An Attachment-Informed Approach to EMDR for Obsessive-Compulsive Disorder (OCD)

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Introduction: Beyond the Standard Protocol:

For experienced EMDR therapists, adapting our practice to address complex presentations such as obsessive-compulsive disorder (OCD) is an important next step for professional development. This booklet introduces a modified **attachment-informed EMDR (ai-EMDR)** model. This approach moves beyond the standard EMDR protocol to specifically address the developmental and attachment ruptures that are often at the core of OCD presentations. Our focus is on gaining insight into how these early experiences shaped the client's internal world and how to use ai-EMDR integrated with the evidence-based treatments for OCD, to facilitate holistic and lasting healing.

The epidemiology and burden of OCD:
It is estimated that 2-4% of the general population will experience OCD during their lifetime (Stein et al., 2025) with the prevalence appearing relatively consistent across cultures (Stein et al., 2025). The societal and personal impact of OCD is immense. The average delay between symptom onset and treatment is 12 years, commonly due to the individual's sense of shame, fear of treatment, and a belief that their thoughts are uniquely terrifying and/or untreatable.

The condition's reach often extends far beyond the individual, placing a significant emotional and practical toll on friends, family, and relationships. OCD rituals can drive a wedge between parents and children and between partners, who often feel unable to comprehend the pain a loved one is experiencing. OCD can impact every area of an individual's life and tends to hook into the values that are most important to them.

The CBT Model and Its Limitations:
The CBT model of OCD posits that distress stems from the individual's misinterpretation of intrusive thoughts and clients are facilitated in developing a less-threatening interpretation of these thoughts in treatment.

In an innovative study, Purdon & Clark (1993) recruited 293 students and asked them to complete a 52-item self-report based on the characteristics found in clinical obsessions. They concluded that **99%** of these **non-clinical participants** had experienced intrusive thoughts, images and impulses that were similar in content to those experienced by individuals with OCD. What distinguishes the individuals with OCD is their subjective evaluation of these thoughts as dangerous or unacceptable

This endorsed the theory that OCD is a consequence of the individual's subjective evaluation of intrusive thoughts and images. This poses the questions of how and why the person with OCD came to evaluate their thoughts/images in this way. What are the formative experiences and beliefs (schemas) that drive these evaluations?
There is a growing body of research to suggest that these evaluations commonly connect to underlying beliefs that there is something bad about the individual or that

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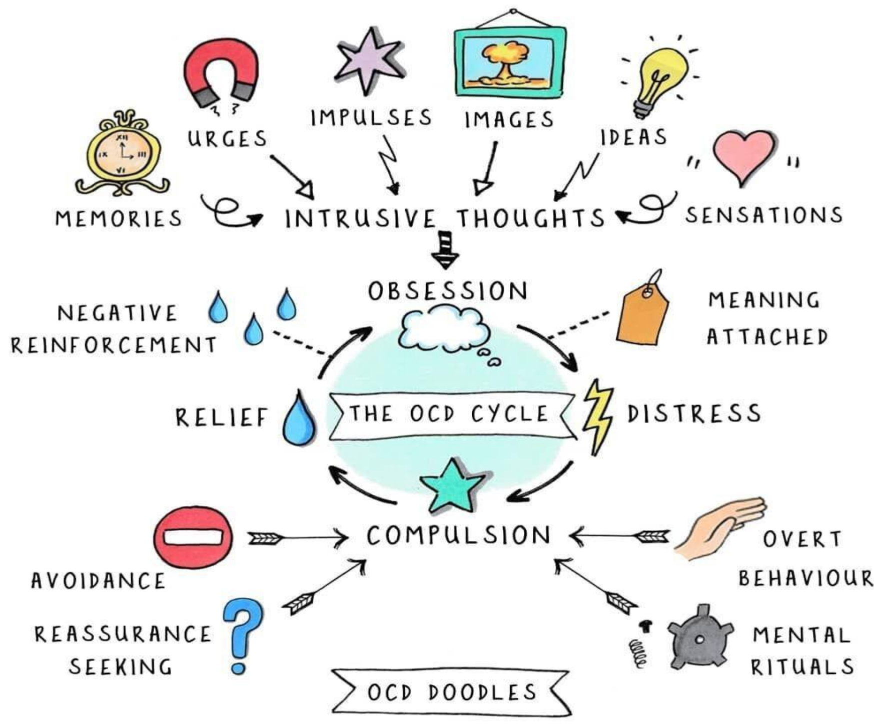
they are personally responsible for preventing harm to others (Radomsky et al., 2014; Moulding & Kyrios, 2006; Rachman & de Silva, 1978). The obsessional preoccupations and compulsions are undertaken to alleviate the distress caused by these beliefs (Clark, 2004; Rachman, 1998; Shafran et al.,1996).

