

## Use of EMDR in the Treatment of Obsessive-Compulsive Disorders: A Case Series

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### Keywords

EMDR · Obsessive-compulsive disorder · Psychotherapeutic method · Psychotherapy research

### Summary

**Introduction:** Various studies have demonstrated that cognitive behavioural therapy with exposure response prevention is the most effective method to treat obsessive-compulsive disorders. However, 15–40% of patients do not respond to it; they cannot be motivated to undergo treatment, drop out, or experience persisting difficulties in regulating their emotions. In this article, EMDR is presented as an additional method for these specific problems. **Method:** Three case studies are reported and descriptively analysed. Special focus is placed on the patients' motivation and on how they regulate their emotions. Different ways of applying EMDR in the course of psychological treatment are described as well. EMDR before confrontation therapy are described as well. EMDR before confrontation therapy was applied in the first patient (checking behaviour); the second patient (compulsive thoughts) was first treated with confrontation therapy and then with EMDR; in the third patient, EMDR and confrontation therapy were applied alternately. **Results:** All three patients showed a reduction of symptoms by about 60%. They experienced EMDR as a useful and motivating method. Furthermore, they felt encouraged to deal with their emotions in additional psychological treatments. Confrontation therapy markedly reduced OCD symptoms in two of the patients. **Discussion:** EMDR could be a useful augmentation method in treating patients with OCD, but further controlled and randomised studies are required to validate this conclusion.

### Schlüsselwörter

EMDR · Zwangsstörung · Behandlungsmethode · Psychotherapieforschung

### Zusammenfassung

**Hintergrund:** Die kognitive Verhaltenstherapie mit Exposition und Reaktionsverhinderung ist die am besten untersuchte und derzeit wirksamste Therapie bei Zwängen. 15–40% der Patienten können jedoch nicht von diesem Verfahren profitieren. Sie berichten Motivationsprobleme, brechen die Behandlung vorzeitig ab oder zeigen anhaltende Probleme in der Emotionsregulation. Der zusätzliche Einsatz der Therapiemethode «Eye Movement Desensitization and Reprocessing» (EMDR) zur Reduktion dieser Schwierigkeiten wird vorgestellt und beschrieben. **Methode:** Es werden drei Kasuistiken vorgestellt, die mittels deskriptiver Analysen ausgewertet werden. Hierbei wird auf das inhaltliche Vorgehen sowie die Therapiemotivation und Emotionsregulation im Therapieverlauf eingegangen. Ein Patient mit Kontrollzwängen erhielt zunächst EMDR-Sitzungen und anschließend Expositionsübungen. Eine andere Patientin mit vorwiegend Zwangsgedanken wurde zuerst mit Expositionen und danach mit EMDR behandelt. Im dritten Fall wurden Expositionen und EMDR-Sitzungen abwechselnd durchgeführt. **Ergebnisse:** Die drei behandelten Patienten berichteten eine Reduktion der Zwänge um etwa 60%. EMDR wurde von allen drei Patienten als motivierend und hilfreich beschrieben. Die Arbeit an den Emotionen konnte durch EMDR angeregt und verstärkt werden. Eine deutliche Reduktion der Zwänge durch die Expositionen zeigte sich bei 2 Patienten, während diese im Zuge der EMDR-Sitzungen nur leicht abnahmen. **Diskussion:** EMDR könnte eine vielversprechende Augmentationsoption bei der Behandlung von Zwängen darstellen. Für eine bessere Beurteilung sind kontrollierte und randomisierte Studien erforderlich.

## Introduction

The psychotherapeutic technique Eye Movement Desensitization and Reprocessing (EMDR) is not usually mentioned in relation to obsessive-compulsive disorders. Originally developed to treat post-traumatic stress disorder (PTSD) [Shapiro, 1989], and empirically validated [Bisson and Andrew, 2007; Sack et al., 2001; Van Etten and Taylor, 1998], EMDR today is also increasingly being used with other disorders, including those that involve self-destructive behaviour [McLaughlin et al., 2008] and phobias [Muris et al. 1997; De Jongh et al., 1999; Goldstein et al., 2000; Grös and Antony, 2006; De Jongh et al., 2002]. The treatment of obsessive-compulsive disorders with EMDR had been mentioned earlier [Shapiro, 1999], but so far only individual case reports exist [Bekkers, 1999]. Empirical studies are pending.

