is functioning in a regulated and integrated way because of the safety that comes from a secure attachment, the AIP system would work well in its task of memory integration. It seems then that the markers of healthy intra- and interpersonal functioning that attachment theory and the AIP model propose (a secure attachment and a well-functioning AIP system, respectively) are theoretically complementary constructs with promising clinical applications. Conversely and referring to the origins of dysfunction, from the perspective of the AIP model (Shapiro, 2017), it can be inferred that a couple's over or under-regulation, such as screaming or stonewalling, may have originated in unprocessed memories of attachment trauma. When inadequately processed and stored, salient attachment events can become activated in the dyadic context, causing distortions and blocks (Moses, 2007), which manifest in the negative cycles that are targeted in EFT. The premise that contact with a loving partner can function as a safeguard against the stress and pain from upsetting traumatic memories (Capps et al., 2005; Capps, 2006; Coan et al., 2006; Johnson, 2002, 2004, 2019; Moses, 2007) aligns with the results of this study. Whereas trauma physiologically dysregulates, secure bonds physiologically regulate (Coan et al., 2006). Likewise, whereas trauma induces helplessness and fear, secure attachment offers a sense of safety and protection (Johnson, 2002). With clinical examples, participants illustrated how, because EFT facilitates (in the present) the corrective emotional experiences that were likely lacking during the traumatic events reprocessed in EMDR, clients' partners' supportive responsiveness was helpful in solidifying their gains in therapy. Similar observations have been reported by Moses (2007) and Negash et al. (2018) in their descriptions of EMDR in couple therapy. Social support and close relationships continue to appear in the literature as the most relevant factors in the experience of and the recovery from trauma (Herman, 2015; Johnson, 2002, 2019; Legg, 2013; Kardiner & Spiegel, 1947). Traumatic events also tend to be experienced with a sense of intense loneliness, which secure attachment can powerfully mollify when activated and cultivated (Coan et al., 2006; Johnson, 2002). The results of this study are consistent with these ideas. In the participants' experiences of integrating EMDR and EFT, a common goal of both models seemed to be the healing of attachment injuries and other types of relational traumas. An unresolved past attachment injury can activate couples when their current partner's behavior resembles an aspect of it (Wallin, 2007). This can create barriers in the relationship (Johnson, 2004). The findings of this study indicate that integrating EMDR

could be way to address these barriers (Moses, 2003, 2007). EMDR has shown to be effective with different presenting problems, including attachment trauma (Shapiro, 2017; Wesselmann et al., 2012). In addition, healing attachment trauma with EMDR manifests in improved relationships for clients. Wesselmann and Potter (2009) discovered positive changes in clients' relationships after individual EMDR treatment.

Findings from the study also suggest the relational benefits of EMDR could be potentiated when this model is used in tandem with EFT. This finding is echoed in literature on the use of EMDR in conjoint sessions and the integration of EFT and EMDR. For example, Moses (2003, 2007) shared that a unique benefit of conjoint EMDR is the presence of an observing partner that can be a container for the processing partner, offering support. This could reduce the amount of individual resource building needed in Phase 2 since the partner's presence can provide emotional safety (Moses, 2007). Likewise, Knox (2016) found that the combined EFT-EMDR approach raised attachment security in military couples compared with the three other groups in his study (EFT only, EMDR only, and control). That said, sample size and attrition may have accounted for this being a statistically nonsignificant finding.

Participants reported that integrating EMDR into EFT helped clients self-regulate more effectively. One of the key symptoms of trauma is difficulty modulating one's affect (Johnson, 2002; Johnson et al., 2005; Van der Kolk, 2015) as reminders of the traumatic event can elicit intense fear, anger, or helplessness. This is one reason Phase 2 of EMDR exists early in treatment (Shapiro, 2017). As reported by participants, preparation, stabilization, and resource-building (Phase 2) strategies in EMDR were useful for de-escalation (Stage 1) in EFT; the more self-regulated each partner was, the less emotionally flooded they were and thus better able to express their attachment needs clearly. Similarly, using EMDR in conjoint sessions, Moses (2007) found that a central objective of conjoint EMDR was to decrease the reactivity of attachment triggers, which fostered self-regulation. In addition, in Legg's (2013) study on the experiences of therapists and clients using EMDR in conjoint couple therapy, the couples that could effectively manage their reactivity and were committed to being part of the solution instead of trying to change their partner attained better results in conjoint EMDR.

Desensitization and reprocessing (Shapiro, 2017) were also reported by participants to help with self-regulation, de-escalation, and enhancing bonds. In their clinical practice, participants' found that the "root" of a couple's negative cycle was often unresolved attachment or relational trauma that generally occurred before the couple met. When these traumas were addressed with the use of EMDR, other tasks of EFT that require attunement to the partner, low defensiveness, and vulnerability were accomplished more fluidly. Protinsky, Flemke, et al. (2001) and Protinsky, Sparks, et al. (2001) also found that integrating EMDR and EFT helped couples access the primary emotions when they were stuck in the reactivity of the secondary emotions in their negative cycle, which resulted in improved accessibility and vulnerability. Their integrated EFT-EMDR approach, EMRE, enabled couples to be more mindful and receptive with each other after each partner took turns processing traumatic material in front of the other (Protinsky, Flemke, et al., 2001; Protinsky, Sparks, et al., 2001).

