

EMDR 17th European Conference. The Hague- Orlanda 2016



Treating Obsessive Compulsive Disorder [OCD], using Eye Movement Desensitisation and Reprocessing [EMDR]: A case series design.

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OCD CSI



"Oh no! That painting's askew!"

Different forms of OCD

"I can't stand the uncertainty, I need the guarantee of safety"

Session Plan

- What is OCD?
- Psychological Rational for OCD
- Has EMDR something to offer?
- EMDR OCD research to date
- Introduction to our research & Results
- Case presentation



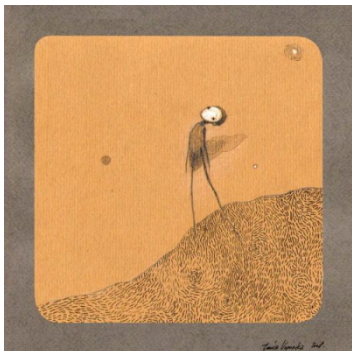
Learning Objectives

- I. To gain a deeper critical understanding of the utilisation of EMDR in the treatment of OCD.
- II. To be able to discuss critically how EMDR may be used in reducing the emotional valance, significant to “Intolerance of Uncertainty” as experienced in OCD.
- III. To examine critically the limitations, if any, in the application of EMDR with OCD with particular reference to the Adaptive Information Processing (AIP) model.



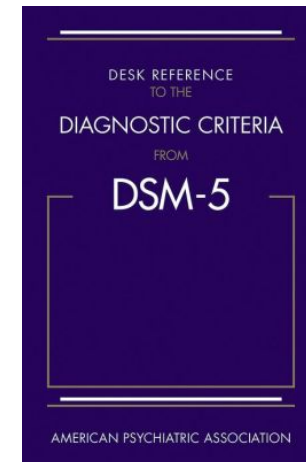
The Diagnostic Phenomenology of OCD (DMS-IV)

- Intrusive thoughts, Images and Impulses
- Obsessions and or Compulsions
- Compulsions are meaningfully related to fears
- By definition, the person seeks to ignore or suppress intrusions
- Key to diagnostic is distress/disability



DSM-5 OCD & Related Disorders

- **OCD**
- **BDD**
- **Hoarding Disorder**
- **Trichotillomania**
- **Excoriation Disorder**
- **Substance/Medication-induced Obsessive Compulsive and Related Disorders**
- **Obsessive Compulsive and Related Disorders Due To Another Medical Condition**



Defining features of Obsessions:

- Intrusive quality
- Unacceptability
- Subjective resistance
- Uncontrollability
- Ego-dystonicity

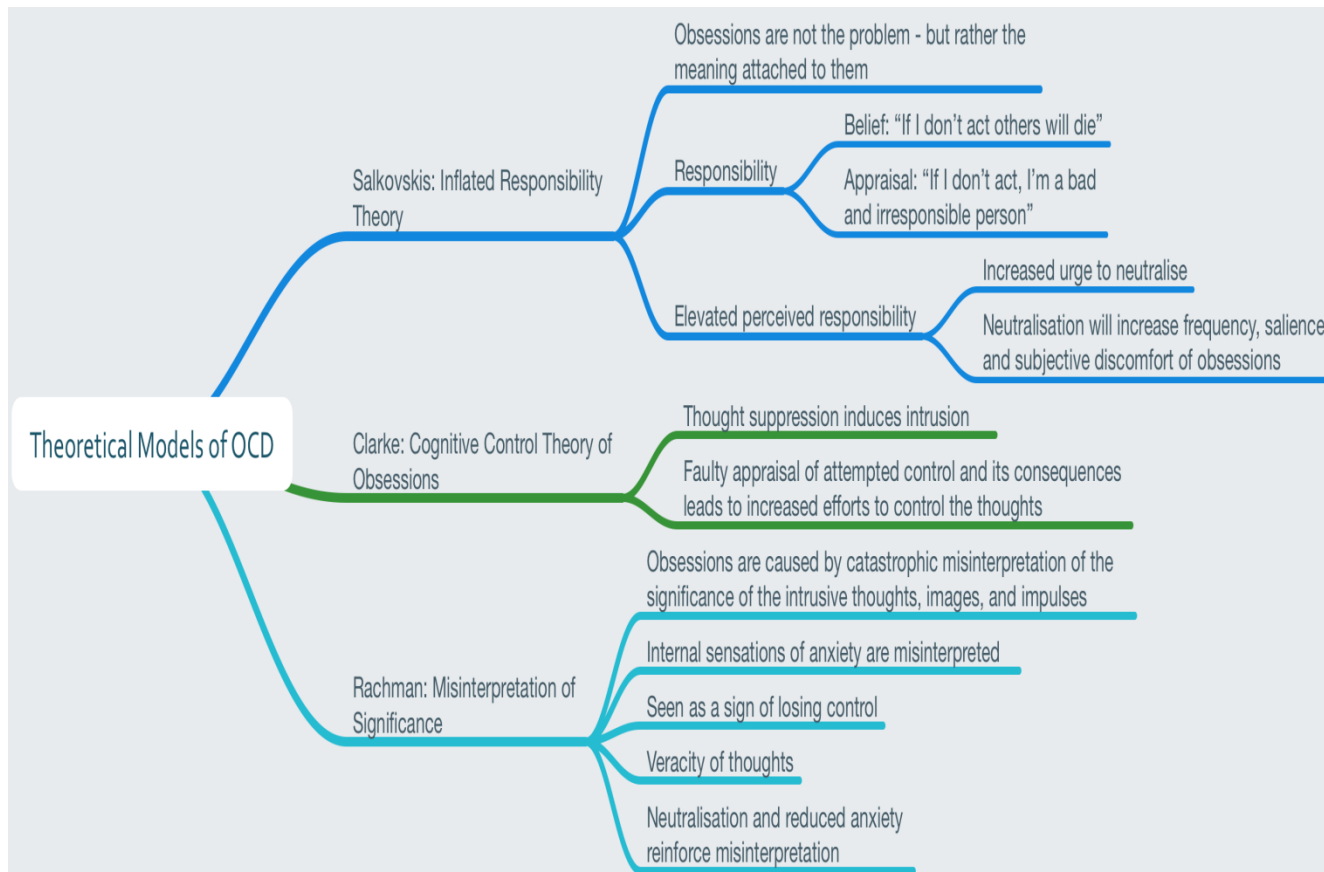
Compulsions

- Compulsions are repetitive behaviours that are overt or covert.
- Overt compulsions are those that can be seen and include hand washing, checking, ordering and lining up objects.
- Covert compulsions are mental acts therefore cannot be seen, such as praying, counting, saying certain phrases, or bringing images to mind.
- The goal of all compulsions is to prevent or reduce distress and from a cognitive perspective to neutralise or prevent danger (which the intrusive thought has created) and to diminish responsibility for its occurrence.