Cognitive behavioural therapy with exposure response prevention (ERP) is currently the best studied and empirically confirmed therapeutic method to treat compulsions (summarized in NICE Guideline No. 31 [National Collaborating Centre for Mental Health, 2006] and by Fisher and Wells [2005]). Exposure treatment is, however, experienced as extremely stressful and arduous by many patients, leading to withdrawal from therapy and loss of motivation [Pinto et al., 2007; Vogel et al., 2006]. Alternative treatments or enhancement of existing approaches are therefore of great therapeutic interest.

Bekkers [1999] views the primary effect of EMDR in patients with obsessive-compulsive disorders as the activation of feeling during the stimulation sessions. Connections on the emotional level can thereby be made and demonstrated between the compulsions and their underlying functionality. Bekkers observed a significant symptom reduction in 4 out of 5 compulsive patients treated with EMDR. However, ERP was performed simultaneously, in unreported sequences, making it difficult to clearly assign the effects to a single therapeutic element. Bekkers recommends the use of EMDR as part of an overall treatment plan, in addition to proven interventions [Schubbe, 2004; Hensel, 2006; Bekkers, 1999]. The isolated use of EMDR for compulsions, contrary to initial findings, appears to have little effect [Bekkers, 1999]. The present case series combines EMDR with exposure exercises for treatment of obsessive-compulsive disorders.

## Method

Three patients with the primary diagnosis of obsessive-compulsive disorder had EMDR sessions, in addition to the conventional intervention with ERP, as part of an overall treatment plan. Before and after the 8- to 12-week inpatient treatment, the severity of the OCD was quantified using Y-BOCS. The participating patients were informed of the study's approach at the beginning of the treatment, and at the beginning of therapy, they filled out a battery of questionnaires (including the BDI [Beck's Depression Inventory], the PDS [Post-Traumatic Stress Diagnostic Scale] and the DES II [Dissociative Experience Scale II]). During EMDR sessions, two process variables were compiled: the Subjective Units of Distress (SUD; Likert

scale 0 = no stress, to 10 = maximum stress) and the Validity of Cognition Scale (VoC; 7-point Likert scale, to convince the patients of the central cognitions) and to get direct feedback from the patients about the EMDR sessions. The aim of the EMDR approach is to reduce the stress that triggered the obsessive idea, and to associate the patient's mental image with a positive cognition, appropriate to the patient.

## Case Reports

### *First EMDR, then Exposure: Control Compulsions*

Mario O. (all names have been changed by the authors) was a 34-year-old industrial salesman of Italian origin, with distinct control compulsions. For several years he had lived alone and in seclusion, in a two-bedroom apartment. In the first discussion, he reported on his distinct compulsive behaviours, which consumed up to 8 hours a day (Y-BOCS: 36). Checking the stove, doors, taps, and accumulated mail were especially time-consuming activities. He would examine them to see whether anything was wrong. Two outpatient behavioural therapy programs and administration of an SSRI (Zoloft 200 mg/d) had brought no significant improvement. At work he had to check the accuracy of all shipping documents and invoices with the greatest of care, working through his breaks; but even so, he could no longer manage. At home, the checking continued.

His compulsive symptoms began when he was 11 years old. At that time, he was treated for his fear of abandonment in a paediatric and adolescent psychiatric institution. He said he missed his parents and began to count on his fingers, to keep anything from happening to them: 'If I get to four, our family stays together, and nothing happens to anyone'. Stressful life events that might have been associated with the formation and functionality of the compulsions were discussed, but none met the criteria for PTSD. Mario O's worst experience was his separation from his parents from age 7 to 11. His parents wanted to build a home in their native southern Italy, and so both worked in Germany. Therefore for a short time, they took their two sons to stay in southern Italy with their grandparents, whom Mario hardly knew. In the next session, Mario reported that he had expressed no feelings for a long time. He could no longer cry, he said, and was afraid of doing it. Control was important to him. In a polite and reserved way, he tried to participate actively in the therapy. He always showed eagerness to meet my expectations and to do everything right.

