Eye Movement Desensitization and Reprocessing in Counseling a Male Couple

Stacee Reicherzer
Walden University

This practice-based article discusses the use of eye movement desensitization and reprocessing (EMDR) in counseling "Paul" and "Eddie" (aliases), a couple for 4 years who presented with what they identified as "communication problems." Through the use of psychosocial assessments of the men's personal histories, it was determined that Paul's experience of feeling controlled and Eddie's struggles to believe that he mattered in the relationship were linked to traumatic memories in each man's childhood that related to his sexual identity development. EMDR was used to target the men's traumatic memories, alternating between Paul and Eddie. Following each EMDR treatment series, the work was integrated by talking through how the reprocessed material integrated into the overall couple experience, leading to both men's increased satisfaction in the relationship.

Keywords: eye movement desensitization and reprocessing (EMDR); gay; couples counseling; sexual abuse

Work with same-sex couples requires not only general skill in couple counseling, but also specific awareness of the unique challenges in relationship development within a culture of heteronormativity. All couples share basic structural needs of personal boundaries, the ability to manage intimacy in relation to their partners, and acceptance of partners' personality distinctions (Tunnell & Greenan, 2004). Additionally, as Gottman et al. (2003) identified through a 12-year longitudinal study that identified similar variables in relationship satisfaction for same-sex couples, mutual validation has been found to be particularly important for male couples when compared to both lesbian and heterosexual couples.

In work with male couples, the counselor should remain clear on the degree to which abilities to meet these needs are impeded by both covert and overt cultural forces that have shaped the men's lives (Reicherzer, Patton, & Pisano, 2009). Each man's personal history of gay identity development may be marked with significant disruptions in his history, such as shaming, silencing, or violence enacted against him (Dew, Myers, & Wightman, 2005). In turn, these disruptions may inhibit his ability to form intimate partner bonds, particularly when these bonds do not provide needed sources of validation (Gottman et al., 2003).

In illustrating the challenges for coupling that gay men experience, Green (2004) identified both the legal history of discrimination in housing and employment that has existed in the United States, as well as the active social oppression of gay identity and expression. As Green described, these experiences become internalized, inhibiting many gay men in relationships from self-acceptance or from their abilities to come out about their relationship statuses. Of significant focus for counselors, Green stated, "To reach that point of 'outness,' lesbian and gay partners must have successfully challenged in their own minds the negative views they were taught about homosexuality and their fears of being seriously harmed by discrimination" (p. 290). Green concluded that negative internalized views of gayness, reinforced by legal and sociocultural forms of discrimination, contributed to the stress of same-sex relationships.

In a study of domestic violence screening protocols in work with gay couples, Chan and Cavacuiti (2008) indicated that a culture of homoprejudice serves to simultaneously: (a) instill and perpetuate, sometimes violently, gay men's self-hatred; (b) normalize violence against and between gay men to such a degree that gay men could not see themselves as victims of abuse; and (c) provide no societal remediation for recognizing

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and addressing abuse in gay relationships. These authors illustrated that historical violence throughout a gay man's identity development often led to domestic violence in his adult relationships.

Similarly, Craft, Serovich, McKenry, and Lim (2008) used survey research of gay and lesbian adults to examine the relationship between disrupted childhood attachments experienced in coming out and emotional or physical relationship aggression. Of the gay men sampled, 93.5% of those who reported disrupted childhood attachments with caregivers indicated that they had participated in "psychological aggression" (Craft et al., 2008, p. 65) in relationships with partners during the previous year. Developmental disruptions during men's coming out experiences can create numerous additional challenges for gay couples (Connolly, 2004; Rostosky, Riggle, Gray, & Hatton, 2007). These include problems related to partners' communication styles (Domingue & Mollen, 2009), sex (Neilands, Chakravarty, Darbes, Beougher, & Hoff, 2010), and power differentials (O'Ryan & McFarland, 2010).

