

Treating OCD with Attachment-Based Integrative EMDR

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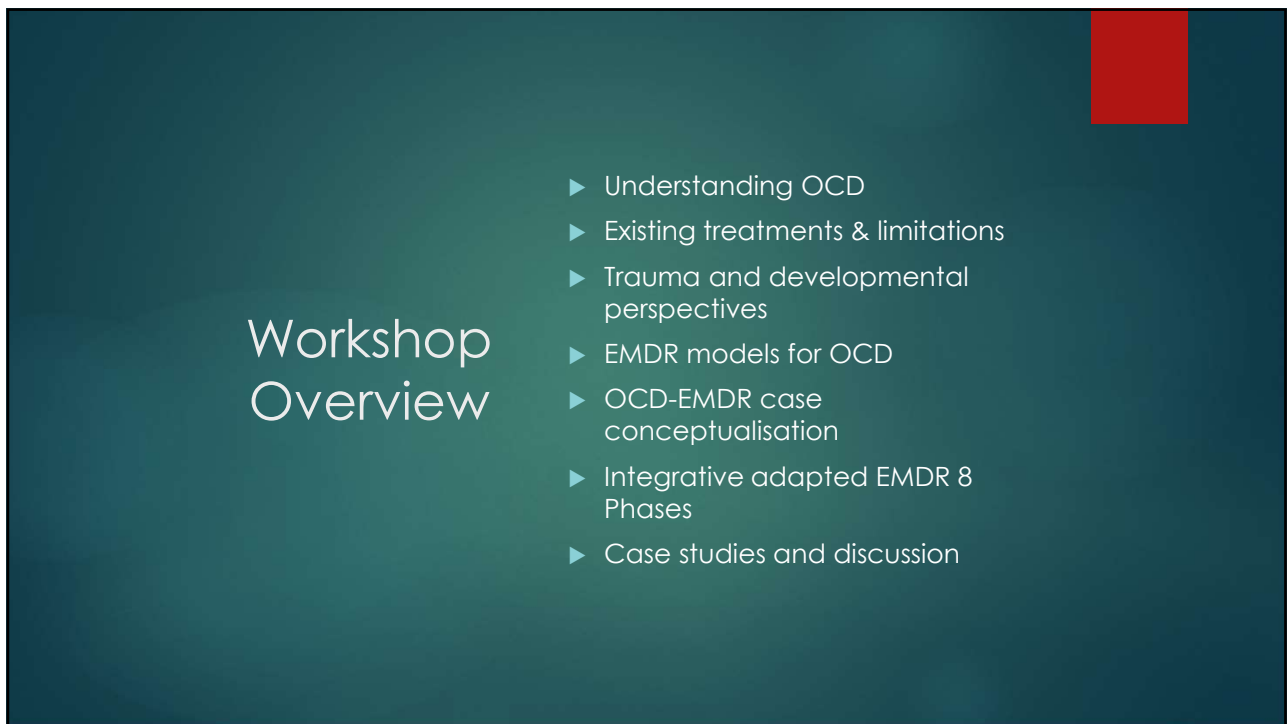
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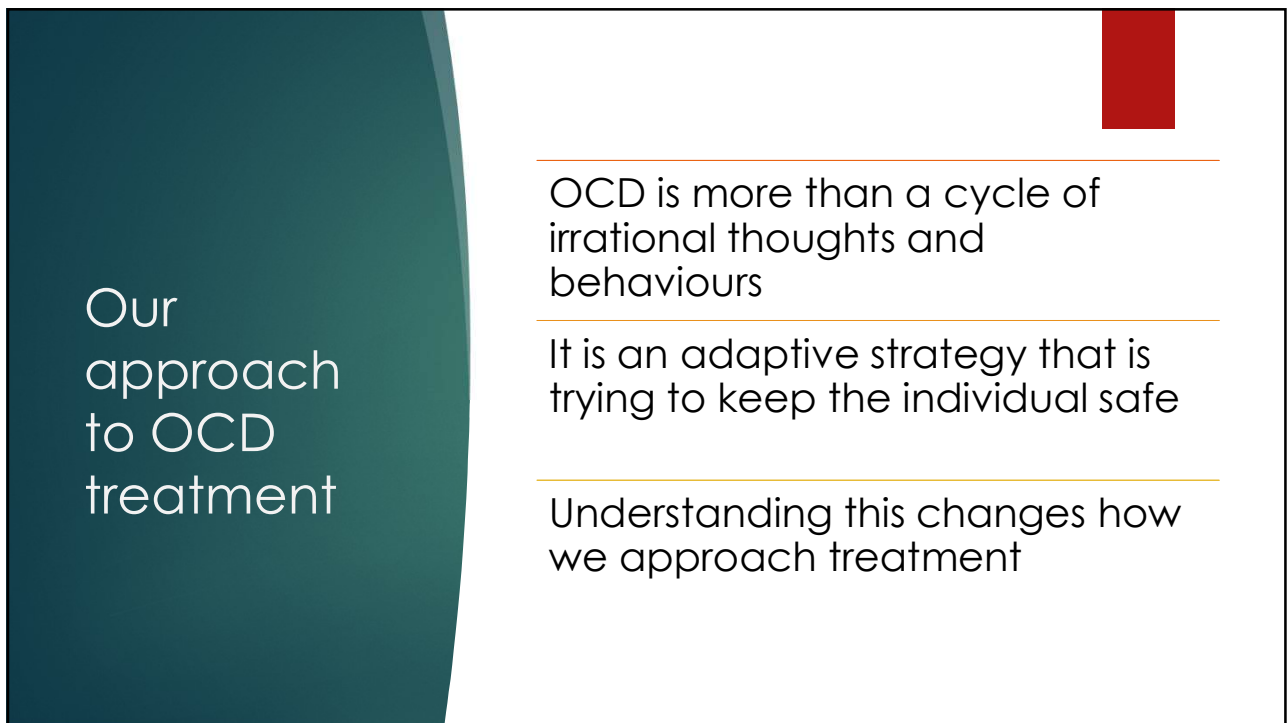
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A dark teal slide with a red square in the top right corner. The title 'Workshop Overview' is on the left, and a bulleted list of topics is on the right.