It was agreed that we would start with EMDR and process his worst experience, the sense of abandonment in childhood. To this end, he described his image, as he stood at the gate weeping and watched his parents' car drive away. His grandparents held him back, to keep him from running after them. The SUD (degree of stress) was 7 (range 0–10). The following is a partial transcript of the first EMDR session.

**KB:** Please imagine the scene along with the negative sentence 'I am alone'; notice where you feel it in your body. Are you in contact? If so, please nod.

**MO:** [nods].

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** Sadness. I see the car.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** I feel calmer, the tension is decreasing; but I am still sad.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** Somehow, I feel an acceptance. I see myself turning to my brother and taking him by the hand.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** I feel sad. And somehow relaxed.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** I feel somewhat angry and empty.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** It's funny. I feel looser. Relaxed.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** I feel somewhat more self-confident again.

**KB:** If you return now to the precipitating event, what is there now?

**MO:** Sadness. However, I see the departure, but unlike before, it is now more of a normal departure.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** I'm more relaxed than before, but I'm still uneasy. It's hard to describe.

**KB:** [etc.] **MO:** I see the image of my brother and myself turning around. We go back, with my grandparents. My grandmother, my grandmother comforts me, puts her arm around me. I am not alone.

**KB:** [etc.] **MO:** I thought just now about playing. Playing with my brother in the garden.

**KB:** [etc.] **MO:** We are playing.

**KB:** I would like to return to the precipitating event. Is that okay?  
**MO:** Yes.

**KB:** What do you see? **MO:** I see us standing there. I am sad, with tears in my eyes. I hold my brother by the hand.

**KB:** [etc.] **MO:** We return to the house, sad, but composed.

**KB:** [etc.] **MO:** We become looser, go outside.

**KB:** [etc.] **MO:** We are outside, doing nothing in particular, playing.

**KB:** [etc.] **MO:** The departure is finished. We concern ourselves with very different things. We do this with a certain satisfaction.

**KB:** If you return now to the precipitating event, what is there now?

**MO:** [Pause, thinking] (...) I see a smile on my face, at the departure.

**KB:** If you think about the precipitating event now, on a scale of 0-10, how stressful does it feel?

**MO:** 2.

**KB:** What about the remaining stress?

**MO:** I still feel somewhat alone. Not as much as before. I can say that I feel it much less. But it is still there. It's deep inside me.

**KB:** [etc.] **MO:** I am very sad. I am still sad.

**KB:** [etc.] **MO:** This sorrow inside you, it hurts so much.

**KB:** [etc.] **MO:** Sad, and totally powerless. That's how I see myself.

**KB:** [etc.] **MO:** I see myself sitting at my grandparents' table, feeling sad.

**KB:** [etc.] **MO:** My grandmother comforts me; my brother is not sad at all, he's already playing again. He's playing under the table.

**KB:** [etc.] **MO:** I get up and play with him.

**KB:** [etc.] **MO:** I lie in bed and think about my parents, but I am calm; I can fall asleep.

Mario O. also described, at a later stage, a constant stress level of 2 when he imagined the scene. But now he concluded: 'Such departures are painful. That's normal. Otherwise it would also be bad for me, because it would mean that I did not miss my parents at all'. After the first EMDR session, he felt calmer, but also 'flat and totally exhausted'. In the next session, he answered my question about how his compulsions were going: 'They happen just as frequently. I always have the feeling that I have forgotten something. Then I control them with my mind (secretly). (...) I'm not as talkative as usual, somewhat depressed, but also more genuine'.