Cognitive Theory of OCD, simply put:

- Unacceptable intrusions are a normal occurrence.
- When intrusions have occurred, the obsessional patient believes that they might be responsible for harm, if they don't react to prevent it (TAF)
- They respond by ***TRYING TOO HARD*** (to get rid of the thought, to prevent harm, to be sure, to be clean...and so on)
- As time goes by, ***THE SOLUTION BECOMES THE PROBLEM***

Theoretical Models of OCD



Empirically supported treatments for OCD

- Cognitive Behavioural Psychotherapy
- Exposure in Vivo and Response Prevention {Ex/RP}
- Medication (SSRI Anti-depressants)
- (Veal 2007; NICE 2005 ; Salkovskis et al 2000 ; Foa et al 1997 ; Marks 1997)

Assessment of OCD

- **As part of a general clinical assessment, including risk (not just to the person but to others in their environment, especially children).**
- **People with OCD can also be depressed and may have other anxiety disorders, GAD, Social Anxiety etc.**

Assessment

- Engagement in assessment involves helping the person to feel understood.
- Aspects of engagement to be mindful of:
 - 1) Coming to appointments 45 minutes early or arriving late because of OCD.
 - 2) Having intrusive thoughts and/or carrying out mental rituals during sessions which impacts on attention and concentration

Assessment

- 3) Seeking reassurance from you (passing responsibility)
- 4) Linger at the end of sessions (checking the therapy room in case they have left something)
- 5) Fear of contamination
- 6) Having difficulty completing questionnaires (sometimes perfect isn't good enough)

Assessment

- 7) Having to do things a certain number of times
- 8) Talking about obsessions can be deeply embarrassing / shameful and anxiety provoking (talking about sexual images or thoughts of wanting to harm children)
- 9) You will probably never uncover all the obsessions or compulsions: don't worry about it

Assessment

OCD measures:

- **Yale Brown Obsessive Compulsive Scale (Y-BOCS)**
- **Maudsley Obsessive-Compulsive Inventory (MOCI)**
- **Responsibility Attitudes Scale (RAS)**

OCD clients who could not engage in therapy

- ❑ Although Ex/RP can be highly effective for around 50% of people who complete treatment, there are a number of recognised drawbacks (Marr 2012)
- ❑ Ex/RP is much less effective in clients who experience obsessive ruminations rather than overt compulsions
- ❑ The actual level of improvement is extremely variable (Roth 2006)
- ❑ High Drop out rates {40%}, (Rector et al 2009)
- ❑ High relapse rates {57.3%} (WHO 2010)

So what are the options?

- Do as we are told, carry on with Ex/RP
 - Medicate..(may be necessary anyway if co-morbid depression)
 - Engage in Exploratory Psychotherapy ?
 - EMDR?
- *De Silva & Marks (1999) suggest that there may be a causal link between the onset of OCD and a traumatic event that has a direct effect on pathology*

EMDR & OC Spectrum disorders

- **Body Dismorphic Disorder (Brown et al 1997)**
- **Olfactory Reference Syndrome (McGoldric 2008)**
- **Hypochondriasis (van Rood 2009)**

OCD Recovery Centre: Dr. C Komor, Arizona USA

- In vitro exposure, not as effective as in vivo exposure (Schwartz, 1998)
- Use EMDR with In Vitro exposure, using the anxiety provoking image.
- EMDR appears to accelerate the rate and depth of anxiety processing, it seems to “supercharge” the in vitro habituation process and lessen the clients discomfort.

Marr (2012)

- Treated (14-16 sessions) 4 subjects using adaptation of Shapiro Phobic protocol..
- Marr's work is based on the theoretical view that OCD is a self perpetuating disorder, with OCD compulsions and obsessions and current triggers reinforcing and maintaining the disorder (Marr 2012)
- Clients were assessed using the Yale-Brown Obsessive Compulsive Inventory (Goodman et al 1989), (Y-Boc) significant improvement was noted in all clients at the end of therapy and at follow up.



Developing a Comprehensive/Collaborative EMDR-focused Case Conceptualisation.

- Understand the relationship between **past, present and future**, consider acts of Commission (Physical & Sexual abuse) and Omission (neglect, deprivation).
- Evaluate **self-capacity/readiness** for trauma processing.
- Identify, preparation/stabilisation /resourcing : *Extra time/space may be needed where perfectionism is an issue.*
- Identify any developmental/attachment targets related to disrupted psychological needs: *? the onset of responsibility/safety/control plateaus.*
- Identify **traumatic events {if present}** related to current symptoms and difficulties.
- Identify Obsessions, Compulsions & Current Triggers (**could be many**) and future action goals.

Case Conceptualisation (Cont:)

- Motivation, expectations, any secondary gain issues?
- Previous experience with psychotherapy
- Activated schema themes (Young, 1994;2003), Responsibility, Safety, Choice, Control, also think, Salkovskis (**responsibility**), Clark (**control**), Rachman (**safety**).
- Blocking beliefs (**TAF**), Fears/Phobias.
- Unmet developmental needs (Trust issues/attachment issues).
- Risk issues
- Medication

Current Research Project

➤ Treating Obsessive Compulsive Disorder [OCD] using Eye Movement Desensitisation and Reprocessing [EMDR] A Case Series Design





Originality

Published studies to date and indeed anecdotal experiences have usually discussed/used EMDR in conjunction with Ex/RP. This project aims just to use EMDR to target unprocessed traumatic memories and or anxiety generated from Intolerance of uncertainty

The Team

Paul Keenan: EMDR Consultant & Facilitator;
Cognitive Behavioural Psychotherapist, Trainer & Supervisor, Senior Lecturer in Mental Health (Principal Investigator).

Lynn Keenan: EMDR Consultant and Facilitator;
Cognitive Behavioural Psychotherapist.

