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Review Article

Adaptation of the EMDR Standard Protocol for Obsessive-Compulsive Disorder

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Abstract:

Obsessive-compulsive disorder (OCD) is characterised by the persistence of recurrent and intrusive obsessions accompanied by repetitive compulsions that seek to alleviate the associated anxiety. Although its prevalence is significant, its clinical complexity is a therapeutic challenge due to the variability of symptoms, resistance to exposure and the frequent presence of comorbidities such as depression and anxiety disorders, and the partial or insufficient response to pharmacological treatment

Key words: obsessive-compulsive disorder; cognitive behavioural therapy; neurobiological

Introduction

Obsessive-compulsive disorder and its therapeutic challenges.

Obsessive-compulsive disorder (OCD) is characterised by the persistence of recurrent and intrusive obsessions accompanied by repetitive compulsions that seek to alleviate the associated anxiety. Although its prevalence is significant, its clinical complexity is a therapeutic challenge due to the variability of symptoms, resistance to exposure and the frequent presence of comorbidities such as depression and anxiety disorders, and the partial or insufficient response to pharmacological treatment. Treatments are often prolonged, and adherence tends to decrease over time, complicating the therapeutic approach to OCD and highlighting the importance of adopting comprehensive approaches and personalised strategies to maximise the treatment's effectiveness and optimise the patients' quality of life.

Review of traditional approaches and limitations

Cognitive Behavioural Therapy (CBT), one of the conventional therapeutic approaches to treating OCD, postulates that obsessions arise from dysfunctional interpretations of intrusive thoughts, while compulsions act as emotional regulation strategies to reduce anxiety (Salkovskis, 1985). CBT has strong empirical support for OCD treatment (Reid et al., 2021; Kathmann et al., 2022; Öst et al., 2022; Guarnizo-Alvarez, 2023; Barboza-Anaya, 2023, among others). In this approach, Exposure with Response Prevention has been shown to be effective, although it is often perceived as stressful (Reid et al., 2021; Pareja, 2001).

Acceptance and Commitment Therapy is another approach, although its empirical support is more limited (Soondrum, 2022; Philip, 2021; León-Quismondo et al., 2014).

From a neurobiological perspective, pharmacological treatment aims to correct alterations in the cortico-striatal-thalamic-cortical circuits and in the balance of neurotransmitters such as serotonin (Stein et al., 2019). However, the evidence on their efficacy remains limited despite the large number of drugs studied and tested.

Other theoretical models have provided new perspectives on OCD: the Emotional Regulation model views it as a dysfunctional strategy for managing intense emotions such as guilt or disgust (Shafran et al., 1999). An evolutionary approach proposes that certain aspects of OCD derive from adaptive control mechanisms that have been overemphasised (Woody & Szechtman, 2011). The psychoanalytic model understood it as the result of unconscious conflicts and defences related to early emotional development (Freud, 1909). These models highlight trauma as a relevant aetiological factor in OCD (Van der Kolk, 2014), a relationship now recognised in the DSM-5. However, they do have significant limitations.

The difficulty of patients to apply adaptive coping strategies is a recurring problem in treating OCD, even when they understand the obsessive processes. This difficulty, associated with multiple factors (requiring specific attention), could explain the lack of response to cognitive-behavioural techniques in 15% to 40% of cases (Ruiz, 2009), while the high relapse rate remains a major problem.

Rationale for the adaptation of the standard eye movement desensitisation and reprocessing (EMDR) protocol for the treatment of obsessive-compulsive disorder (OCD)

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR, 2023) considers any stressful or traumatic events suffered in childhood as OCD risk factors, for example physical and sexual abuse. Ibáñez et al.

(2013) has shown the link between stressful and/or traumatic events and OCD symptoms, highlighting early recurrent experiences that have compromised basic needs for safety and well-being. Although the aetiology of the disorder is multifactorial, the importance of childhood trauma is highlighted as a crucial factor in its development (Cromer et al., 2007; De Silva et al., 2007; Bey et al., 2017; Pinillos, 2010) as well as a barrier to conventional treatment (Arenas Pijoan et al, 2022).

Eye Movement Desensitisation and Reprocessing (EMDR) therapy works specifically on traumatic memories and associated stress symptoms, such as those found in post-traumatic stress disorder (PTSD).