The effectiveness of eye movement desensitization and reprocessing (EMDR) as a therapeutic modality for neutralizing traumatic experiences that impede romantic partner bonds for gay men will be demonstrated in this practice-based article. Following a description of the modality in work with couple and family concerns, this author will detail her counseling work with Paul and Eddie, in which she used EMDR to target specific trauma memories that disrupted each partner's identity development, and consequently created challenges to intimacy building in the couple's relationship. In addition, the use of the relational-cultural theory (RCT) model for resource building between EMDR sessions will be discussed. The case description will include the couple's presenting concerns, a brief description of their histories, the assessment in planning to use EMDR, and the therapeutic procedures. As a central focus, this author will discuss the impact for each partner in witnessing the other's EMDR work, as it expanded both understanding and intimacy in the couple's relationship. The article will conclude with a description of the outcomes of this counseling journey, identifying recommendations for future research and clinical application.

Eye Movement Desensitization and Reprocessing in Couple's Therapy

Partners and families of sexual abuse survivors have benefited from the use of EMDR in addressing secondary and vicarious forms of trauma (Bardin, 2004), and from the use of EMDR in addressing reactive attachment disorder within family therapy (Taylor, 2002). In addition, there is a growing body of evidence-based literature that guides counselors in EMDR work with couples. Initial findings identify the therapy's value in couples' counseling in the fact that there is, for the partner being treated, a mechanism for accessing and reprocessing trauma memories that inhibit emotional accessibility (Flemke & Protinsky, 2001). This lack of emotional accessibility is thought to be attributed to learned patterns of behavior that originated in couple members' families of origin and that are later played out in relationship dynamics (Flemke & Protinsky; Litt, 2010; Moses, 2007).

Shapiro (2001) identified challenges in carrying out EMDR in work with a couple because of the emotionally challenging experience of witnessing a partner's reprocessing of trauma memories. For this reason, Shapiro (2001) recommended that EMDR therapists give great consideration of whether to conduct sessions jointly or individually, with decisions based on the therapist's judgment of both the safety and therapeutic value in conducting sessions with both partners present. Preparing the couple to witness each other's abreactions during the sessions is essential, including an outline of expectations for care and support that should take place during and after the experience of witnessing a partner's EMDR work.

In the development of joint couples' work using EMDR, Protinsky, Flemke, and Sparks (2001) pioneered a method they called "Eye Movement Relationship Enhancement (EMRE) therapy" (p. 157), which relies heavily on a foundational therapeutic alliance that establishes the trust and safety between partners and the counselor. These authors (Protinsky et al., 2001) stressed that a central concern exists in the partners' willingness to commit to supporting each other throughout the reprocessing work, and in the counselor's ability to manage her or his own emotional reactions that may occur during session.

As both Protinsky et al. (2001) and Moses (2007) indicated, a contributing factor to EMDR's function in couples' counseling is that emotional closeness can be enhanced through one partner's witnessing of the other partner's reprocessing of traumatic stimuli. To illustrate this further, Protinsky et al. provide a case example of work with a couple, stating, "The EMDR process combined with compassionate witnessing had decreased their relational 'stuckness' while increasing the closeness and intimacy that they had both been seeking" (p. 162). To this end, Moses outlined stages for reflecting on the experience of witnessing a partner's EMDR sessions, reflecting on the experience of witnessing, and integrating

the material that was learned by both the working partner and the witnessing partner into the couple's relationship.

Developing couples' abilities to observe and support each other's reprocessing work has led to the combination of EMDR work with imago therapy (Flemke & Protinsky, 2001; Talan, 2007), gestalt therapy (Capps, 2006), and structural therapy (Koedam, 2007). Whereas there is a growing body of evidence that demonstrates EMDR's effectiveness in treating couples, evidence of the therapy's use for addressing trauma-related lesbian, gay, bisexual, and transgender (LGBT) couple concerns is relatively limited. Balcom (2000), however, suggested that EMDR holds great potential in addressing the uniquely traumatic challenges to self-esteem and wellness that gay men experience in a culture of homophobia.