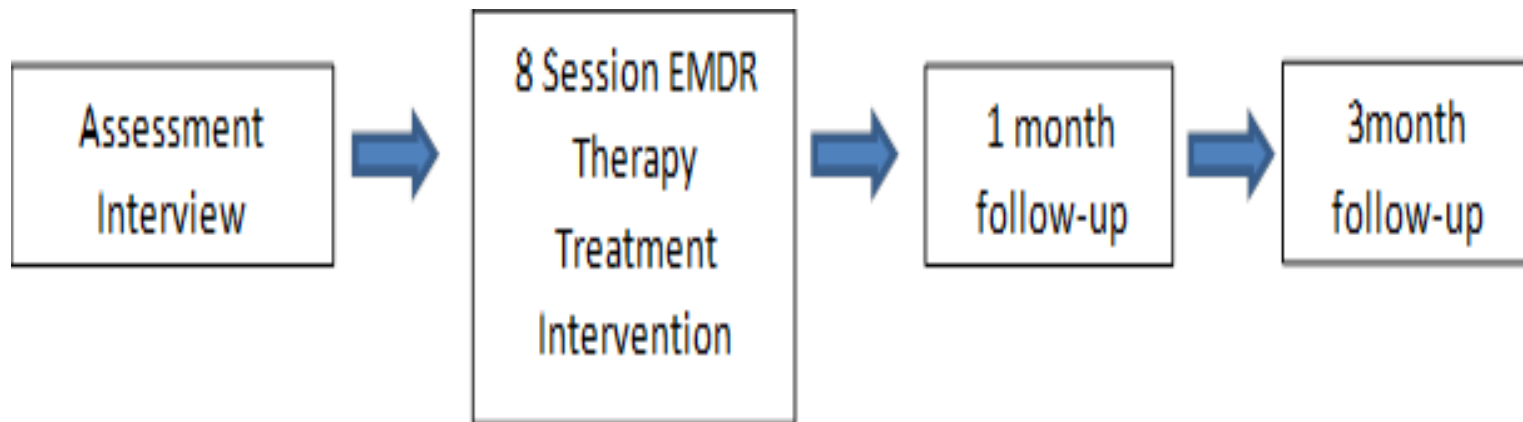
Claire Ingham: EMDR Practitioner; Cognitive Behavioural Psychotherapist

Dr Derek Farrell: EMDR Consultant & Trainer;
Cognitive Behavioural Psychotherapist, Senior Lecturer in Psychology

Research Method

- 8 subjects, who have been diagnosed with OCD, have had CBT intervention within the last 5 years but symptoms have not abated.
- Psychometrics:
 - Y-BOC (Goodman et al 1989)
 - PHQ-9 (Kroenke et al 2001)
 - GAD-7 (Spitzer et al 2006)
 - Dissociative Experience Scale (DES II)
- Each subject received 8 sessions of EMDR, *[in an effort to mirror IAPT services]* plus 1 and 3 month follow (EMDR will not be administered at follow up)
- Normal EMDR protocol used for clients with past aversive life events (PALE)
- EMDR focussing on “Intolerance of uncertainty” will be used where no PALE was identified.

Psychological Treatment Intervention Design and Psychometric Measures



Intolerance of Uncertainty

- “ Intolerance of uncertainty (IOU) can be understood as negative emotional, cognitive and behavioural reactions to uncertain situations and events. Individuals with IOU experience uncertainty as upsetting and stressful, something to be avoided and often have trouble functioning in uncertain situations, E.G. “have I touched someone inappropriately?” (Buhr & Dugas 2002)

8 Subjects (N=4 Trauma; N=4 Non-Trauma

- (A) Contamination [Asbestos] IOU
- (B) Contamination/Disgust [Buttons] Trauma Memories
- (C) Hoarding [Dropped out, did not wish to engage...actually wanted a bigger house]
- (D) Checking & Safety [Damage to eyes] IOU
- (E) H-OCD [Fear of being Lesbian or Gay] IOU
- (F) Unwanted Violent or Sexual thoughts....Trauma Memories.
- (G) Scrupulosity....Trauma Memories.
- (H) Contamination [maggots]...Trauma Memories
- (I) Contamination with Magical thinking. IOU

Results

- **YBOC**
- **GAD-7**
- **PHQ- 9**



Figure 1: EMDR Therapy with OCD Psychometric Scores (n=8)

