Integrating EMDR and Couples Therapy

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Integrating EMDR therapy into couples therapy is a promising new trend in psychotherapy. The earliest published offering was by Snyder in 1996, and not again until Protinsky *et al.'s* article in 2001. In the latter's paper, the authors integrate EMDR into their emotionally focused couples therapy (EFT) to help partners work through traumas and enhance intimacy. Subsequent authors have described using EMDR with EFT (e.g., Errebo & Sommers-Flanagan, 2007; Knox, 2016; Linder, 2022; Moses, 2007), Imago therapy (Talan, 2007), Bowen Theory (Knudson, 2007) and ego-state informed Contextual Therapy (Litt, 2007) to name a few. (For a detailed literature review, see Linder et al. (2022).) Authors' practices of combining modalities vary from pluralistic, side-by-side interventions to seamless integration, yielding a genuine hybrid of EMDR relational therapy.

Across different approaches to couples therapy, authors roundly credit EMDR with increasing empathy, improving secure attachment, reducing reactivity, and increasing the couples' relationship satisfaction (Linder et al., 2022). While there is little empirical support for this hybrid approach (Doğan et al., 2021), such improvements should come as no surprise as they are expected outcomes in individually focused EMDR therapy. Despite this, few articles or papers discuss this integration (Howard, 2023; Linder, 2021). This observation comports with my own experience that very few clinicians integrate EMDR and couples therapy. Therapists face three main challenges: epistemological, modal, and countertransferential.

Epistemological Challenges

In the 1960s, the emerging field of family therapy gave rise to couples therapy as we know it today (Litt, 2007). Anchored in the paradigm of *general system theory* (Bertalanffy, 1950), the family therapy movement regarded individual behavior and experience as structurally determined by the complex relational system in which they found themselves. The locus of assessment and intervention was the system of relationships—not the individual.

Modern systems-oriented therapists are more willing to consider family members' motivations, personality, and attachment needs and integrate interventions drawn from individual psychotherapy (Kaslow, 2009). While much the same can be said of modern couples therapy (Lebow & Snyder, 2022), systemic purists may be hobbled if they restrict their assessment and interventions to the unit of the "couple" as its own anthropomorphic agent (Boszormenyi-Nagy & Krasner, 1986; Litt, 2007).

This legacy of systemic determinism includes couples therapy practices that neutralize each partner's needs, behavior, or responsibility. They favor a non-blaming, even-handed view that reframes issues as belonging to "the couple" (Errebo & Sommers-Flanagan, 2007; Johnson & Greenberg, 1985; Tofani, 2007; White & Epston, 1990). In the interests of "balance," such practices include equal talk time, making sure that both partners equally share the "hot seat," or the rote assignment of an equal number of individual sessions for each partner (e.g., Moses, 2007)—with or without utilizing EMDR—regardless of each partner's

individual needs or goals. Indeed, some therapists may be tempted to offer an EMDR session to an asymptomatic or unready partner or to perform bilateral stimulation with both partners simultaneously (Doğan et al., 2021) to satisfy this superficial criterion of balance.

Consistent with these practices, clinicians may eschew individual assessment or diagnosis, reframing one partner's acting-out behavior or insecure attachment as a "relationship issue." Therapists may accept the presenting problems of "*we* want to improve communication" or "*we* want to become closer" as actually meaningful statements when, in fact, they serve to avoid personal accountability and obviate the opportunity to offer support and healing (e.g., EMDR therapy). In these tortured efforts to avoid taking sides (and thereby assigning the "bad object" role), individual responsibility is forfeited, and problems are externalized. Instead, they are attributed to a blameless, abstract entity: "The *relationship* did it!" Anyone who runs a household knows that *we* don't take out the trash; only one of us does.