In a clinical trial, Carbone (2008) used the EMDR model with cognitive behavioral therapy (CBT) and rational emotive behavior therapy (REBT) in the treatment of three gay men diagnosed with posttraumatic stress disorder (PTSD). In each of the cases, severe social mistreatment occurred throughout childhood and adolescence in peer and familial reaction to the boys' developing gay identities. Of the three participants, "Andy" reportedly responded very little to the REBT cognitive restructuring exercises, but reprocessed his trauma memories following two sessions of EMDR; "Ben" reached a point early in CBT work in which "Ben was stuck in a cognitive mode of feeling like he had no right to ask people to treat him better" (Carbone, 2008, p. 313), but reduced his trauma on the Subjective Units of Disturbance (SUD; Shapiro, 2001) scale from "10" to "0" after two sessions of EMDR (Carbone); "Harry" responded favorably to his REBT work that sought to address his irrational beliefs, which were then targeted using EMDR to a result of notable relief. Following each of their EMDR sessions, as Carbone reported, participants were able to describe positive beliefs about themselves in response to their memories of the traumatic events and identified reductions in the somatization of these traumatic experiences.

No studies were found that discussed the practice of EMDR in work with same-sex couples. However, the demonstrated effectiveness in the studies of couple and family work, and Carbone's (2008) successful clinical trial in the work of the three gay male participants, suggest that EMDR holds promise for work with this community. This would be particularly true when using a therapeutic lens that specifically introduces issues of social justice in the lives of gay men.

Relational-Cultural Theory

RCT is a feminist modality (Miller & Stiver, 1997) for counseling that places central emphasis on the role of growth-fostering connections (Miller & Stiver) in developing human wellness. This model has been used successfully in work gay men (Goode-Cross & Good, 2008; Reicherzer et al., 2009). EMDR's function within a RCT model should be understood not as working exclusively on individual concerns for each couple member, but rather as modality for addressing aspects of the relationship that hinder its growth and wellness. Focus is placed on changes that occur over a relationship's lifespan, rather than an exclusive focus on the individual. In couples counseling, the emphasis is placed on examining the quality of the relationship in real time, observing its movement in and out of disconnection. As such, this model is founded an emphasis in supporting clients' abilities to represent themselves with authenticity in an effort to engender mutual empathy (Jordan, 2004) with others throughout their relational networks. RCT has held particular applicability in addressing power imbalances that occur in both societal and interpersonal relationships because of homophobia and heteronormativity (Reicherzer et al., 2009; Slater, 1995; Walker, 2002). The emphasis on representing oneself with authenticity supports the ability to approach another's authenticity with compassion (Miller & Stiver), while also fostering the ability to identify and name injustices or other disruptions to relational wellness (Walker, 2004).

Couples counseling using the RCT model has been identified, through clinical case examples, to enhance men's capacity to experience mutual empathy (Bergman & Surrey, 2004). This is caused by recognition of each person's impact on the relationship, which leads to an awareness of power imbalances along with greater clarity of how to address them. As Bergman and Surrey describe in work with coupled men:

> I am usually working to help him move off of a self-centered way of seeing, opening up the idea that men can attend to the "we" and to the *different* experiences of the other, and *be moved* by the other and the relationship. (p. 185)

RCT's emphasis of the function of building intimacy through mutual empathy extends to the counselor's function in couples work (Walls, 2004). Thus, the counselor participates with authenticity, allowing herself or himself to be moved by the counseling process (Miller et al., 2004) and to "grow in ways we are asking our clients to grow" (Walls, 2004, p. 109). In practice, an RCT-practicing counselor uses

the knowledge gained through authentic contact with couples to facilitate their movement through the therapeutic process.

RCT provides a logical context for the use of EMDR in conjoint couples' counseling. The process of witnessing a partner's EMDR session allows, within the growth-fostering relationship developed through the RCT model, for the genuine experience of empathy that Protinsky et al. (2001) and Moses (2007) identified as a central focus for EMDR within the couple setting. In addition, RCT's placement of the counselor as a partner in addressing client experiences of marginalization (Reicherzer et al., 2009; Slater, 1995; Walker, 2004) and its success in work with gay men (Goode-Cross & Good, 2008; Reicherzer et al., 2009) indicates the logic of RCT for work with gay couples.