The EMDR protocol consists of eight standardised phases, is applied to both the adult and child populations. This approach recognises that clinical pathology resides in dysfunctional stored memories and focuses on transforming these into functional memories through the natural process of memory consolidation (Shapiro, 2001; Solomon & Shapiro, 2008) based on a multifactorial conception of pathology that recognises the interaction of genetic and environmental influences.

Numerous international clinical guidelines, such as those of the World Health Organization (2013), the American Psychiatric Association (2021) and the National Institute for Clinical Excellence (2018) endorse EMDR as a therapy of choice for post-traumatic conditions. Although initially designed to address the stress associated with PTSD, it has also been proposed for other pathologies: trauma-based disorders can obtain significant benefits from EMDR (Van der Hart et al. 2010; Farina et al., 2019; Knipe, 2008; Forgash & Copeley, 2014), by adapting the standard EMDR protocol, as in Hofmann's (2004) inverted protocol and the alternative modes proposed by Leeds (González, et al., 2012).

The traditional CBT treatments use procedures that directly affect the person's beliefs and behaviour (e.g. prolonged exposure, questioning beliefs) and can re-traumatise the patient. However, focusing on the spontaneous associative processing of memories with a component of bilateral stimulation (auditory, tactile or eye movement tracking of a visual stimulus) does not involve working directly on types of behaviour or performing daily tasks; nor does it require detailed description of the traumatic event or prolonged exposure, all of which facilitates the therapeutic process in the general clinical population and in OCD cases in particular.

Evidence for the efficacy of EMDR in OCD treatment

The efficacy of EMDR therapy for treating OCD has been evaluated by different approaches and clinical contexts through comparative studies, finding evidence of its effectiveness and highlighting the following conclusions:

- EMDR was more effective than Citalopram in improving OCD symptoms in the short term (Nazari et al., 2011).

- Combining EMDR with Response Prevention (RP) is an effective strategy to enhance the effectiveness of RP in treating OCD (Bohm & Voderholzer, 2012).

- After treatment with EMDR there was evidence of significant improvement in obsessive-compulsive symptoms (Van den Hout et al., 2012).

- Meta-analysis supporting the efficacy of EMDR as a therapeutic option to reduce OCD symptoms (Moreno-Alcázar et al., 2017).

- EMDR therapy was as effective as cognitive behavioural therapy treating obsessive-compulsive disorder (Marsden et al., 2018).

- Case study in which the participant received 15 sessions of EMDR: at 90 days post-treatment follow-up there was a substantial reduction in OCD symptoms (moderate to subclinical) as measured by the Yale-Brown Childhood Obsessive-Compulsive Scale, indicating a large effect size (d = 0.81). This study provides insight into OCD treatment and how the use of the triple (past, present and future) EMDR approach can be an effective tool (Cusimano, 2018).

- EMDR therapy was effective in reducing obsessive-compulsive symptoms and improving the patients' quality of life (Lee et al., 2019 in Houben et al, 2019).

- Two randomised controlled trials (RCTs)on 55 and 90 patients with OCD: one RCT showed that EMDR was superior to Citalopram in reducing OCD symptoms, while the other found that EMDR treatment and exposure and response prevention were equally effective in reducing symptoms, with the results maintained at 6-month follow-up (Böhm, 2019).

- EMDR therapy may be as effective as exposure/response prevention (ERP) and more effective than selective serotonin reuptake inhibitors (SSRIs) in treating OCD (Talbot, 2021).

To sum up, the research shows promising results on the effectiveness of EMDR in reducing OCD symptoms in a variety of clinical contexts. These findings suggest that EMDR therapy, whether used alone or in combination with other interventions, may be a valuable tool in treating OCD. Several authors have expressed the need for further research to strengthen the validity and efficacy of this therapy (Marsden et al., 2018; Mazzoni et al., 2017; Marr, 2012; Keenan et al., 2014; Cusimano, 2018) and reinforce Bohm's perspective (Böhm et al., 2012; Böhm, 2019), which considers the contribution of EMDR therapy to OCD treatment in a holistic context that brings together diverse perspectives, emphasising the fundamental role of reprocessing traumatic memories in the therapeutic approach to this disorder.

