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# Emotionally Focused Therapy and Eye Movement Desensitization and Reprocessing: An Integrated Treatment to Heal the Trauma of Infidelity

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Despite the prevalence of infidelity and the serious harm it causes relationships, scarce clinical literature exists about how to use trauma-informed approaches to help couples in conjoint therapy. Emotionally focused therapy (EFT) and eye movement desensitization and reprocessing (EMDR) have been empirically proven in their own right to be effective in the treatment of trauma and couples, respectively, and were utilized conjointly in this article as a means to heal trauma related to infidelity in couple therapy. The combined EFT-EMDR approach consists of using EMDR as an intervention within specific stages of EFT. A case example is presented to illustrate use of the integrated approach. Suggestions from this article may help couple therapists understand the role that trauma plays in maintaining the attachment injury of infidelity and to adequately attend to the traumatic impact of infidelity on both partners.

*Keywords:* EMDR, EFT, infidelity, trauma, couples



Monogamy is normative in the United States, yet discussions about infidelity are pervasive among Americans. Conservative estimates suggest that between 15% and 20% of individuals in the United States have engaged in sexual infidelity (Negash, Cui, Fincham, & Pasley, 2014). What constitutes infidelity can be a subjective experience, but in general, the common thread in all types of infidelity (i.e., sexual, emotional, cybersex) is that it is a violation of the commitment to an exclusive relationship (Glass, 2002).

Infidelity is associated with numerous harmful outcomes, including, but not limited to, a reduction in trust, an increase in conflict, a diminished sense of unity and shared identity, and relationship instability (Negash et al., 2014). Research suggests that nonstraying partners may experience depression, anger, feelings of abandonment, a sense of rejection, reduced self-esteem, and symptoms of posttraumatic stress (Cano & O'Leary, 2000; Glass, 2002; Johnson, 2002). Straying partners also can experience related emotions, such as guilt, anger, embarrassment, and depression (Johnson, 2002, 2008). Similarly, couples that present infidelity as the presenting problem report higher distress than couples facing other presenting problems (Atkins, Eldridge, Baucom, & Christensen, 2005).

Given the widespread prevalence of infidelity and the harm it brings to relationships, it is no surprise that it is a common presenting problem for couples entering conjoint treatment (Weeks, Gambescia, & Jenkins, 2003). Unfortunately, infidelity is also among the most difficult prob-

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lems to treat in conjoint therapy (Blow & Hartnett, 2005; Howell, Gilbert, & Gordon, 2016; Scuka, 2015), with "severely limited" treatment options (Blow & Hartnett, 2005, p. 193). One reason for this may be that therapists who treat couples dealing with infidelity may not adequately attend to the traumatic impact of the infidelity on both partners, as documented by a growing body of literature (e.g., Sauerheber, Graham, Britzman, & Jenkins, 2016). Further, despite knowledge regarding the link between infidelity and trauma, there is scarce clinical literature about how to use trauma-informed approaches to help treat couples who present with infidelity in therapy. The current article attempts to address this deficit by outlining a proposal for augmenting emotionally focused therapy (EFT) with the use of eye movement desensitization and reprocessing (EMDR) to improve the treatment of couples working through infidelity. Although research has examined the integration of EFT with trauma-informed care, studies on EFT and trauma have typically focused on traumatic events that occurred prior to the romantic relationship (e.g., Blow, Curtis, Wittenborn, & Gorman, 2015; Dalton, Greenman, Classen, & Johnson, 2013; Greenman & Johnson, 2012; MacIntosh & Johnson, 2008). Conversely, this article focuses on trauma that occurred in the context of the couple relationship. Recommendations from this article may help couple therapists to understand the role that trauma plays in maintaining the wound of infidelity and to integrate trauma-informed practices when working specifically with couples dealing with infidelity.

## Infidelity and Trauma

### Trauma

Trauma, which activates the autonomic nervous system, occurs when unpredictable and uncontrollable events violate core tacit beliefs and assumptions that otherwise promote safety, stability, well-being, purposefulness, and cause persistent disabling distress, dysfunction, and vulnerability (e.g., Litz, 2004). In general, the trauma literature identifies generalized reactions to traumatic stress that involve physiological and psychological reactions to threats on one's psychological integrity (such as dehumanization, humiliation, and degradation), negative feelings (such as horror, fear, or anger), and feelings of vulnerability, powerlessness, confusion, depression, despair, and withdrawal (American Psychiatric Association, 2013; Shalev, 2002). These symptoms may include recurrent intrusion symptoms (e.g., flashbacks, nightmares, intrusive memories); heightened arousal affecting reactivity, sleep, and concentration; changes in cognition and mood; and prominent patterns of avoidance designed to prevent reexposure to stimuli associated with the original trauma (American Psychiatric Association, 2013; Shalev, 2002).