We then turned directly to the compulsion, taking on the first appearance of his compulsion, in the paediatric psychiatric institution. This is also in a direct relationship to the first EMDR stimulation. After the children returned to their parents, 5 years later, Mario was not doing well in school. He actually found the assignments easy, but always suffered massively from separation anxiety and always wanted to be with his parents. As the problems got worse, the parents sought help, and Mario was admitted to a psychiatric institution. It was when he stood at the window of his room

there, shortly after his parents had visited him, that his compulsions began. He kept counting on his fingers up to four (without the thumb), while saying softly: 'Nothing is happening, nothing is happening, nothing is happening ...' (SUD 9). During the eye movement exercise, he described the pain of his parents' departure. He noted a discrepancy between his love for his parents and his anger at them, because he was not allowed to go home with them. The image switched back to play with other children, 'but always with the ulterior motive that I must control everything, and also that the compulsions must continue in parallel'. The following transcript is from the fourth repetition (channel) of this EMDR session.

**MO:** I am standing at the window, and have to count to four to make sure that nothing happens. I am very anxious, tense and sad. But at this moment, anxiety is primary.

**KB:** Stay there and watch my fingers [30 stimulations with eye movements]. Let your mind go blank ... What is there now?

**MO:** Over and over again, the counting ritual – I repeated that one really often – I do it again and again, because after each ritual I am always still unsure. I'm not sure whether I have really counted all my fingers.

**KB:** [etc.] **MO:** In the end, the compulsive actions become extremely stressful, because I have repeated them countless times, trying finally to stop. But I never really attain a sense of security. Only slight relief.

**KB:** [etc.] **MO:** I interrupt this ritual with a somewhat reassured feeling and leave the room, but I know it will turn up again spontaneously, somewhere else.

**KB:** [etc.] **MO:** I now feel increasing annoyance, but this time I am annoyed at myself. Because I know that they [the compulsions] are so stressful, yet still I perform them.

**KB:** [etc.] **MO:** I also connect this compulsive behaviour directly with my enormous tension. That's where the tension comes from.

**KB:** Do you have an image in mind right now?

**MO:** Yes, I can really feel it. I am standing there, as I said, with the others and am performing my actions [counting] secretly [in my mind]. This creates an enormous inner tension.

**KB:** [etc.] **MO:** I have also felt, when contact with others prevented me from carrying out my compulsive behaviour, aggression welling up in me.

**KB:** Can you feel it?

**MO:** Yes, we are playing a board game with the nurse. I'm about to start my ritual. It's my turn. Someone speaks to me, but I am no longer in the game at all; I am preoccupied with my compulsions. I don't want to play any more.

He still did not show his emotions openly, but he could identify them better. In a subsequent session, he reduced his image of the psychiatric institution to a stress level of 'between 0 and 1'. The rest of the stress 'is always there; it should stay, it is part of me'. Finally he had an image that he was playing with other children in the hospital and made the nurses mad [he laughs]: 'Much, much better; those were real little rascals' pranks'. After 6 weeks of therapy, he himself raised the issue of the exposure exercises. Usually with compulsions, we use a graduated approach toward stimulus confrontation. In our joint review of his compulsive hierarchy, Mario O. said that he was now ready for the most difficult ones. I was surprised that he did not choose a simpler exercise, but acknowledged his desire to take this approach. At the very top of the hierarchy was 'my letter collection'. To prevent triggering his compulsions, he had stopped opening his mail long ago. He now brought these letters, forms and bank records to the clinic in a large suitcase. In a joint exercise, he dumped the entire contents on his bed and rummaged through the letters with his eyes closed. He decided to tear up a flimsy piece of paper, without looking at it, and throw it away. He said he wanted to run the risk of throwing away something important. This would hitherto have been absolutely unthinkable. His tension shot up to nearly 100%. He placed a rubbish bin nearby and began to sort out the documents. One stack for filing what he wanted to keep, and the rest right into the rubbish bin. He continued to work until