Introduction to the Case of Paul and Eddie

Paul, who was 29 years old, and Eddie, who was 28 years old, had been together for 4 years. Both men were professionals and well established in their careers, although Eddie, a middle school teacher, felt unable to self-identify as gay at work because of the limitations of nondiscrimination laws in the state in which he lived. In all other areas of their lives, the men were able to be out as a gay couple.

They owned their home in a suburb of a major metropolitan area of the Southwestern United States, where they had a support network of close friends. Although both men reported feeling close to their families of origin, Eddie experienced a degree of estrangement because he did not feel supported in discussing his sexual orientation with some family members, including his mother. Paul's family accepted his gay identity and embraced both him and Eddie.

Presenting Concerns

The couple presented for counseling with an expressed desire to work on "communication." For Eddie, this meant that he struggled with what he perceived as Paul's lack of empathy and frequent mood changes that included angry verbal outbursts. Paul described concerns with Eddie's "controlling" behaviors and withdrawals, which Paul identified as leading to his angry outbursts. The couple identified that these concerns affected their ability to experience emotional and sexual intimacy together. In addition, they reported that practical concerns of managing their household and social needs were being impacted by their challenges in communicating with each other.

Both partners recognized that their relationship could be improved by each person's willingness to take steps toward change. Just as each was able to share an explanation of the complications he had with the other, both partners readily acknowledged their own contributions to the problems in the relationship. They wanted to use couple counseling to change their own behaviors in relation to the other partner to have a more rewarding relationship.

The Couple's History

Early in the counseling relationship, each partner was given a self-paced psychosocial assessment to complete at home. When they returned the assessments, they reported that they completed their assessments individually, and then shared their results. The assessments asked questions about counseling history, health and medical status, family of origin, experiences throughout school, coping mechanisms, adult relationships, occupational histories, and other developmental experiences of note.

Eddie identified that he had a history of depression, and had previously participated in individual therapy for a period of 9 months. He described fears about being "outed" at his job, and that job stress weighed heavily on his mind, as a result. In his history, he indicated that he had been an obedient student and son, getting along well with teachers. However, he also discussed being disciplined for any infraction by his mother, whom he viewed as loving, yet controlling and stubborn. Eddie identified smoking and overeating as coping mechanisms, and expressed concern about his health. In describing his relationship with Paul, Eddie identified that problems had accumulated over the previous 3 years (a significant period for a relationship of only 4 years).

Paul's psychosocial history revealed what he described as "a lot of drama" in his household while growing up, including bickering with his siblings and parents, whom he described as affectionate and close, but manipulative. During a period of depression at the age of 12, he attempted to suffocate himself to death. He described his adolescence as a period of "rebellious" behavior, during which he reported a high degree of sexual activity. Paul discussed that he was estranged from his father after coming out as gay until the age of 22, but that following a series of emotional discussions between them, he and his father were now "best friends." Paul corroborated Eddie's report of the 3-year development of relationship problems, but expressed his belief that he and Eddie would be making "changes for the better" in coming to counseling. Both men reported casual use of marijuana and social drinking.

Assessing the Couple's Needs

In identifying the systemic nature of their responses to each other, each partner began to clarify how the problems in the relationship impacted each other. Eddie identified, in addition to stressors that related to being fear of being "outed at work," his hurt in reaction to Paul raising his voice at him and getting "snappy." For him, the reaction of anger was extremely disconcerting, and, as Eddie described it, felt like rejection. Paul expressed confusion about how the situation occurred. For Paul, anger was the only way to have "voice" in a situation in which he did not feel heard. Paul experienced frustration when Eddie withdrew or alternatively demonstrated "caretaking," identifying Eddie's behaviors as attempts to control or manipulate, which Paul identified as "typically gay." This frustration often led to angry outbursts. Eddie withdrew from Paul when he identified Paul becoming angry. The cycle perpetuated, creating chronic experiences of disconnection and isolation in the relationship.

Early in the work, it became evident that each partner was committed to changing behaviors that disrupted the relationship. For example, Paul began to cry when Eddie discussed how he was impacted by Paul's volatility, and Paul expressed his desire to stop being hurtful. Eddie described his feelings of love for Paul, and his own hurt in learning how his withdrawal impacted Paul.