The literature often demarcates two central trauma categories: large-T and small-t events (F. Shapiro & Forest, 2016). Large-T traumas are indisputably life-threatening, distressing, and often warrant a posttraumatic stress disorder (PTSD) diagnosis. Examples are war combat, physical abuse, automobile accidents, loss of a loved one, terminal illness, or natural disasters, which can result in PTSD for many. By contrast, small-t traumas are not directly life-threatening, less conspicuous, commonplace events in which people are left feeling unloved, unsafe, or helpless. Small-t traumas comprise failures, humiliations, or losses of many types. Examples of a small-t trauma are being a victim of bullying, a job loss, and separating from a partner. Both small-t and large-T traumas can deluge the brain's processing system (F. Shapiro & Forest, 2016; Solomon, Solomon, & Heide, 2009) and cause information to be stored dysfunctionally (i.e., disconnected from adaptive information processing; Adúriz, Bluthgen, & Knopfler, 2009; Oren & Solomon, 2012; Schubert & Lee, 2009; F. Shapiro, 2007; F. Shapiro & Forest, 2016; R. Shapiro, 2005; Solomon et al., 2009). With one exception (i.e., the event is not life threatening), small-t trauma symptoms meet the criteria for a PTSD diagnosis. Therefore, small-t traumas are often coded as Other Specified Trauma- and Stressor-Related Disorder (*DSM-5* code 309.89, American Psychiatric Association, 2013).

### Physiological Associations Between Trauma and Infidelity

Recent research suggests that physiological trauma symptoms may also result from infidelity (Heintzelman, Murdock, Krycak, & Seay, 2014; Johnson, 2002; Sauerheber et al., 2016),

suggesting that infidelity can also be experienced as traumatic. Symptoms associated with PTSD (i.e., limbic sensitivity, emotional numbness [avoidance], hypervigilance) may lead to conflict dynamics, emotional distance, suspicion, and guilt (Heintzelman et al., 2014; Sauerheber et al., 2016). Given this traumatic element, subtle echoes of infidelity tend to evoke sharp fight, flight, and freeze responses as well as nightmares (Johnson, 2002), further contributing to relationship distress. Exaggerated sensitivities and hypervigilance for future signs of the betrayal are also common. Consistent with these symptoms, Johnson (2005) described a case wherein her client experienced "excessive rumination, hypervigilance, reliving or flashbacks of key scenes, alternating and numbing, and avoidance paralleled, in a less intense-form, the classic symptoms of post-traumatic stress disorder" (p. 24). The onset of psychological and physiological trauma symptoms triggered by infidelity highlights why it is important to evaluate the use of trauma approaches to treat infidelity in couple therapy.

## Psychological Associations Between Trauma and Infidelity

Upon learning about infidelity in one's relationship, the core, tacit assumptions one holds about themselves and their relationship quickly transform. Feelings of disillusionment (Negash et al., 2014), worthlessness, betrayal, loss, fear, and anger (Boekhout, Hendrick, & Hendrick, 2000) may trigger thoughts such as "Who is this person I've been with for so long?"; "Have they ever actually loved me?"; "How did I not see this coming?"; "Were they ever actually honest with me?"; "Was what we had a farce all along?"; and "Who am I to this person?" (adapted from Johnson, 2002). From this vantage point, infidelity often becomes a cycle of ruminative thought punctuated with moments of fear, doubt, and suspicion that become stuck in the nervous system and are subsequently replayed repetitively with overwhelming emotion.

Individuals who experience the aforementioned loss of illusions may suffer from a loss of intimacy, trust, and hope within their relationship. This significant and often unexpected loss is what constitutes trauma for these individuals (Johnson, 2005). As mentioned, trauma occurs when a person's assumptions about the world and others are unexpectedly altered, prompting them to doubt their concept of reality (Howell et al., 2016). In effect, it abruptly becomes significantly challenging for said person to trust their partner again. They may doubt if they ever actually knew their partner (Scuka, 2015). This pervasive sense of mistrust seeps into the way they understand their past as well as how they perceive and manage their expectations in the present and future. Suddenly their life becomes terrifying and uncertain. This is often followed by a deep sense that one's emotional well-being, security, safety, and overall sense of self are under siege.

The partner who committed the infidelity may also experience a profound sense of loss and confusion that may result in trauma as well (Johnson, 2002, 2008; Sims, 2015; Spring, 2013). They may begin to doubt their own judgment, feel like a failure of intimacy, or believe that they are flawed. Moreover, the straying partner may be grossly unprepared to manage the devastation both they and their partner experience when their infidelity is discovered or revealed (Johnson, 2002; Sims, 2015; Spring, 2013). The nonstraying partner may also separate from the partner who committed the infidelity at a time when they need compassion to cope with their own self-shaming cognitions or emotional despair related to the infidelity.

## Theoretical Framework

Attachment theory is a theory about both bonding and trauma (Johnson, 2002). The desire to form attachments to significant others is an innate drive with significant survival value (Wallin, 2007). Research suggests that the desire for secure attachments is present throughout the life span (e.g., Main, Kaplan, & Cassidy, 1985), including in marital relationships (e.g., Hazan & Shaver, 1987). Secure attachment bonds offer a sense of confidence and reassurance to explore and engage the world in new ways, and provide a "safe haven" to return to for comfort and soothing when coping with stressors becomes difficult (Wallin, 2007, p. 12). The current article promotes the use of an attachment-based framework because it captures the fear and threat to survival that infidelity poses to both partners in the relationship. Consistent with this, there is some literature that supports the utility of an attachment framework

to treat infidelity as a traumatic attachment injury (e.g., Baucom, Pentel, Gordon, & Snyder, 2017; e.g., Johnson, 2005; Johnson, Makinen, & Millikin, 2001).