Modal Challenges

Modes of treatment include individual, couples, family, and group therapy. While there is considerable overlap, each mode is its own discipline, with its own theories and methods that distinguish it from the others. Therapists may conflate modes of therapy with the number of clients in the session. In the context of an integrated, systemically informed EMDR therapy approach, everyone is a client. The issue of session attendance is tactical as opposed to approach-driven. Attendance is in the service of achieving a specific goal for a specific individual for a specific session. For example, conjoint sessions are indicated if each partner agrees to work on repairing a rupture, delineating boundaries of personal responsibility, or aligning their relationship goals. Working through trauma with EMDR can be accomplished individually or in conjoint sessions (Linder, 2021; Litt, 2009a; Litt, 2009b).

To honor the autonomy of each individual in the couple, the clinician must create a therapeutic environment where both parties feel heard, understood, and validated. The requisite therapeutic stance is called multidirected partiality (Boszormenyi-Nagy & Krasner, 1986). Multidirected partiality is both method and commitment. The method involves empathizing with and supporting one person's unique perspective, helping them articulate a "valid claim" (Litt, 2019, The marriage of EMDR and ego state theory in couples therapy) on the relating partner, and—as appropriate—eliciting accountability about how their own behavior affects the other.

A valid claim is an appropriate request for empathy, understanding, or behavior change between two mature, relating adults. It is actionable in a way that regressive wish fulfillment is not. Then, in turn, the therapist engages with the other partner similarly.

As a commitment, the therapist embraces accountability for everyone potentially affected by the therapy—those whose well-being is bound up in the client's relational behavior—whether the therapist ever sees them (Boszormenyi-Nagy & Ulrich, 1981). Children are of paramount concern due to their developmental vulnerability. For parents seen in couples therapy, the welfare of the children is implicitly, if not explicitly, part of the treatment contract. This stance differs from the detached attitude of strict therapist neutrality (Boszormenyi-Nagy & Krasner, 1986). (For a thoughtful critique of therapist neutrality, see Woolley, 2016.)

Therapists are encouraged to bring the individual back into systemically informed couples therapy and employ the insights and interventions drawn from individual psychotherapy, including EMDR. Therapists can be more creative and collaborative in formulating goals for each partner, choosing the interventions, and deciding who should attend which sessions.

Countertransference

Exposure to lasting and deep parental conflict and mistrust can be a source of relational trauma for children. Below are four pathogenic relational configurations that can cause maladaptive relational patterning.

- *Parentification* (Boszormenyi-Nagy, 1965) occurs when children are inducted into the role of peacemaker or referee or are expected to take sides. The parentified child paradoxically feels responsible for their parent's relationship yet is helpless to effect change. The inability to resolve hyper-responsibility with helplessness can leave a child frozen in shame and feelings of worthlessness.

- *Split loyalty* (Boszormenyi-Nagy & Krasner, 1986, p.421) is a double-bind in which loyalty, or care, for one parent means betraying the other. The no-win predicament sabotages the child's ability to form trusting relationships, can yield intense internal conflict, and the internalized sense of failure becomes a source of lasting distress.

- *Abandonment trauma* may occur when parents are too preoccupied with their conflict to attend to their frightened and confused children. Children, perhaps especially younger ones, may be caught in the dilemma of seeking safe harbor at the risk of either becoming a target of parental hostility or retreating into dissociation.

- *Pseudomutuality* (Wynne et al., 1958) describes a process by which family members pantomime harmony by concealing or dissociating genuine interpersonal conflicts and antipathies. Parental conflict is smoothed over without authentic repair, and children are expected to disregard yesterday's brawl and embrace today's apparent togetherness. Parents who cannot help their children integrate the dichotomous experiences of mistrustful conflict and apparent harmony unwittingly promote "dissociative relating" (Litt, 2019, The marriage of EMDR and ego state theory in couples therapy), which may engender dissociative freeze and compromise reality testing and self-trust.

Therapists with this formative background can be retraumatized by conflicting couples in their practice. Accordingly, they may rely on unconscious relational patterning, such as those described above, when dealing with couples., The therapist's desire to avoid worsening conflict between their own parents may be unconsciously transferred to the clients, manifesting as therapeutic neutrality, externalizing issues, or placating hurt feelings by reframing actions positively or prematurely seeking harmony or pseudo-reconciliation.