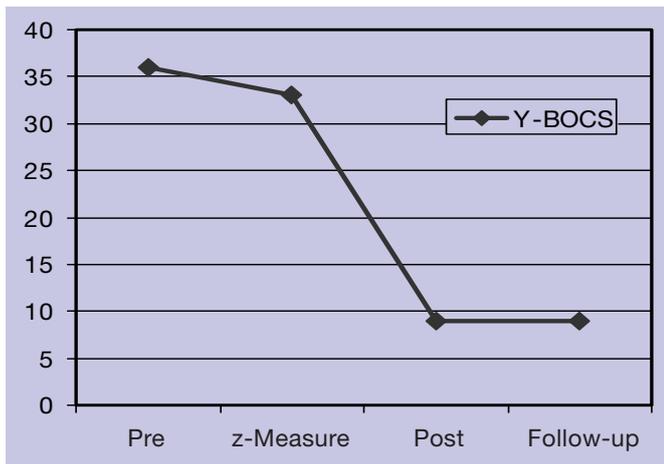


Fig. 1. Y-BOCS clinical rating, Mario O.

the tension had fallen to about 30%. In doing so, he visualised the worst possible consequences of his actions. Could he be guilty of something, rejected again and pushed aside? He told me about these thoughts, looking sad as he did so, but also particularly determined.

After a few weeks of exercises, we arranged for a home exposure at his flat. Everything there was in perfect order; the flat looked almost sterile. During the flooding exercise, Mario O. threw his entire flat into disarray, used many electrical devices simultaneously and sorted out things that his parents had bought for him that he did not need or want. But this evoked in him the conflict between his love for his parents and his anger against them. Could he treat his parents' things that way? Would they be terribly disappointed? Mario O. decided to take the risk. On the evening after the exercise, he wept long and hard. His parents only noted, on the following weekend, that he must have been practising at home, which pleased them. He was very surprised and also relieved. He asked his parents to stop loading up his flat with well-intended objects. He said he wanted to take his life into his own hands. He was able to reduce his compulsive behaviour by about 90%. Obsessive thoughts continued, he said, but were reduced (fig. 1; Y-BOCS total: 9). Also at a 6-month follow-up, the improvement proved to be stable. When I asked what, in his view, the EMDR sessions had contributed, he said that he was better able to understand his compulsions. He said he had identified the stressful feelings, which allowed him to put up more specific resistance to the exposures and to take risks

#### First Exposure, then EMDR: Obsessive Thoughts

Claudia D. (24 years old) had suffered from aggressive and sexual obsessions since the age of 14. In the admission interview, she reported: 'Then I see naughty pictures and I'm afraid ... that I could, for example, do something violent to a girlfriend with a knife. I don't want to do that at all [she cries]'. Because of this obsession, she no longer went to seminars at the university, for fear of endangering her fellow students. Girlfriends were no longer allowed to stay with her overnight, although she really longed for contact. She no longer watched television or read the newspaper, lest they provoke new obsessive impulses. If an obsessive thought or image came to her, she felt completely at its mercy. 'I have nothing to counter it with; I can only try to keep away from it, but it won't leave me alone'. The Y-BOCS for obsessive thoughts was performed and gave a value of 16 (of a maximum of 24). No traumas were present in the sense of PTSD.

At the beginning of therapy, the obsessions were given closer scrutiny. Claudia D. had had no significant treatment for her obsessive behaviours and saw herself as completely at their mercy. In the graduated stimulus confrontation it quickly became clear that Claudia D. was subject to strong avoidance tendencies. She did not want to disappoint our expecta-

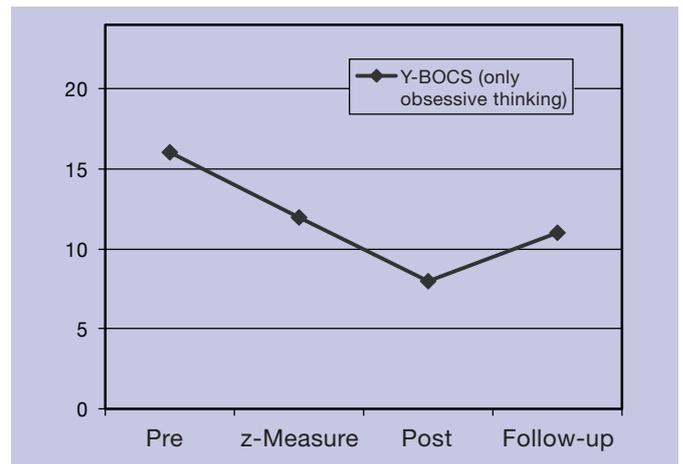


Fig. 2. Y-BOCS clinical rating, Claudia D.