As each partner revealed core feelings of rejection (Eddie), and being silenced (Paul), the author hypothesized that there was a traumatic response occurring for each person that related to these emotionally intense experiences. This conclusion was made after reviewing the material they presented in counseling, along with the information from their psychosocial assessments. The author wished to identify clearly how themes of silencing (Paul) and rejection (Eddie) had developed in previous relationship dynamics in such a way that their experiences were now blocking this couple's intimacy.

Case Conceptualization

The focus for counseling was to stop this cycle by creating new ways of experiencing each partner's range of emotional responses. The author chose to use EMDR within the couple counseling because she wished to not only target the memories in which these themes were embedded, but also use a therapeutic modality that allowed each partner to witness the other's healing. As Flemke and Protinsky (2001) identified, the reprocessing of traumatic memories that inhibit intimacy, along with the experience of witnessing a partner's reprocessing of intense memories, allows greater understanding and intimacy within the couple's experience. The author believed that this modality would help the couple reach their goals for counseling.

Establishing EMDR Safety Protocols

As with any modality addressing trauma, it is critical that counselors follow safety protocols to assure the client's well-being is maintained throughout treatment (Shapiro, 2001). In addition to the psychosocial history that she had obtained, the author needed to ensure that the clients were clear on the treatment's procedures and intended outcomes. She reviewed with the couple the potential benefits of the therapy, as well as risks associated with recalling traumatic memories. Additionally, the support system that each person needed to have in place while undergoing this therapy was identified. Following the couple's informed consent to participate in EMDR, they were both screened for dissociative symptoms using the Dissociative Experience Scale (Carlson & Putnam, 1993). After identifying that neither Paul nor Eddie met the clinical threshold for dissociative identity disorder, the author determined that each partner was a candidate for EMDR.

The positive effects of EMDR on persons who actively use drugs are largely unknown (Shapiro, 2001). Under the suggestion of an EMDR consultant with experience in working with addictions, the author asked the men to refrain from marijuana use for at least 48 hours prior to a session.

Therapeutic Process

The "safe place" (Shapiro, 2001, p. 125) exercise was used first to establish for each person a self-relaxation technique. Eddie envisioned a large home library with shelves of books and elegant leather chairs, along with classical music in the background. This image brought feelings of "contentment, calmness, and laziness" that he felt in his stomach. Paul envisioned a sunny day at the beach with summer activity all around. This was accompanied by feeling happy, safe, and comfortable, which he felt in his knees, fingers, wrists, and joints.

Over the course of the remaining treatment (17 months), EMDR sessions were alternated between the two men. One person was treated, followed by processing the experience both of completing the EMDR session and of witnessing the other's treatment, and then the other person was treated. Thus, some of the 45-minute sessions were used entirely

on EMDR, while others were exclusively dedicated to processing and integrating the work into the couple's emerging experience. Initially, three sessions were typically dedicated to reprocessing a traumatic memory before the disturbance reached its lowest level on the SUD scale. However, in later sessions, reprocessing occurred faster for both men, with a memory typically taking no more than two sessions to reprocess.

The EMDR work began with Eddie. To start, the author used the float back technique (Shapiro, 2001) to target a central theme of "I don't matter." Eddie was asked to think about the feelings that were associated with "I don't matter" and to "float back" to the earliest memory he had of feeling this way. Eddie relayed a story of riding with his father as a 7-year-old. In trying to engage his father to talk to him, Eddie had asked his father questions about science, in which he had known his father was interested. His father had replied with, "You don't have to talk all the time."

Eddie described how the experience created his perception that he was unwanted (negative cognition), with accompanying feelings of shame, disgust, and self-contempt that he experienced as a body sensation in his stomach. The positive cognition that he wished to believe in response to the situation was "I'm a good person and able to enjoy life."