Consistent with EMRE (Protinsky, Flemke, et al., 2001), participants in this study reported that conjoint EMDR (when one partner observes while the other is doing EMDR with the therapist) helped build emotional closeness between partners. The closeness, in turn, led to further compassion, empathy, awareness, and understanding. Other authors have reported similar findings. Snyder (1996) wrote the first published account of conjoint couple EMDR and found that it helped foster intimacy for both partners in a lesbian couple with a history of sexual abuse and addiction. To enhance the bonding potential in conjoint EMDR, the

witnessing partner may be encouraged to comfort the processing partner if this does not occur naturally (Moses, 2007; Negash et al., 2018; Protinsky, Sparks, et al., 2001). EFT therapists can use this experience of trauma reprocessing through EMDR as an opportunity to create enactments where, for example, an observing partner can offer a corrective emotional experience of support and acceptance to a partner who has reprocessed a traumatic event of their childhood.

Legg (2013) highlighted that conjoint EMDR is more likely to be therapeutic when the witnessing partner can be silently supportive without judging, interrupting, or questioning their partner's EMDR process. EMDR in the conjoint couple context may be more clinically effective in certain cases than separating participants for EMDR or referring each to their individual EMDR therapist. Related research and published case examples (Capps et al., 2005; Capps, 2006; Flemke & Protinsky, 2003; Knox, 2016; Legg, 2013; Moses, 2003, 2007; Protinsky, Flemke, et al., 2001; Reicherzer, 2011; Snyder, 1996) have consistently suggested that conjoint EMDR can expand intimacy between partners, which is consistent with findings in the present study.

Being able to directly address the traumas at the center of their clients' negative cycles seemed to be one of the most important clinical benefits that participants found when integrating EFT and EMDR. Participants reported that unprocessed past experiences from clients' families of origin fueled the couple's negative cycles. In EMDR, these are called "feeder memories" (Shapiro, 2017). So, when participants explored earlier client experiences of abandonment, neglect, unresponsiveness, and "not feeling good enough" using EMDR tools, they reported getting at the "root" of the distress in the couple's negative cycle. Participants reported using the floatback procedure (Shapiro, 2017) precisely for this purpose. For example, they would use this intervention in the precise moment when partners were intensely engaged in the negative cycle and were not responsive to standard EFT interventions. The floatback intervention allowed to identify the specific traumatic memory fueling the negative cycle, which could then be reprocessed using EMDR. As reported by participants, when clients saw the connection between present emotions and behaviors and past relational traumas (addressed with EMDR), they reached a different and more empathic understanding of their own and their partner's contributions to the current couple dynamic. Developing this awareness helped client couples make progress in EFT. Other authors have reported similar experiences when using EMDR conjointly or integrated with EFT. For example, Capps (2006) and Legg (2011) noted partners increased their commitment to change their behavior, strengthen their attachment, and refrain from triggering their partner after learning more of their partner's intrapsychic wounding during conjoint EMDR.

Furthermore, Legg (2013) found that one of the changes in perspective that come from having a better understanding of one's partner's relational trauma through conjoint EMDR is de-personalizing the partner's responses. Legg (2013) exemplified this by sharing how an observing partner realized "it's not about me" after watching their significant other's EMDR process (Legg, 2013, p. 265). Participants in this study also reported this type of "insight." Although this finding speaks to the importance of insight and awareness for both models, it is important to remember that, albeit useful, awareness alone is insufficient. According to these two models, true transformation needs the experiential sense of connection (EFT) (Johnson, 2019), and the desensitization and integration of adaptive memory networks (EMDR) (Shapiro, 2017).

It seemed that this change of perspective about the extent of the influence of past traumas in present interactions was also something that participants themselves realized. Participants