tions of her and did the exercises willingly. On her own, however, it was very hard for her to continue the confrontation exercises without avoidance. The avoidance tendencies proved to be very persistent and were often difficult for the patient to recognize. It was clear that she sometimes did not want to give them up. After 7 weeks of exposure therapy, she still showed a broad persistence of obsessive symptoms (fig. 2). Therefore EMDR sessions were conducted for another 4 weeks. The accompanying stimulus confrontations were not performed further at this time. The patient, however, could continue them at her own discretion and could also discuss them in therapy. The image presented in the first 2 EMDR sessions was of a traumatic experience at age 9, in which the patient described how she fell from her bunk bed onto the back of a chair and felt a wrenching pain between her legs. 'I'm going to die!' was her associated negative cognition. Imagining that scene led to an SUD of 10. During both stimulation sessions, there were very long periods in which the image remained unchanged. After 1.5 hours, the stress slowly decreased: 'I can stand it better' (SUD = 5). In the next session, the stress (SUD) was reduced to zero, and the positive cognition 'it's finished' took hold (VoC = 7). Also at that session there were long stretches of unchanging feelings and thought content. By interweaving (cognitive support by the therapist), the attempt was made to speed things up. The patient tried hard to change, but was blocked again. At the end of the session, she looked at the image from a new perspective (not from above, but from the front).

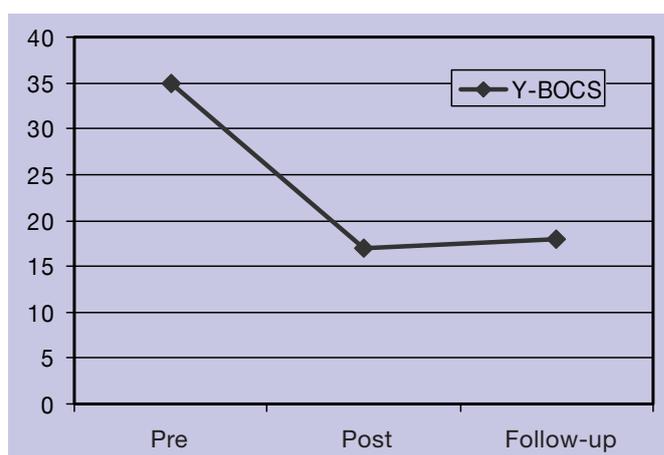
In a later EMDR session, the worst imaginable scenario came into play. She said that only after death would she know how she would be punished. 'God punishes fairly. It is my own fault; He cannot be to blame. There is a curse on me'. I asked her whether she had an image of this, and she described a kind of hell in which she had to suffer incredible agony and pain forever. She estimated the degree of pain at 8 (SUD). She said she felt shame and disgust. The disgust she felt with herself: 'That I am throwing up and that blood is running from my nose'. The bleeding, she said, stands for the feeling that everything had to be purged. During the eye movements, the image was initially more intense and clearer, 'even more disgusting!' After a few more sets, she described a feeling of 'that's okay, the image is there, but somehow more distant, farther away; it is drifting farther and farther away'. The stress at the end of the session was 3-4. A week later, the next eye movements followed the same scenario. The first 5 sets already resulted in an SUD of 1: 'I can no longer summon up the image as well. It is difficult for me to summon it up during eye movements. It keeps disappearing again. Am I doing something wrong?' I explained to her that this is completely normal and, on the contrary, it is a good sign. That seemed to relieve her, but it also became clear that her fear persisted, that she would make herself guilty; it would be her own fault. In the debriefing, she reported: 'Since that session, I have not been so afraid of the image - actually, hardly at all. It strikes me