Note that some of these interventions are enshrined in various models of couples therapy, in which some clinicians may seek refuge to manage re-traumatization. However, these interventions often lead to neglecting the exploration of a partner's actual or perceived grievances, their history of trauma, and the subsequent projection process—as well as failing to hold them accountable for the effects of their actions on the other. The following section will address assessment, contracting, and treatment considerations.

Assessment

Much has been written about various assessment methods in EMDR-based couples therapy (e.g., Errebo & Sommers-Flanagan, 2007; Knox, 2016; Knudson, 2007; Linder, 2022; Litt, 2007, 2009b; Moses, 2007; Talan, 2007). Each author brings a hybrid of EMDR-informed assessment combined with those methods associated with their respective couples theory. This section will address certain practices that integrate individual and systemic dimensions.

McGoldrick and Gerson (1999) describe two axes of inquiry in their genogram-based assessments: the vertical and the horizontal. The vertical axis refers to historical, intergenerational patterns and influences and, by extension, the intrapsychic realm. The horizontal axis refers to here-and-now concerns and the recursive transaction patterns that dominate the couple's relationship.

Couples typically seek therapy to address conflict or dissatisfaction with their partner: so-called horizontal issues. Psychoeducation, problem-solving, and coaching about effective communication techniques and conflict-resolution skills are often necessary but rarely sufficient. If we allow that no one is perfect, then we must allow that all couples participate to some degree in "fusion" (Boszormenyi-Nagy, 1965, p. 49). In this dynamic, so-called undifferentiated partners (Bowen, 1965) have diffuse ego boundaries and merge their thoughts, feelings, and needs as if to create a singular personality out of two or more people.

While this condition fits the ideal of romantic love captured by the phrase: "two of us become one," it is a pathological form of mutual dependency that comes at the expense of autonomy and thwarts more authentic options for personal growth, trust building, and intimacy. Failures in empathy, mentalization, compassion, mutuality, and self-regulation are rooted in the vertical dimension of internalized relational trauma and consequent personality structure.

Accordingly, the couple's therapist must assess the dysfunctional patterns in the relationship but also segue into assessing each partner's vertical dimension. Litt (2009b) describes a five-step method for transitioning from the horizontal to the vertical dimension of assessment, which is the bridge to offering EMDR therapy.

Step one is to identify the pathological recursive patterns to decode underlying forms of fusion. I have operationalized the concept by identifying specific, observable transactions, referred to here as forms of "pathological dependency" (Litt, 2007, p.12). Pathological dependency involves an affinity for displacing autonomous ego functions into the partner. These include:

1. *Ego, id, and superego functions*. In this configuration, the ego, id, and superego functions are shared or distributed between two partners. For instance, one partner may embody the superego function while the other takes on the id function. The resulting polarization leaves the couple battling for control of the ego function or symbiotically creating a shared ego. While healthy couples can use these differences as a resource, fused couples become trapped in a symbiotic, role-determined parent-child dynamic (e.g., Framo, 1982).

2. *The soothing function.* Self-soothing and affect tolerance in adulthood depend on the ability to evoke corresponding representations from early childhood (Brown & Elliot,

2016). The soothing function in healthy dependency involves reciprocity of coregulation and empathy (e.g., Johnson & Greenberg, 1985; Schnarch, 1991). In times of distress, each person has internal resources to fall back on should the partner be emotionally unavailable.

Couples in which one or both partners have an insecure attachment style are likely to manifest patterns of pathological dependency. This pattern involves rigid, complementary roles of rescuer and victim, bound in a dialectic of obligation and entitlement. The "winner" in this scenario—i.e., the one who receives comfort—is co-determined by who cries the loudest vis-à-vis the partner most susceptible to guilt and over-responsibility. In some couples, these roles are relatively fixed. Other couples actively compete for soothing, and the ensuing competition for the filial role manifests as a "race to the bottom," with each partner vying to showcase their suffering as more deserving of care than the other.