When infidelity occurs, the sense of availability and closeness in a secure attachment is threatened (e.g., Johnson, 2005; Johnson et al., 2001). The nonstraying partner perceives their attachment figure as disinterested, distracted, and distant, and becomes preoccupied with fears concerning loss and abandonment. This prompts intense affect, including depression and shame, as well as a confusing array of behaviors as they alternatingly attempt to repair the rupture and protectively withdraw to limit further attachment injury (Johnson, 2005). The partner who committed infidelity may also experience an attachment loss when their partner pulls away or when they themselves are driven by shame and guilt to isolate from their partner. Johnson (2005) highlights an example of this when describing a client whose husband committed infidelity, stating, "In therapy when her husband would weep, apologize, and reach out for her, her eyes would fill with tears and she would turn away" (p. 24). This client, feeling emotionally unsafe, protected herself from vulnerability by limiting relatedness, which her husband experienced as a rejection of his sincere attempt to atone for his actions. The experience of infidelity may also trigger traumatic attachment injuries substantial enough to inhibit couples from trusting and being vulnerable both within and outside their romantic relationship (Johnson, 2002).

## Emotionally Focused Therapy for Infidelity

EFT is an empirically validated (Dalgleish et al., 2015) treatment model for couples based on attachment theory, with an emphasis on promoting more effective emotional relatedness (Burgess Moser et al., 2016). Therapists use this experiential approach to coach couples to interrupt relational conflict grounded in the expression of secondary emotions (e.g., anger, defensiveness) that are conceptualized as defensive reactions to more vulnerable, attachment-driven primary emotions (e.g., insecurity, betrayal). Couples learn to identify, express, and respond more effectively to these primary emotions, thereby strengthening the security and effectiveness of their relational bond (Greenman & Johnson, 2013). Many therapists use EFT to treat couples dealing with infidelity because infidelity occurs and may be, to some extent, forgiven within an attachment context (Johnson, 2005; Schade & Sandberg, 2012).

The attachment injury resolution model (AIRM) is a specialized treatment protocol developed to address attachment injuries in EFT (Makinen & Johnson, 2006). According to this model, processing the fear, anger, and sadness that underlie an attachment injury is vital for reconciliation and forgiveness between partners. When an injured partner is effectively able to express their feelings of pain, the person who injured them should apologize in a deeply engaging manner. Subsequently, this may facilitate reparative consolation, serve as the antidote to the original injury, and ultimately restore a secure attachment. In an outcome study of 24 couples with an attachment injury, Makinen and Johnson (2006) discovered that, using AIRM, 63% of injured partners were able to resolve the injury and forgive their partner, continue therapy, and advance to the main bonding events in Stage 2 of EFT. In another study, couples who received AIRM 3 years prior reported reduced severity of the attachment injury and improvements in relationship satisfaction, trust, dyadic adjustment, and forgiveness (Halchuk, Makinen, & Johnson, 2010).

Using EFT and AIRM, anger and disengagement originating from infidelity can be transformed into a conversation regarding loss, insecurity, and previously unmet relationship needs, creating opportunities for deeper emotional understanding and connection (Johnson, 2005). Because infidelity represents an attachment injury for both parties (Johnson, 2005), each party is coached, starting with the nonstraying partner, to express the emotional and attachment impact of the infidelity. The nonstraying partner often initially demonstrates anger, a secondary emotion that masks primary emotions stemming from the threat to the attachment bond, including fear of the relationship ending, shame at perceived shortcomings that are believed to have contributed to their partner's decision to stray, and helplessness about feeling unable to influence their partner's behavior. The partner who engaged in infidelity is coached to understand the attachment significance of these feelings and to hear this disclosure as evidence of their importance to the nonstraying partner

rather than as an indictment of their own worth (Johnson, 2005). The straying partner is then coached to acknowledge the impact of their actions, express regret, and provide validation and reassurance in response to their partner's insecurities.

The partner who engaged in infidelity often demonstrates defensiveness or disengagement, masking primary emotions of guilt and shame surrounding the infidelity. To help reduce defensiveness and move toward healing, the partner who engaged in the infidelity is encouraged to describe the factors contributing to their decision to seek a secondary partner. In particular, the therapist may help the straying partner identify and process primary emotions arising from unmet attachment needs prior to the infidelity. Through this process, the nonstraying partner gains insight about the attachment motivations of their partner (i.e., "I wanted to feel cared for by someone"). Moreover, opportunities are created for the couple to work through these concerns to foster new relationship dynamics that are more responsive to the attachment needs of both partners. When this work is complete, the couple cocreates a new narrative about the infidelity that highlights the role of attachment in both the injury and repair.

The emotions, relational conflict, and attachment injuries evoked from infidelity are a cornerstone of EFT. However, the utility of EFT to treat infidelity is not without its limitations. The primary attachment figure who committed the infidelity is both the source of and solution to the fear and pain (Johnson, 2002), making it challenging for the nonstraying partner to trust their attempts at showing contrition. This process is further complicated when one or both partners are still actively experiencing traumatic symptoms associated with the infidelity. EFT helps couples to reestablish conscious trust and a capacity for coregulation. However, the lingering symptoms of trauma for both partners can interfere with functional proattachment dialog, and over time, can test the patience of both partners as they try and fail to support each other in overcoming the symptoms. Providing each partner a space to process their trauma without triggering the trauma or shame of the other partner can be challenging and requires special consideration. Because infidelity is a traumatic event that occurs within the context of the relationship, the authors propose the integration of a trauma-focused approach with EFT to address these limitations.