Workshop Overview

- ▶ Understanding OCD
- ▶ Existing treatments & limitations
- ▶ Trauma and developmental perspectives
- ▶ EMDR models for OCD
- ▶ OCD-EMDR case conceptualisation
- ▶ Integrative adapted EMDR 8 Phases
- ▶ Case studies and discussion

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A slide with a dark teal background on the left and a white background on the right. The title 'Our approach to OCD treatment' is on the left. Three lines of text on the right are separated by horizontal lines.

Our approach to OCD treatment

OCD is more than a cycle of irrational thoughts and behaviours

It is an adaptive strategy that is trying to keep the individual safe

Understanding this changes how we approach treatment

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Diagnostic Framework

DSM-5 (American Psychiatric Association)

ICD-11 (World Health Organization)

Key features: obsessions, compulsions and distress

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Epidemiology

Approximately 2-3%
lifetime prevalence

Often begins in childhood
or early adulthood

Can become chronic
without treatment

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Cultural Expression of OCD

OCD prevalence is similar worldwide

However obsessional themes are influenced by culture as to what is deemed threatening, immoral or unacceptable

Religious cultures: more prone to religious scrupulosity OCD (Antony et al, 2001; Stein et al, 2019)

Western cultures: more prone (or acknowledge) sexual/ sexual orientation OCD (Williams et al. 2017)

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What is OCD?

- ▶ Obsessions: intrusive unwanted thoughts, images or urges
- ▶ Compulsions: overt behaviours or mental acts used to reduce anxiety/ neutralize/ fix the problem/ try to stop bad things from happening/ regulate distress
- ▶ Thoughts are ego-dystonic
- ▶ Causes distress and functional impairment



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The OCD Cycle

Trigger (external & internal)/ Intrusions

Intrusions & Appraisal (attached meaning- e.g. 'I'm bad/ responsible')

Anxiety / distress

Compulsions

Temporary relief that reinforces the cycle



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Overt vs Covert Compulsions

- ▶ Overt behaviours: checking, washing, reassurance seeking, avoidance
- ▶ Mental rituals: rumination, reviewing memories, silent counting
- ▶ Mental compulsions can be difficult to detect and prevent

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Common OCD Themes

Contamination

Doubt /checking

Aggression/ Responsibility for harm

Religious/moral

Relationship OCD

Unacceptable or taboo thoughts

Symmetry and ordering

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Current Treatments

CBT with Exposure and
Response Prevention (ERP)

Selective serotonin
reuptake inhibitors (SSRIs)

ERP remains the most
established treatment

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Inhibitory Learning Model

Exposure builds new learning about safety

Feared outcomes do not occur

Compulsions become unnecessary over time

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Limitations of ERP

Approximately 30% refuse or drop out

Mental compulsions difficult to treat

Shame may interfere with engagement

Trauma-related learning experiences may remain unresolved

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Further limitations of ERP

- ▶ Many clients struggle when undertaking ERP primarily because of their difficulties with affect regulation and limited ability to self-soothe (Blake, 2024)
- ▶ In her book, Rose Cartwright (2024) describes her experience of undergoing ERP:
- ▶ *'Exposure therapy... shows little interest in why they're afraid, diving straight into confrontation without preparation and resourcing. This meant that I faced the abyss, not with abandon but with resistance, leading me to dissociate during exposure exercises and misinterpret that numbing as a reduction in anxiety'*

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Trauma and OCD

Higher trauma exposure reported in OCD populations

Attachment disruptions may shape fear learning

Early experiences shape emotional regulation

Beliefs about danger and responsibility form early

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OCD as an Adaptive Response

Obsessions may
distract from
emotional pain

Compulsions
create a sense
of control

Adaptive then,
but
maladaptive
now

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Small-t
Trauma/
formative
experiences

Rejection

Humiliation

Chronic criticism

Emotional neglect

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Why Consider EMDR?

- Processes emotional memory networks
- Targets shame and responsibility beliefs
- Addresses earlier learning experiences
- Learning to approach previously avoided feelings/ body sensations
- Encouraging mindful present focus

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EMDR Research for OCD

- ▶ Emerging evidence suggests symptom reduction
- ▶ Current evidence base includes case studies and small trials
- ▶ Further research needed



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Flashforward EMDR Model

- ▶ Targets feared future catastrophe
- ▶ Compulsions driven by catastrophic predictions
- ▶ Associated with de Jongh and Logie

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Trauma / Learning History Model

- ▶ Targets earlier learning experiences
- ▶ Responsibility and shame memories
- ▶ Associated with Marsden and Crichton
(and us!)

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Our Integrative Model for OCD



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Integrative Treatment Approach

- ▶ OCD-EMDR provide a rationale and framework for OCD treatment underpinned by attachment-based EMDR

This can be (and is often) integrated with:

- ▶ Compassion-Focused Therapy
- ▶ Acceptance and Commitment Therapy
- ▶ Parts / ego-state work
- ▶ ERP/ CBT



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Terry Real Quote

"By the time a man enters your office, he's already in crisis. You don't see his pain. You see what he's doing to defend against it... This is the result of boys as young as 3 years old learning to deny vulnerability, disconnect from their feelings, and cut off half of their humanity"





"But underneath it all, there's still a boy. A boy who wasn't seen, wasn't heard, wasn't allowed to be soft. A boy who learned that vulnerability was a liability, so he buried it under anger, withdrawal, and control [and sometimes OCD]

[And usually in therapy] it is that boy who is in the driver's seat. What worked for him best as a child is not working for him now.

The message: It was Adaptive then – and it's maladaptive now.