Although the contributions of various models are valuable in explaining different factors in the development and maintenance of OCD, a new complementary perspective is also needed to conceptualise the problem within the framework of complex traumatisation. There is thus a need to address the disorder by an integrative and eclectic approach that includes the various influences to achieve a more complete and effective understanding of the condition, following the Three Phase Functional Structural Model of OCD (3FTOC) developed by Pinillos (2010, 2022, 2023) and Pinillos and Albiñana (2024). This model integrates the EMDR approach with clinical findings from various scientifically validated approaches, highlighting the consideration of psychological trauma as an essential transdiagnostic construct for understanding and addressing OCD. The approach is described as both integrative and innovative and structures OCD development and manifestation into three distinct phases as described below.

Phase I: Vulnerability and Defensive Scheme (DS).

Phase 1 is the phase prior to the manifestation of obsessions and is characterised by the influence of epigenetics and adverse experiences (including neonatal) early in life, attachment styles and parental communication (Rodríguez, 2018; Chávez and Tinajero, 2019). All these factors contribute to hindering brain integration processes and to neurochemical and neuroanatomical alterations that predispose to emotional vulnerability.

Of these adverse experiences, the source memory (SM) stands out, which we consider to be a key disruptive event in the origin of the phobia of suffering and which establishes a defensive schema or pattern (DS). This is based on the retraction of consciousness, emotional suppression and the implementation of control behaviours aimed at managing the causes attributed to the suffering. These behaviours, aimed at avoiding pain and its associated mental contents, are reflected in a neurophysiological activation that keeps the person alert to the areas perceived as threatening, giving shape to the concept of "nuclear fear" (NF).

Phase II: Traumatisation to Defensive Failure

In this phase the concept of "traumatisation to defensive failure" (TDF) is introduced as a singular experience that triggers OCD. This type of traumatisation arises because of defensive failure in the face of suffering associated with 'nuclear fear'. The resulting high activation causes a structural effect (Shapiro, 2006), generating 'dysfunctional stored information', including both autobiographical memories and dysfunctional elements generated in the patient's intrapsychic experience (González & Mosquera, 2012).

Traumatisation in the face of defensive failure has two relevant consequences in OCD: structural dissociation from the previous defensive scheme and the emergence of a perfectionist controlling belief that reinforces defensive security. This leads to a specific type of structural dissociation in which elements derived from the same event are stored in different networks and remain dissociated from each other (Leeds, 2011). Because of this structural dissociation, the memory of the event, the memory of the interoceptive information and the defensive schema become dysfunctional stored information in different brain networks and levels of consciousness.

This traumatisation, which sensitises to defensive failure, generates a structural effect by dissociating the OCD part within the system. The OCD part, made up of a set of defensive action tendencies (defensive cluster), incorporates new strategies within the existing defensive framework to strengthen protection because of this experience. Obsessions are the response of a part made up of several action tendencies involving complex defensive manoeuvres in the face of a precipitating event. Within this set of action tendencies or even defensive parts, it is important to highlight the defence that dissociates from the feared painful contents through mechanisms that are also defensive, such as suppression, the retraction of consciousness or the displacement of contents, which has its origin in the source memory (SM). Another part of this set is responsible for activating alertness to certain perceived threats, with the aim of promoting control, which arises because of the effect caused by traumatisation due to defensive failure (TDF). This leads to intrusive thoughts, images and impulses as a result.

Phase III: Obsessive Traumatisation (OBT).

The occurrence of intrusive thoughts, images and impulses constitutes the first obsessive-compulsive event, giving rise to 'obsessive traumatisation' (OT). A precipitating event together with an anxiogenic trigger activates the obsession and triggers mental and behavioural coping responses, which, due to the intense emotional charge they provoke, can generate a blockage of stored information, as occurs in simple trauma.

Research with neuroimaging techniques reveals that the worry circuit (orbitofrontal cortex, cingulate and caudate nucleus) is blocked in OCD patients. The persistence of consecutive disturbing events each time an obsessive intrusion is triggered contributes to a progressive accumulation of the traumatic impact (Brewin, Andrews, & Valentine, 2000), preventing memory consolidation and keeping the memory network in a permanent excitatory state (Jarero et al., 2013). The OBT is a structurally dissociated network that is formed from obsessive-compulsive events from their onset to the present.