3. *The self-validation function.* For infants and children, seeking caregiver approval is an evolutionary strategy to recruit parental investment and learn survival skills. Parental approval is internalized as the "good" part of the self, while disapproval becomes the "bad" part (Kernberg, 1980, p.112). Transferring this approval-seeking behavior to an intimate partner is a form of parentification, implicitly objectifying the other to a supra-human judge determining the parentifier's worthiness.

The differentiated, self-validating person has a resilient ego boundary and secure sense of self, not requiring external validation. They transcend the good/bad split via the mechanism of "mourning work" (Boszormenyi-Nagy & Krasner, 1986, p. 161) and self-compassion (Neff, 2003). Such individuals intuit that worth, like beauty, is entirely in the eyes of the beholder. When judged, they interpret such appraisals as expressions of the partner's internal state: "It's not about me."

Since couples seeking therapy are unlikely to be in this highly differentiated group, they only vary in the degree to which they rely on this strategy of using each other as a mirror of self-worth. While one form involves extracting praise, another involves the *bad object game* (Litt, 2019). The latter can be observed in the couple's reliance on attributions of fault and blame. These constructs connote "badness" such that accountability—an essential component of trust-based relating—is conflated with self-worth. To be accountable—apologize, make amends, validate the other—is tantamount to accepting the bad object role. Responsibility becomes the "hot potato."

However painful, conflicts over the assignment of the bad object-role have a game-like structure with four possible options:

- Turn-taking, in which one partner adopts the bad object-role for the "coherence" (Dell, 1982, p.21) of the system (e.g., the role of the "scapegoat" (Boszormenyi-Nagy, 1965, pp. 70-71)).
- Competition, in which partners actively fight over bad object-role assignment.
- "Proportional badness" (Litt, 2019, The marriage of EMDR and ego state theory in couples therapy) refers to a process in which couples diffuse their conflict by each accepting *some badness*—with or without a shared narrative of proportionality. Statements such as, "Yes, I am to blame, but you are more to blame," "Okay, it's both our faults," characterize this effort at compromise.

The ingenuity of proportional badness is that partners can achieve détente

with a shared narrative of equivalency while privately harboring the fantasy that the other is worse. In any case, as Boszormenyi-Nagy points out, "…collusive good or bad object-role assignments are important components of intersubjective patterns and are indicative of deficient person-delineations" (1965, p. 71.).

- Triangling (Kerr, 1981) or scapegoating, in which the partners agree that they are good and someone (e.g., their child, the therapist) or something else (e.g., the school, the economy) is to blame.

4. *Locus of control.* The externalization of locus control in pathological dependency is more than a misapprehension about boundaries. It represents the deeply felt sense that one's thoughts, emotions, and behaviors originate in the other. A corollary to the bad object game, statements such as, "My partner does not make me happy," "You make me feel worthless," or "You made me do it" imply that the subject is a captive object to a powerful other (Boszormenyi-Nagy, 1965; Framo, 1982).

Step two is to isolate the negative cognition, affect, and sensation of a given partner once some form of pathological dependency emerges. This is essentially the setup procedure in EMDR phase 3 (Shapiro, 2001). Here, the therapist turns from the horizontal complaint (e.g., "she makes me feel worthless") to the vertical dimension of core beliefs and affective dysregulation. The complaint may or may not have merit, but the intervention here attempts to probe for relational traumas and the resulting negative identity being activated.

By necessity, the therapist must choose one partner to begin this exploratory, one-on-one dialogue in the presence of the other. Because these transactions are recursive, choosing which partner to turn to first may be arbitrary. However, below are some considerations that may prioritize starting with a particular partner:

1. Therapists should start a vertical inquiry with the dominant or more aggressive partner if there is one. Holding the dominant member accountable signals the therapist's capacity to function as a firm but fair superego for the couple. Challenging defensive and hostile behavior, preventing interruptions, and regulating the pace of dialogue and who speaks when are part and parcel of winning the battle for structure (Napier & Whitaker, 1978). Only then can the therapy room be a trustworthy holding environment in which both partners can risk being vulnerable.

