An Integrated Approach to Treating OCD with EMDR

Does EMDR work for OCD?
This is a very common question with my consultees and in the Facebook EMDR Therapist groups. The answer is….it depends.

Let's start at the beginning…to give us a framework and context to have the discussion about whether EMDR works for OCD.

Overview of OCD:

- What is OCD?
  - OCD is characterized by unwanted, persistent thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) that an individual feels driven to perform. These obsessions and compulsions can significantly interfere with daily life and cause distress.
- What is happening in the brain of someone who is struggling with OCD?
  - Neuroimaging research suggests that there's abnormal cycling in the cortico-striato-thalamo-cortical (CSTC) circuit. To oversimplify, clients are getting stuck in a loop where the brain responds too much to errors (possibility) and too little to stop signals. (did I lock the door? Unsure of the errors and then they can't stop themselves from checking, for example.)
- What does the research say about the etiology of OCD?
  - Research shows that the origins of OCD seem to be a combination of genetic predisposition, epigenetics, learned behaviors and the impact of trauma and stress. Approximately 50% of the risk for developing OCD can be attributed to genetic factors and having a first-degree relative with OCD significantly raises the risk of developing the disorder.
  - Research indicates that individuals with OCD often report higher rates of childhood trauma. For example, a study by Mathews et al. (2008) found that childhood trauma was significantly associated with more severe OCD symptoms and an earlier age of onset.
  - Stress and trauma can trigger the onset of symptoms in individuals who are genetically predisposed or have a subclinical case of the disorder. One study found that 82% of participants with OCD reported a trauma history (Gershuny et al, 2008).
  - Another study notes that OCD can sometimes even develop as an adaptation to trauma and helps the client avoid traumatic material (Wadsworth, 2023).
  - And yet another study from 2017 suggests that individuals with a primary diagnosis of OCD tend to have more severe and impairing obsessive-

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compulsive symptoms if they have a lifetime comorbid PTSD diagnosis (Ojserkis, 2017).

- OCD Complexity & Difficulty in Treatment – OCD is often difficult and complicated to treat (Mancebo et al., 2008). Brain patterns are rigid and well formed, there is often a lot of defensiveness in the system and clients often hide their symptoms because they feel a lot of shame.
    - Not everyone responds well to the high doses of SSRIs which is often frontline treatment (Fineberg et al.,2013).
    - There is not always the motivation to face fears and feel anxiety that is required for ERP (Foa et al., 2005).
    - Defense mechanisms - Research on patients with Obsessive-Compulsive Disorder (OCD) indicates that many individuals use defense mechanisms like denial, rationalization and avoidance, which can complicate treatment (Smith et al., 2022).
    - Lack of insight - A significant proportion of OCD patients lack insight into their condition, meaning they may not fully recognize their thoughts and behaviors as irrational (Zhang et al., 2023).
    - Meta-Cognitive Biases - Research has shown that OCD patients may have meta-cognitive biases, such as thought-action fusion, where they believe that having a thought is morally equivalent to acting on it.
    - Insecure attachment styles have been found to be common in those struggling with OCD (Leewan et al., 2020).
    - Shame is a significant barrier to the disclosure of OCD symptoms. Individuals with OCD often experience intense shame about their obsessions and compulsions, which can lead to reluctance in sharing these details with therapists (Cândea & Szentagotai-Tătar, 2018).
    - Dissociation: Research shows a strong link between dissociation and OCD (Soffer-Dudek, 2023).
    - There are often co-occurring disorders with OCD. One study reports that approximately 90% of individuals with OCD have at least one comorbid psychiatric disorder (Fontenelle et al., 2021).

Which leads us to a very important question to consider - what other co-occurring disorders are present when someone comes in with OCD? And what intervention is the best approach in treating those disorders?

OCD Treatment Options

The treatment of Obsessive-Compulsive Disorder (OCD) often involves a combination of ERP and an SSRI, these being the most common and the most evidenced-based

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treatment options. The primary goal of treatment is to reduce the severity of symptoms and improve the patient's quality of life. There is some new research showing promise for ketamine, TMS (Transcranial Magnetic Stimulation) and a few other neuromodulation techniques.

Let's explore the research on EMDR and its effectiveness in treating OCD.

