How does the literature inform us regarding the use of EMDR for the treatment of obsessive-compulsive disorder (OCD)?

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Abstract

Illustrated with the author's own cases, this critical review of the literature, examines the current 'state of the art' regarding the use of EMDR for the treatment of obsessive-compulsive disorder (OCD).

Introduction

Prior to 2006, nothing had been published in relation to the use of EMDR in the treatment of obsessive-compulsive disorder (OCD). Since that time, there have been an increasing number of published case reports, case series and two randomised controlled trials (RCTs) regarding the use of EMDR for OCD. Different protocols have been proposed and tested and specific issues regarding the use of EMDR with this client group have been addressed. It is therefore time to take stock of the literature and summarize what we can learn from it.

Obsessive–compulsive disorder (OCD) is characterized by one or both of the following: 1. Recurrent and persistent intrusive thoughts causing anxiety, which the individual attempts to suppress; 2. Repetitive behaviours (e.g. hand washing or checking) which the individual feels compelled to carry out in order to reduce anxiety. The person recognizes that the obsessions or compulsions are unreasonable although this is not always the case for children with OCD. The symptoms are time consuming and significantly interfere with the person's functioning or relationships (American Psychiatric Association, 2013). OCD affects 2.3% of the population within their lifetime (Goodman, Grice, Lapidus, & Coffey, 2014).

Is the Adaptive Information Processing model relevant for OCD?

I will illustrate the main developments and questions arising from the research on this topic with my own experiences of work with real clients with OCD. Let us begin with Annie.

Annie, aged about 10 suffered from OCD with obsessions and compulsions relating to food and, in particular, eating in public places. This had a very clear onset, the occasion on which she vomited on a long family car journey a few years before. This had been the first time she had vomited in her life as far as her parents could recall. Vomiting on a car journey would not usually be regarded as a trauma or significant adverse life event. However, for a child with an anxious temperament and no prior experience of vomiting, this event, for her, would constitute a trauma.

What is the rationale for using EMDR for the treatment of OCD? EMDR is based upon the Adaptive Information Processing (AIP) model. This model (Shapiro, 2007) describes how new experiences are integrated into existing memory networks. Normally, memories are processed and assimilated using the individual's past experience and understanding of themselves and the world they live in. However, if the experience is traumatic, the information processing system stores the memory in a 'frozen' form without adequately processing it to an adaptive resolution. Traumatic memories fail to become integrated into the individual's life experience and self-concept. The assumption therefore is that EMDR may be a suitable treatment only for those psychiatric disorders that have their roots in unresolved traumatic or adverse life events.

To what extent is OCD caused by trauma or adverse life events? Miller & Brock (2017) carried out a meta-analysis of the connection between past trauma exposure and current severity of obsessive compulsive symptoms in 24 studies. Four types of interpersonal trauma (violence, emotional abuse, sexual abuse, and neglect) were associated with such symptoms. So, there is clearly a link, but is this the case for all individuals? Cromer, Schmidt and Murphy (2006) found that 54% of individuals with OCD had experienced at least one traumatic life event. More recently (Ozgunduz, Kenar, Tekin, Ozer, & Karamustafalıoğlu, 2016) found that at least 70% of individuals with OCD had suffered a childhood trauma. This indicates however that some individuals (30 to 50% perhaps) with OCD did not experience any identifiable trauma. However, it is important to consider what we define as a "trauma". Dykshoorn (2014), writing about OCD and trauma, suggests that if we adopt a more "liberal" definition to include concepts such as "adverse experiences" the picture may be different. "Essentially, any event can be considered traumatic if the individual experiences it as such." (Dykshoorn, 2014, p 521.). For example Briggs and Price (2009) found that children, with a tendency to be more anxious and/or depressed before a traumatic experience, are more likely to develop OCD.

Is the use of EMDR appropriate for such individuals? Presumably Annie would be described as such an individual and EMDR would clearly be an appropriate therapy for her as one can see how the AIP model would be relevant to understand her OCD symptoms.