Exposure and Response Prevention (ERP) was traditionally based on the habituation to anxiety model where the client is exposed to a trigger situation and requested not to undertake any physical or mental compulsions until their anxiety has reduced (Hezel & Simpson, 2019). There is however an emerging shift in the understanding of the mechanism of change in ERP, whereby previous learning experiences are suggested to have an important role to play (Inhibitory Learning Theory). This suggests that new learning experiences have an inhibitory function on the feared predictions that stemmed from the individual's past learning (Craske et al, 2014). While effective for some, ERP can be highly taxing, leading to high dropout rates (Ong et al, 2016) and continued suffering. This underscores the need for alternative, more tolerable treatment options.



Beyond Neurobiology: The Relational Aspect of OCD:
The exact neurobiological aetiology of OCD remains elusive, and findings regarding neuropsychological deficits in the OCD population are often contradictory across studies. OCD cannot be identified on a brain scan (Grant & Chamberlain, 2020). Interestingly, Takahashi et al. (2004) found similar brain activity between OCD patients exposed to stimuli eliciting OCD symptoms, and nonclinical subjects exposed to stimuli eliciting guilt.

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Research does suggest a link between environmental context and the specific content of obsessions, with studies showing that the themes of obsessions often align with what a society considers taboo or morally significant (Williams et al., 2014). For example, concerns about contamination may focus on syphilis in one region, or on HIV in another (Lewis-Fernandez et al., 2010). OCD with a religious theme is more prevalent in countries where religion has an important role in society (Matsunaga & Seedat, 2007). This cultural influence on symptom characteristics suggests that OCD is, at least in part, a **relational phenomenon**.

Miller & Brock (2017) found that four types of interpersonal trauma (violence, emotional abuse, sexual abuse, and neglect) were associated with OCD symptom severity. In their research, exposure to a traumatic event was defined as an event that caused actual or perceived threat to the physical integrity of an individual or others.

A study by Mancini & Gangemi (2006) found that individuals with OCD, when compared to participants with other anxiety disorders, showed higher levels of distress when shown Ekman's (1976) Pictures of Facial Affect for anger and disgust, especially when they were asked to imagine that these expressions were targeted at them and that they were deserved. Individuals with OCD were also found to recall being the target of these hostile facial expressions more frequently than the controls in this study.

Luyten et al. (2020) established a link between attachment insecurity and obsessive-compulsive disorder, suggesting that OCD symptoms are deeply intertwined with how individuals regulate emotions within relationships. This meta-analysis from sixteen studies, found that both attachment anxiety (a fear of abandonment) and attachment avoidance (a discomfort with intimacy) are significantly associated with OCD severity, with anxiety showing a particularly strong correlation. These findings suggest that attachment insecurity acts as a developmental vulnerability that fuels dysfunctional beliefs and "self-soothing" compulsions and argues that integrating attachment-based strategies could improve outcomes.

Tenore et al. (2018) describe how parents who withdraw love and are not prone to forgive, may have taught the child that just making a small mistake is sufficient to receive aggressive, demeaning approaches by a primary caregiver. This dynamic does not allow the possibility for the child to justify themselves or be forgiven and they are left with the perception that their behaviour can determine the end of the relationship. Pace et al. (2011) suggest that OC behaviours may be an adaptive strategy used by the child to obtain approval, with these coping strategies continuing into adult life.

Hezel et al. (2012) describe how shame can have a profound effect in OCD, leading to feelings of being morally flawed and maladaptive coping strategies (Weingarden & Renshaw, 2015). Valentiner & Smith (2008) suggest that OCD is characterised by shame, especially when it is associated with moral-laden intrusive thoughts or images relating to sexual, aggressive or religious themes. Rachman (2007) describes how shame may function as a warning signal to the individual, to avoid putting themselves in

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unfavourable situations where they may be rejected. In this way, shame could be seen as an adaptive process that facilitates the individual with OCD in preventing social rejection.

EMDR: The Standard Protocol:
***"Learn the rules like a pro, so you can break them like an artist"* ~ Pablo Picasso**

EMDR (Eye Movement Desensitisation and Reprocessing) as first developed by Francine Shapiro to treat symptoms of PTSD has continued to evolve and develop with various modified protocols proposed for the treatment of different presentations including anxiety, phobias, and depression. It is highly recommended that all EMDR therapists understand the standard protocol and the adaptive information processing model that underpins the theory. The eight phases of the standard protocol are outlined in Table 1.