- One small RCT found that EMDR performed better than citalopram and the other found that it was at least as effective as ERP (Bohm, 2019). These studies also recommend a comprehensive treatment model which also utilizes in vivo exposure.
- There are also numerous case studies and small studies showing the effectiveness of EMDR in reducing OCD symptoms (Bohm, 2019; Keenan et al., 2018; Marr, 2012; Marsden, 2016).

It will be important, therefore, to take all of this into consideration when creating a treatment plan.

Personally, I have yet to work with a client who did not have co-occurring disorders and/or a trauma history. In my experience and in hearing from other EMDR clinicians, clinicians do have success using EMDR along with other modalities in reducing OCD symptoms.

Looking at OCD through the AIP Lens

Sandra Paulsen describes OCD as "a child's magical coping solution." I see it as a pre-disposed and/or learned adaptation to stress. I tend to work somatically and from the bottom of the brain up, so I see this adaptation as a direct attempt to avoid bodily sensations and cope with underlying distress.

Considerations for Phases 1-7 in Using EMDR to Treat OCD:

Phase 1 – History Taking

In this phase, I conduct a comprehensive assessment to understand the client's trauma history, attachment background, motivation for change, and insight into their condition. I also evaluate their stability, window of tolerance, and maladaptive coping mechanisms. Screening for co-occurring disorders is crucial, as clients rarely present with only OCD.

When creating a treatment plan, it's so important to always align with the client's goals, not your own or what you might see as the work to be done. And what modalities you use to treat depends many factors, including what disorders are present, how the client prefers to work and what you find in the history taking.

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Phase 2 – Preparation

I find that effective OCD treatment often requires extensive preparation, which can itself help reduce symptoms. It's also important for me to understand the rationale behind each intervention I use rather than following recommendations blindly. Key areas I often address include:

1. **I-CBT**: I often have clients complete I-CBT modules as homework, providing a cognitive framework to discuss the looping thoughts typical of OCD. Psychoeducation about OCD is often very helpful.
2. **Therapeutic Alliance**: Attunement is critical. Plans may need to be flexible to maintain attunement and avoid recreating past relational dynamics. I try to come into each session with an open mind.
3. **Emotional Regulation**: Clients with OCD often have a narrow window of tolerance and avoid emotions and bodily sensations. Techniques like mindfulness, grounding, the 54321 method, affect tolerance protocols, and DBT skills can be helpful.
4. **Internal Conflict/Ambivalence**: I find that techniques such as the two-handed interweave and parts work (IFS, Robin Shapiro, or Dolores Mosquera) can significantly reduce OCD symptoms.
5. **Attachment Resourcing**: I address attachment gaps with imaginary attachment figures and methods from Attachment-Focused EMDR (Laurel Parnell) or Dyadic Resourcing (Philip Manfield).
6. **Dissociation**: I use parts work, grounding techniques, and CIPOS (Jim Knipe) to manage dissociation. I also slow way down in session when someone has dissociated.
7. **Somatic Exposure**: I often ask clients where they feel sensations in their body and use Peter Levine's somatic tracking techniques (pendulation, sensation inquiry, psychoeducation about the nervous system) to build exposure tolerance and resourcing over time.
8. **Distancing Technique**: Sometimes, psychoeducation about meta-cognitive biases (thoughts are not actions) in combination with distancing is helpful.

Phases 4-7

Target Selection: I often let clients guide what comes up in the session and use float backs to find the source of their current distress. This helps me attune to their immediate needs and leverages their high motivation to address present issues. Other therapists might target the worst fear or the worst/first memory or even the obsession or compulsion itself.

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I also explore and target the sensation that arises if the client does not complete the compulsion, identifying the negative cognition (NC) associated with it and then floating back or just somatically tracking the sensation. Some therapists focus on the triggers for obsessions, which often leads to the same sensation or core memory.

There is no single right answer; it's about what works for you and your client in that moment.

I use Standard EMDR Protocol to process memories.