Should EMDR be a "treatment of choice" for OCD?

There appears to be a consensus (American Psychiatric Association, 2010; Franklin & Foa, 2011; NICE, 2006; Ponniah, Magiati, & Hollon, 2013) that the treatment of choice for OCD should be medication alongside Cognitive Behaviour Therapy (CBT). The CBT approach that has been found to be particularly efficacious in the treatment of OCD is Exposure and Response Prevention (ERP). ERP is a behavioural therapy that involves repeated exposure to distressing situations or cues (e.g., objects perceived to be contaminated) while preventing the use of ritualized or repetitive behaviours (e.g., handwashing) that are used to neutralize distress or to relieve obsessive preoccupations (e.g., fear of becoming contaminated and ill) (Meyer, 1966).

Although there is considerable evidence in support of CBT (Olatunji, Davis, Powers, & Smits, 2013) it is often pointed out that exposure tasks can be difficult to tolerate; clients often find it too frightening to face their worst fears and some clients do not complete their treatment (Maher et al., 2010). Estimates indicate that 25% of patients drop out of treatment (Aderka et al., 2011). Even in the CBT world therefore, the search continues to find a more effective treatment for OCD (Foa, 2010) and there is good reason for EMDR to be considered as a possibility.

In addition to several case studies and case series (Bekkers, 1999; Böhm & Voderholzer, 2010; Keenan, Farrell, Keenan, & Ingham, 2018; Marsden, 2016; Mazzoni, Pozza, La Mela, & Fernandez, 2017) two RCTs have indicated the effectiveness of EMDR in the treatment of OCD. The first of these, carried out in Iran (Nazari, Momeni, Jariani, & Tarrahi, 2011), compared EMDR with Citalopram, both of which produced a significant and comparable reduction in OCD symptoms. However, this study gives no detail of the actual EMDR protocol used. In addition, it has suggested that the dose of Citalopram was less than adequate (Ponniah et al., 2013). A more recent study in the UK (Marsden, Lovell, Blore, Ali, & Delgadillo, 2017) compared EMDR with CBT which showed promising results, indicating that both therapies were equally effective in treating OCD.

The current literature indicates therefore that EMDR can be an effective treatment for OCD and is comparable with CBT in its effectiveness.

Should we use the EMDR standard protocol for treating OCD?

The literature appears to indicate three main issues in relation to this question:

- Should target selection be in the usual order of past, present and future?
- Should we use EMDR alone or use it as part of a package?
- Why is flashforwards particularly relevant for treating OCD?

I will address each of these questions in turn.

Should target selection be in the usual order of past, present and future?

Janet, in her 30s, had suddenly developed OCD following a road traffic accident. She always had an obsessional personality, but her OCD became much worse after an RTA in which she was seriously injured, and which appeared to be her own fault. She described an affectionless controlling mother, which could explain the genesis of her OCD. However, I chose to start by tackling the current symptoms first as these seemed very pressing and there was an urgency to tackle the presenting problems. Initially we targeted the mini-trauma of not washing hands twice after putting some rubbish in the bin.

The standard protocol for EMDR teaches us that past events, which have sown the seeds for a client's disorder, should always be processed first, followed by present and then future events (Shapiro, 2018).

However, John Marr hypothesised that this may not apply to individuals with OCD and he offered the following rational:

> "Although OCD may have originated in early experiences, it appears to be a self-maintaining disorder. The author hypothesizes that OCD is best understood as a series of self-perpetuating and interlaced traumatic events, or as a complex multiple event. Each current trigger - each obsession and compulsion - is viewed as a separate recent "traumatic event," which links with other related events, and with past memories, to reinforce and perpetuate multidimensional disturbing patterns of thoughts and behaviors. OCD is not one continuous event, but instead it is a number of interlaced events that both support and reindoctrinate each other.
>
> Consequently, it is recommended that treatment starts by addressing the current events. Therapeutic interventions that begin by addressing past incidents will almost always be undermined by the more recent OCD events. OCD treatment is most successful when it focuses on first reducing the power of present experiences." (Marr, 2012, p.11)

Marr experimented with two protocols in which he used EMDR to process targets in the sequence present-future-past or present-past-future. Using each protocol with two clients he successfully treated four individuals with OCD who had previously been unsuccessful with CBT (Marr, 2012).