Table 1: EMDR Standard Protocol and the 8 Phases

Overview of eight-phase EMDR therapy treatment

Phase	Purpose	Procedures
History taking	• Obtain background information • Identify suitability for EMDR treatment • Identify processing targets from events in client's life according to standardized three-pronged protocol	• Standard history-taking questionnaires and diagnostic psychometrics • Review of the selection criteria • Questions and techniques to identify 1) past events that have laid the groundwork for the pathology, 2) current triggers and 3) future needs
Preparation	Prepare appropriate clients for EMDR processing of targets	• Education regarding the symptom picture • Metaphors and techniques that foster stabilization and a sense of personal control
Assessment	Access the target for EMDR processing by stimulating primary aspects of the memory	Elicit the image, negative belief currently held, desired positive belief, current emotion, and physical sensation and baseline measures
Desensitization	Process experiences toward an adaptive resolution (no distress)	Standardized protocols incorporating eye movements (taps or tones) that allow the spontaneous emergence of insights, emotions, physical sensations and other memories
Installation	Increase connections to positive cognitive networks	Enhance the validity of the desired positive belief and fully integrate the positive effects within the memory network
Body scan	Complete processing of any residual disturbance associated with the target	Concentration on and processing of any residual physical sensations
Closure	Ensure client stability at the completion of an EMDR session and between sessions	• Use of guided imagery or self-control techniques if needed • Briefing regarding expectations and behavioral reports between sessions
Reassessment	Ensure maintenance of therapeutic outcomes and stability of client	• Evaluation of treatment effects • Evaluation of integration within larger social system

The table above has been adapted with permission from Francine Shapiro's article "The Role of Eye Movement Desensitization and Reprocessing (EMDR) Therapy in Medicine: Addressing the Psychological and Physical Symptoms Stemming from Adverse Life Experiences," published in the Winter 2014 issue of *The Permanente Journal*.

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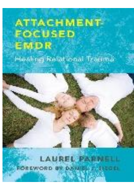
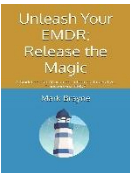
From Standard to Attachment-Informed EMDR:

The approach we take with OCD clients is an integrated model that aligns with the **attachment-informed EMDR modifications** of Mark Brayne and **Attachment-Focused EMDR** by Laurel Parnell (we will refer to these moving forward as **ai-EMDR**). These modifications are not a replacement for the standard protocol, but a sophisticated adaptation designed for clients whose presenting issues are rooted in formative experiences, learned emotional responses, unmet needs, developmental and attachment trauma.

Attachment Modification:



Parnell (2013) describes how to conceptualize the client's presenting difficulties in relation to their attachment history, with the therapist paying particular attention to the client's emotional responses to attachment-related triggers and the present attunement in the therapeutic relationship.



Brayne (2023) describes how the central aim in his ai-EMDR is to identify and repair early attachment ruptures. The primary questions for conceptualizing clients difficulties are 'how the person got to be the way they are?' and 'how, where and in what context did they learn to emotionally self-soothe?'.

Core Philosophical Shifts:
Brayne's (2023) and Parnell's (2013) ai-EMDR is a paradigm shift in how we conceptualize a client's difficulties. Instead of asking, "What is the specific trauma to target?", we ask:

- ***"How did this person get to be the way they are?"***
- ***"How, where, and in what context did they learn to emotionally self-soothe?"***

The Rationale for an Attachment-Informed EMDR Approach for OCD Treatment:

This perspective views OCD not as a pathology, but as an **adaptive response** to early formative experiences. The obsessions and compulsions may have initially served as a way for the child to gain a sense of control or protect themselves from overwhelming emotions (e.g., anger, shame, sadness) in an unpredictable or misattuned environment.

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The rationale for adapting EMDR for OCD is driven by clinical experience and a growing body of research suggesting that OCD is a disorder of emotional dysregulation rooted in early psychosocial experiences. These attachment-informed modifications are particularly well-suited to address the core challenges of an OCD presentation, including:

1. **Resourcing and Self-Soothing:** ai-EMDR places a strong emphasis on **resourcing**: For clients whose early experiences left them without adequate self-soothing skills, this is a vital prerequisite for any form of ERP-style processing, whether in CBT or EMDR. The client's challenges with self-regulation may explain the high attrition rates in traditional ERP and EMDR studies as clients lack the internal capacity to tolerate the affect generated by exposure work.

2. **Processing Guilt and Shame:** Attachment modifications facilitate the processing of deep-seated negative emotions, such as guilt and shame, which are central to many OCD themes. Parental emotional neglect or a punitive rearing style can leave a child with the perception that their mistakes are catastrophic, leading to a profound sense of shame that persists into adulthood (Tenore et al., 2018).

3. **The Power of Bridging:** The ai-EMDR approach, which proactively uses a **bridging** or "floatback" technique, allows the therapist to trace current OCD symptoms and triggers back to their developmental roots. This is crucial for OCD, as the core issue is often not a single traumatic event, but a longer-term pattern of relational misattunement, unmet needs, or emotional neglect.