   By contrast, starting with the submissive partner signals the therapist's fear of the dominant one, risks colluding with the couple's asymmetrical structure, and reaffirms the submissive partner's identity as the "sick," "bad," or "needy" one. The submissive one may, in fact, be massively insecure and in need of individualized therapy. However, the couple's use of this fact may function to mask the trauma and accountability of the dominant partner.

2. Vertical inquiry should generally start with the partner whose dysregulation destabilizes the relationship (Litt, 2007). At the appropriate time, the therapist will turn to the second partner and inquire about that person's internal reaction and relational response to the activated partner's dysregulation.

3. When partners differ in their motivation for therapy, tempting as it may be to start with the more motivated one, this is likely an error. As in the configuration above, the path of least resistance is often wrong for the same reasons. Starting vertical inquiry with the less motivated partner may deepen that person's investment in the process, shed light on why they lack motivation, and negotiate a more trust-based contract with

the dyad that acknowledges that person's lack of commitment to therapy in particular or the relationship in general.

4. Start with the therapy naïve partner if the other is already well versed in their vertical issues.

These guidelines are no substitute for clinical judgment and, in some cases, may conflict.

Step three: Contextualize the core belief, affect, and sensation elicited in step two. This involves using the affect bridge with whatever trauma-informed history has been ascertained. This step can result in the powerful experiential revelation that distress and its attendant meaning (i.e., negative core belief) is a subjective reaction whose locus is internal and whose genesis is in childhood.

Step four: Contract for surrender of the acting-out behavior. Realistically, this goal will take more than one session's agreement to change. However, if step three has its desired impact, the therapist gains leverage to help clients see that their reactive behavior is archaic and destructive. This injunction includes prohibiting one's ego states, or "emotional parts of the personality" (Nijenhuis & van der Hart, 2011, p. 423) from interacting with the partner. When dysregulated, immature ego states engage with the partner, mature options for secure relating are forfeited, and a traumatic reenactment is all but guaranteed (e.g., Koedam, 2009). The client's general acceptance of the traumatic origins of their experience and resultant reactivity paves the way to step five.

Step five: Contract for individualized treatment (e.g., EMDR therapy). Once the etiological relational traumas are uncovered, and the partner agrees that their reaction is problematic, it makes sense to negotiate a *discussion* of EMDR therapy (phase 2 work). Identifying an issue and agreeing to work on it are not the same things. Partners may be reluctant to become a "patient" as it threatens their identity or destabilizes the dyad. They may be more invested in blaming their partner than becoming part of the solution. Last week's agreement to discuss commencing EMDR therapy may be "forgotten" in the wake of this week's fight. Accordingly, this "step" may be better characterized as a phase of treatment that may be revisited often.

Each partner will be assessed for the appropriateness of individualized EMDR therapy. The treatment structure becomes an ongoing negotiation with numerous options, with the therapist helping each partner set their own goals and preferences for session attendance (Boszormenyi-Nagy & Ulrich, 1981). For example:

- Partner A may wish to commence EMDR with partner B present; B prefers to do EMDR alone.
- Partner A may wish to invite Partner B to attend a conjoint session to work through a conflict.
- One partner wants an individual session to prepare for a family visit.
- One partner wants a family session with a child from a former relationship.

Treatment Considerations

While it is beyond the scope of this article to describe this approach fully, I wish to highlight some unique elements.