As Bekkers (1999) has pointed out, addressing the complexity of OCD requires specific adaptations to the standard protocol, particularly in the assessment and desensitisation phases. These modifications are intended to maximise the effectiveness of the treatment by considering the unique characteristics of this disorder. In the following we provide an adapted protocol for the practical application of EMDR for OCD based on the Three Phase Functional Structural OCD Model (3FTOC).

EMDR PROTOCOL FOR OCD

Phase 1: Collection of the history adapted to OCD

Phase 1 of the EMDR in OCD demands specialised attention to establish a solid therapeutic relationship that addresses any difficulties that may arise as manifestations of dysfunctional stored information.

Accurate differential diagnosis is essential, as the characteristic intrusive and recurrent thoughts in OCD can occur in a variety of psychological conditions including anxiety disorders, specific phobias and major depressive disorders. It is essential to recognise these manifestations in diverse contexts to provide appropriate personalised treatment, while the symptoms may be compatible with complex PTSD or dissociative disorder.

Given OCD's complex and specific traumatic origin, in which the associated traumatic events, both the so-called traumas with a capital 'T' (man-made disasters: wars, terrorism, explosions, fires, traffic accidents; natural disasters: hurricanes, tornadoes, floods, forest fires, tsunamis, volcanic eruptions and events such as rape, sexual abuse, assault, heart attack, all kinds of situations in which we feel that our life or that of a loved one is in serious danger), as well as so-called 'hidden traumas' or lower case 't' traumas (relational traumas with attachment figures (father, mother, etc.) or other types of relationships, which impact on the way one sees oneself, others and the world) are dissociated from certain painful interoceptive aspects, therapists may face difficulties in accessing this information. Moreover, obsessions, far from being simple memory fragments, are defensive secondary symptoms and imply the need for strategic access to address all the associated memory components.

A specific strategy for the conceptualisation of the case is therefore required when collecting the clinical history. It is proposed to use specific assessment instruments, such as the Yale-Brown OCD Scale, questionnaires that address the history and evolution of the disorder, information on the patient's culture of distress, attachment, family environment and possible traumas. It is also useful to carry out a functional recording of the obsessive-compulsive process and to conduct a structured interview including 'floating backwards techniques' (see worksheet interview in Appendix 2), complemented by exploration of the patient's internal world and especially of the constituent parts of the defensive cluster involved in OCD (Pinillos, 2023; Pinillos & Albiñana-Cruz, 2024). This helps to identify the traumatic events underlying OCD that need to be reprocessed in therapy.

As a result of this conceptualisation strategy, oriented towards obsessive-compulsive symptomatology, several key elements are accessed, such as obsessive traumatisation (OBT), which covers the history of the problem from the first obsessive event to the current problem, the defensive failure traumatization (DFT) as a consequence of the structural dissociation of a previous defensive schema and the perfectionist controlling slogan, which feeds obsessions and compulsions, the source memory (SM) origin of the phobia of suffering in the face of core fear contents and the defensive schema, the feeder memory of the catastrophe underlying the obsessive fear and the memories associated with the triggers of the obsessions that feed the obsessive fears. If there is a feeder model of the OCD defence or transgenerational trauma, they are also collected and memories related to vulnerability and lack of security and self-esteem are compiled. These memories may include traumatic perinatal events and insecure attachment styles, among others.

Phase 2: Treatment Plan and Preparation Adapted to OCD

Treatment Plan

The selection of targets and the order of treatment require adaptations to the eight-phase EMDR protocol (Shapiro, 1995, 2001), which recommends beginning with sequential reprocessing of all traumatic incidents from the oldest to the most recent. It is proposed to begin treatment by first reprocessing targets related to obsessive-compulsive symptoms and then addressing other symptoms present in the disorder, such as insecurity and low self-esteem whenever the case conceptualization indicates it, based on the analysis of the function of the

OCD component within the structure of the internal system and the type and degree of structural dissociation present.

Within the targets related to obsessive-compulsive symptoms, it is proposed to first address obsessive traumatization (OBT), which includes past and present obsessive-compulsive events and a future template. This strategy would be implemented through a protocol adapted from the Continued Traumatic Stress Protocol, whose effectiveness has been supported by several studies (Jarero, Artigas, & Luber, 2011). Before beginning, any resistance to change or success of the treatment must be identified and addressed by EMDR tools.