4. **Moving Past the "Noise":** OCD's intrusions and compulsions (the "noise") can easily tangle with the left-brain, numerical focus of a standard protocol (e.g., ratings of VoC and SUDs). The ai-EMDR's simplified structure of **Emotion-Body-Belief**, combined with a de-emphasis on rating scales, helps the client move past the cognitive compulsions and access the deeper, right-brain processing required for true healing.

Key Differences in Practice:
The attachment-informed approach differs from the standard protocol in four crucial ways:

1. **Therapeutic Focus:**

Standard:	**Attachment-Informed**
Primarily targets specific trauma memories and their associated negative cognitions (NC) and unprocessed emotions.	Places a significant emphasis on **identifying, understanding and repairing early attachment ruptures** and the resulting **internal working models** and **schemas**.

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2. **Assessment and Preparation:**

Standard:	Attachment-Informed
Focuses on identifying the history and traumatic events. Attempts to sequence target memories, events, or symptoms in the order to process. Standard calm place resourcing.	In addition to the present problems, the assessment is **curious about the client's early life and attachment experiences** to understand their influence on current emotional and psychological difficulties. This involves being curious about their attachment-related schemas, and how they learned to emotionally regulate (or not). This assessment phase informs the subsequent therapeutic work, ensuring that it is both relevant and impactful. Preparation includes calm place and in addition to an attachment figure and/ or resource team with protective, nurturing, wise figures.

3. **The Use of the Protocol and Interweaves:**

Standard:	Attachment-Informed
Follows a structured protocol in Phase 3, utilizing target images, negative cognitions (NC), positive cognitions (PC), and rating scales like the **Validity of Cognition (VoC)** and **Subjective Units of Distress (SUDs)**. In phase 4 the therapist is advised to stay out of the way of the clients processing and only intervene with interweaves if the processing is looping or stuck. Interweaves are brief in order that the therapist can move back to 'staying out of the way'.	Modifies Phase 3 to focus on the client's **right-brain experience**—imagery, emotion, and body sensations. The use of numerical scales like VoC and SUDs is minimized or removed entirely, as these left-brain functions can disrupt the deep-seated, right-brain accessing of formative experiences and schema formation. As Parnell (2013, p. 184) notes, asking for a numerical rating can feel like a "maths quiz," pulling the client out of the very memory network we are trying to access. Additionally, therapist interweaves (interventions) can be rich in imagination and utilized to reveal, rewire, and repair early attachment wounds. Interweaves are used more frequently in attachment EMDR to address the developmental experiences that require repair.

4. **Bridging / Float Back:**

Standard:	Attachment-Informed

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This process is commonly known as 'floatback' in standard EMDR terminology	Parnell (2013) and Brayne (2019) endorse more proactive use of what is termed 'bridging'. This is used to trace the client's present issues back to their developmental roots and key memories (so with OCD in the present prong we bridge back to the past prong instead of attempting to find and sequence memories).

5. **The Therapeutic Relationship:**

Standard:	**Attachment-Informed:**
The therapeutic relationship is important but not the central focus of the work.	The **therapist-client relationship is seen as a central healing mechanism**. For clients with attachment wounds, the compassionately attuned relationship itself is a reparative experience, providing a safe container for the processing of early experiences.

The above differences highlight how ai-EMDR tailors the therapeutic process to address the foundation of present disturbance that is related to attachment experiences and provides a more personalised approach to healing. These attachment-based modifications are in keeping with the work of Schore (2003) and Siegel (2003) who both describe how clients often bring deep-seated emotional issues to therapy that may not be fully accessible through conscious left-brain verbalisation.

Parnell is an EMDR consultant and trainer who was psycho-dynamically trained and her focus is more on practice-based clinical knowledge, rather than academic research in the field of attachment and trauma psychology. Parnell (2013) describes how individuals whose parents were inconsistent, unavailable or overly intrusive may develop an ambivalent, avoidant or preoccupied attachment response. These individuals may feel shame that 'there is something wrong with me' because of their needs only being met inconsistently.

For many of these individuals parental misattunement may have commenced at a pre-verbal stage of development, resulting in implicit emotional flashback type symptoms that are consistent with some OCD presentations (Dykshoorn et al., 2014). Schwartz (2018) describes the way that healing preverbal trauma involves working with current symptoms of anxiety, panic, dissociation or somatic distress. Parnell (2013) explains how EMDR can be used to work through 'stuck' sensations in the body to attend to unmet childhood needs and proposes that, with a compassionately attuned therapist,

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the client will take in the relational healing alongside the healing of the original traumas. She emphasizes the need for these clients to have tools to calm their anxiety and soothe their self-criticism and shame. They need to develop positive self-talk to counter their negative thoughts and calm the brain's right hemisphere to create new neural pathways.