reported seeing how clients' history (especially salient attachment-related traumas) could affect present couple dynamics. Other clinicians who have integrated EFT and EMDR share this perspective. A central assumption in EMRE (Protinsky, Flemke, et al., 2001) is that couples come to therapy in high distress because of disowned primary emotions, often stemming from previous painful relational experiences that underlie their secondary emotional responses to each other. These disowned emotions can distance partners from each other and reinforce their negative cycle (Johnson, 2004, 2008, 2019). That is why in EMRE, Protinsky, Flemke, et al. (2001) recommended targeting each partner's secondary emotions in conjoint EMDR because it allows them each to access the primary emotion from earlier trauma to heal and reprocess it in the dyadic context. As reported by participants, a cue to integrate EMDR and EFT was when it was apparent that unresolved past attachment-based issues were repeating themselves in the couple's current distress. The consensus among participants was that integrating EMDR essentially makes EFT work faster because it helps directly resolve the traumas that fuel the defensiveness, fear, and secondary emotions that get in the way of partners reaching to each other for comfort and connection. The efficiency of EMDR, related to significant clinical improvement in a low number of sessions, has been well supported by the literature. At least five meta-analyses of peer-reviewed publications on psychological and pharmacological interventions for PTSD have found EMDR to be at least as effective, but also more efficient than other PTSD treatments (Carlson et al., 1998; Shapiro, 2002b, 2017; Van der Kolk, McFarlane, et al., 2007; Van der Kolk, 2015). The participants in this study seem to be capitalizing on EMDR's efficiency and therapeutic potential to reprocess trauma to overcome barriers and facilitate essential bonding moments in EFT.

As reported by participants, one of the reasons that prompted integrating EFT and EMDR in their clinical practice was finding that, for certain clients, EFT alone was insufficient to heal the trauma that was maintaining their clients' cycles of disconnection. To address this gap, participants spoke of incorporating their EMDR trauma training in the context of EFT. Three participants reported that finding themselves stuck with some couples in EFT was what attracted them to learn EMDR.

Conversely, participants also found that implementing EMDR (a therapy initially developed to be delivered individually) in a relational context enhanced its clinical potential. Humans are innately interdependent beings, bonding mammals that count on each other for survival and fulfillment (Johnson, 2019). Because humans primarily derive a sense of safety, protection, and calm from attachment figures (Johnson, 2004, 2019), the individual nature of EMDR may be unnecessarily confining. Relational forms of EMDR, such as conjoint EMDR, could open opportunities for dyadic comforting and bonding, unlike individually administered EMDR. As Moses (2007), Negash et al. (2018), Protinsky, Flemke, et al. (2001), Protinsky, Sparks, et al. (2001) illustrated, conjoint EMDR can clinically benefit both partners, the reprocessing and witnessing partner, especially when these roles are interchangeable during therapy. In addition, because there is an inherent risk to talking about traumatic events with a therapist (Marich, 2011), EMDR therapists may increase the client's emotional safety by inviting an attachment figure to the sessions. So, if relational therapies like EFT can work well with EMDR, this could open the door for more nurturing and less isolating ways to process trauma for couples.

Knowing two therapeutic models well that fill each other's gaps and potentiate each other's gains left participants feeling they had a clinical advantage over other therapists that might know about trauma therapy or couple therapy, but not both. This clinical advantage, as described by participants, was experienced as a "big change" in their clinical effectiveness.

4.1 | Limitations and recommendations for future research

The focus of this article was on two of the seven themes of a thematic analysis on the experience of clinicians who integrate EFT and EMDR in couples therapy (Linder, 2020). Other themes referred to the potential risks of integration and factors that participants considered when deciding to adopt the integrated approach. A thorough description of these factors can be found in Linder (2020). Self-selection bias might have affected the findings of the study (Robinson, 2014). Those who seemed to have positive experiences with this integration might have been more available to participate in this study.

Although this study drew some important findings about combining EFT and EMDR in couples therapy, one limitation is that this study focused on therapists' experiences. A more definitive assessment of the clinical potential of EFT-EMDR integration would need to include clients' perceptions and experiences and other markers of positive clinical outcomes. In addition, a look at the clients' processes and outcomes could shade light to other dynamics, such as how members of the couple use self-soothing and coregulation when coping with the consequences of trauma, and whether the ending of the couple relationships could reactivate processed traumatic injuries. These are areas for further research.

Another limitation of the study is that the racial makeup of participants was mostly homogenous. Eleven of the 13 participants identified as White. The racial makeup of the sample might speak to the economic and logistical nuances associated with becoming EFT and EMDR trained and certified. These processes are often expensive and lengthy, and therefore, not accessible to therapists who come from different socioeconomic backgrounds. Enhancing accessibility to training for more diverse populations would allow to eventually find a more racially diverse group of therapists who are integrating these models.

The study also did not focus on participants' or clients' contextual realities such as social location, nationality, language, ethnicity, ability, gender, sexual orientation, among others such as Linder, Walsdorf, and Carlson (2020). During the interviews, topics such as how the clients' social locations were related to their experiences of trauma or their couple dynamics were unfortunately not addressed. More specifically, therapists should understand and respond to the sociocultural influences that act as barriers and pathways to integrating EFT and EMDR.

4.2 | Conclusion

Although scarce and generally based on clinical cases, literature on conjoint EMDR and the integration of EFT and EMDR is optimistic about integration. The findings of the study also indicate that this integration could be promising. Many couples arrive to therapy with trauma experiences that are barriers to intimacy and connection. The integration of EMDR and EFT could potentially offer clinicians an opportunity to draw from two empirically supported models to provide couples with well-rounded experiential and trauma-sensitive care.

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