1. *Conjoint EMDR.* This practice involves EMDR with one partner—the "working partner"—while the "observing partner" silently bears witness, offers empathy, and gains insight about their partner (Litt, 2007, p.27). According to Litt (2007), conjoint phase four processing is contraindicated if any of the following apply:

    a) The working partner cannot emote freely in the partner's presence.

    b) The working partner is not ready to disclose personal history or issues with the partner.

    c) The observing partner will likely use the working partner's revelations in retaliation.

    d) The observing partner is unlikely to tolerate the working partner's affect or disclosures.

    e) The observing partner is unable or unwilling to let the working partner have all the therapist's attention (for example, interrupts the processing with comments or questions). (p. 27)

    Conjoint sessions may be suitable for one partner but contraindicated or not preferred by the other. Respecting the needs of the individuals versus imposing an arbitrary quid pro quo models mature relating and does not play into the bad object game. For a thorough discussion of the indications and contraindications of conjoint EMDR, see Linder (2021).

2. *Conjoint sessions as serial dialogues with the therapist*. Rather than inviting (or allowing) partners to talk with each other, I insist that they speak with me unless or until they demonstrate the ability to engage in respectful dialogue. Most couples therapists know the futility of trying to play referee or determine who started it. The therapy room is a place for trust and safety; hosting reenactments is retraumatizing and unnecessary.

    A primary task for the therapist is to convert a complaint into a valid claim. Complaints can be disguised wishes for empathy, accountability, or behavior change. They could also be the latest salvo in a cycle of the bad object game—or both. Complaints stemming from pathological dependency are met with vertical exploration, as in steps two through five above.

    For example, "I want to feel safe with my partner" could mean anything from a veiled disclosure of interpersonal violence to projection anchored in a past relationship. Or it could be a dig. Or it could be any combination of these. Examining specific examples of the couple's transactions can reveal whether the complaint has merit and/or manifests pathological dependency.

    Only when the therapist and complaining partner arrive at a valid claim does the therapist turn to the second partner for a response. For example, "I want my partner to spend more time talking with me at the end of the day" or "I want my partner to know what it's like for me when his mother visits" are mature, actionable claims.

    The partner is then asked to tell the therapist what they heard the other say. The ensuing *hearing test* becomes an assessment of that person's available resources

of mentalization, ego strength, and concern. Failure of the hearing test due to defensiveness, dysregulation, or lack of curiosity leads to vertical exploration.

3. *The triangle in couples therapy.* In conventional couples therapy, the therapist asks partners to turn to each other and engage, with the therapist intervening as needed. This process is ripe for a drama triangle, in which victim, persecutor, and rescuer roles are traded or competed for (Karpman, 1968). The therapist who accepts the rescuer role vis a vis the victim will be seen as a persecutor to the accused.

   The therapist may also be drawn into the role of judge or parent—the displaced superego function. Therapists who are not sufficiently differentiated to transcend the bad object are vulnerable to colluding in the couple's pathological dependency. For example, the therapist may adopt the persecutor role out of identification with the "victim."

   Another option is to reframe that "the relationship" or some other externalized social structure is the persecutor, with both partners bound in solidarity as victims. Alternatively, the therapist may equalize or assign proportional blame utilizing the gyroscope of their countertransference to intuit which partner can handle the most heat.

   While some of these interventions may provide temporary relief, they do nothing to help the partners themselves transcend the bad object. The use of multidirected partiality and serial dialogues with each partner mitigate against these reenactments.

4. *One-stop shopping*. In this approach, the therapist offers individual and conjoint sessions instead of referring out each therapeutic component. Utilizing a single therapist for individual and couple sessions offers advantages beyond the obvious benefits of enhanced information gathering and avoiding splitting the therapy team.

   This approach creates leverage through multilateral accountability. It is harder for clients to conceal or minimize problematic behaviors, knowing that their partner will likely inform on them. Therapeutic integrity is maintained, as the therapist is individually and collectively accountable to the clients. Clients can hold the therapist accountable for interventions with their partner, ensuring transparency and a more cohesive therapeutic process that balances individual needs with relationship goals (Litt, 2007).

Significant Advancement Partnering EMDR with Couples Therapy

The integration of EMDR therapy into couples therapy represents a significant advancement in the field of psychotherapy, offering a multifaceted approach that addresses both individual and relational dynamics. This article has referenced the historical context and theoretical underpinnings of combining EMDR with various couples therapy modalities, highlighting its potential to enhance empathy, secure attachment, and overall relationship satisfaction. Despite the promising anecdotal evidence and theoretical support for this hybrid approach, it still needs to be represented in empirical research.