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Table 1*:* A comparison of the standard EMDR and the AI-EMDR phase 3 and brain hemisphere involvement (adapted from Brayne, 2023).

Standard EMDR	**Primary Brain hemisphere Activated**	**AI-EMDR Protocol** *As seen in Table 2*	**Primary Brain hemisphere Activated**
Event	Right/Left	Event	Right/Left
Image	Right	Image	Right
Negative Cognition	Left	Emotion	Right
Positive Cognition	Left	Body	Right
Validity of Cognition (1-7)	Left	Thought/Belief (about self) No rating scale	Right/Left
Emotion	Right	Bridge	Right
SUDS (1-10)	Left	SUDS (1-10) optional	
Body	Right	Position in space and time + Image, emotion, body, belief	Right/Left

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FURTHER RESOURCES:

Present prong - What brings strong feelings or triggers you?

Think about your current triggers that bring strong feelings for you. To understand them better, use the chart below to describe (1) what triggers strong negative emotions for you, (2) the emotional response you have, (3) the body response you have, (4) what urges arise in response to these feelings and body sensations, and (5) any thoughts that also arise.

1.What triggered you? (e.g. images, sounds, smells, body sensations, people, places, activities, dreams)	***2.Emotional response***	***3.Somatic response (e.g. headache, chest tight)***	***4.Urges in response***	***5.Thoughts in response***

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<u>"The Rules" from *Codependent No More* by Melody Beattie</u>

THE OLD RULES:

1) Don't feel or talk about feelings.
2) Don't think, figure things out, or make decisions--- you probably don't know what you want or what's best for you.
3) Don't identify, mention, or solve problems--- it's not okay to have them.
4) Be good, right, perfect, and strong.
5) Don't be who you are because it's not good enough.
6) Don't be selfish, put yourself first, say what you want and need, say no, set boundaries, or take care of yourself--- always take care of others and never hurt their feelings or make them angry.
7) Don't have fun, be silly or enjoy life--- it costs money, makes noise, and isn't necessary.
8) Don't trust yourself, your Higher Power, the process of life, or certain people--- instead put your faith in untrustworthy people and then act surprised when they let you down.
9) Don't be open, honest, and direct--- hint, manipulate, get others to talk for you, guess what they want and need and expect them to do the same for you.
10) Don't get close to people--- it isn't safe.
11) Don't disrupt the system by growing or changing.

THE NEW RULES:

1) It's okay to feel my feelings and talk about them when it's safe and appropriate, and I want to.
2) I can think, make good decisions, and figure things out.
3) I can have, talk about, and solve my problems.
   It's okay for me to be who I am.
4) I can make mistakes, be imperfect, sometimes be weak, sometimes be not so good, sometimes be better, and occasionally be great.
5) It's okay to be selfish sometimes, put myself first sometimes, and say what I want and need.
6) It's okay to give to others, but it's okay to keep some for myself too.
7) It's okay for me to take care of me. I can say no and set boundaries.
8) It's okay to have fun, be silly sometimes, and enjoy life.
9) I can make good decisions about who to trust. I can trust myself. I can trust God, even when it looks like I can't.
10) I can be appropriately vulnerable.
11) I can be direct and honest.
12) It's okay for me to be close to some people.
13) I can grow and change, even if that means rocking a bunch of boats.
14) I can grow at my own pace.
15) I can be love and be loved. And I can love me, because I'm lovable. And I'm good enough.