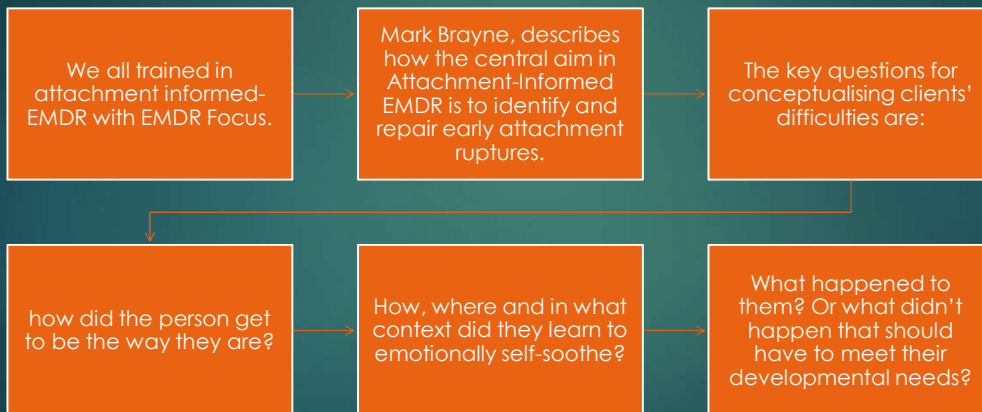
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Rationale for Attachment-based-EMDR adaptations to the SP for treating OCD

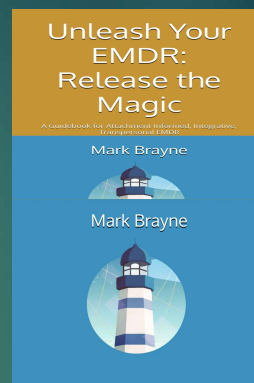
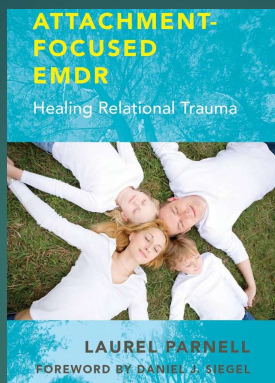
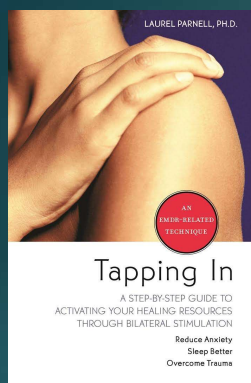
-  Parnell (2013) describes how individuals whose parents were inconsistent, unavailable or overly intrusive may feel shame that 'there is something wrong with me'.
-  She emphasizes the need for these clients to have tools to soothe their anxiety and soothe their self-criticism and shame.
-  Parnell proposes that when clients develop positive self-talk to counter their negative thoughts, it has a calming effect on the right-brain hemisphere.
-  This is compatible with neuropsychological research suggesting that right brain systems are relevant for attachment, affect regulation and developmental change (Schore & Schore, 2007; Siegal, 2024)

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The Attachment-Informed EMDR framework – Mark Brayne <https://emdrfocus.com/workshops/>



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Integrating attachment theory with EMDR

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Attachment insecurity and OCD meta-analysis

- ▶ Exploring the link between attachment insecurity and OCD
- ▶ Suggesting that OCD symptoms are deeply intertwined with how individuals regulate emotions within relationships.
- ▶ 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.
- ▶ Suggests 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.

van Leeuwen WA, van Wingen GA, Luyten P, Denys D, van Marle HJF. Attachment in OCD: A meta-analysis. *J Anxiety Disord.* 2020 Mar;70:102187. doi: 10.1016/j.janxdis.2020.102187. Epub 2020 Jan 7. PMID: 31951931.

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The difference between Attachment –based EMDR and the standard protocol

- ▶ **Therapeutic Focus:**
- ▶ Standard EMDR primarily targets specific traumatic memories, and the negative beliefs associated with them.
- ▶ Attachment-based EMDR, on the other hand, places a significant emphasis on understanding and **repairing early attachment experiences**. This involves exploring their **internal working models**, **attachment-related schemas**, and **unresolved attachment wounds**.

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The difference between Attachment -based-EMDR & the standard protocol contd.

Assessment Process:

- ▶ In standard EMDR, the assessment focuses on identifying the target issue, memory, event, or symptom that the client wants to work on.
- ▶ In attachment-based EMDR, the assessment is curious about the client's formative experiences, early life, belief formation, experience of affect regulation, and attachment experiences - to understand the possible influence on their current emotional and psychological difficulties.

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Adaptations following an attachment-based approach

- ▶ **Rating Scales**
 - ▶ The use of rating scales like VoC is removed in phase 3 and minimised in later phases, as it is considered unnecessary and also suggested that it potentially disrupts accessing neural pathways holding disturbance and processing all channels.
 - ▶ Clinical observations with OCD is that over thinking is part of the problem and asking for numbers in early phases feeds the over thinking part and closes down the neural pathway we want to light up.
- ▶ **Interweaves**
 - ▶ Additionally, therapist interweaves (interventions) are used more frequently in attachment EMDR to address early developmental experiences. See the ai-EMDR framework phase 4 (shared in our longer workshop).

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Adaptations following an attachment-based approach contd.

- ▶ Standard EMDR follows a structured protocol in phase 3 that includes identifying a target image, negative cognition, positive cognition, and using rating scales like the Validity of Cognition (VoC) and Subjective Units of Distress (SUDs).
- ▶ Parnell and Brayne propose that number scales are not necessary in phase 3.
- ▶ Attachment EMDR modifies phase 3 to connect more to the client's emotive experience, and body sensations (**both often avoided by those with OCD**).
- ▶ We also draw on attachment approaches to increase imaginal resourcing beyond the SP calm place. Installation of an imaginary attachment figure, as well as the standard peaceful place in phase 2 (extending further if necessary).

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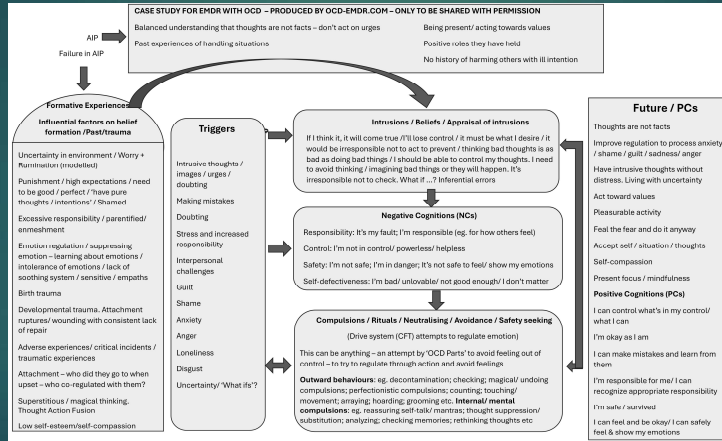


Phase 1

History /
getting to
know you!