It should be noted that a standard precondition for therapy is that the straying partner has ended the affair and severed all contact with the other party. EFT is best utilized under such conditions because the role of trauma is relatively straightforward and reasonably contained by the clean break from the affair; the requisite emotional and relational safety is easier to establish because of the clear gesture of recommitment by the straying partner. However, some couples do present for treatment while the affair or some form of extramarital contact continues. This ongoing insult exacerbates and perpetuates trauma symptoms for the nonstraying partner and creates barriers to emotional trust and effective dialogue. Although it is ideal to insist that the straying partner sever the relationship prior to proceeding with treatment, the factors behind the maintenance of the extramarital relationship may be complex and can also include attachment trauma.

## Eye Movement Desensitization and Reprocessing

The use of EMDR offers a brief and potentially powerful treatment for couples that have experienced trauma. EMDR was developed by Francine Shapiro in the late 1980s (F. Shapiro, 2001, 2007; F. Shapiro & Forest, 2016). The theoretical basis for EMDR arises from the adaptive information processing model (F. Shapiro, 2001). This model is informed both by Pavlov's conceptualization of information processing systems (Lanius & Bergmann, 2014) and more contemporary models of neurophysiological processing (Christman, Garvey, Propper, & Phaneuf, 2003). In short, the model suggests that when a person experiences an event that triggers an autonomic arousal that is beyond their capacity to regulate, the nervous system fails to fully process the information gathered during that event in the manner similar to a casual or standard event. This disruption results in a neurological maintenance of experiential details surrounding the event, including sensory, cognitive, affective, and physiological aspects. Thus, when a traumatic event is recalled, one often has the experience of reliving the moment, sometimes complete with affect and physical sensations that were present during

the trauma. According to the tenets of EMDR, the experience of bringing to consciousness the unpleasant memory in combination with bilateral stimulation (BLS) of the brain—through rapid eye movements or other stimulations now in use—allows for a normal processing of the memory to occur and results in the observed desensitization (i.e., stimulating the brain's associative processes to promote new insights and memories, paving the way for positive emotions to replace negatives ones, and the adaptive integration of pertinent information into larger memory networks; F. Shapiro, 2007).

Although originally developed and tested with clients whose lives were disrupted through major traumatic experiences such as combat and sexual violence, researchers and therapists began to find that the technique appeared to benefit those persons who had "small-t" traumas (i.e., Parnell, 2010; F. Shapiro, 2001). In other words, those life events, although not directly life threatening, result in troubling memories and carry with them such negative cognitions as "I'm worthless," "I'm not safe," or "I'll be abandoned" (F. Shapiro, 2001; F. Shapiro & Forest, 2016) and related traumatic symptoms. EMDR has also been used in the treatment of attachment trauma, also referred to as relational trauma (Parnell, 2013; Wesselmann et al., 2012; Wesselmann & Potter, 2009).

EMDR consists of an eight-phase protocol. During the first phase, *gathering client history*, the clinician collects history and other clinical data in a manner similar to many other approaches to treatment, although the clinician should be alert for traumatic events and associated negative cognitions (F. Shapiro, 2007). The second phase, *preparation*, involves psychoeducation regarding trauma and the EMDR process, and the bolstering of emotional safety through resourcing and affect regulation skills training. The *assessment* phase entails having the therapist help the client identify a memory to target for processing. The target may be the incident that precipitated treatment or an older associated *feeder memory* identified through the *floatback procedure* (i.e., in which the therapist links the current disturbing memory to an earlier, more salient one, often via shared emotions and/or physiological sensations; F. Shapiro, 2001). In addition to identifying the target event, therapists also help clients identify the underlying negative cognition associated with the memory (such as "I'm worthless") as well as a self-cognition the client would prefer to believe instead, such as "I'm a good person" (F. Shapiro, 2007).

At the conclusion of the first three phases, therapists begin processing the trauma with clients (Phases 4–6). In the fourth phase of the protocol, *desensitization*, the client is asked to allow their mind to "float" while BLS is administered, with brief intermittent breaks in which the therapist remains mostly silent and the client briefly reports what is coming to mind, followed by more BLS. This process is repeated until the client demonstrates a shift in perspective and a reduction in distress associated with the target image. During the fifth phase, *installation*, the positive cognition is paired with the traumatic image to increase neural connections to positive cognitive networks (linked to the preferred personal cognition and the other closing steps to the therapy). In the sixth phase, *body scan*, therapists work to complete processing of residual disturbance by examining and concentrating on any remaining physical sensations linked to the target.

During the seventh phase, *closure*, therapists may use various self-control or relaxation techniques (as needed) as a way to bring the client back to a state of emotional equilibrium at the conclusion of sessions. Lastly, during the eighth phase, *reassessment*, the therapist assesses the client's progress at the beginning of every new session to ensure long-term maintenance and integration within the larger system (R. Shapiro, 2005). Because a single traumatic event can consist of many submemories, successful completion of EMDR may often require multiple, extended sessions (Manfield, 1998; Parnell, 2010).

It should be noted that some experts have challenged the necessity of BLS in EMDR (e.g., Davidson & Parker, 2001). Conversely, in a recent review of the literature, Jeffries and Davis (2013) highlighted multiple studies that found support for the use of BLS in treatment, particularly in the context of increasing access to episodic memories and working memories (both of which can help clients reprocess traumatic memories, to the extent that memories are experienced in a decreased psychological arousal state). Recent studies, moreover, have demonstrated the unique neurobiological effect of BLS on negative emotional processing

(Amano & Toichi, 2016; Herkt et al., 2014). For these reasons, BLS was utilized in the later case example.