Subsequently, Marr's protocol was subjected to a more rigorous analysis when it was used as the basis for an RCT using the present-future-past sequence of processing (Marsden et al., 2017). The protocol was compared with CBT incorporating ERP with 29 participants randomly allocated to the EMDR and 26 allocated to the CBT arm of the experiment. Overall, 61.8% completed treatment and 30.2% attained reliable and clinically significant improvement in OCD symptoms, with no significant differences between groups.

There is therefore now empirical evidence that, for OCD, it may be efficacious to target present behaviour and symptoms first before targeting past events when using EMDR.

Should we use EMDR alone or use it as part of a package?

Eleven-year-old Marc had compulsions about touching certain things. He had to do actions in threes or multiples, for example, switching the light on and off nine times or twirling nine times before descending the stairs. He believed that his family would be murdered if he did not carry out these rituals. He would be awake until 2am worrying that he would die if he did not sleep in a certain way. EMDR therapy targeted an image of switching on the light just once only and, within three sessions, he reported that he was completely symptom free. A few months later, Marc experienced a further relapse and saw another psychologist who used CBT and, in particular, ERP.

I subsequently met with Marc and his mother. They both agreed that, whilst the EMDR had produced a rapid improvement, it had been insufficient on its own to promote a long-term change because it did not equip him with the necessary strategies to prevent further episodes of OCD. Marc said, "Your way was quicker but it didn't last long." He thought the CBT had shown a longer-term effect because he was given the opportunity to "talk through everything that worries me." Marc's mother agreed that the speed of change had differed in the two therapies. Whilst he reported feeling completely better after just two or three sessions of EMDR, it had taken four sessions of CBT before any change was detected. Both Marc and his mother agreed that a combination of the two therapies would have been best. His mother added that when he saw me his problems were more severe and therefore the fast acting EMDR had been particularly helpful at that stage.

Several published research studies regarding the use of EMDR for OCD indicates that EMDR may be more effective as part of a package that includes CBT, and in particular, ERP.

Böhm and Voderholzer (2010) described three case studies in which EMDR had been combined with ERP. In one case, EMDR was used first, in another it was used second and in the third, EMDR and ERP were used alternately. The rationale for this was provided by evidence from some previous research by Bekkers (1999) who had found that isolated use of EMDR for compulsions, "appears to have little effect" (p. 2 of English translation).

The use of EMDR as part of a package is being explored in more detail by Pozza et al (2014). In the "Tackling Trauma to Overcome OCD Resistance (*The TTOOR Florence trial*)" for clients with "Resistant" OCD, they are carrying out an RCT to compare 1) ERP alone *versus* 2) ERP combined with EMDR. It is based on the premise that an extra ingredient needs to be added to the traditional ERP approach in the case of some individuals who are particularly hard to treat. Whilst the findings of the RCT have not yet been presented, the research group has published a preliminary paper regarding the results with three cases studies (Mazzoni et al., 2017). Similar to the Böhm and Voderholzer's study these illustrate the use of EMDR before ERP, after ERP and simultaneously with ERP with all three patients showing a significant reduction in symptoms.

I learnt from my experience of working with Marc that EMDR is not usually effective on its own when working with children. Often EMDR needs to be combined with elements of CBT, although not necessarily using ERP. In particular, I have found that children require preliminary psycho-education regarding OCD. This is commonly used in CBT for children with OCD (for example, Waite & Williams, 2009). In the psycho-education phase, Waite & Williams characterise OCD as a "bully" which the child needs to overcome. This does appear not sit well with the AIP model. I have, instead, described OCD to children as being like an "unwanted friend" who initially make one they are on your side but starts to be manipulative and nasty and ultimately the friendship needs to be jettisoned.