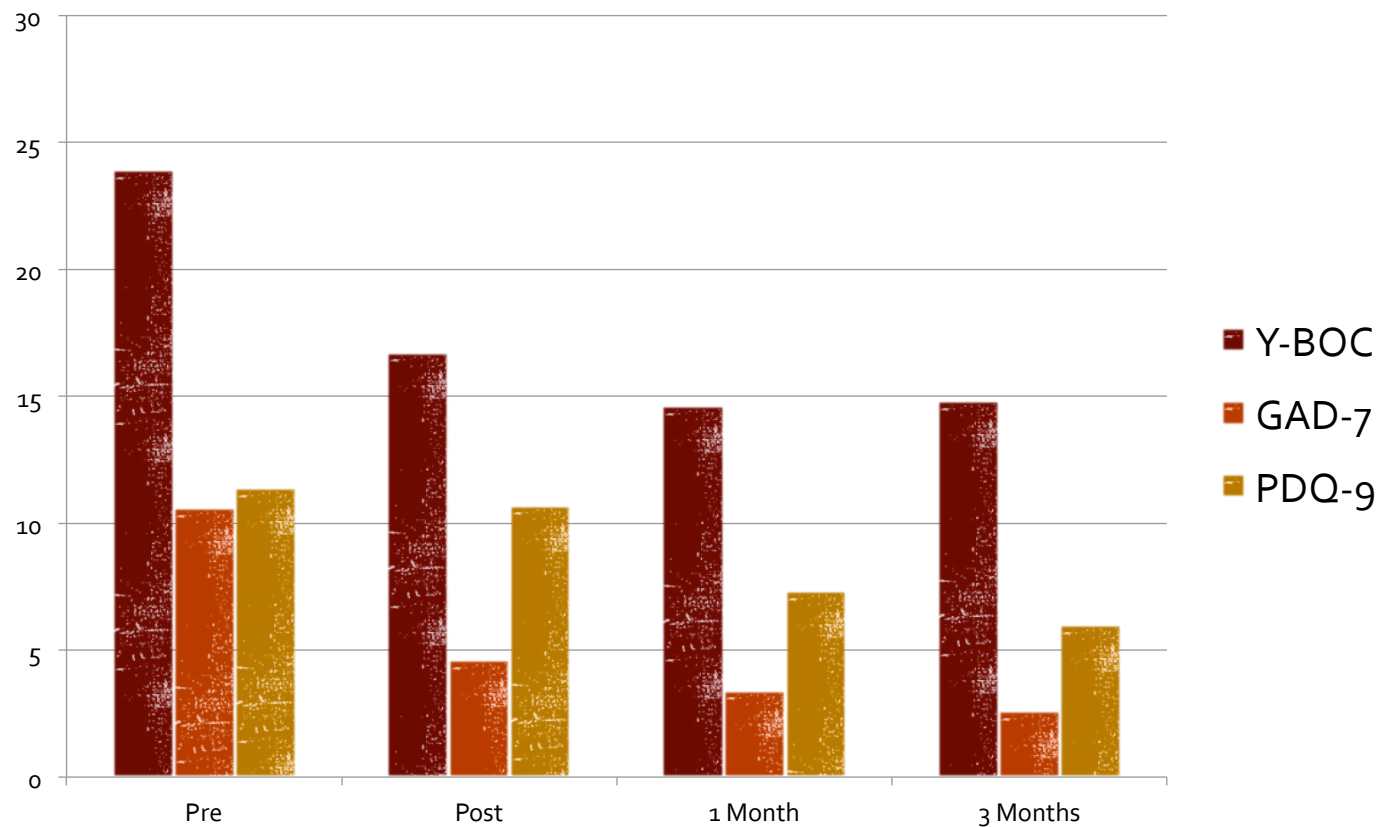


Figure 2: Psychometric Scores with OCD and Past Trauma (n=4)

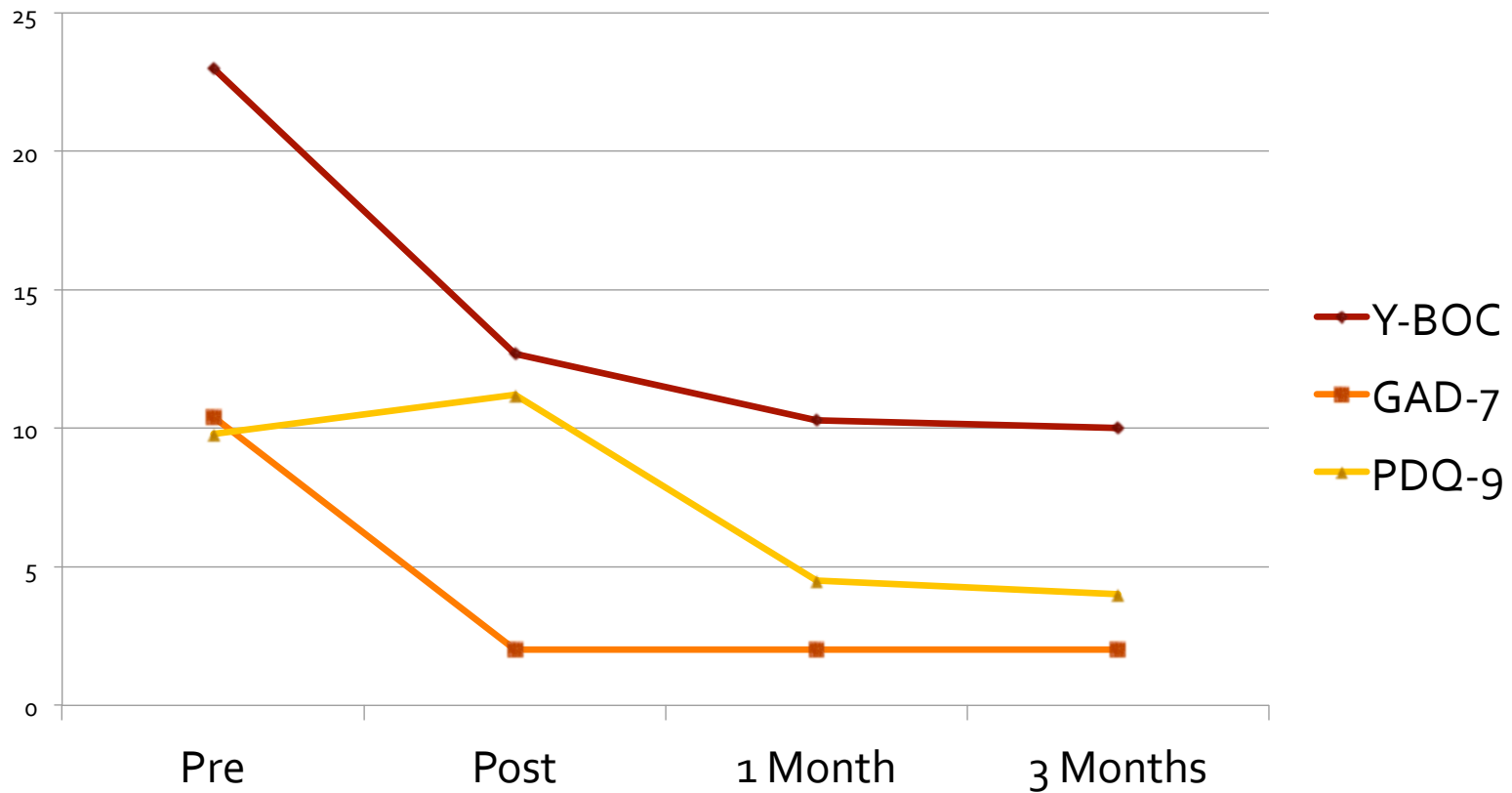


Figure 3: Yale Brown Obsessive Compulsive Scale (YBOC) scores comparing Trauma with Non-Trauma Participants with OCD
significant (.036 / * $p < .05$)