The challenges of integrating EMDR into couples therapy are multi-faceted, encompassing epistemological, modal, and countertransference issues. This approach enriches the therapeutic process and aligns with contemporary views advocating integrating individual psychology within systemic frameworks. The assessment, contracting, and treatment considerations discussed offer practical guidelines for therapists striving to implement this integrative approach effectively. By navigating the complexities of pathological dependency,

balancing individual and relational needs, and carefully managing the therapeutic stance of multidirected partiality, practitioners can enhance the efficacy of couples therapy. The use of EMDR not only addresses traumatic residues but also promotes a more profound and authentic connection between partners.

References

von Bertalanffy L. An outline of general system theory. *The British Journal for the Philosophy of Science*. 1950; *I*:134–165.

Boszormenyi-Nagy, I. (1965). A theory of relationships: Experience and transaction. In I. Boszormenyi-Nagy, & J. Framo (Eds.), *Intensive family therapy: Theoretical and practical aspects.* (pp. 33-86). New York, NY. Harper & Row

Boszormenyi-Nagy, I., & Ulrich, D. N. (1981). Contextual family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 159-186). Levittown, PA: Brunner/Mazel.

Boszormenyi-Nagy, I., & Krasner, B. (1986). *Between give and take: A clinical guide to contextual therapy*. London, U.K. Routledge.

Bowen, M. (1965). Family psychotherapy with schizophrenia in the hospital and in private practice. In I. Boszormenyi-Nagy, & J. Framo (Eds.), *Intensive family therapy: Theoretical and practical aspects.* (pp. 213–244). New York, NY. Harper & Row.

Brown, D.P., & Elliott, D. S. (2019). *Attachment disturbances in adults.* New York, NY. Norton.

Dell, P. F. (1982). Beyond homeostasis: Toward a concept of coherence. *Family Process, 21*(1), 21–41.

Doğan, C.K., Yaşar, A. B., Gündoğmuş, I. (2021). Effects of the EMDR couple protocol on relationship satisfaction, depression, and anxiety symptoms. *Journal of EMDR Practice and Research, 15*(4), 218-230.

Framo, J. (1982). Marriage and marital therapy: Issues and initial interview techniques. In J. Framo (Ed.), *Exploration in marital and family therapy.* New York, NY. Springer.

Howard, K. (Host). (2023, March 1). "EMDR Therapy with Couples" with Dr. Jason Linder, LMFT (Season 2, No. 5) [Audio podcast episode]. In the *Let's Talk EMDR Podcast*. EMDR International Association. www.emdria.org/letstalkemdrpodcast

Johnson, S. M., & Greenberg, L. S. (1985). *The practice of emotionally focused couple therapy: Creating connection*. Levittown, PA. Brunner/Mazel.

Karpman, S. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin, 7*(26), 39–43.

Kaslow, F.W. (2007). Family systems theories and therapeutic applications: A contextual overview (pp. 35–75). In Shapiro, F., Kaslow, F. W., & L Maxfield (Eds.) *Handbook of EMDR and Family Therapy Processes*. Hoboken, NJ. John Wiley & Sons.

Kernberg, O. F. (1980). *Internal world and external reality: Object relations theory applied.* Lanham, MD: Jason Aronson.

Kerr, M.D. (1981), In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 143-172). Levittown, PA: Brunner/Mazel.

Knox, M. R. (2016). *The effectiveness of EFT combined with EMDR for military couples* [unpublished doctoral dissertation]. Virginia Beach, VA: Regent University.

Koedam, W. S. (2007). Sexual trauma in dysfunctional marriages: Integrating structural therapy and EMDR (pp. 223-242). In Shapiro, F., Kaslow, F. W., & L Maxfield (Eds.) *Handbook of EMDR and Family Therapy Processes*. Hoboken, NJ: John Wiley & Sons.