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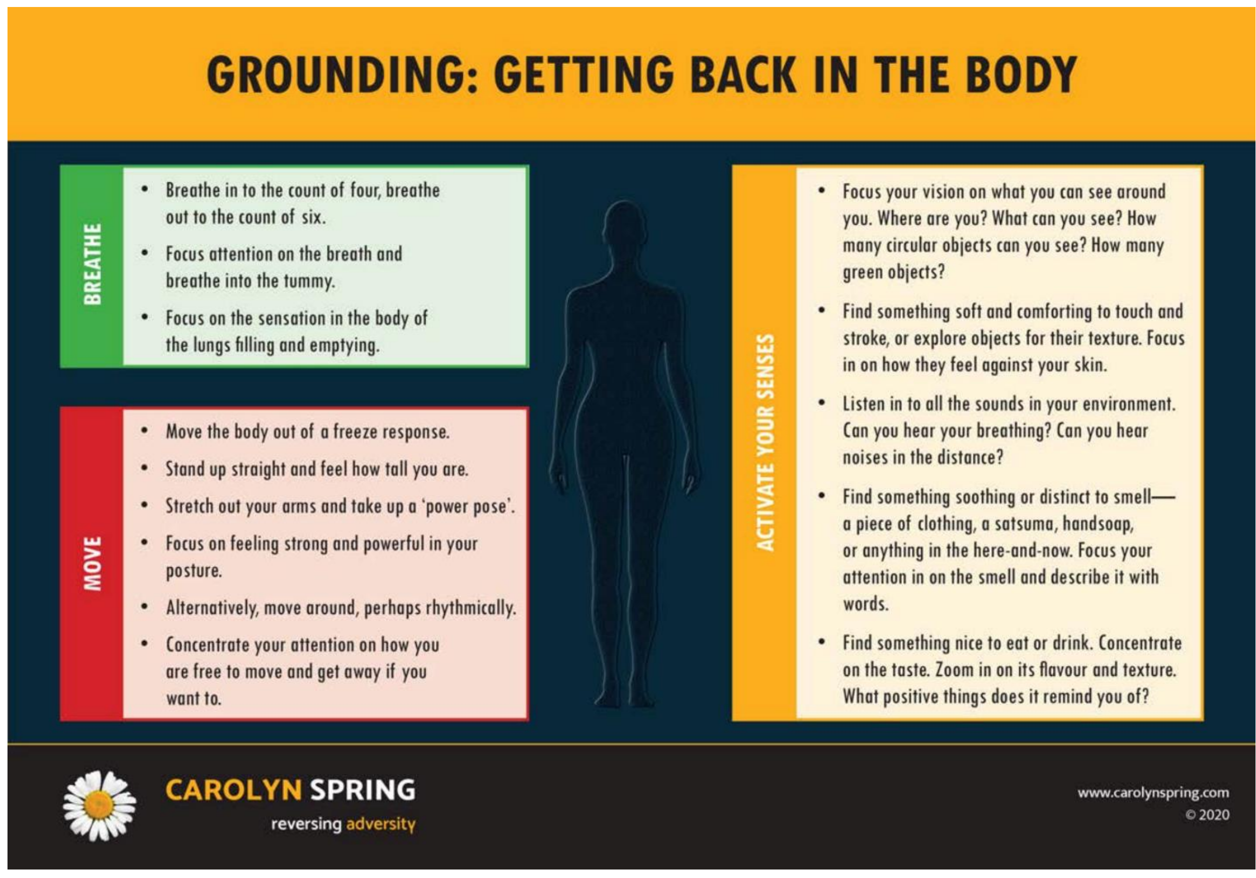
Reference Guide for Clients

Resources for Grounding:
Grounding techniques are extra preparation for individual clients who can benefit from further strategies to manage the emotional intensity of processing. These tools can be practiced between sessions to maintain emotional regulation. The therapist's clinical judgment will guide which techniques are most appropriate and when the client is ready to tolerate the affect necessary to process past memories.



Here is a reference to various possible preparation/stabilization/resource/grounding techniques your therapist can utilise to prepare you for processing and to use during processing if necessary. These tools and techniques can continue to be practiced between sessions and into the future to maintain emotional regulation and self-care strategies you have gained throughout the therapy process. Some individuals may not be able to do Calm/Peaceful/Safe Place, so there are many possible alternatives. Your therapist will use clinical judgment in determining when you can tolerate the affect necessary to process the past adverse/distressing/traumatic memories and will of course discuss with you when ready to proceed.

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Breathing Skills "Make yourself as comfortable as you can in your chair. Just take a big, deep breath, all the way down into your belly and hold it for just a moment." (Pause for a moment, but not to the point of discomfort.) Just breathe that out. What do you notice now? Just allow yourself to take that deep, slow breath again, and really notice what that feels like as the air goes into your lungs, holding it for just a moment, and then allowing yourself to exhale slowly, noticing what it's like as the breath leaves your lungs. You can practice this skill throughout the days following the session.

Double breath through nostril – this is a very quick and simple technique that can reset your nervous system in seconds and can be done anywhere. Breath in quickly through your nostril like a sniff, with mouth closed, as far as the breath will top up, hold for the count of 2 and then take one more quick sniff before gently and slowly releasing through the mouth (imagine the gentle slow release as flickering a candle light but not blowing it out). You may feel an urge to yawn or stretch following this exercise as your nervous system shift into 'rest and digest'.

Calm/Peaceful/Safe/Happy/Chill/Free Place (call it whatever feels most comfortable to your system and please let your therapist know if any of the other reference/labels/words are uncomfortable for any reason).

The goal of this exercise is to support you to create imagery of a place that can be accessed during sessions for regulation when needed, and potentially after processing. To develop and install an imaginary place or the memory of an actual experience which feels calm, safe, peaceful, maybe the best you have ever felt. Think of a place you feel peaceful and calm. Maybe a beach, forest, lake, garden etc. Imagine what you can see, hear, smell or feel as you imagine this place. Breath it in, notice what it feels like.