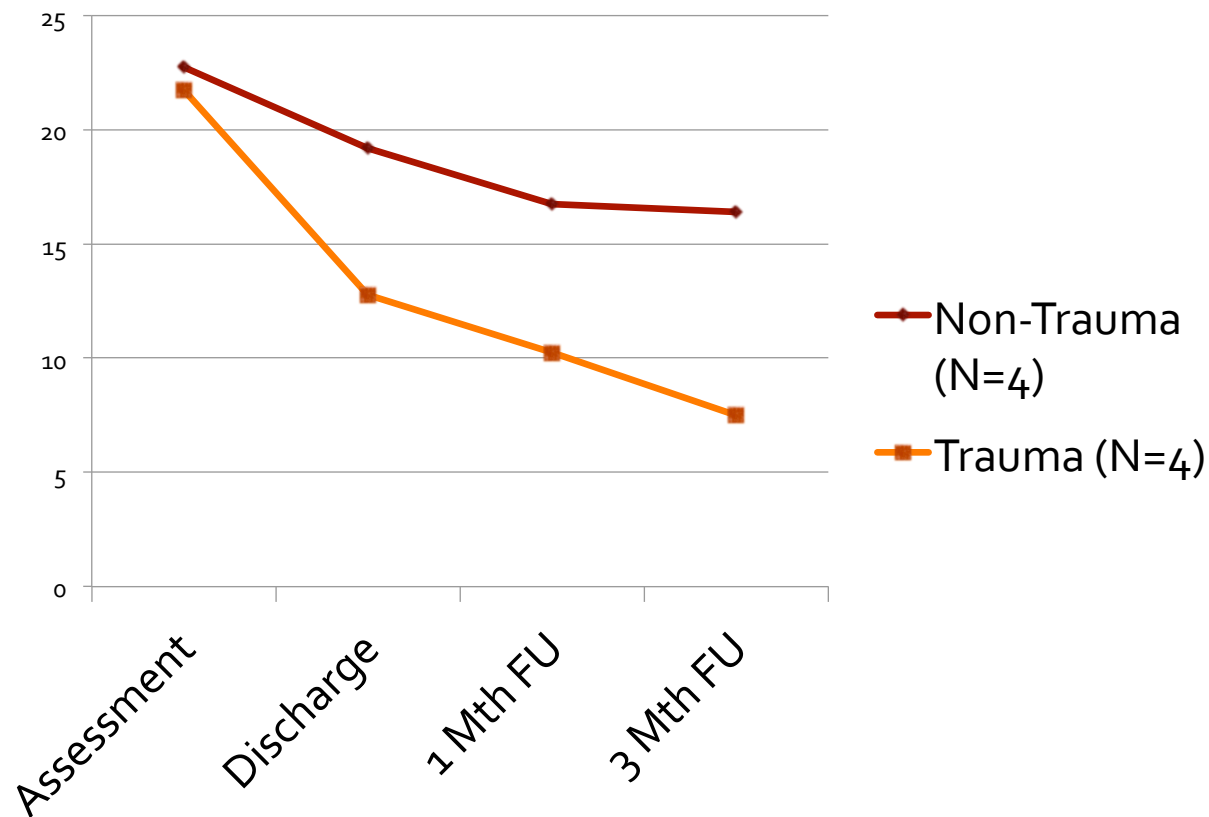


Figure 4: GAD-7 Scores comparing Trauma with Non-Trauma Participants with OCD

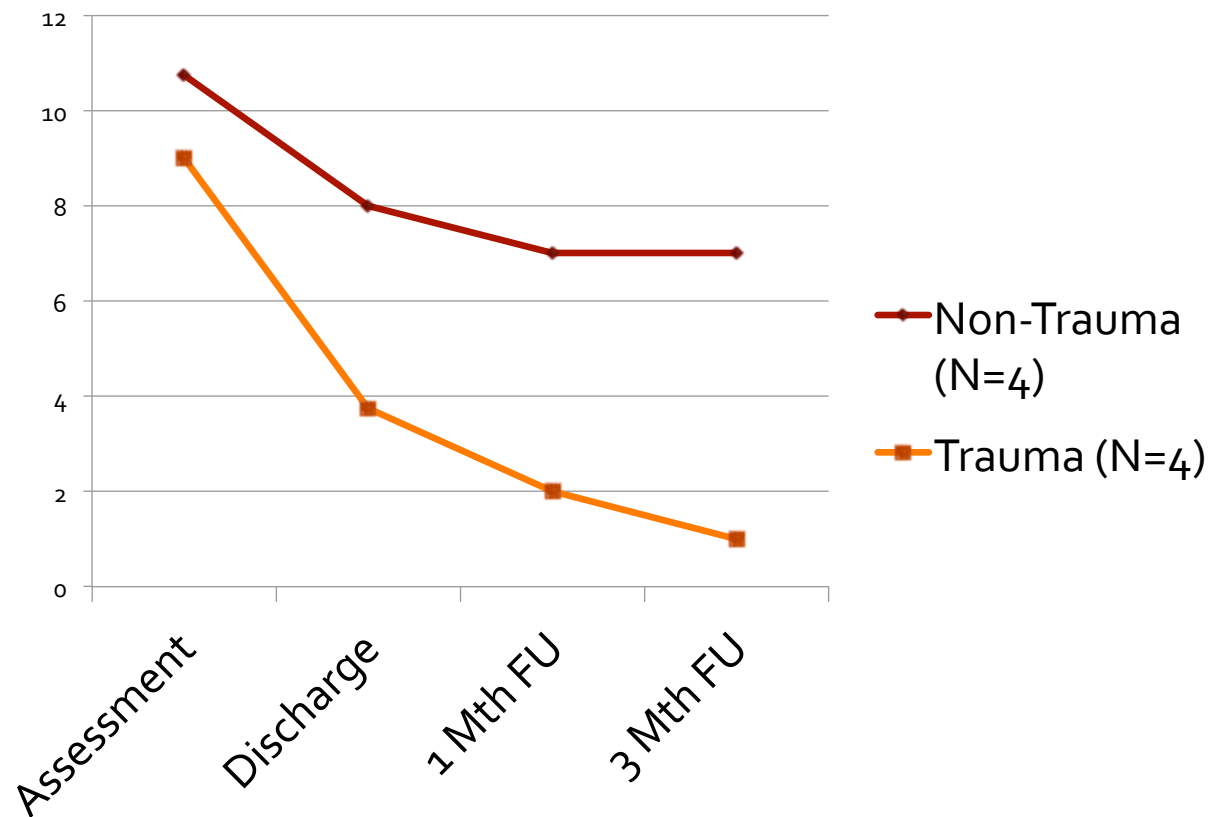