that it is a lot easier to think about it, and I look at it longer. Since then, the image no longer shows up on its own. But during the session, I find it hard to articulate how I feel after each eye movement phase. I often feel nothing at all. So then I pulled myself together and told myself that now I will just describe what I feel. I had to overcome the sense that you might be irritated. In the end, I actually no longer felt that the image was as bad as it used to be'. Four weeks after the treatment ended, Claudia D. reported that she was studying again, that two girlfriends had stayed overnight with her and that she was going out again in the evening. She has still not watched violent films; she generally avoids watching television. But she can enjoy life again. One year after the end of therapy, Claudia D. wrote to me: 'How did EMDR go for me? I can only say: very well! The images we dealt with seem almost never appear to me any more, and if they do, they are just not as bad as they were. I think this is quite tremendous, considering that, if I have other stressful chaos images in my mind at all, they are not the ones from the EMDR sessions!!!'

#### *Exposure and EMDR Alternately: Washing and Control Compulsions*

In the admission interview, 27-year-old electrician Rainer B. reported that for 1.5 years he had been suffering from the fear of losing something important. He said that he checks to make sure he still has his cell phone, wallet, keys and other personal items. He often goes back or turns around to see if he has lost something. Such fears also extended to insignificant items such as cigarettes and notepads. Overall, he is busy with his control behaviours for 6 hours a day, and therefore has been on sick leave for 5 months. Since then he has become very withdrawn and is suffering from increasing depression (BDI: 28). He said he was sleeping a lot, to escape from the compulsions. There were no traumas reported in the medical history.

In the preparatory phase, in addition to an in-depth exploration and behavioural analysis, the EMDR absorption technique (resource work) was introduced. Rainer B. found it difficult to perceive and to identify his emotions. He said he always wanted to do everything perfectly and correctly. If this desire was thwarted, he would have an occasional outburst of rage, especially at his mother. However, he avoids showing outward signs of weakness and vulnerability. For the initial exposure, Rainer B. chose the following exercise (60% difficulty): while we took a walk together, he placed the contents of his wallet on a window ledge. His tension rose markedly; his eyes moved quickly back and forth to keep all his ID cards and papers in view. After I mentioned this, he decided to stop that control behaviour. Then a strong gust of wind unexpectedly blew away some of the papers. His tension rose to 100%, and Rainer B. wrestled with himself, wanting to search the ground carefully one more time. Then he said: 'I'll take the risk. I don't care about it now, I'll just do it. Three days after that exercise, we had our first EMDR session. We chose imaginary blocking. He imagined his compulsions at work, as he tried to place his personal belongings in exact order in his locker. He visualised himself standing in the dressing room, with the impulse to start running through his ritualized control behaviours. We now prevented the compulsive actions by having him imagine that the lock on the locker was broken. He could not lock up his valuables. 'I have no control', he said. The stress of this imaginary scene rose to 8 (SUD). He felt a lump in his throat. During the subsequent stimulation with eye movements, four sets were required for him to be able to communicate his feelings: 'It is very far away, somehow less important. I can almost look at it with composure. Other things are just much more important. I feel ashamed, ashamed to fail, ... and afraid not to be taken seriously by others. But that is just what happened with my compulsions. But still, I'm anxious about it, and the compulsions help me. I often don't say what I'm thinking. I always appear so self-confident and strong, but I am also uncertain'. A total of eight eye movement sets was performed, until the stress level of the image went to zero. But in both our evaluations, the image had not gone away at all during the session. 'My protective armour is chipped. I was able to reveal myself, show my feelings. This is new. I'll first have to think about it. But it feels better. I am relaxed. Still, I've also noticed that my compulsions



**Fig. 3.** Y-BOCS clinical rating, Rainer B.

are incredibly strong. I think they also help me cope with stress and pressure in my life ... But now I don't know how to cope'. In the debriefing, he found this session particularly valuable, as it had stirred up feelings and he was able to deal with that.