Important Considerations for Working with OCD:

- **Avoid Reinforcing Compulsions**: It's crucial not to feed a client's OCD by helping them complete the compulsion. For example, instead of giving reassurance to someone seeking it, use it as part of the work. Ask, "What happens when I don't reassure you? What do you feel in your body?"
- **Slow Down**: There is often a lot of energy behind wanting to eliminate anxiety quickly, which can transfer to us and make us feel pressured to perform. This can indicate that the client wants us to fix them, which means they are not taking ownership of their experience.
- **Indirect Approach**: Directly targeting obsessions can be ineffective as defenses kick in. It's more helpful to subtly tease apart the defenses or approach indirectly. Address blocking beliefs, internal conflict, increase motivation, and directly address resistance to feeling somatically (e.g., feel the sensation of bracing or resistance in your body and track it).
- **SEEK CONSULTATION**! For more information about consultation, see my website: https://findyourstillwater.com/emdr-perinatal-case-consultation/. This webpage also has a free resourcing guide that I often share with my consultees.

<u>Techniques/protocols/resourcing I often use in OCD treatment:</u>

- Two handed interweave – chapter 6 in Shapiro, R. (Ed.). (2005). *EMDR solutions: Pathways to healing*. W. W. Norton & Company.
- Affect tolerance protocol - p. 16 in Abel, N. J., & O'Brien, J. M. (2014). *Treating addictions with EMDR therapy and the stages of change*. Springer Publishing Company.
- DeTUR – Popky, A. J. (2005). DeTUR, an Urge Reduction Protocol for Addictions and Dysfunctional Behaviors. In R. Shapiro (Ed.), *EMDR solutions: Pathways to healing* (pp. 167–188). W. W. Norton & Co.
- Level of Urge to Avoid (LUOA) – Jim Knipe, Chapter 8 in Shapiro, R. (Ed.). (2005). *EMDR solutions: Pathways to healing*. W. W. Norton & Company.

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- What's Good About…(insert blocking belief, maladaptive thinking or behavior)? Unknown source.
- Attachment resources - **Attachment-Focused EMDR: Healing Relational Trauma** by Laurel Parnell or **Dyadic Resourcing** by Philip Mansfield.
- Detail-oriented interweave from Karsten Bohm when they are afraid they aren't going to do it right (doubt) and start obsessing and they start looping
- Parts work: IFS (https://ifs-institute.com), Dolores Mosquera (https://emdradvancedtrainings.com/product/3-days-of-learning-with-dolores-mosquera-m-s/) or Robin Shapiro (https://emdradvancedtrainings.com/product/easy-ego-states-interventions-robin-shapiro-january-12-13-2024/).
- Somatic Tracking – Peter Levine in An Unspoken Voice.
- CIPOS - https://emdrtherapyvolusia.com/wp-content/uploads/2016/12/The_Method_of_Constant_Installation_of_Present_Orientation_and_Safety.pdf

Common EMDR protocols/approaches used with OCD:

- Flash Forward - Developed by Ad de Jongh, this protocol focuses on desensitizing an individual's mental representation of a future "worst-case scenario".
- Distancing Technique – Developed by Paula Krentzel, the Distancing Technique is designed to help to become detached observers of their thoughts, sensations, images, and urges by pairing the thought with an adaptive coping statement (labeling the thought – that is my OCD).
- Sandra Paulsen – combination of EMDR/ERP and parts work.
- Karsten Bohm – ERP and standard EMDR as part of a comprehensive treatment plan; ERP to address the OCD and EMDR to address trauma – she advocates EMDR first if client has low motivation.

EMDR OCD Trainings

- Did I Lock the Door? Sandra Paulsen – Parts/ERP/EMDR – is currently being revamped but can find small pieces of it here:
  https://www.youtube.com/watch?v=xB1s2ccLnmU
  https://www.youtube.com/watch?app=desktop&v=xkWuo5OR3ME
- The Distancing Technique – C. Paula Krentzel, PhD & Jennifer Tattersall, LCSW https://www.emdria.org/course/the-distancing-technique-ocd-and-anxiety-disorders-how-to-treat-with-emdr/
- Flashforward - EMDR Therapy for Panic Disorder, OCD and Specific Phobias - De Jongh and Matthijssen https://emdradvancedtrainings.com/product/emdr-

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therapy-for-panic-disorder-ocd-and-specific-phobias-6-ceus-de-jongh-and-matthijssen/

Research about OCD & EMDR

https://www.emdria.org/blog/emdr-therapy-and-ocd/

Reading

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Other Links

- I-CBT (Inference-based Cognitive Behavioral Therapy) - https://icbt.online (free modules for therapists and worksheets for clients)

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