Figure 5: PDQ – 9 Score comparing Trauma with Non-Trauma Participants with OCD

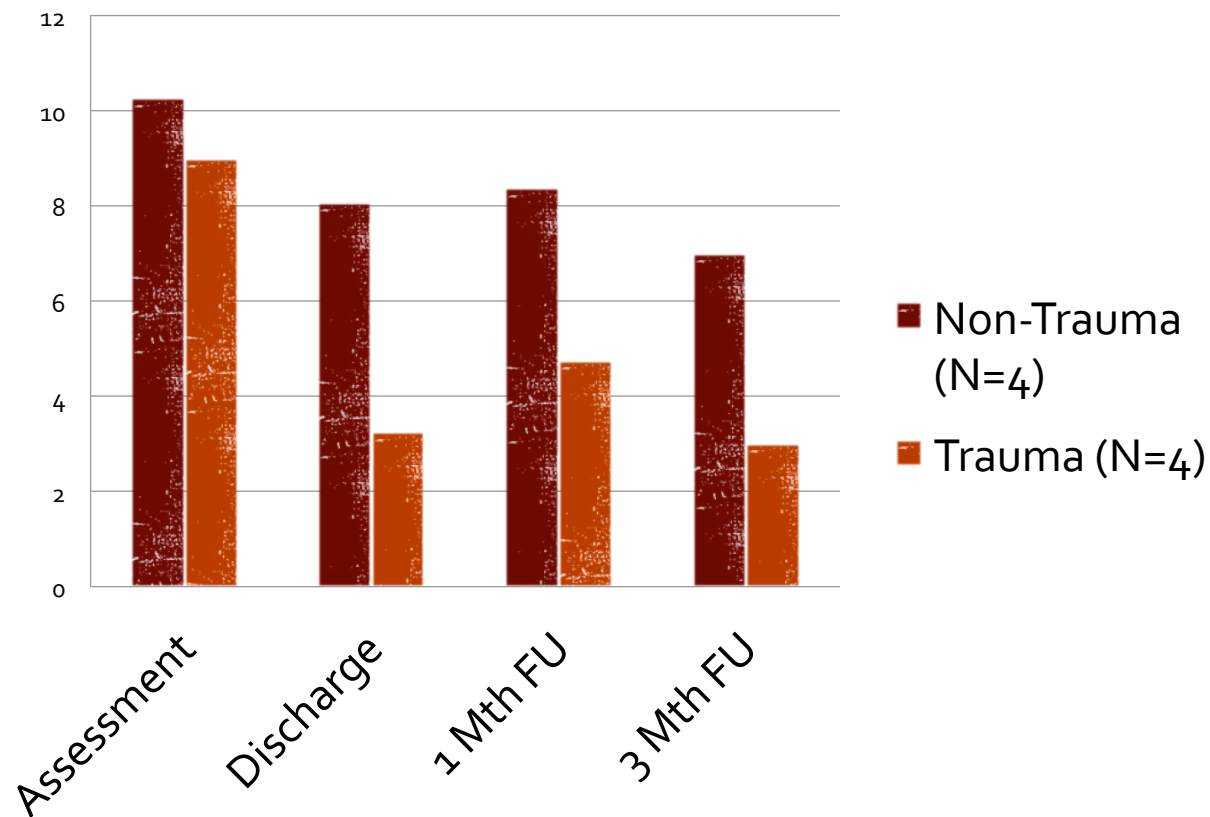
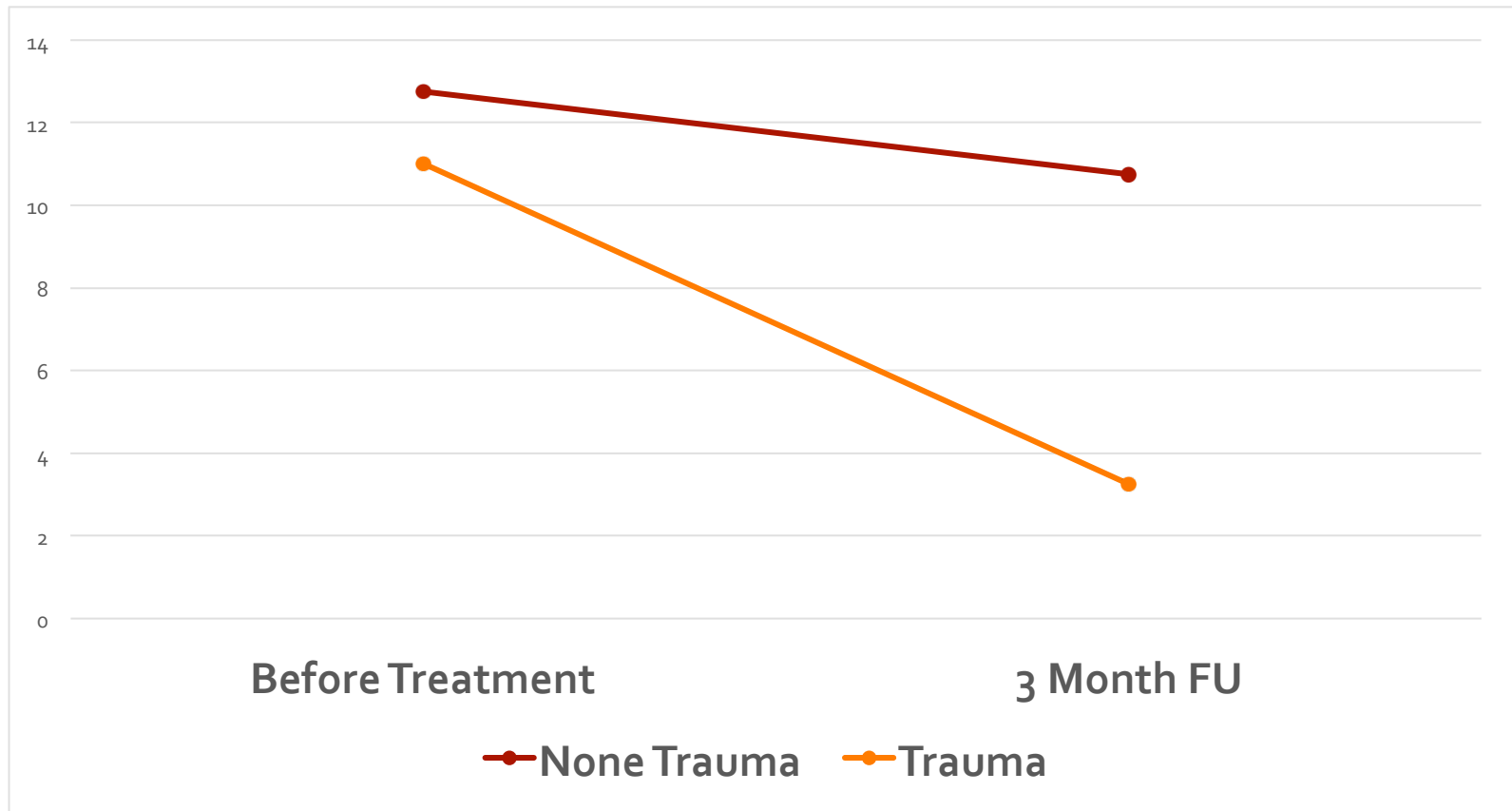