Containers - Using an imaginal (or real) container allows you to modulate the amount of material you are accessing at any given time. Use of a container can reduce or slow down processing between sessions and can create a feeling of distance from the memories or material you do not want to be readily accessible. This allows you to practice containing off thoughts or memories that feel too much to process. Imagine a container of some kind that you could use to hold uncomfortable or intolerable feelings/etc. Think of something that can be temporarily sealed up, like a box, a jar, a chest, a small room, etc. It can be as big or small as you need it to be. What comes to mind? Maybe a box or a barrel. Using your imagination, just see yourself putting all that unfinished material/uncomfortable or intolerable feelings/etc in that container. Take all the time you need and get it all in there. Taking all the time you need, when it's all in there, just seal it up in your imagination with a lid, lock, or whatever seems like it fits for you.

Resource Extending
Identify a skill, strength, or resource you feel will help deal with the distress/trauma. After thinking and focusing on that resource, notice how it feels. This resource can be anchored with a cue word or physical anchor (pressing a knuckle, etc.) and then should be practiced regularly.

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<u>Four Elements "Light"</u>
This version is useful for quick grounding.
The "four elements" are AIR, EARTH, WATER and FIRE.
For AIR - take a deep breath. Take a moment to stay with that.
For EARTH - notice your feet on the ground, the chair under and behind them, and again, take moment to stay with that.
For WATER, make saliva, and take a moment to notice that.
For FIRE - look around for something the color of fire, such as red, orange, yellow, blue, and white.
Come back to air, with a big deep breath, and then take notice – what do you notice? Some of the time, people will notice something like, "better," "more present," "calmer," etc.
Based on the "Four Elements Exercise for Stress Management" by Elan Shapiro (in Luber, Basics and Special Situations, 2009).

<u>Future Healthy Adult Self</u>
Take a moment to think about how you want life to be, what you want to be different, how you want to feel, when treatment is complete. It may be, "I want to be happy, calm, independent, leave home without panic, have a job I like, go out with friends and enjoy interacting, communicate more effectively with my partner". Create an image of that "future healthy self"; what does it look like? This question can develop an image in the mind's eye of what it will look like/feel like/act like as that future healthy adult, and then further develop that image by asking questions like "what are you wearing as that future healthy adult?" "How does that future healthy you feel in his/her body?. Create a word or name for that future healthy self, things like "Healthy Joe," "Happy Susan," "chilled Julie" etc. You can practice this resource in the days following therapy sessions, by bringing up this image/name, until you notice a shift in body sensations.

<u>Oasis/Healthy Pleasurable Activities</u>
This tool can also help develop skills of affect regulation/self-soothing. Think about "What is a favorite activity that you have?" It may be things like "reading", "Dancing", "needlepoint," "watching football on TV," "running," "petting my dog," etc. Keep the focus on a non-addictive/compulsive activity (i.e., not smoking, drinking alcohol, taking elicit substances, etc.). "Bring up an image of yourself doing that. Describe the scene. What do you see, hear, smell, and feel?" Staying focused on the positive aspects only of this experience, further develop as necessary. Create a cue word and possibly anchor to a knuckle, etc. Practice in the days after the session.

<u>Spiritual Beliefs</u>
This is another possible resource to assist with affect management and tolerance, self-soothing, etc. Think about: "What spiritual beliefs do you have that are particularly helpful to you?" It could be things like, "I believe in God,", "I believe in Buddha", "I know there is something there to guide me but don't have a specific idea of who/what," "I really like to say the rosary," "I believe everything happens for a reason,", "I believe in spirituality and the energy of the universe" etc. "What do you notice in your body when

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you say that?" You might notice things like, "My heart feels warm," "I feel calmer," "I feel more hopeful," etc. "Focus on that,". Perhaps find a cue word for this resource, install with a physical anchor. You can practice this resource in the hours or days following the session.

Skills/Strengths you Would LIKE to Have

"What do you feel you need inside to be able to reach your goals for therapy?" It may be something like "courage." "think of a time when you felt courage, when you really faced the fear and did what you needed to do even though you were afraid.". Once you think of a memory can you describe the time you had that experience. "What image represents that experience?" Create a cue word and/or physically anchor in the body. You can practice going to this resource in the days following the session.