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EMDR Case Conceptualisation – how did they get to be this way?



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Phase 1 History

- ▶ Getting to know your client (ever evolving)
- ▶ Often OCD (but not always) has been around since childhood and no specific memory of linked causal events
- ▶ Developing a therapeutic relationship
- ▶ Significant people in life

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Phase 1 History cont...

- ▶ History of problem (headlines not entire story)
- ▶ Look out for shame and guilt and family beliefs about emotions
- ▶ Strengths and coping and values
- ▶ ACEs
- ▶ Present nature of OCD intrusions and compulsions and the underlying self-referencing beliefs – map onto case conceptualization - ask for a recent example
- ▶ History of OCD - be aware of not becoming overly involved with obsessions and compulsions but listen and ask for beliefs – what do you believe completing the compulsion does? What would happen if you don't - What do you believe about the intrusive thoughts? What does it mean about you? Where did you learn that?
- ▶ Get to know the inner critic – there is usually a very harsh inner critic
- ▶ What is meaningful to them / what do they want from therapy / present life

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Getting to know your client

- ▶ Attachment History – birth - who soothed them – who was physically and emotionally present / absent
- ▶ Exploring the story of early experiences
- ▶ Perfectionism
- ▶ Over-inflated responsibility
- ▶ Magical superstitious thinking
- ▶ Looking out for unhelpful belief formation in childhood / around the age of magical thinking / hyper responsibility
- ▶ Unsafe to feel their emotions and working hard to get rid of them
- ▶ Intolerance of uncertainty
- ▶ Illness
- ▶ Religious/moral influences

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Getting to know your client contd.

- ▶ Excessive expectations of responsibility, performance, behaviour
- ▶ Punishment for mistakes
- ▶ Shaming
- ▶ Over estimation of danger
- ▶ Over importance of thoughts
- ▶ Thought Action Fusion / Thought Event Fusion
- ▶ People pleasing
- ▶ Parentified
- ▶ Emotional neglect/ lack of emotional attunement
- ▶ Abuse
- ▶ Trauma small – t and big T

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10 Minute
Comfort
Break

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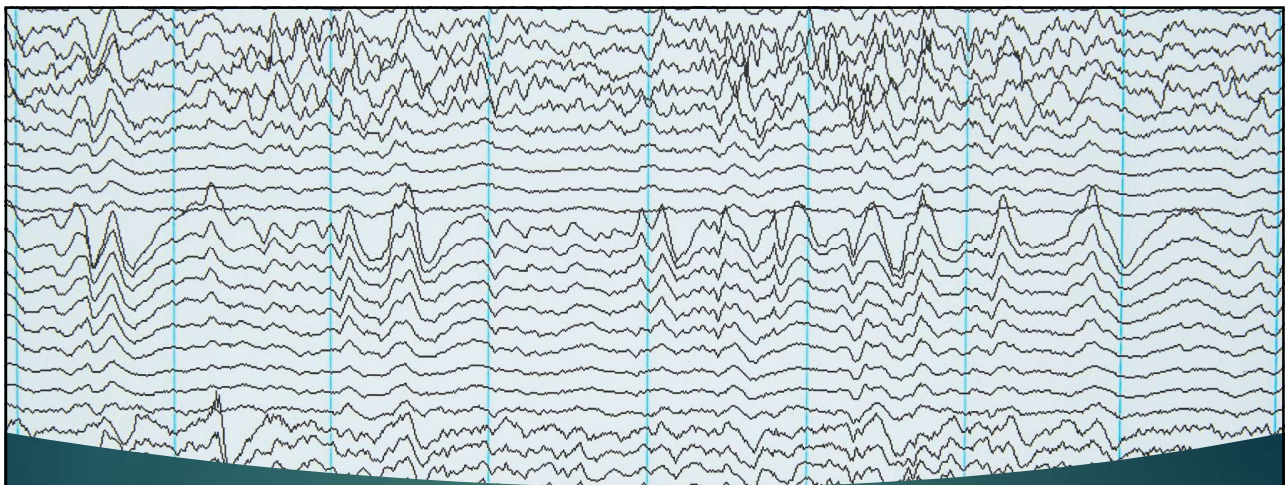


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Example: How might the past relate to OCD?

- ▶ **Contamination OCD:** Example of a client who was sexually assaulted many years ago but didn't initially see this as related to OCD fears of being contaminated by bugs.
- ▶ OCD had taken over life to the point that the trauma was something they didn't even think about.
- ▶ Compulsions were excessive washing rituals, checking, not allowing people to enter the home, avoiding being next to anyone on public transport, obsessive rumination and worry
- ▶ To be clear, there's not always a link to a specific DSM-5 criterion traumatic incident and if there's trauma in history it isn't always clear or even in awareness
- ▶ The attachment-based EMDR bridge went to formative experiences of learning not to express emotions or needs
- ▶ Eventually leading us back to the trauma to process and compulsions started to fall away

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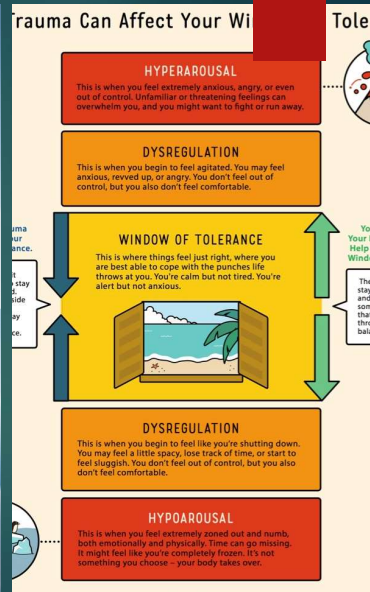
Phase 2 –

capacity to regulate – befriend emotions and body – therapeutic relationship – connect to self-compassion – develop understanding of OCD as a protector and explore the role of the inner critic – integrate what the client will benefit from