## EMDR and Couple Therapy

Although originally conceived as a technique in individual psychotherapy, a growing body of work demonstrates how EMDR may be useful for couple and family therapists. The 2007 publication of the *Handbook of EMDR and Family Therapy Processes* identifies ways in which therapists are finding this method helpful when working with families (F. Shapiro, Kaslow, & Maxfield, 2007). Protinsky, Flemke, and Sparks (2001) and Protinsky, Sparks, and Flemke (2001) published one of the first accounts of successfully using EMDR as part of conjoint couple therapy. More specifically, Protinsky and colleagues recognized EMDR as a powerful tool to help couples overcome both negative memories from earlier life experiences and negative cognitions about the other partner's roles in present-day emotional upsets. Using a modification of EMDR that they called eye movement relationship enhancement therapy, Protinsky and colleagues discovered that couples had more valuable experiences (i.e., greater compassion) when one partner remained in the therapy room to witness the other partner receiving BLS. The authors also found that when individuals revisited the details of their trauma, their observing partners gained a greater sense of the loved ones' history and helped the observing partner develop greater patience and understanding.

Several others have demonstrated how EMDR can help partners actively receiving treatment reduce their reactivity associated with attachment triggers and repair their attachment injuries (D'Antonio, 2010; Errebo & Sommers-Flanagan, 2007; Moses, 2003, 2007). These studies also demonstrate how EMDR can increase empathy among partners who bear witness to their partner actively engaging in the treatment. More recently, Moore (2016) explicated a similar approach combining EMDR with relationship-enhancement therapies to help a couple facing medical challenges. Conjoint couple therapy helped the clients understand how each of their individual past traumas fueled present triggers, which, in turn, helped to improve their communication and strengthen their relationship. This treatment combination also harnessed their attachment bond to reduce current conflict and related reactivity.

## EMDR for Infidelity

Capps, Andrade, and Cade (2005) published a case study successfully using EMDR to treat a couple who had experienced infidelity. More specifically, they examined the emotionally salient experience of many couples, wherein the partners who had committed infidelity assumed the role of silent supporter while their spouses engaged in a treatment session. Within the safe environment of a BLS session, partners who committed infidelity were better able to see and hear how the relational trauma influenced their spouses. Consequently, partners who committed infidelity experienced more empathy for their partner and a greater desire to avoid committing infidelity again in the future.

When using EMDR with couples who have experienced infidelity, the client may choose from a variety of memory *targets*. Although some clients process a memory target pertaining to the infidelity itself, some may process a *touchstone memory* from their past that is contributing to the distress about the infidelity. In the case of the former, the therapist would then attempt to identify targets by soliciting the most powerfully triggering memories related to the infidelity. This is done by asking clients to identify an image that captures the worst aspect of this experience, including where they were and who was with them during that experience. For some clients, the image may be of the moment when the nonstraying partner learned that their partner committed infidelity. Alternatively, partners might identify different images, such as the last time they saw the other with the secondary partner. In some cases, an entirely imagined event might be the source of much trauma for the injured partner, such as a nightmare of walking into the bedroom and finding the unfaithful spouse together with the other person. Finally, sensory stimuli (e.g., the smell of cologne a partner was wearing when the nonstraying partner learned about the infidelity) and associated body sensations (e.g., pounding heartbeat, muscle tension, shortness of breath) might be used to identify more robust targets or to amplify the emotional salience of an appropriate target.

## The Integration of EFT and EMDR

EFT and EMDR, although distinct in many ways, are both commonly used to treat relational trauma (Johnson, 2005; Parnell, 2013; Wesselmann et al., 2012; Wesselmann & Potter, 2009). In the context of infidelity, both EFT and EMDR help clients revisit the moment of betrayal, prompt and process deeper emotion, and reconstruct the narrative pertaining to the infidelity (Schade & Sandberg, 2012). In her book *EMDR Solutions*, Robin Shapiro (2005) notes the application of EMDR to infidelity in couple therapy, recommending the use of the Recent Events Protocol described by Francine F. Shapiro (2001). According to this model, EMDR should be introduced only after some relationship repair has occurred using standard EFT protocol (i.e., when strong secondary emotions have been bypassed, and when both partners demonstrate the ability to listen nonjudgmentally and nonreactively and are able to offer effective attunement and reassurance). Partners who continue to demonstrate one or more of Gottman's Four Horsemen (criticism, defensiveness, contempt, and stonewalling; Gottman, Ryan, Carrère, & Erley, 2002) and/or those who demonstrate significant reactivity grounded in past attachment trauma are probably not good candidates for conjoint EMDR, as the safety necessary for effective processing will not be available. Furthermore, if the infidelity appears to be part of a larger pattern of sexual addiction for the straying partner, this should be addressed in individual therapy prior to beginning EFT.

The combined EFT–EMDR approach consists of using EMDR as an intervention within specific stages of EFT. A determination of whether or not to use the combined approach should be based on the outcome of the assessment in Step 1 of EFT. In addition to the standard assessment, therapists should examine for any small-t trauma symptoms that one or both partners may be experiencing related to the infidelity. The combined approach may be adopted when one of both partners report persistent small-t trauma symptoms. Under circumstances in which the couple report infidelity as a primary or secondary problem in their relationship but neither report having small-t symptoms, therapists are recommended to proceed with standard EFT protocol.