Lebow J., & Snyder, D. K. (2022). Couple therapy in the 2020s: Current status and emerging developments. *Family Process*, *00*, 1–27.

Linder, J. N., Niño, A., Negash, S., & Espinoza, S. (2021). Integrating EMDR and EFT to treat trauma in couple therapy: A literature review. *Journal of International Systemic Therapy*, 32(4), 251–272.

Linder JN, Niño A, Negash S, Espinoza S. (2022). Thematic analysis of therapists' experiences integrating EMDR and EFT in couple therapy: Theoretical and clinical complementarity, and benefits to client couples. *Journal of Marital and Family Therapy*. 48(3):777-797.

Litt, B. (2007). EMDR in couples therapy: An ego state approach. In C. Forgash, and M. Copeley (Eds.), *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (pp. 267–293). New York: Springer.

Litt, B. (2009a). In Ricci, R. J., Clayton, C. A., Foster, S., Jarero, I., Litt, B., Artigas, L., & Kamin, S. Special Applications of EMDR: Treatment of Performance Anxiety, Sex Offenders, Couples, Families, and Traumatized Groups. *Journal of EMDR Practice and Research, 3*(4), 279–288.

Litt, B. (2009b). EMDR in couples therapy. In M. Luber (Ed.) *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Special populations* (pp. 139–149). New York, NY Springer.

Litt, B. (2019). The marriage of EMDR and ego state theory in couples therapy [EMDR Advanced Training]. Self-organized.

McGoldrick, M., & Gerson, R. (1999). *The Genogram: Assessment and Intervention*. New York, NY. W.W. Norton & Co.

Neff, K. D. (2003). Self-Compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, *2*(2), 85–101.

Napier, A. Y., & Whitaker, C. A. (1978). The family crucible. New York, NY. Harper & Row.

Nijenhuis, E. R. S., & van der Hart, O. (2011). Dissociation in trauma: a new definition and comparison with previous formulations. *Journal of Trauma & Dissociation*, *12*(4), 416–445.

Protinsky, H., Sparks, J., & Flemke, K. (2001). Using eye movement desensitization and reprocessing to enhance treatment of couples. *Journal of Marital and Family Therapy*, *27* (2), 157–164.

Schnarch, D. (1991). *Constructing the sexual crucible.* New York, NY. Norton.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing (EMDR): Basic principles, protocols, and procedures* (2nd ed.). New York, NY. Guilford Press.

Snyder, M. (1996). Intimate partners: A context for the intensification and healing of emotional pain. *Women & Therapy, 19*(3), 79–92.

Talan, B. S. (2007). Integrating EMDR and Imago relationship therapy in couple treatment. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and Family Therapy Processes* (pp. 187–201). Hoboken, NJ. John Wiley & Sons.

Tofani, R. (2007). Complex separation, individuation processes, and anxiety disorders in young adulthood. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and Family Therapy Processes* (pp. 265–283). Hoboken, NJ. John Wiley & Sons.

White, M., & Epston, D. (1990)**.** *Narrative means to therapeutic ends*. New York, NY: Norton.

Woolley, S. R. (2016). Neutrality of Therapist in Couple and Family Therapy. In J. Lebow, A. Chambers, & D. Breunlin (Eds.), *Encyclopedia of Couple and Family Therapy* (pp. 1–3). New York, NY. Springer International Publishing.

Biography:

Barry Litt received his Master's in Family Therapy in Philadelphia,PA., where he studied Contextual Therapy with his founder, Ivan Boszormenyi-Nagy. He is an EMDRIA Approved Consultant. He has authored three chapters and a journal article on integrating EMDR with couples and family therapy. Litt has presented workshops at numerous EMDR and ISST-D conferences and provides advanced training on EMDR and attachment, complex trauma, intergenerational trauma, and couples therapy. Litt is dedicated to advancements in theoretical integration and technical innovation in EMDR therapy. He has a private therapy and consulting practice in New Hampshire.