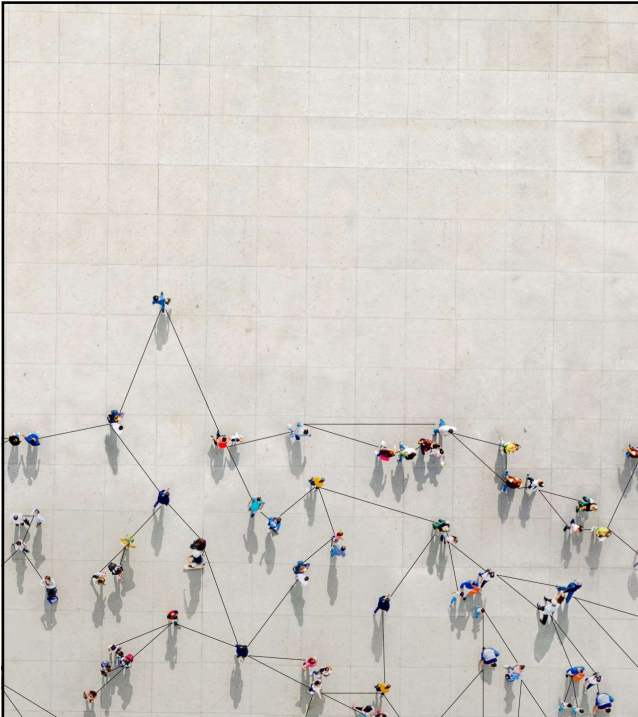
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Stabilization

- ▶ Capacity to maintain dual attention
- ▶ Returning inside Window of Tolerance
- ▶ Boat is sturdy enough for fishing expedition
- ▶ Able to regulate for daily functioning
- ▶ Safety – compulsions not so extreme to be physically harming
- ▶ Be with emotion and model to client that their emotions are tolerable, valid, human, acceptable, allowed
- ▶ Communicate control – stop signal
- ▶ Usual metaphors



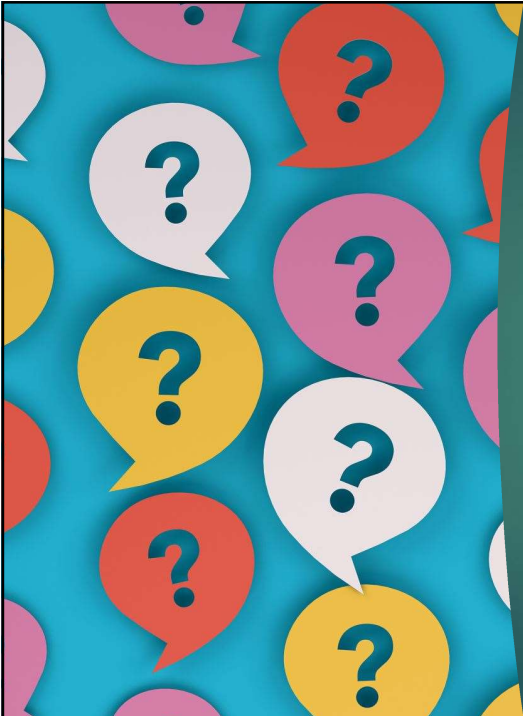
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EMDR Preparation

- ▶ Usual Calm/Peaceful / Safe place / container
- ▶ Relational
- ▶ Attachment Figure &/ or Resource Team – connecting every session
- ▶ Discovering what the client needed in childhood
- ▶ What didn't happen that should have
- ▶ What did the attachment figure communicate

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OCD Psych-ed

- ▶ Intrusive Thoughts in the general population
- ▶ Thoughts are not facts
- ▶ Thought Experiments
- ▶ ERP and habituation curve
- ▶ ACT
- ▶ CFT
- ▶ Mindfulness
- ▶ Worry modules - CCI
- ▶ I-CBT workbook

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Somatic techniques

- ▶ Getting into the body to change state can be helpful for shifting out of thinking
- ▶ When the problem is of thinking, more thinking might not help
- ▶ Therapeutic relationship – use your regulated nervous system to support the client/ use your 'Self energy'
- ▶ Introduces 'just notice' language
- ▶ Gives information about how they connect to body sensations
- ▶ Empowers with quick simple regulation
- ▶ Can begin to shift energy from the body

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Affect Self-regulation – as an adult

- ▶ Co-regulation leads to self-regulation
- ▶ Often an absence of affect regulation skills (links to formative experiences). Often affect-phobic.
- ▶ Learning to feel and not suppress emotions
- ▶ Learning to regulate through the soothing system rather than the drive system



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General regulation techniques

- ATTENTION TRAINING
- BREATHING
- SELF-COMPASSION (CFT – TARA BRACH, KRISTEN NEFF, JACK CORNFIELD, PEMA CHODRON, PAUL GILBERT)
- SOMATIC AND SENSORY TOOLS – POLY-VAGAL TECHNIQUES
- CONSCIOUS MOVEMENT – SINGING - DANCING
- GROUNDING TECHNIQUES
- GUIDED IMAGERY
- PROGRESSIVE MUSCLE RELAXATION

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Regulation techniques

- Somatic techniques that are easy to practice.
- Double nasal breath
- Stop and drop hands/shoulders/jaw,
- Orientation to present
- Eyes moving round like the numbers on a clock face

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EMDR for OCD integrative approach

- ▶ CBT psych-ed definitely helps in phase 2 to prep the AIP
- ▶ I-CBT workbook can be completed by client between sessions
- ▶ ERP in many cases is more successful to approach after some EMDR resourcing and processing
- ▶ Future template: usually spontaneously includes some sort of movie doing what has previously been avoided / Exposure to living life with response prevention
- ▶ Everyone is individual – attachment informed means attune and adapt to client
- ▶ ERP after EMDR has done some of the heavy lifting, otherwise it often feels like an uphill battle.
- ▶ EMDR can adaptively update some of the negative beliefs of 'I'm bad, I'm responsible, I must be in control' etc. that underpin OCD, resulting in a generalising effect and ERP becomes more acceptable

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CBT Behavioural Experiments – integrate

- ▶ When appropriate BE can support connection to the adaptive information needed in later processing
- ▶ Introducing the adaptive information that the client may never have learned – always consider on an individual basis.
- ▶ Can result in access to adaptive information such as "I had the thought but no intention to act", "these are thoughts" and not facts" – can also link later to a self-referencing meaning – PC:" I can trust myself" "I'm safe" etc.