In conclusion, it appears that, whilst EMDR can be effective in treating OCD, this may only be the case when it is part of a treatment package combined with other therapies such as CBT.

Why is flashforwards particularly relevant for treating OCD?

14-year-old Rosie had a complex bedtime ritual which prevented her settling at night leaving her exhausted and causing increasing frustration for her mother. The only identifiable adverse life event was the death of her grandmother two years previously. The death was expected; Rosie grieved normally and was able to share her feelings with her family. Thus, there were no past events to target and we therefore proceeded straight targeting her worst fear. This was that the bedroom window might be left open and that an intruder would kill her. As a result, "I would be dead" which would be "boring"! After two sessions of processing she was symptom free.

Developing the rationale of John Marr, described above, it appears that OCD differs, for example, from PTSD in that the client is preoccupied by the present ("what might happen") rather than by the past ("what did happen"). Whilst a PTSD client may have symptoms of re-experiencing, arousal and avoidance in relation to some past traumatic event, the OCD client fears what might happen now or in the future and tends to catastrophise about what may occur. For this reason, the Flashforwards procedure appears to be particularly relevant when treating OCD with EMDR.

The Flashforward procedure (Logie & De Jongh, 2014) is identical to the standard EMDR protocol, except that the target relates to a feared catastrophic future event rather than to a past one. For example, a client who still fears driving after the trauma of a road traffic accident (RTA), despite having fully processed the traumatic memory, would be asked what future catastrophe they fear the most. They might anticipate their own death in an RTA. This image would be used as a target. More details of this procedure can be found elsewhere (Logie & De Jongh, 2014, 2016).

Although not specifically described as Flashforwards, one of the case studies in Böhm & Voderholzer (2010), describes using EMDR to target and successfully process a future scenario in which the client with OCD believes that she will be punished in hell.

The first published articled which has specifically addressed the use of Flashforwards for the treatment of OCD was recently published by Keenan, Farrell, Keenan, & Ingham (2018). Eight clients for whom ERP had previously been unsuccessful, were treated with EMDR. For four of these individuals, it was decided that the Flashforwards procedure would be utilized without targeting any past events as these individuals reported no past traumas. In both groups there was a reduction in symptomatology although there was a greater reduction in the trauma/standard protocol group than in the "notrauma"/flashforwards group. Whilst group sizes are too small for statistical comparison, this difference may reflect that the groups differed because the "notrauma" individuals may be more treatment resistant as a function of either their obsessional temperament or, perhaps, as yet unidentified traumatic experiences or adverse life events.

Children and Adolescents

Very little attention in the literature has been paid to the use of EMDR for the treatment of children and adolescents with OCD. The only exception to this is the recent article (Cusimano, 2018) describing a case study with a 13 year old boy. Cusimano utilised the standard protocol, targeting events in the order past-present- future over 16 sessions. An 82% reduction in OCD symptoms was achieved. Although, ERP was not utilised, Cusimano incorporated psychoeducation about OCD in the Preparation phase, using a workbook entitled "*It's only a false alarm*" (Piacentini, Langley, & Roblek, 2007)

My experience of working with children who have OCD is that they tend to be difficult to treat, whatever treatment approach is used (including EMDR) and many children are resistant to any kind of intervention. However, EMDR has been successful in children for whom other approaches, such as CBT, have been unsuccessful. It is therefore well worth including EMDR as a possible intervention for such children although it needs to be

incorporated into a treatment package that will include psychoeducation. I have found Flashforwards to be particularly useful when treating children with OCD.