Within Eddie's first few sets of eye movements, he experienced an increase in stomach pains and tightness in his chest, alternating with naming "shame" and "disgust." With continued sets, he experienced a reduction in pain and an increase in relaxation. After three sessions, the target memory was no longer disturbing, nor did its memories create feelings of shame, disgust, or self-contempt. The positive cognition, "I'm a good person and able to enjoy life" was identified as valid. Finally, the memory held no associated pain in his body.

Following the first sessions of EMDR with Eddie, the experience was discussed with both Eddie and Paul. While Eddie described feeling relaxed, Paul identified feeling hurt in witnessing Eddie's story. Paul also identified that he felt "closer to Eddie," having witnessed Eddie's reprocessing of his experience, and "better able to understand his [Eddie's] reactions to things."

In the following weeks, we targeted Paul's memories of "not feeling heard," again using the float back technique (Shapiro, 2001) to identify the earliest memory of this experience. Paul's memory was of coming home from elementary school (he was in second grade at the time) and looking for his dog, only to find that his father had had the dog euthanized. His negative cognition of "I am alone" was experienced with sadness and fear that manifested as pain in his temples. The positive cognition that he wished to believe about the situation was "I have all of the people around me that I need."

Within a few sets of eye movements, Paul began to experience disorientation, identifying a great deal of anger and confusion followed by a numbing sensation, and experiencing himself in a "white room." After about 20 minutes of unsuccessfully attempting to guide Paul visually and ground him during the EMDR work, the author elected to discontinue the EMDR for the session (which, because the work took place in a community agency, was strictly governed by a policy of session lengths). The author instead worked to ground Paul by guiding him to notice physical sensations, such as sitting in his chair, the feel of the air in the room, and sounds of clocks and street traffic. Paul was asked of specific memories about the day, what he had for breakfast, and other details the authors wanted to bring to his present moment of awareness. Finally, the author had him manipulate his body, wiggling his toes and fingers, and stretching his arms and legs. Although Paul shifted back out of his abreactive state, arrangements for Eddie to drive home and for a follow-up phone call the next day with the author. Paul reported no additional disturbances over the next week.

In the next session, the EMDR sets were began using the original targets. In the event of dissociation within abreaction, the author was prepared to ask Paul to visually manipulate his picture of the target memory if necessary, imagining himself as if an old photo or with his child "self" holding the hand of his adult self. However, these steps were not needed. As the sets began, Paul experienced intensified pain in his shoulders as if being "held down," as well as fear and flashing images of looking for his dog. Unexpectedly for him, he moved into an image of his older brother holding him on the ground and rubbing his penis on Paul's face. Two sets later (following "being made fun of for crying" and then "anger"), Paul experienced "confidence." In the next set, he made the statement, "I stand by what I believe in." Five sets later, his SUD score was reduced to "0." With a few additional sets that worked to strengthen his SUD score, validate the positive cognition of "I have all of the people around me that I need," and address muscle tension, Paul ended this session with feeling "love, warm, and support from Eddie."

The time that followed this session was dedicated to building on Paul's feelings of closeness with Eddie,

and with Eddie's responsive compassion in the revelation of Paul's experience of sexual abuse. Eddie moved into closer connection with Paul in learning that he represented safety and love in response to Paul's memories of feeling alone and frightened. Over the next several months, this pattern of alternating EMDR sessions between the two men was continued, allowing time between EMDR sessions to process the impact of one man's EMDR work on the couple's experience. This focus included sexual identity development during adolescence for Paul and fears of job loss because of being "outed" for Eddie.

Paul did not dissociate in session again following the initial episode, and additional sessions focused to strengthen his personal safety in response to associated trauma memories with his brother. In sessions that followed, Paul identified additional memories of sexual shame as his orientation developed over the course of adolescence. Specifically, these focused on feelings such as the "shame and disgust" Paul identified in one session that were associated with memories of early sexual encounters with other adolescent males. Targeting this and other feeder memories that were associated with negative memories associated with gay encounters allowed Paul to experience the positive cognitions around his identity that included "I accept myself as gay," and "my sexuality is normal and healthy."