Figure 4: EMDR Therapy Intervention on Compulsions (Y-BOC) - Mean Value N=8



Two Clients

- **Ruth: Early Childhood Trauma, Issue Contamination [maggots] Method, Past, Present & Future**
- **Tom : Denies any Childhood Trauma, Issue Contamination [Asbestos] Method, Intolerance of Uncertainty**

Case Presentation: Ruth

- 58 year old woman, divorced, living alone.
 - Profession :Social worker, no financial problems
 - Gregarious, intelligent women, her church is an important part of her life.
 - Self referred, as she is part the self help group for OCD, based in her local area.
 - Has had CBT in the past (with me)
- The Issue
- Severe anxiety, obsessional thoughts and compulsive rituals re becoming contaminated by contact with maggots
- Critical Event
- Moved into a new home (to her), cleaning the kitchen, opened a cupboard and “a million maggots fell on me”

Ruth: the symptoms

- Almost continuous obsessional thinking re contamination trail
- Compulsive hand washing: 30/40 times per day [a hand wash consists of washing and drying fingers individually, 2/3 minutes per wash]
- Clothes changing after every time she goes out.
- Washing coins before putting in purse
- Washes food, vegetarian “meat could have maggots in it”
- Avoids dating men, CSA and Interpersonal violence in past
- Avoiding friends, as she believes them contaminated
- Scrubs house clean, 2 hours every day, takes 3 hours to decontaminate herself each night before she goes to bed.
- Always feels dirty, can never get clean .

Ruth Psychometrics Pre EMDR

➤ Ruth: Psychometrics

- Y-BOC = 25 (severe OCD)
- GAD = 15 (moderate/severe)
- PHQ-9 = 14 (moderate/severe)
- DES = Sub clinical

Ruth: Phase 1 – History Taking

- 4th eldest child of 10 siblings, elder sister deceased (RIP), still friendly with other siblings.
- Parents deceased (RIP)
- Mother was very anxious, over protective, father, very strict, “ I was petrified of him”
- Bullied at school for being “fat and ugly” Could not tell mum as she would worry, could not tell dad, as he was not interested.
- SA from the age of 5, at Sunday School.
- SA at 11 “ I was a 36 Bust at 11 years of age, told I was a dirty little bitch”
- Noticed OCD symptoms starting then, rituals involving the opening and closing of doors.
- Married at 21, husband, critical, jealous, violent, abusive. After 4 years she left him. She moved to a rented house infested with maggots....OCD +++

Background Information & Phase 2: Preparation

- I had worked with Ruth many years earlier, using CBT to combat her ritualistic behaviours
 - Ruth new about EMDR, as she is part of a self help group for OCD
 - She had never tried to address any of her early life experiences, only recently talking about them within her church.
 - She was able to see the possible connection , between the early sexual abuse and her feeling dirty.
-
- Special Place
 - On holiday, in a field with a stream, lying in sun, reading a book.
 - Cue word, Happy.

Phase 3: Assessment of Target Memory

- **Memory : Sexual Abuse**
- **Image : Sitting on Knee of man at Sunday School, his hand up my skirt**
- **Negative Cognition : I'm Dirty, its my fault. {Responsibility}**
- **Positive Cognition : I'm clean, it was him. {Responsibility}**
- **Stuck Point : Its my fault, its my body attracting this.**
- **Interweave : Who wanted this to happen, you or him?**
- **Outcome : "Its not me, I'm being forced, its him, its him, I can be clean"**

Ruth: Psychometric Data

- Y-BOC = 3
- GAD = 0
- PHQ-9 = 1.
- Behaviours: Still has OCD, still engages in cleaning behaviours, however, hand washing much less (5 or 6 per day), only cleans house twice per week, bedtime ritual, mostly 10 minutes, (however still has bad days, she says she thinks about the EMDR sessions and it helps steady her)

Case Presentation: Tom

- 32 yrs. old, white male, living with female partner & two children
- Self employed architect, no financial problems
- Wide social network, well liked by peers
- Self referred when heard about the project from a friend.
- Appeared motivated to work.

Tom: The Issue

- C/o Constant anxiety, concerning harm coming to his wife and children through contact with Asbestos.
- He believed he was responsible for his families safety.
- If anything happened to them, it would be his fault, as he had already considered the catastrophic outcomes.

Tom: The Symptoms

- Myriad of checking behaviours, including, children, dog, internet (looking for location of old buildings which may contain asbestos).
- Hand washing, 30 times per day (a normal hand wash could take up to 5 minutes)
- Washing clothes
- Bathing Children
- Questioning partner and children re their activities
- Insisted that nephew leave his place of work as Tom believed it not to be safe.
- Avoiding: garden, shops, pubs, certain parts of the house, certain belongings (golf clubs)
- Also complained of low mood impacting on his motivation to go to work
- Relationship difficulties

Tom: psychometrics

- Y-BOC = 20 (Moderate OCD)
- GAD-7 = 7 (Mild)
- PHQ-9 = 14 (Moderate/Severe)
- DES = Sub clinical

No Suicidal/self harm issues identified

Tom: Phase 1 – History Taking

- Oldest of two children, both parents still alive.
- Described his family as “Middle Class”, expected to do well at school, but not pressured to??
- Denies any PA, SA or EA.
- Quiet child, reflective, “a bit geeky”
- Never liked making mistakes, but denied any obsessional behaviours, such as “do over's”
- Did well academically, went to university.
- Met a girl, split up, then he began to notice obsessional thinking, originally centring on making decisions.

Tom

- Throughout history taking Tom denied any aversive early life experiences.
- OCD could be conceptualised as dysfunctionally stored information that leads to a present level of disturbance which is reinforced via overt and covert neutralising behaviours.
- Tom had read widely on EMDR and understood the technical aspects of a treatment session.
- I explained the Intolerance of Uncertainty model (IOU) and Tom agreed to continue.

Tom

- **Image:** Kids in kitchen having been playing out in the local field. He does not ask them to change and bathe, he does not know if they are contaminated (IOU).[Cognitive Dissonance]
- **Negative Cognition:** I am Irresponsible (Choice) *or* "I'm bad" (responsibility/defectiveness)...
- **Positive Cognition:** I can let it go (Choice) *or* "I'm ok" (R/S)

Stuck point: Tom “They're in danger”

➤ Cognitive Interweaves

- **Process,** Change direction of eye movement
- **Content, Th.** “ Do you know that or do you think that? “
What would you do if you did not suffer from OCD” “ What
is Intolerance of uncertainty”

Tom

- Tom saw the OCD as a BLOB, initially, I used EMDr to keep him focussed, then normal protocol as he began to focus.
- He began to talk to the OCD, becoming angry, he eventually spoke out loud “ Get out, you have lost !”