Either the memories that fuel obsessive fears (Defensive Failure Traumatization (DFT)), those associated with obsession triggers transgenerational trauma if present, or the OCD defence-feeding model, if present, will then be reprocessed using a standard EMDR protocol.

Once the key targets of obsessive-compulsive symptoms have been addressed, other manifestations of the disorder, such as insecurity and low self-esteem, will be treated.

Past targets include the source memory (SM), traumatic perinatal events, insecure attachment, and, if applicable, other memories elicited during case conceptualization, for which the standard EMDR protocol is applied for reprocess. The Two-Method Questionnaire Approach developed by de Jongh, ten Broeke, and Meijer (2010) is used for the memories that fuel beliefs of low self-esteem.

Adaptive Preparation for OCD

Although target reprocessing is combined in the progressive approach with a selection of interventions pertaining to Phase 2, before beginning reprocessing of the first obsessive-compulsive traumatization (OCT) target, certain specific interventions are necessary. These include assessing the patient's awareness skills and providing training if necessary, promoting meta-awareness from the beginning of treatment through self-reflective and psychoeducational interventions, instructing the patients on how to always maintain orientation and equipping them with emotional self-regulation skills. It is also essential to provide psychoeducation on the disorder, explaining the components of the obsessive-compulsive process, the brain areas involved, the factors that contribute to maintaining the disorder and the expected effect of therapy. This is complemented by the development of OCD adaptive coping strategies, addressing any limitations in their implementation with emotional management techniques, resources, and desensitization or ad hoc reprocessing processes.

It is also important to assess the patients' tolerance for a positive effect, which can be done indirectly by observing their reaction when establishing the safe place or by using bilateral stimulation with positive elements as resources.

A minimalist approach to preparation is suggested initially, avoiding excesses and gradually incorporating other Phase 2 interventions as required by the work with the parts or the reprocessing of therapeutic goals. Strategies such as using the body to stop traumatic acceleration, addressing hypoarousal, training cardiac coherence, performing exercises to integrate paralyzing fear, increasing tolerance to certain affects, dismantling adaptive beliefs, or installing resources based on the challenges that arise throughout the therapeutic process are preferable.

In Phase 2 it is crucial to work with the part that makes up the cluster of action tendencies of the structurally dissociated defensive schema linked to the obsessive-compulsive problem. This cluster keeps certain painful contents and emotions dissociated from consciousness and alerts to triggers to control the causes and circumstances associated with the feared threats.

After identifying these parts or action tendencies, the intervention is carried out based on the case and clinical judgment. One can begin with the part responsible for the obsessive intrusions (thoughts, images, impulses), helping it recognizes the futility of the paradoxical strategies it uses and replacing them with adaptive resources, qualities, feelings, skills, strengths, or parts of the system, as needed, to help the adult self-confront the trigger that activates it internally and externally. If the resource is not in place, it would need to be. When the obsessive action tendency is an impulse, the agreement is oriented toward proposing to the part in charge that it directs the impulses toward behaviours that are effective medium- and long-term resources to help the adult self-confront the trigger that activates it internally and externally. The other aspect of the agreement is to channel the underlying painful traumatic burden into dreams, a natural channel for its release, and which can be recalled when both the system and reprocessing are necessary.

Limitations and needs must also be investigated and addressed to carry out the agreement. This work may include learning emotional control and management skills, so that the patient develops an internal locus of control, which once achieved would be reinforced with bilateral stimulation. Progressive exposure and desensitization using the adapted Omaha Emotional Management Skills Method (2000) is recommended, starting with obsession triggers. Techniques such as the EMDR method for fear immersion, the Distress Tolerance Protocol, the Linda Jacobson method for working with affects, and the Popky protocol can also be used.

If the obsessive-compulsive strategies derive from learned patterns, it is suggested to reprocess them with the basic EMDR protocol.

With the perfectionist and controlling part, the core belief about control and associated logical errors are addressed, using psychoeducation, interweaving, cognitive shocks, and the two-handed technique with bilateral stimulation, with the goal of dismantling the activation of alerts in the face of unreal dangers and to foster any awareness of errors as learning opportunities.