In his EMDR sessions, Eddie tended to experience somatization of his trauma memories as stomach pains, which gradually reduced in duration and intensity. Significantly, as we continued to treat feeder memories of his initial trauma that he had experienced of his father's rejection in the initial sessions, his experiences in coming out began to surface. He recalled a memory of coming out to his mother as gay at the age of 13 in which he stated that she had dismissed him as "confused." His picture was of himself sitting in the corner of his bedroom, crying. His negative cognition of "I am unlovable" was accompanied by feelings of hurt, sadness, and anger. His positive cognition, "I am very lovable" was rated as a 2 on the VOC. Once again, he experienced the body sensation of nausea, this time with tightness in his chest.

As Eddie's sessions progressed, he experienced a movement in his chest and body, with alternating emotional experiences of confusion and guilt. Although by the end of a 45-minute set of EMDR, Eddie's Validity of Cognition (VOC) score was at a 3 and his SUD score was at a 5, he identified feelings of "calmness." We continued over the next two appointments with this target memory. Beginning in his second session, Eddie began identifying memories of positive coming out experiences that had occurred in his adulthood, as well as more neutral and even positive interactions with his mother that clustered around his sexual identity and his relationship with Paul. These were interspersed with continued feelings of "relaxed" and less discomfort in his physical sensations. By the end of the second 45-minute session of EMDR, Eddie's VOC score was 8 and his SUD score was 2; however, he still had some of the sensation of nausea occurring. In our next session, the nausea was completely neutralized after 8 sets, although the SUD score remained 2 because as Eddie stated, "It's not going to ever be completely okay that she didn't take me seriously when I came out." This proved to our most significant set in addressing his identity development as a gay man.

The sessions following both Paul's work of his adolescent sexual development and Eddie's coming out experience were particularly reflective around the shared pain of identity development that both the clients and the author (a transsexual woman) all had experienced. These periods were particularly meaningful in that both Paul and Eddie expressed their sense of being "duped" into believing that gay identity development was inherently wrong (in Paul's case) or merely a state adolescent confusion (Eddie). In each instance, both the witnessing partner and the author were able to hold with the partner who had just completed the EMDR session the outrage of social opprobrium. Consequently, these were also opportunities that allowed the couple to focus attention to what they enjoyed about their relationship, including sex, identity, male intimacy, and their relationship network, that were uniquely gay.

As both men reprocessed and integrated their traumatic memories, they began to experience several positive changes in their lives that impacted their relationship. Each partner had a greater emotional responsiveness to the other, based not only on the removal of trauma-based reenactment responses that they used previously, but also in the heightened understanding of the other's cognitive and emotional processing of his lived history and present circumstances. Intimacy was heightened and the couple came to experience greater joy in their lives together.

EMDR work was concluded following the implementation of the "positive templates" (Shapiro, 2001, p. 210) protocol to strengthen the couple's abilities to carry their skills into their future. Both men identified strongly with statements that they could resolve problems in their relationship through their shared

willingness to take risks and to be vulnerable with each other.

In speaking with the couple 2 years following the conclusion of our work together, both men reported continuing satisfaction with their relationship. As Eddie wrote to the author in a recent e-mail:

> We continue to grow each day and still strive to find ways to love each other even better . . . . We are committed to making things the best we can and hold space for the shit that comes with two men loving and living with each other.

Discussion of Treatment Implications

EMDR proved effective in addressing traumatic histories that blocked Paul and Eddie from experiencing trust and intimacy in their relationship. Further, witnessing each partner's EMDR process of moving from feeling alone, isolated, and silenced evoked tremendous understanding and emotional regard for the other. The author was tremendously impressed with the personal commitment that each of them showed toward improving their relationship.

Particularly, rewarding were the periods when, after processing one of the men's memories, the couple had time to reflect on the experience together for the remainder of a session. Immediately following the EMDR session that neutralized Eddie's response to his mother's dismissal of his coming out, Eddie was clearly relaxed and relieved. Paul was demonstrably excited by Eddie's demeanor, which was markedly different. He shared with Eddie how he appeared to be "glowing," and that he had not seen such confidence and centeredness in Eddie before. The couple reported the next week that their sex life had "been fantastic" following the session and that Eddie's enhanced vulnerability invited Paul to be similarly vulnerable about their shared experiences in coming out as gay men, creating a space for emotionally intense dialogue and romantic exploration between them.