Tom

➤ Outcome after 8 sessions with 3 month follow up :Psychometrics

- Y-BOC = 13 (Mild OCD)
- GAD-7 = 7
- PHQ-9 = 12

Tom

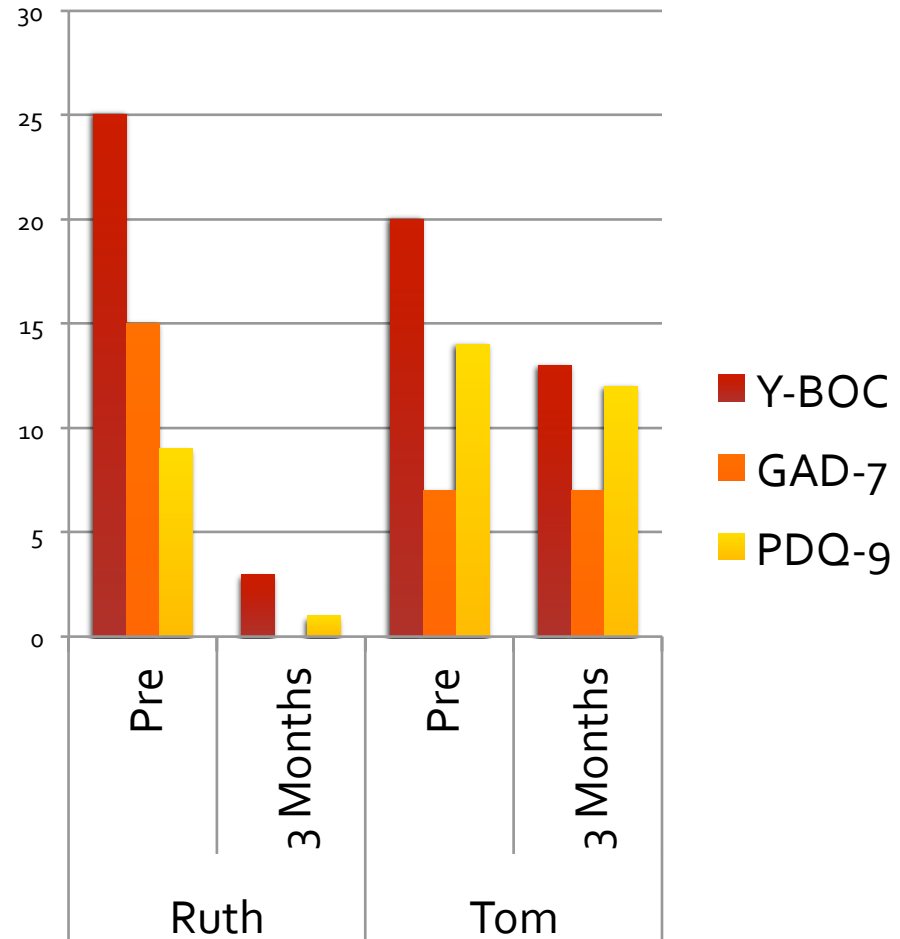
➤ Behaviours

- General decrease in all behavioural excesses, most difficult proved washing hands and issues concerning children
- Spontaneously began to implement some of the approach behaviours he had learned in previous CBP.

Fig 6: Psychometric Scores between EMDR Therapy Conventional Protocol versus Inverted Protocol (Flash-Forward)

➤ Ruth: Primary OCD issue (contamination) - Early Childhood Trauma Target – Conventional EMDR Therapy Protocol

➤ Tom: Denied any Childhood Trauma however his primary clinical issues related to 'fear of contamination – IOU Model, Inverted Protocol (Flash-forward)



Conclusions - research questions to generate four null hypotheses:

1. The overall symptoms of OCD, as measured by the Yale-Brown Obsessive Compulsive Scale (Y-BOC), demonstrate no difference between the trauma and non-trauma groups in response to EMDR Therapy? - **REJECTED**
2. There is no difference between the trauma and non-trauma groups in respect of Sub-Compulsion symptoms as measured by the Yale-Brown Obsessive Compulsive Scale (Y-BOC) in response to EMDR Therapy? - **REJECTED**
3. There is no difference between the trauma and non-trauma groups in respect of levels of depression as measured by the GAD-7 in response to EMDR Therapy? - **ACCEPTED**
4. There is no difference between the trauma and non-trauma groups in respect of levels of anxiety as measured by the PHQ-9 in response to EMDR Therapy? - **REJECTED**

Conclusions

- EMDR Therapy has demonstrated that it is a safe and well tolerated treatment for Obsessive Compulsive Disorder
- The Theoretical paradigm of EMDR Therapy – Adaptive Information Processing is useful part of case conceptualisation
- EMDR Therapy is more effective with Traumatic component OCD than Non-traumatic OCD
- More research is needed to further explore the utilisation of EMDR Therapy with OCD populations



Future Project

EMDR vs EMDR with Exp & RP vs Exp & RP in
the treatment of OCD.

Some reading & sites to visit

- **Bohm, K. & Vorderholzer, U. (2010).** Use of EMDR in the treatment of Obsessive Compulsive Disorders: A case series: English version of Verhaltensterapie Vol 20. 175-181
- **Brown, K. W., McGoldrick, T., & Buchanan, R. (1997).** Body dysmorphic disorder: Seven cases treated with eye movement desensitization and reprocessing. *Behavioural and Cognitive Psychotherapy* 25, 253-207
- **Keenan, P.S. & Farrell, D.F (2000)** Treating morbid jealousy with EMDR utilising Cognitive Interweave. *Counselling Psychology Quarterly* Vol 13. No. 2. 175-189
- **McGoldrick, T., Begum, M. & Brown, K.W. (2008).** EMDR and olfactory reference syndrome: A case series. *Journal of EMDR Practice and Research* 2, 63-68.
- **Shapiro, F., Kaslow, F., & Maxfield, L. (Eds.) (2007).** *Handbook of EMDR and Family Therapy Processes*. New York: Wiley.

www.ocdtreatmentreviews.org.uk

www.ocdaction.org.uk

www.ocdrecoverycenters.com.ocd/art_eyemovement.html

Final Thoughts

THE PAJAMA DIARIES

BY TERRI LIBENSON