In the combined EFT–EMDR approach, therapists should go through the first two steps of EFT, focusing primarily on the dyad. Subsequently, during Step 3 of EFT, Phases 1 to 8 of EMDR may be utilized to address trauma that might inhibit emotional safety as well as to augment the depth of emotional experience and disclosure. In other words, through the process of EMDR, therapists help each partner take a deep dive into some of the unearthed or unacknowledged primary emotions linked to the infidelity. The integration of EMDR in this way may be particularly helpful for couples who sometimes struggle to access deeply painful underlying emotions and express vulnerability to one another (Step 3 of EFT). Once the negative feelings linked to the infidelity are accessed and sufficiently diminished (recommended a Validity of Cognition Scale [VOC; F. Shapiro, 1989] score of 5 or higher and a Subjective Units of Distress Scale [SUDS; Wolpe, 1982] score of 3 or lower), therapists are encouraged to continue with Step 3 of EFT to help couples identify their primary negative emotional experiences in the context of their negative interaction cycle.

As suggested earlier, conjoint EMDR requires couples to have engaged in some degree of repair. For instance, individuals who exhibit low distress tolerance in session, which will typically manifest in the form of one partner constantly interrupting the other as they attempt to identify their negative interaction cycle in Step 2 of EFT, may not be prepared to shift to conjoint EMDR. Similarly, prior to proceeding with EMDR, each partner should feel that they can trust themselves and one another to refrain from entering the negative interaction cycle during session. For instance, at the beginning of each EMDR session, the therapist may ask each partner, "How confident are you that you and your partner will get through the session today without a visit from your negative interaction cycle?" Inherently, there may be challenges to achieving an adequate threshold of relationship repair prior to beginning EMDR. Repair may be particularly challenging in cases in which details of the infidelity continue to be unearthed, contact with the secondary partner continues, the partner who committed the infidelity continues to deny aspects of the infidelity that nonstraying partners believes to be fact, or there are long-standing power imbalances.

Upon integrating EMDR with EFT treatment, therapists should remain focused on the attach-

ment needs of the dyad at all times. In other words, therapists should remain attuned to couples' dyadic processes and maintain the goal of examining and treating couples' attachment-based trauma symptoms throughout EMDR. For instance, at the onset of each session, therapists might remind couples of the challenging but important trauma work they are doing to build or restore the attachment bond in their relationship. Also, given that the combined EFT–EMDR approach is conducted with both partners in the room, therapists should begin each couple session by engaging in a careful assessment of each partner's experience of the prior session of EMDR using an attachment-focused lens.

After attending to the dyad at the onset of each session, the EMDR protocol may be utilized. While one partner actively engages in the protocol, the other partner functions as a witness or silent support. What is supportive should be dictated by the processing partner during the preparation phase (with suggestions from the therapist). The witness or silent partner should remain attuned and empathically observe what their partner is processing so that they have an opportunity to better appreciate the psychological complexity of their partner's reaction and their own contribution to the post-infidelity dynamic. When a processing session is complete, the partner actively engaged in EMDR usually achieves some relief from their distress (as determined by the VOC and SUDS). Subsequently, the witness is coached to reflect on and express a deeper understanding of the attachment significance of their actions and their impact on their partner. Communicating their understanding may promote emotional safety and create opportunities for them to repair attachment injuries.

A decision must be made prior to beginning EMDR regarding which partner will undergo processing first. This decision should be made on the basis of the therapist's assessment of attachment trauma, specifically which partner's trauma appears to present the larger obstacle to treatment. The nonstraying partner's mistrust and reactivity is typically more problematic, although the straying partner's shame and guilt can also be the larger impediment. Under these circumstances, the partner who committed the infidelity is directed to process whatever affect and cognitions were associated with their decision to engage in infidelity or in the aftermath of the infidelity. Typically, they express feeling guilt and shame and experience negative self-directed cognitions concerning their own self-worth. At the same time, the nonstraying partner is coached to remain attuned and to listen empathically. As a consequence, the nonstraying partner may witness the complexity of their partner's emotional process and better understand their partner's motivations for committing infidelity. When the nonstraying partner has achieved some relief and is sincerely open to reinvest in the attachment relationship, the focus shifts to the other partner, if trauma symptoms are present (completing Phases 1 through 8 in their entirety is recommended before switching to the other partner).

At the conclusion of EMDR, the couple should (a) have a deeper understanding and sensitivity toward each other's emotional process; (b) be more attuned, reassuring, and comforting toward one another; and (c) possess a shared narrative about the infidelity that highlights their importance to one another as attachment figures and their strength as a couple in overcoming the threat to their bond. Couples who are able to successfully accomplish these objectives may find that it feels safer to engage more fully in EFT treatment, and may thus overcome the trauma of infidelity to develop a more secure attachment bond.

It should be noted that there are no specified number of sessions needed for EMDR to be effective in couple therapy. Instead, therapists may use the VOC and SUDS scores to determine when to conclude the protocol. Using a modified version of EMDR, the benchmarks for success in EMDR may be adjusted (i.e., VOC and SUDS scores may be slightly lower or higher, respectively, than would otherwise be the case at the conclusion of standard EMDR treatment). Any distressing cognitions and emotions that remain at the conclusion of EMDR are expected to be resolved through Stage II of EFT (i.e., the development of new interaction patterns and attachment events). Therapists who find it difficult to enter Stage II of EFT because of ongoing escalation between partners may need to shift back to EMDR to clear or considerably diminish the influence of other target memories that may be inhibiting effective dyadic treatment.