This author has observed that socioculturally in the United States, little is done to prepare men to understand or appreciate vulnerability in their relationships, particularly those with other men. There is a societal stricture to impress on boys and men the need to appear invulnerable in male relationships. This is a major deficit, as an inability to be vulnerable blocks intimacy that is needed for emotional wellness in partner bonds (Shepard, 2005). In Paul and Eddie's case, Paul's witnessing of Eddie's movement through vulnerability and the subsequent healing that occurred as a result led to Paul's enhanced emotional attraction to Eddie, culminating in the couple's heightened romantic intimacy.

The structure of these sessions not only taught the couple members how to appreciate vulnerability in their partner relationship, it gave them a template for understanding how and when to be vulnerable in other close relationships. Toward the end of their time in counseling, Paul reported that he had told his family that "being vulnerable is a good thing."

Couple counseling with these men highlighted what the author observes to be a natural advantage for same-sex couples. Counseling heterosexual couples can often involve a great deal of effort to work through gender differences that influence expectations for their relationships. Personal histories of each couple member that have shaped worldviews are largely abstract and difficult for the other partner to comprehend. However, for Paul and Eddie, feelings of pain and loss that were associated with coming out during adolescence were a familiar and accessible source of empathy. For this reason, it was relatively easy to engage the men in each other's EMDR process.

Eddie and Paul's case is an encouraging work that demonstrates potential for EMDR's strength in addressing trauma in the lives of gay couples. However, this case example should be understood within its limitations. Eddie and Paul are both educated men, White, and of an upper-middle-class socioeconomic status. Their ability to attend sessions every 1–2 weeks for 17 months is not a privilege that all gay couples have. While EMDR can effectively be used in brief therapies to target specific sets of memories (Carbone, 2008; Shapiro, 2001), its use in couples work may require a larger time commitment than many couples can make. The process of targeting one partner's memories, integrating these memories by discussing them between the couple in follow-up conjoint sessions, and continuing by processing the other partner's memories is a methodical journey that is best undertaken with clear client understanding of the time commitment that might be involved.

Additionally, the use of EMDR with gay couples in which one or both members are not White should be considered within culturally appropriate boundaries. EMDR was an easy fit for Paul and Eddie's worldviews, and these men consented to the therapy following the explanation of the procedures. Care should be taken to explain the tenets of EMDR, with respect given to the uniqueness of each client.

Finally, EMDR's effectiveness for drug abusers is not largely known and may be contraindicated in cases in which a person is likely to use drugs in response to

the intensity of the treatment (Shapiro, 2001). Paul and Eddie casually used marijuana, from which they were asked to abstain for 48 hours prior to an EMDR session to assure the effectiveness of treatment. For clients of whom a current substance addiction is suspected or known, care should be taken to assure that the client is not actively using or prone to use as a coping mechanism prior to the session.

Recommendations for Future Study

Paul and Eddie's success in EMDR work corroborates the positive outcomes of Carbone's (2008) clinical trial in treating trauma experiences in gay men. Additionally, the success in work with this couple was similar to results found by Protinsky et al. (2001) in work with heterosexual couples. This suggests potential for EMDR's use in the treatment of same-sex couples.

Additional EMDR research is needed to further determine the value of this treatment with others in the LGBT community. Couples case studies and experimental research that examine a spectrum of LGBT experiences would enhance clinical knowledge of the practice of EMDR for this diverse community. More work in examining the mechanisms of trauma for LGBT persons, with specific focus on the coming out process and identity development, would advance counselors' knowledge of treatment needs for the community. This could lead to more targeted and efficacious treatment methods for addressing a spectrum of LGBT trauma concerns.

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Correspondence regarding this article should be directed to Stacee Reicherzer, LPC, Assessment Coordinator of Counseling Programs, School of Counseling and Social Service, Walden University, 155 Fifth Ave. South, Minneapolis, MN 55401. E-mail: stacee.reicherzer@waldenu.edu