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Understanding OCD as a Part / Ego State/ defence mechanism

- ▶ Mapping parts – get to know the OCD Part
- ▶ Loving eyes – Jim Knipe (adapted versions)
- ▶ Ovals - Jim Knipe
- ▶ Robin Shapiro – Easy Ego States
- ▶ Terry Real – Adapted Child / Wise Adult
- ▶ Inner child
- ▶ Chair work
- ▶ Unblend from the OCD Part – IFS informed – 6 F's 5 P's (Self led therapist)
- ▶ Self Energy – IFS informed – like the sun, always there, even behind clouds
- ▶ Witnessing, retrieval, unburdening, invitation to come to present, playful / peaceful / calm place (DNMS style)

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Demo of working with intrusions during resourcing phase

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Joyce's Paedophile- Themed (POCD) Case Study

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Terry Real – Adapted Child

Adaptive Child / Wise Adult

(Adapted From Pia Mellody)

Adaptive Child

- Black & White
- Perfectionistic
- Relentless
- Rigid
- Harsh
- Hard
- Certain
- Tight in body

Wise Adult

- Nuanced
- Realistic
- Forgiving
- Flexible
- Warm
- Yielding
- Humble
- Relaxed in body

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Rose Cartwright – ‘The Maps We Carry’

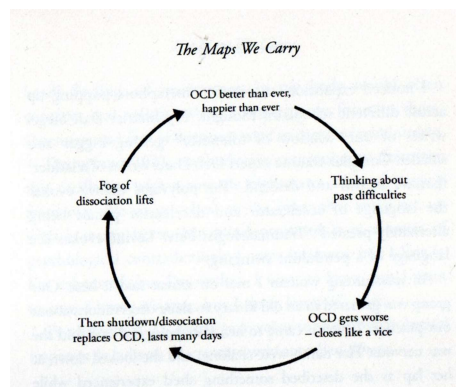
- ▶ "December 2020: There is a gap between the thunder and the lightning, the anxiety and the thought. The trauma sensation and the invented story. The pain and the language... A decoupling has started.
- ▶ January 2021: I don't have to escape myself. That call-back mechanism that was always putting stories to my feelings – I don't need those stories anymore because I don't need to escape those feelings
- ▶ March 2021: The sensation that keeps returning,... that my mind puts stories to, that sensation is uncertainty. It's asking me over and over again: are you safe?
- ▶ Now I can tell it: you are Rose Cartwright"



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The recovery process in OCD From Rose Cartwright: *The Maps we Carry*

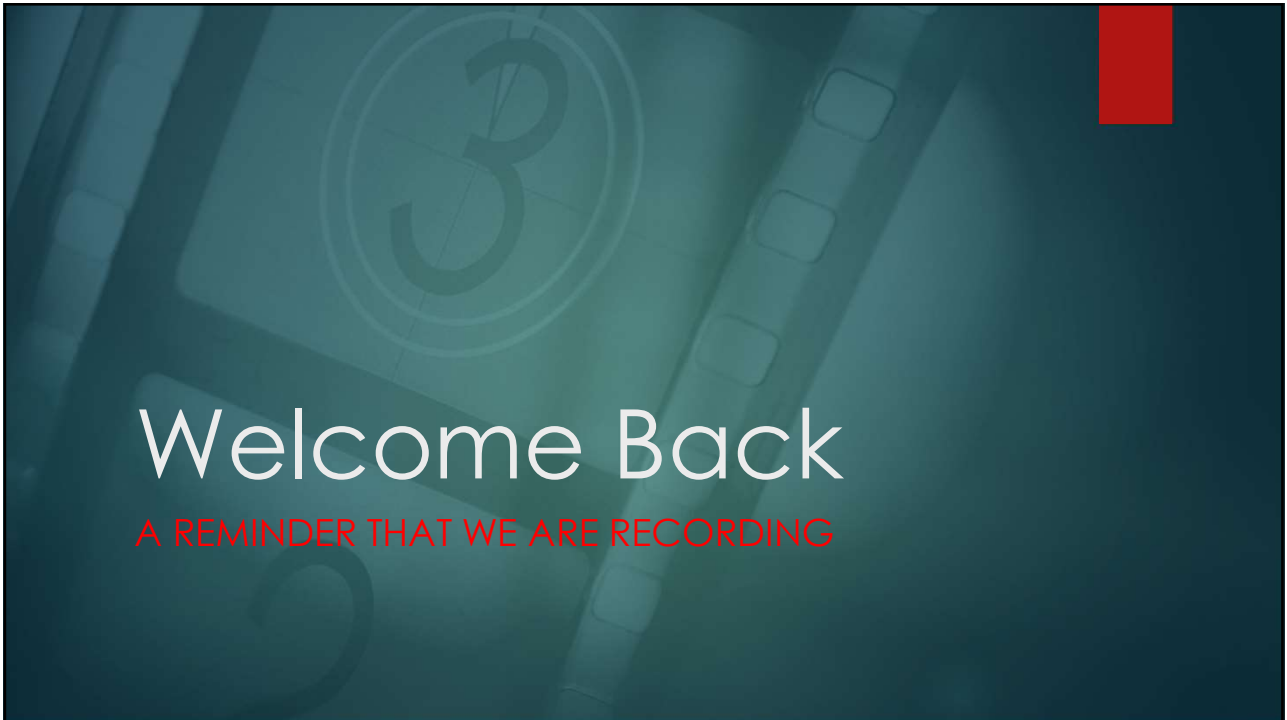
- ▶ When emotions got too much, OCD would rush in as a distraction replacing feelings related to the past with irrational preoccupations in the present: 'Look over there'
- ▶ Soon the anxiety would become untenable, and I would numb out for a few days, before the fog started to clear and I'd feel well again.
- ▶ As my system was gradually building the confidence to feel more intense and complex feelings (expansion), my defences were reacting in kind, intensifying in an attempt to contain a potentially threatening influx of emotion (contraction).
- ▶ What was difficult to notice was that each time I expanded a little more and contracted a little less.