## Case Example

The following case was selected because it illustrates the role of attachment trauma in both partners' presentation, particularly that of the straying partner whose trauma response is less obvious. The case was also selected because it helps demonstrate how attachment trauma presents barriers to effective treatment within the EFT framework. Furthermore, it demonstrates how addressing attachment trauma directly helps overcome impasse surrounding the maintenance of contact to deepen emotional disclosure and understanding.

Jane and John presented to therapy 4 months after Jane learned of John's sexual infidelity (three encounters over the course of 2 months) with another woman. Jane learned about the infidelity after discovering electronic communications between John and the other woman. Jane presented with a number of PTSD-like symptoms, including heightened anxiety with a strong somatic component, decreased appetite, poor sleep, impaired concentration, labile affect, nightmares, and intrusive memories of particularly salient moments related to this attachment injury. John had come clean once confronted, appeared open to process and repair, and came willingly to treatment. However, he had yet to sever ties with the other woman; their continued contact became a significant trigger for Jane, causing her to become suspicious and intrusive into John's day-to-day activities. John reported that Jane's surveillance of him made him feel like a "bad guy," and that he felt overwhelmed by guilt, shame, and sadness concerning his actions. He also felt that he deserved to suffer for his mistake and perceived his feelings as an unfair burden on Jane. Consequently, he was unable to reach out to her for support and reassurance, and instead continued to seek consolation and validation from the other woman. This created a self-maintaining positive feedback loop from which the couple was unable to escape.

Couple therapy is typically counterindicated when the straying partner maintains contact with the person with whom they committed the infidelity. However, John's initial presentation was not consistent with that of an unrepentant partner with one foot out the door. Rather, he presented with significant guilt and shame and a palpable desire to rectify his wrongs and repair trust and intimacy. He reported that the only reason he maintained contact with the secondary partner was because she had threatened self-harm should he sever contact, which he "did not want on [his] conscience." Otherwise, he stated emphatically that he was "done with her" and that he now found her "repulsive." Despite her traumatic reaction, Jane stated that she believed John no longer wanted contact with the secondary partner and expressed a desire to rebuild trust, and even to help John to sever contact. Furthermore, the couple's initial scores on the Dyadic Adjustment Scale (DAS; Spanier, 1976; John = 93, Jane = 104), a measure often used in efficacy studies for EFT, suggested a strong relationship foundation without many of the typical struggles that impede intimacy. Apart from the affair, the only problem area that appeared significant in their relationship was an ongoing pattern of petty arguments and a shared sense of missing one another, which the therapist reframed as indicative of their unmet attachment needs. For these reasons, the therapist decided that treatment could proceed while contact continued with the secondary partner.

Initially, EFT was utilized to help Jane articulate the sense of loss, betrayal, and fear that she experienced in response to learning about John's infidelity. John was coached to listen nondefensively to Jane's expression of her primary emotions, to understand them as a statement of his importance to her as an attachment figure, and to more effectively mirror this back to his partner and offer reassurance and emotional support. John was also encouraged to speak to the factors that led him to stray. He identified a lack of shared quality time and emotional safety surrounding certain topics of conversation as factors that contributed to his infidelity. He also identified ongoing petty conflicts as sources of dissatisfaction that strained the marital attachment. Jane readily acknowledged and validated these concerns, and together, the couple problem-solved ways to address them. As a result, the couple immediately began to feel more emotionally bonded, started spending more quality time together, and enjoyed each other's company more than they had in years.

However, despite feeling more connected, John was still unable to sever contact with the other woman. Moreover, although he remained transparent with Jane when communicating

with the other woman and tried to offer reassurance, these episodes continued to fuel the aforementioned feedback loop. John appeared unable to fully receive Jane's reassurance and forgiveness, or to forgive himself for his transgression, and continued to seek comfort in his marital relationship with the other woman. Jane continued to demonstrate emotional reactivity to this woman's ongoing interference in their marriage and remained suspiciousness of John's behavior.

Further discussion revealed past attachment injuries that appeared to have bearing on the current episode. John reported a history of misbehavior as an adolescent and a period of substance dependence, during which he was disowned by his parents. He reported a strong sense of shame and pervasive self-schema content regarding his own "badness" and lack of self-worth. Jane reported never truly feeling part of her blended family, an experience she attributed to being the only daughter from a previous relationship. Jane also reported feeling different and frequently stigmatized because of a highly visible congenital physical anomaly. Upon learning more about family and childhood experiences, it became clear that both partners felt "rescued" by their relationship and that this was the first secure attachment bond that either of them had truly experienced, making the current rupture more acute. The therapist thus reframed the infidelity as an attachment trauma for both parties and highlighted how it maintained the homeostasis of mistrust and shame within the relationship. The metacommunication function of the triangle created by the infidelity was also highlighted. John was telling Jane, "I am angry you are so distant from me." However, he was afraid to do so directly because he feared initiating conflict would further erode their attachment bond.

EMDR was introduced around the 10th session, with the intent of deepening emotional disclosure and opportunities for attunement as well as targeting the older schema content (e.g., "I am bad," "I am defective") and feeder memories that appeared to have bearing on the current episode (e.g., emotional abandonments by family members). Although the approach described by Robin Shapiro (2005) recommends starting with the nonstraying partner, processing began with John. This provision was made because ongoing contact with the other woman continued to be a major trigger that made it very difficult to ensure Jane's emotional safety. During the preparation phase, John was asked to identify a target image that best captured his feelings of guilt and shame. He selected the moment when Jane discovered his infidelity, particularly the look on her face. He then identified and stated his negative cognition, "I don't deserve my wife," and his positive cognition, "My wife and I deserve to be happy together." He rated his belief in this positive cognition (VOC) as a "1 or a 2" on a scale from 1 to 7.