Likewise, activating the alert in response to a mistakenly perceived danger must be questioned. The goal is to dismantle underlying beliefs and reach functioning agreements, such as promoting awareness of errors and learning from them and limiting alertness to a real danger only. Finally, to enable the patient to carry out the therapeutic agreements as efficiently as possible, it is recommended to review them and address any limitations and needs they may have.

Addressing the defensive intentionality and logical errors underlying compulsive behaviours with EMDR tools and implementing the positive feeling state addiction protocol

When working with the part of the cluster in charge of defence against the phobia of suffering, which uses action tendencies based on the suppression of emotions and the withdrawal of consciousness, several aspects must be addressed. One fundamental aspect is for the patient to understand that, as an adult, he/she can confront painful emotions from the past, present and future and to be aware that past experiences of vulnerability are now simply memories. Another is to offer psychoeducation on suffering and show patients the effects of not confronting it. The goal is to reach an agreement that allows for the self-care experiment between the adult self and the ego state or vulnerable part that experienced suffering in which the defensive scheme was activated (source memory). The agreement proposes to function in coordination with the adult self on a daily basis. Painful emotions can be allowed to reach a certain intensity, while the adult self confronts them with the resources available, thus becoming increasingly stronger. Reinforcing the agreement to divert repressed painful material into dreams (REM sleep helps the brain metabolize disturbing material), which will gradually be recalled as the patient is ready to process it in therapy.

Finally, the therapist is asked to allow access to the information and be the guide who shows the way to the hidden core of the problem in the safe space of the consultation. The therapist also asks the patient to release the

material and its emotional burden into conscious awareness in therapy with the support of a person who can view it wisely.

Throughout this process it may be helpful to introduce techniques, resources and work with defences.

Phase 3 Onward

Addressing obsessive-compulsive symptoms requires adaptations in these phases by reprocessing the Obsessive Traumatization (OBT). This target includes past and present obsessive-compulsive events and the future template, using a protocol adapted from the Continuous Traumatic Stress Protocol. Before the therapist begins with the Obsessive Traumatization (OBT) target, the patients are asked if they can imagine what their life would be like if the therapy were successful, or if there is any part of them that does not believe it possible. If resistance is noted, it is addressed with EMDR tools or if necessary, with the person in charge (see protocol worksheet attached as Appendix3).

For memories that fuel beliefs on low self-esteem, targets related to other symptoms present in the disorder, we propose using the Two-Method Questionnaire Approach (Jongh, E. ten Broeke, and S. Meijer) for reprocessing.

All other targets proposed in the treatment plan are addressed with the basic EMDR protocol, requiring no adaptations in these phases of reprocessing.

A summary of the EMDR protocol adapted for OCD is included in Appendix 4 to facilitate understanding and application of the procedure. A clinical case is described below to illustrate its application.

Application of the EMDR protocol adapted to OCD

The clinical case involved a 38-year-old woman, a nurse and mother of three daughters, who sought treatment to free herself from intrusive thoughts and images related to her health and her daughters' well-being. The obsessions regarding negative thoughts about the progress of her health arose after experiencing an anaphylactic shock triggered by a thyroid condition that occurred when she was awake in bed or during times of stress at work.

She also suffered intrusions of unpleasant images of violence toward her daughters, which have been present since the birth of her first daughter, when she first visualized herself harming her with a knife. These images currently appear at many times of the day in any aspect of daily life related to the care and attention of her daughters, e.g. while driving, in relationships with colleagues, when discussing problems with her children, in her relationship with her husband, etc.

In the evaluation summary, the patient obtained a score of 26 on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) and generally low symptoms on the Symptom Checklist-90-R (SCL-90-R) but moderately high scores for obsessive-compulsive symptoms and anxiety. She also experiences a certain degree of psychoticism to a lesser extent. In the International Personality Disorders Examination (IPDE) there are no indications of the presence of a Personality Disorder. The maladaptive beliefs on which she scores highest are that external events are the cause of most of humanity's misfortunes; people simply react according to how events affect their emotions; one should feel fear or anxiety in the face of anything unknown, uncertain or potentially dangerous, and one needs to rely on something larger and stronger than oneself. The following is an excerpt from an interview for the OCD case history:

T: Bring to your mind a current obsession and the situation or aspect that triggered it.