Conclusions

This review of the literature indicates that there is now encouraging published evidence for the use of EMDR when treating OCD. Whilst there is no evidence that EMDR is any more effective than CBT in the treatment of OCD, the research indicates that EMDR should certainly be added to the toolkit for treating OCD. This is because several studies suggest that EMDR can be effective for clients for whom CBT was not successful (Keenan et al., 2018; Marr, 2012; Mazzoni et al., 2017). This is particularly important for a disorder such as OCD for which the dropout rate is particularly high. My own experience of treating clients with OCD is that, even when using EMDR, the dropout rate is still higher than for other disorders. However, if both CBT and EMDR (or a combination of both) are available to the therapist, there is a chance that a greater number of clients will be successfully treated.

In my opinion the research indicates that we need to be flexible about the order in which we target past, present and future, depending on the individual client. Often, processing the present is more effective than processing past events, which would be the case using the standard protocol. In addition, flexibility is required as to the extent that we should combine EMDR with other therapies such as ERP and psychoeducation.

In conclusion it appears that there is no universally recognised protocol for the treatment of OCD with EMDR. And, I would contend, perhaps there never will be such a protocol, as this complex and diverse client group will always require an individual approach to their needs. Individuals with OCD crave order and certainty in their lives and, perhaps, so do we as therapists when we are attempting to help them. If, perhaps, we can learn to live with the uncertainty and model this for our OCD clients, we will better be able to help them.

References

Aderka, I. M., Anholt, G. E., van Balkom, A. J., Smit, J. H., Hermesh, H., Hofmann, S. G., & van Oppen, P. (2011). Differences between early and late drop-outs from treatment for obsessive–compulsive disorder. *Journal of Anxiety Disorders, 25*(7), 918-923.

American Psychiatric Association. (2010). Treatment of Patients With Obsessive-Compulsive Disorder, retrieved 16.07.10. Retrieved from www.psychiatryonline.com/pracGuide/pracguideChapToc_10.aspx

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*: American Psychiatric Pub.

Bekkers, A. (1999). Enige ervaringen met EMDR bij dwang. *Ongewoon en anders, 25*.

Böhm, K., & Voderholzer, U. (2010). Use of EMDR in the treatment of obsessive-compulsive disorders: a case series. *Verhaltenstherapie, 20*, 175–181.

Briggs, E. S., & Price, I. R. (2009). The relationship between adverse childhood experience and obsessive-compulsive symptoms and beliefs: the role of anxiety, depression, and experiential avoidance. *Journal of Anxiety Disorders, 23*(8), 1037-1046.

Cromer, K., Schmidt, N., & Murphy, D. (2006). An investigation of traumatic life events and obsessive-compulsive disorder *Behaviour Research and Therapy, 45*, 2581-2592

Cusimano, A. (2018). EMDR in the Treatment of Adolescent Obsessive-Compulsive Disorder: A Case Study. *Journal of EMDR Practice and Research, 12*(4), 242-254.

Dykshoorn, K. L. (2014). Trauma-related obsessive–compulsive disorder: a review. *Health Psychology and Behavioral Medicine: an Open Access Journal, 2*(1), 517-528.

Foa, E. B. (2010). Cognitive behavioral therapy of obsessive-compulsive disorder. *Dialogues in Clinical Neuroscience, 12*(2), 199.

Franklin, M. E., & Foa, E. B. (2011). Treatment of obsessive compulsive disorder. *Annual review of clinical psychology, 7*, 229-243.

Goodman, W. K., Grice, D. E., Lapidus, K. A., & Coffey, B. J. (2014). Obsessive-compulsive disorder. *Psychiatric Clinics, 37*(3), 257-267.

Keenan, P., Farrell, D., Keenan, L., & Ingham, C. (2018). Treating Obsessive Compulsive Disorder (OCD) using Eye Movement Desensitisation and Reprocessing (EMDR) Therapy: An Ethno-Phenomenological Case Series. *International Journal of Psychotherapy, 22*(3), 74-91.

Logie, R., & De Jongh, A. (2014). The "Flashforward procedure": Confronting the catastrophe. *Journal of EMDR Practice and Research, 8*(1), 25-32.