John also identified body sensations he associated with the target (i.e., his stomach dropping and his heart pounding) and a strong sense of associated shame and guilt (SUDS = 10). Desensitization began, and he quickly accessed older memories regarding his family of origin and their failure to stick with him through difficult times. A connection was made about how distant he had felt from Jane prior to the affair, which prompted tears. Jane moved close, staying silent but holding his hand. Processing progressed to memories of when he and Jane first met and how connected and safe they had both felt at the time. He recognized, in a much more visceral way than he had previously, how important they were to each other and how he had hurt them both through his actions. When processing ended, he turned to his wife, and raw with emotion, apologized for hurting her and jeopardizing their marriage. She smiled and held his hand, and promised him that she would never let them grow apart again. He reported that he now believed the positive cognition much more strongly than prior to processing (VOC = "6 or 7"). Distress associated with the target image was significantly reduced (SUDS = 2). A week after concluding EMDR, John severed contact with the other woman.

With this safety and deeper understanding achieved, Jane was able to engage in the EMDR process with much less reactivity. She selected an imaginary image of John cuddling with the other woman, identifying a negative cognition of "I am unlovable" and a positive cognition of "I deserve to be loved." She rated the VOC as a 2 on a scale from 1 to 7. She identified shame and powerlessness as the strongest feelings connected to that image (SUDS = 9) and numbness as the primary body sensation. The use of the floatback technique revealed that this emotion–body state was connected to experiences with

her family of origin. Consequently, Jane selected a new target image from these memories. Specifically, she identified an image of her father being emotionally withholding and distant when he was angry. Desensitization began; she demonstrated strong affect initially, in response to which John moved in close and began stroking her hair. To manage the affect related to older family memories, Jane very quickly accessed adult resources (e.g., memories of validating conversations she had with others about her family), returning to memories that highlighted the immaturity and emotional unavailability of her family. She also remembered the love and support she provided John as he worked through issues with his own family and reconnected with her role as an important attachment figure in his life. At the conclusion of desensitization, Jane listed her positive attributes and made statements such as "He is lucky to have me" with conviction. She also reported that she now fully believed the positive cognition (i.e., "I deserve to be loved"), with a VOC rating of 7. Half-jokingly, John stated that he did, too. Revisiting the target image, Jane now reported her associated distress (SUDS) at "1 or 2."

Subsequent to EMDR, the couple was able to resume EFT and reconstruct the narrative of the infidelity around the strength of their attachment bond. Jane was able to understand John's infidelity as a response to feeling disconnected from his most important attachment figure. Although she was still unhappy that he had committed infidelity, Jane was able to accept that it had happened and remain oriented to moving past it. John was able to articulate and acknowledge the full extent of his actions, express remorse, and forgive himself. The conversation was then able to shift to how they could best maintain their positive connection and create space to share and attend to each other's feelings, so that neither party ever felt tempted to stray in the future.

The termination of treatment was initiated by the couple several sessions ahead of the therapist's plan, due mainly to financial constraints. The couple was offered a reduced rate for a final closing session, but they declined, citing the need to shift their focus back to their work and children. In their closing communications with the therapist, the couple expressed deep gratitude for the work that was done together and shared that they had experienced significant improvement in their relationship and communication dynamic. The couple also reported that their sense of trust, security, and intimacy was stronger than at the outset of treatment. Unfortunately, this early termination prevented the readministration of the DAS, a posttreatment outcome measure used to provide a quantitative measure of change.

## Conclusion

The preceding case demonstrates how infidelity can be traumatic for both partners and how this trauma can interfere with attachment and trust in a way that can impede progress in EFT couple therapy. Individual referrals for EMDR or another trauma-focused modality could have been provided; however, progress in couple therapy may have stalled while individual trauma treatment was underway. Furthermore, insofar as the primary goal of EFT is to promote ~~emotional understanding~~, treating the traumas individually would have bypassed opportunities for each partner to witness their partner's deeper emotional process surrounding the trauma. Implementing EMDR with both partners present created richer opportunities for mutual understanding, attunement, and provision of reassurance.

Within the EFT framework, EMDR was utilized to facilitate and deepen access to attachment emotions (Step 3 of Stage 1, de-escalation), which were, in turn, used to construct the attachment reframe that is typical of Step 4. EMDR processing also revealed aspects of self for both partners, including sources of attachment insecurity and disowned needs, and helped them to build a sense of healthy entitlement surrounding these attachment experiences. This new self-understanding served as a starting point for Step 5 of EFT, in which the partners were coached to further explore their own attachment needs. Additionally, witnessing the traumatic underpinnings and associated affect made acceptance of the other partner's needs easier during Step 6 of EFT.

Integrating EMDR and EFT, each of which are empirically validated forms of treatment for trauma and couples, respectively, may help heal the trauma of infidelity among couples in conjoint treatment. The case example, although obviously limited in generalizability, suggests a

potentially clinically useful integration of the two techniques for the treatment of infidelity; controlled clinical trials are necessary to establish the efficacy of this integrated approach. It is also worth noting that the current article provides an introductory, but not comprehensive, examination of how to use an integrated EMDR and EFT approach to treat infidelity. The effective utilization of both approaches requires additional training and certification. Therapists are encouraged to pursue said training opportunities, especially if they regularly work with couples being treated for infidelity.

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