P: When I'm with my daughters, driving or making dinner, and they start arguing, I have an obsessive image of attacking them with a knife or stabbing them in the eye.

T: What fear is associated with that image?

P: Hurting my daughters.

T: What is the worst thing for you if you imagine hurting your daughters?
P: Being a failure as a mother for causing a child to suffer.

T: What are the worst consequences that can arise?

P: Traumatizing my daughters and "thinking I'm bad"

T: How do you think you would feel if you imagined those consequences?

P: So much pain (painful effect of NT)

T: And what would you think about yourself in relation to that feeling?

P: "I can't bear it, I'm helpless against the pain, I'm weak to cope with it, I deserve to suffer" (beliefs about vulnerability to suffering)

T: From your perspective, when did you first begin to fear being aware of what a child's suffering is (core fear content), did you feel so much pain (affective content of core fear), and did you believe things like "I can't bear it, I'm weak, I deserve to suffer"?

P: It has to do with all the suffering I experienced as a child because of my sick father, but I associate it especially with the day my father hit me on the head (I remember the source, the experience that led to the phobia of suffering in the face of nuclear fear).

T: How did you interpret what happened?

Q: "That I was bad."

T: At that moment, what did you think about how you had to be, or what you had to do, achieve, avoid, or anything else to protect yourself from that feeling?

P: I had to be good, obey, be quiet, not yell, and not fight with my sister. And that it was better not to think about how painful it was.

T: Returning to the obsession, it brings up the obsessive image of hurting a child. What would that say about you as a person? What does it mean to you?

P: "I'm a failure as a mother."

T: Why?

P: A good mother never does anything that causes her children to suffer (logical error, maladaptive belief).

T: When do you think you started to fear failing as a mother?

P: The weekend at my friend's house (defensive failure trauma).

T: What did you think about that fear?

P: "I had to be perfect as a mother" (perfectionist defensive belief).

T: What does that mean?

P: That I can never do anything that causes my daughters to suffer.

T: What was happening in your life before the first obsessions appeared? Was there any change, even positive?

P: My first daughter was born (precipitating event).

T: And what was the first situation where the obsessive image appeared?

P: A few days after my first daughter was born, I was in the kitchen with a knife and heard her crying, when the image of me attacking her with the knife came to me (first obsessive event, origin of the obsessive traumatization).

(With the memory of that moment, the therapist explores the emotion and physical sensation.)

T: What did it mean to you?

P: That I can't fail as a mother (perfectionist controlling belief, which is the same as defensive failure traumatization).

T: Imagine, focus on the situation, in the kitchen with a knife in your hand and you hear the little girl crying, the emotion of fear and the physical sensation of tension in your jaw. Let your mind drift back to the past, a time in your life. Don't look for anything specific. Tell me the first image where you experienced something similar and felt fear in the part of your body where you told me.

P: Several memories come back to me. When my mother went out and left me alone in the crib, the first day of school, when I wet myself for fear of my father yelling, when my father yelled at me and hit me on the head, and the weekend at my friend's house (feeder experiences for phobias that allude to or point to the triggers of the obsession, including the source memory (SM) and the traumatization of defensive failure (TDF).

Phase I: The analysis reveals a source memory (SM) where her father hit her on the head for fighting with her sister. This memory is the origin of vulnerability to suffering and of the defensive scheme that uses mental actions aimed at withdrawing consciousness and suppressing pain, as well as actions (behaviours) aimed at avoiding the causes attributed to pain.

Phase II: The TFD memory, which gives rise to a structural effect of the previous defensive scheme by introducing new action tendencies driven by obsessions, arose during a weekend with a friend. She was observing her friend's father and comparing him to her father, which generated the controlling motto "I have to be a perfect mother."

Phase III: The precipitating event occurred shortly after becoming a mother for the first time, with the baby screaming and crying as the trigger, a stimulus conditioned to the "suffering of a child" that alludes to her failure as a mother, at the time when she was in the kitchen with a knife in her hand.

The obsessive content, where the image of her stabbing the baby with a knife appears, is a representation of her total failure as a mother and a person. The obsession is like a warning of the danger of harming a child so as not to let down her guard and thus avoid failing as a mother. In working with parts, this explanation is reinforced.