Subsequently, among other things, we used a future projection with EMDR: the idea of being back at work, keeping his personal items in his trouser pocket and performing his duties without compulsive control behaviours. Here he quickly turned his attention to his thoughts, and the image swiftly receded into the background. At the end of the 10-week therapy, he had eliminated about 60% of the control compulsions (fig. 3). That brought him great relief.

### **Summary and Treatment Recommendations**

The selected case reports involve courses of treatment in which EMDR proved effective or helpful.

In the case of Mario O., the treatment plan began with EMDR. He reported, in the follow-up discussions, that he felt there was less therapist influence there than in the later exposures, and that he could often identify his own desires and goals on a non-verbal level. In his estimation, this had a direct impact on his stimulus confrontations (ERP), in that he deliberately accepted the anxiety-producing risk and showed great personal initiative.

With Claudia D., EMDR was used after the exposure exercises. She was able to process the frightening, obsessive images, which previously had not been successful using exposure exercises. But the patient, who was being treated in the hospital, also felt heavily burdened, after 7 weeks of confrontation treatment, by practicing or performing a new therapeutic method.

Alternating ERP and EMDR sessions were used for Rainer B. The experience of stimulus confrontations in vivo was strengthened here by the therapeutic bond, which was first made possible, in our observation, by an emotional experience in the EMDR sessions. Rainer B. had difficulty in letting the therapist see him as weak and in need of help. EMDR offered him an effective way to reveal these feelings and make

them noticeable. He experienced EMDR as pleasant, especially compared to classical exposure exercises. Nevertheless, he reported that EMDR was 'no cakewalk'. For him to confront his feelings was a challenge not to be underestimated.

These case reports suggest that the directed use of EMDR for obsessive-compulsive disorders can be a useful treatment method. A change in the imagining of experiences during EMDR sessions did not occur in all patients as rapidly as has been often described for post-traumatic stress disorder [De Jongh et al., 1995]. Often incomplete sessions were necessary, as Bekkers [1999] also described. Nevertheless, the amount of effort involved in the treatment was kept within bounds. The often-expressed principle that the best therapeutic help is given with minimal intervention, appeared to be fulfilled by EMDR. However, this technique was more complicated than it seemed at first [Shapiro, 1991]. The use of EMDR, in addition to adequate training, also required sufficient experience with obsessive-compulsive disorders.

Our previous experiences show that exclusive treatment of obsessions and compulsions with EMDR is not indicated, at least not in severe cases. In our opinion, ERP in vivo is always an extremely important component of therapy. As the case of Mario O. showed, EMDR can indeed trigger a central process. Implementation at the treatment level seems to us to be very important, particularly with obsessive-compulsive disorders. Only then did a reduction of symptoms usually occur.

The aim of this study was to explore how EMDR can be used effectively in the treatment of obsessive-compulsive dis-

orders, and to identify areas for future research. In future research projects, it will be necessary to examine more precisely the use of EMDR for obsessions and compulsions. EMDR has been found to be a very effective therapeutic technique in patients with type 1 and type 2 traumas. This raises the question of whether patients with relevant traumatic experiences respond better to EMDR, as was the case with Mario O. Traumas might then be considered as part of the functionality, or as the precondition for the formation of obsessions and compulsions. EMDR could, as an additional module, improve the outcome of cognitive behavioural therapy that has proved insufficient or lacking in response, since up to 50% of treatment-resistant OCD patients have been subject to traumatisation [Cromer et al., 2007]. The question of the order in which EMDR and ERP should be used is also an interesting one. The timing of therapy seems particularly important to us, to assist patients in emotion regulation or to promote this. Studies with larger sample sizes would be desirable for this purpose. The study design should include a randomized assignment and a control group that is given 'treatment as usual' (TAU: ERP), to make the augmentation effect of EMDR visible.

### Conflict of interest

There is no conflict of interest. Financial support was provided by EM-DRIA Deutschland, but no influence was exerted on publication or implementation of the treatments.

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