Logie, R., & De Jongh, A. (2016). The Flashforward Procedure. In M. Luber (Ed.), *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions* (pp. 81- 94). New York: Springer.

Maher, M., Huppert, J. D., Chen, H., Duan, N., Foa, E. B., Liebowitz, M. R., & Simpson, H. B. (2010). Moderators and predictors of response to cognitive-behavioral therapy augmentation of pharmacotherapy in obsessive–compulsive disorder. *Psychological medicine, 40*(12), 2013-2023.

Marr, J. (2012). EMDR Treatment of Obsessive-Compulsive Disorder: Preliminary Research. *Journal of EMDR Practice and Research, 6*(1), 2-15.

Marsden, Z. (2016). EMDR treatment of obsessive-compulsive disorder: Three cases. *Journal of EMDR Practice and Research, 10*(2), 91.

Marsden, Z., Lovell, K., Blore, D., Ali, S., & Delgadillo, J. (2017). A randomized controlled trial comparing EMDR and CBT for obsessive–compulsive disorder. *Clinical psychology & psychotherapy, 25*(1), e10-e18.

Mazzoni, G.-P., Pozza, A., La Mela, C., & Fernandez, I. (2017). CBT combined with EMDR for resistant refractory obsessive-compulsive disorder. Report of three cases. *Clinical Neuropsychiatry*(5).

Meyer, V. (1966). Modification of expectations in cases with obsessional rituals. *Behavior Research and Therapy, 4*, 273–280.

Miller, M. L., & Brock, R. L. (2017). The effect of trauma on the severity of obsessive-compulsive spectrum symptoms: a meta-analysis. *Journal of Anxiety Disorders, 47*, 29-44.

National Institute for Health and Clinical Excellence. (2006). *Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*.

Nazari, H., Momeni, N., Jariani, M., & Tarrahi, M. (2011). Comparison of eye movement desensitization and reprocessing with citalopram in treatment of obsessive – compulsive disorder. *International Journal of Psychiatry in Clinical Practice,, 15*, 270–274.

Olatunji, B. O., Davis, M. L., Powers, M. B., & Smits, J. A. (2013). Cognitive-behavioral therapy for obsessive-compulsive disorder: a meta-analysis of treatment outcome and moderators. *Journal of psychiatric research, 47*(1), 33-41.

Ozgunduz, C., Kenar, J., Tekin, A., Ozer, O. A., & Karamustafalıoğlu, O. (2016). The frequency of dissociation and childhood trauma among obsessive-compulsive patients by comparing with healthy controls. *European Neuropsychopharmacology, 2*(26), S630.

Piacentini, J., Langley, A., & Roblek, T. (2007). *Cognitive behavioral treatment of childhood OCD: It's only a false alarm therapist guide*: Oxford University Press.

Ponniah, K., Magiati, I., & Hollon, S. D. (2013). An update on the efficacy of psychological treatments for obsessive–compulsive disorder in adults. *Journal of obsessive-compulsive and related disorders, 2*(2), 207-218.

Pozza, A., Mazzoni, G. P., Neri, M. T., Bisciglia, R., La Mela, C., Fernandez, I., & Dèttore, D. (2014). "Tackling Trauma to Overcome OCD Resistance"(The TTOOR Florence trial) Efficacy of EMDR plus CBT versus CBT Alone for Inpatients with Resistant Obsessive Compulsive Disorder.

Protocol for a Randomized Comparative Outcome Trial. *American Journal of Applied Psychology, 2*(5), 114-122.
Shapiro, F. (2007). EMDR, Adaptive Information Processing, and Case Conceptualization. *Journal of EMDR Practice and Research, 1*(2), 68-87.
Shapiro, F. (2018). Eye movement desensitization and reprocessing (EMDR) Therapy: Basic principles, protocols, and procedures. In: New York: Guilford Publications.
Waite, P., & Williams, T. (2009). *Obsessive Compulsive Disorder: cognitive behaviour therapy with children and young people*: Routledge.