Light Stream (Shapiro, 2001)

Your therapist will practice this exercise with you before deciding if it's suitable to practice independently. Notice any upsetting sensations in your body. If it had a shape, what shape would it be?", just take a moment to notice what comes to you when you think of these questions, "If it had a size, what size would it be?", "If it had a color, what color would it be?", "If it had a temperature, what temperature would it be?", "If it had a texture, what texture would it be?", "If it had a sound (high pitched, low pitched, etc.), what sound would it be?". "What is your favorite color that you associate with healing?" Wait for response. "Imagine that a light of this favorite color is coming in through the top of your head and directing itself at that sensation in your body. Let's pretend that the source of this light is the cosmos so the more you use, the more you have available. The light directs itself at the sensation and resonates, vibrates in and around it. As it does, what happens to the sensation shape, size, color, temperature texture or sound?" If there is any change, continue to repeat the direction in the paragraph above and keep noticing until the shape is completely gone. This may correlate with the disappearance of the upsetting body sensation. After reducing this sensation, bring the light into every portion of the body, and create a positive statement for peace and calm.

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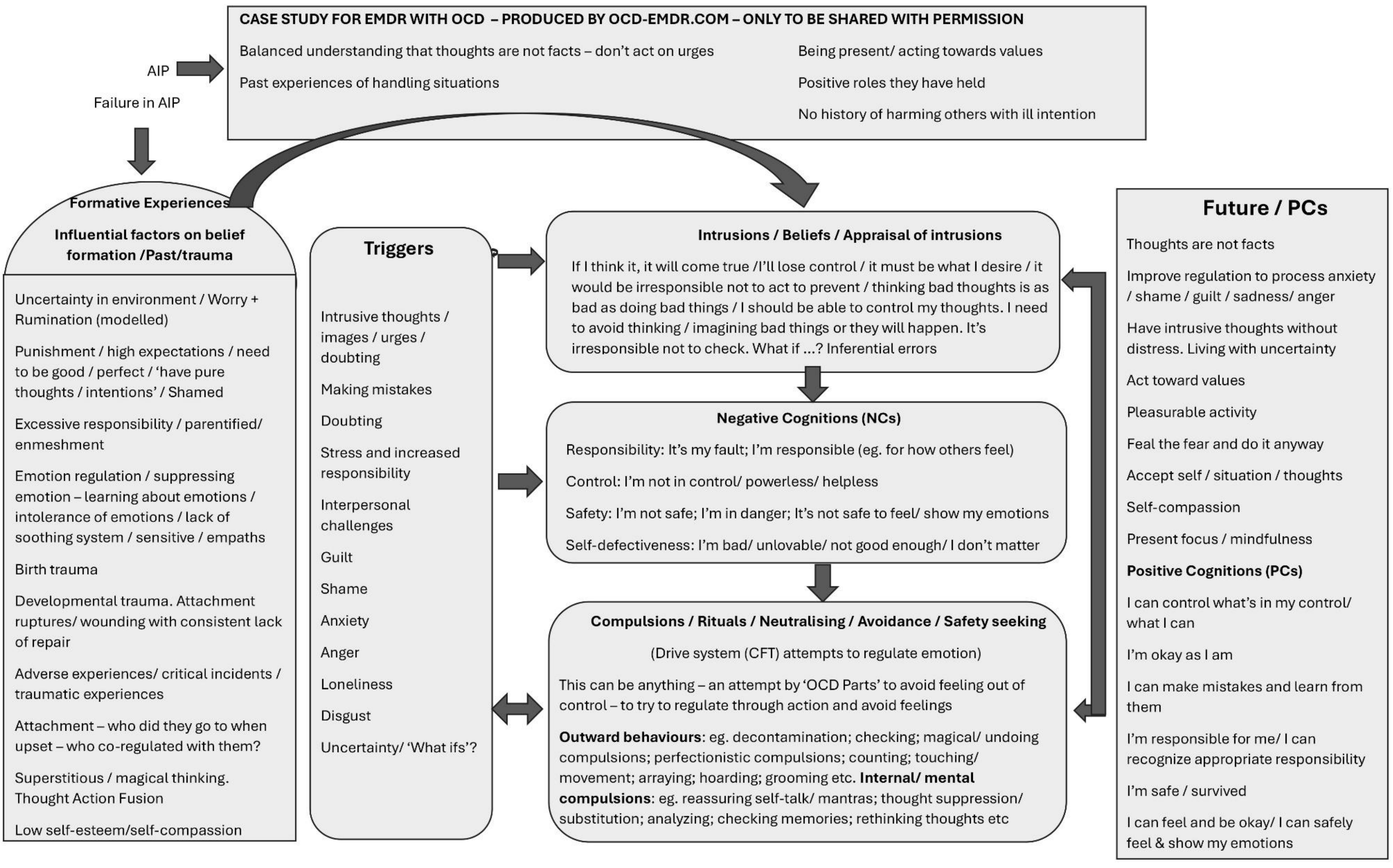
APPENDIX 2 - CASE CONCEPTUALISATION FOR EMDR WITH OCD



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