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<p>2. Go Back as Far as You Can 3. First Place You Land. (WATT) <i>Where are you? How old? If difficult Photo Album of early years, random page? Eagle view? Where did you live at 5?</i> Select target of formative experiences. <i>Re-Activate, positioned in space & time.</i> Note whether Portal, Stepping Stone, Root Target? As with Bridge, check <i>Image/Emotion/Body/Belief</i> OCD specific* At this point, OK to use an image. This will be the wound <i>behind</i> OCD. Use clinical judgment. <i>Connecting with all that (remind) Now, Notice What you Notice. (Let Whatever Happens Happen.)</i> Phase 4 - Processing (with BLS): This is where we are much more creative with the interweaves. Think of this as going back in time with your client and figuring out what needs to be witnessed, heard, updated. What did that young child need that wasn't happening. Walk through the scene with them to attune to their story and understanding to guide the interweave. At that point, the younger child part may not have access to the adult adaptive information, so <i>guide like you would with an actual child.</i> >>>>>> <ul style="list-style-type: none"> • <i>What are you getting? What do you notice?</i> • <i>If things are moving: Go with That/Notice That.</i> • <i>When narrative unfolding: Follow That.</i> • <i>In response to an insight: Think about That.</i> • <i>If a new emotion: Stay with That.</i> OCD specific* If OCD 'parts' intrude during processing (common), ask client to thank it and compassionately request that it 'stays close, but relax back' to allow healing. If necessary, explore this part's fears before continuing. <i>Remember, the block is the way forward.</i> You may need to 'pivot' to work with this first. Interweaves: Reveal, Rewire, Repair: Use curiosity. Video (Zoom Out/In, Rewind/ Play Forward). Educational. Creative. "WTF". Ensure regular return to target. When moment right ("Tipping Point"), once affect & meaning fully accessed, or ready to complete session, proactively ensure sufficient repair/closure. Three Ws. E.g. <ul style="list-style-type: none"> • <i>What Needs to Happen? What Does the Child Need?</i> • <i>Who Can Do That? Who Can Make That Happen?</i> • <i>What Does the Child Need? Who Can Do That?</i> </p>	<p>OCD psycho-ed – OCD brief experiments – top up AIP if needed as per complexity. OCD as the adaptive child/parts language introduced. May use ACT/CFT/ I-CBT/ ERP. If client in crisis stabilisation as needed - see Thomas Zimmerman, Jim Knipe phase 2 complex cases Special/Calm/Peaceful/Safe Place – BLS, heartbeat speed # hashtag/cue word tapped in >>>> <i>An imaginary or real location where, as an adult, you can feel at peace and relax. Notice what you can see, the landscape, the time of day. Notice what you can hear and smell. Maybe there's a taste. Notice the air on your skin, the ground beneath you.</i> An Attachment Figure (see Thomas Zimmerman script attached) BLS, heartbeat speed <i>Imagine an attachment figure (who may borrow qualities from real people who did care about you). What do/might they look like? How does it feel if they give you a hug? How do they show care for you? Is there anything this person could cook for you? How do they play with you? How do they greet you? How do they protect you?</i> Alternative/additional options for affect regulation: Resource Team; Adapted Loving Eyes; Compassionate figure – CFT style; Ideal Nurturer; 4 blinks / Flash Technique; OCD Adapted Future Template /grounding, breathing, body-based regulation exercises Phase 3 - Assessment/Targeting: Determine session focus – collaboratively agree whether to work on known past event or with OCD belief, urge, feeling, or sensation. "If there's one thing you could change today, what would/might that be?" The moment needs to be anchored in space & time. Find a snapshot picture that captures that moment. OCD specific* When working with OCD the aim is to connect to what's behind the OCD (adaptive response/ protective part) and the <i>underlying</i> memories, emotions, body sensations, and belief (e.g. 'I am bad/dangerous/ out of control etc). Present <i>prong images</i> (e.g. worrying they left the cooker on or hurt someone) are often symbolic of the actual underlying wounds, such as shame. For example, as a child being sent to their room and feeling overwhelmingly isolated, or being bullied at school. IMAGE: OCD specific* Use clinical judgement whether the targeting image might be reflecting the OCD parts <i>distraction</i> from suppressed emotions/wounds. The image should NOT depict the obsession itself – this is the catastrophising 'worry chain'. E.g. if client has POCD, do NOT use an image of them abusing a child, or of being arrested. This risks being the distractor/protector part/defence that will take you both down rabbit hole). If in doubt, leave the image out. OCD specific* Starting from the present obsession we can ask 'Imagine that you do not have the obsession. What's the emotion? Or What Are You Feeling?' EMOTION: <i>What's the Emotion? Or What Are You Feeling?</i></p>
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Attachment-Based EMDR Framework

adapted for OCD (in your packs)

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Phase 3

- ▶ Collaboratively agree whether to work on any overt childhood traumas
- ▶ Take an OCD feeling (recent situation / trigger / theme) – emotions, physical sensations, self-referencing belief, and drop them back in time
- ▶ Do NOT use image of the obsessive belief (e.g. being a paedophile, house on fire)
- ▶ Commonly generates really interesting results
- ▶ Often doesn't land on anything that would be on a timeline
- ▶ **We're always accessing info via the adult client in front of us**

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Demo of setting up a target and bridging

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Phases 4-7 – Attachment-based EMDR

- **Phase 4 - Processing (with BLS)**
- This is where we are much more creative with the interweaves. Think of this as going back in time with your client and figuring out what needs to be witnessed, heard, updated. What did that young child need that wasn't happening. Walk through the scene with them to attune to their story and understanding to guide the interweave. At that point, the younger child part may not have access to the adult adaptive information, so *guide like you would with an actual child.* >>>>>>>
- *What are you getting? What do you notice?*
- **If things are moving:** *Go with That/Notice That.*
- **When narrative unfolding:** *Follow That.*
- **In response to an insight:** *Think about That.*
- **If a new emotion:** *Stay with That.*

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Phases 4-7 – Attachment-based EMDR

- ▶ **Phase 4**
- ▶ **OCD specific*** If OCD 'parts' intrude during processing (common), ask client to thank it and compassionately request that it '*stays close, but relax back*' to allow healing. If necessary, explore this part's fears before continuing. *Remember, the block is the way forward.* May need to 'pivot' to work with the part
- ▶ **Interweaves: Reveal, Rewire, Repair:** Use curiosity. Video (Zoom Out/In, Rewind/ Play Forward). Educational. Creative. "WTF". Ensure regular return to target.
- ▶ **When moment right ("Tipping Point"), once affect & meaning fully accessed, or ready to complete session, proactively ensure sufficient repair/closure. Three Ws. E.g.**
- ▶ *What Needs to Happen? What Does the Child Need?*
- ▶ *Who Can Do That? Who Can Make That Happen?*
- ▶ *Would You Like to Imagine That?*

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Phases 4-7 – Attachment-based EMDR

- ▶ **Phase 5 - Installation/Tapping In:**
- ▶ SUDs to zero if possible or option to observe client and attune.
- ▶ Any distress left? If stuck, *What's keeping it there?*
- ▶ >>> Once emotions clear, identify PC (usually reveals itself)
- ▶ VOC optional
- ▶ *What's the belief about yourself that goes with that now?*
- ▶ Or, if incomplete session at Phase 5...*What are you taking from today?*
- ▶ Always tap in a positive even when session incomplete.

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Phases 4-7 – Attachment-based EMDR

- ▶ **Phase 6**
- ▶ **Body Scan**
- ▶ *Holding target and PC. Body scan. Any disturbance?*
- ▶ **If sensation, BLS to resolve/clarify.**

- ▶ **Phase 7 - Closure:**
- ▶ **Even if session “incomplete”, close with a positive and via stepping stones, back over the Bridge. In future, when the adaptive child (the OCD essentially) is activated, their Wise Adult now has the capacity to understand / soothe them, and the client can tap on that.**

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Phases 8 – Attachment-based EMDR

- ▶ **Phase 8**
- ▶ **Re-evaluation**
- ▶ *Let's come back to where we started.*
- ▶ *How is that now?*
- ▶ **Check bridging point, anticipated future.**
- ▶ **Future Template >>> optional.**

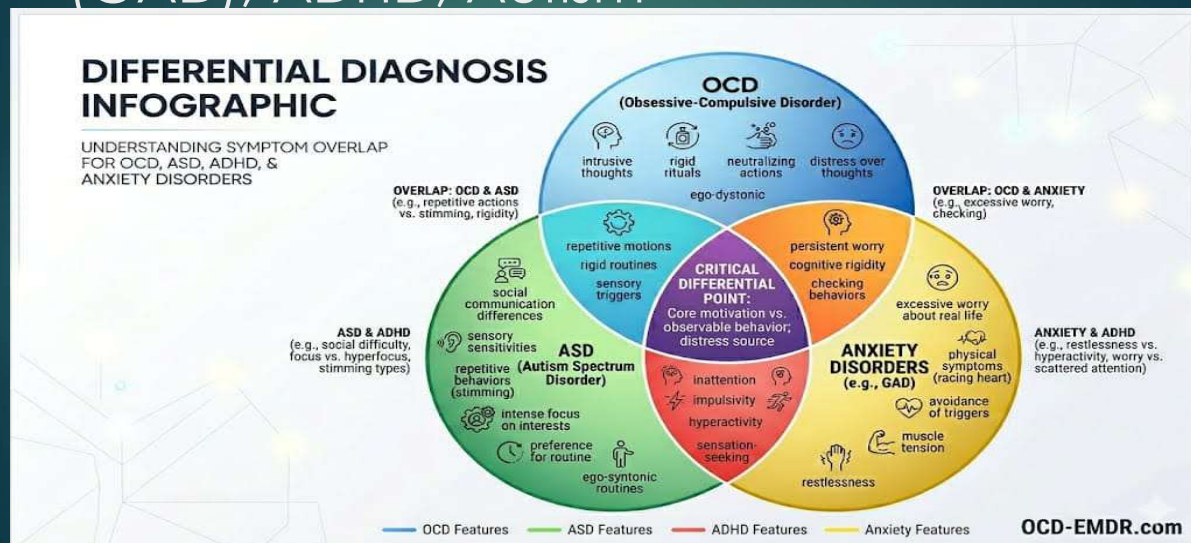
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Phases 8 - Attachment-based EMDR

- ▶ **Phase 8**
- ▶ Continuing after an incomplete session
- ▶ Celebrate and 'tap in' every success
- ▶ Ask the client what's came up between session / any changes
- ▶ Bring up the memory that was incomplete last session
- ▶ Identify the worst bit of the memory
- ▶ Ask for emotion(s)
- ▶ body sensation
- ▶ And then continue
- ▶ If the previous target is complete, go to future template

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Overlap between OCD, Anxiety (GAD), ADHD, Autism



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Case Studies

- ▶ We will now share Bea's generic Relationship-OCD (ROCD) case conceptualisation

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10
Minute
Comfort
Break

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Case Studies

- ▶ Linda is going to discuss a case study that commonly arises, where the client has a complex range of OCD themes

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Thank you all for joining us

We also offer:

Case Consultation Groups. Spaces are strictly limited to ensure high-quality consultation. This will be an ongoing offering. Email us at info@ocd-emdr.com to discover more

- ▶ Blogs & resources: <https://www.ocd-emdr.com>
- ▶ Sign up to our mailing list via the website
- ▶ Specific modules coming soon - release dates pending