Other disturbing memories connected to obsession triggers include: when her mother would go out and leave her alone in her crib, being separated from her mother on the first day of school, wetting herself when she saw her father running towards her shouting, arguing in the car with her sister while her father yelled and hit her, slamming doors, loud noises and shouting while living with her parents.

Table 1 (In Appendix 1) presents a schematic representation of the EMDR treatment for the case described, with a progressive approach and the necessary adjustments. This case reflects the effectiveness of this comprehensive approach to treating OCD.

Results And Discussion

At the beginning of therapy, the patient received a score of 26 on the I-BOCS, while the score was 0 at the end and remained unchanged four years later.

As described in the table, after eight months of therapy all obsessions had disappeared. Four years later, the patient contacted the clinic to consult on an issue related to a family member. It was found that she was feeling well, and her life was progressing without obsessive intrusions of any kind. She also reported that everything she had learned during the psychoeducation phase, as well as the self-regulation resources, had been a great support for her and that having internalized them she had also experienced a profound change in her perception of herself and others, as well as in her existential beliefs and values. The patient stated that until she underwent the therapeutic process, she had never related her traumatic experiences to her obsessive-compulsive disorder, and she had been able to confirm the importance that these had had throughout her life since they occurred and also in the genesis of her obsessions

Discussion And Conclusion

We conclude that adapting the EMDR protocol to OCD based on the 3-OCD phase Structural Functional Model provided the patient with the necessary resources to progress in therapy safely, confidently, motivated and efficiently. The patients suffer from their disorder, from the difficulties and limitations it imposes on their daily lives at the family, relationship, and professional levels, and from the memories of previous experiences that led them to suffer from it. OCD patients are sometimes found to exhibit a high degree of scepticism and low expectations of success in therapy, as attempts to resolve their OCD on their own or with other therapeutic approaches have been arduous but unsuccessful. For all these reasons, we also conclude that the proposed EMDR protocol adapted to OCD offers possibilities not available in therapies based on cognitive restructuring strategies, impulse control, etc., which place high demands on the patient and require a great effort, such as following the therapist's instructions to modify certain behaviours or simply becoming motivated to participate in therapy. As progress is often very slow and costly, many patients are unable to continue and abandon therapy, another adverse experience in their career, which can lead to a worsening of their symptoms, a complete loss of motivation, or both.

On the other hand, over more than thirty years of clinical experience, it has been observed that although the disorder remits in some patients with traditional methods, even when the obsessive intrusions disappear for which they initiated therapy, over time, months or years, they relapse. This may be because traditional approaches fail to integrate problematic, trauma-related neural networks. Instead, alternative networks are somehow generated, but those that gave rise to or sustained the problem remain unintegrated. In other words, the effect of traumatization on neuronal integration is not addressed, so that addressing traumatic experiences prior to the onset of the disorder with EMDR adapted to OCD can greatly facilitate treatment and resolution and provide a therapeutic alternative for patients with a limited response to conventional methods. This novel perspective projects a significant advance in OCD understanding and management. The importance of identifying the parts responsible for the action tendencies that crystallize in obsessions is also observed and highlighted (Schwartz et al., 2019), besides evaluating their degree of structural dissociation and the functional relationship they maintain with other parts of the system, work that is carried out during Phase 2 of the protocol.

It has been found that patient characteristics, the type of intrusions presented (thoughts, images, or impulses), the characteristics of the patient's internal world and the degree of structural dissociation of the personality, the identification of memories implicated in OCD, and the choice of the appropriate time to process the different targets (obsessive traumatization, other memories), among other factors, can significantly influence the implementation and development of the therapy, as well as the results obtained.

The case described here shows that the protocols and resources used have been adapted, considering the conceptualization, the degree of structural dissociation, and the type of intrusions experienced. This adaptability provides the necessary flexibility to address the specific characteristics of different patients. Selecting the therapeutic targets and the order of processing are also key factors, in accordance with the reference model.

Establishing specific and validated protocols for addressing OCD using EMDR can contribute to advancing research and treatment of this complex disorder, offering new perspectives and tools for clinical practice. In this context, a promising line of research is proposed by applying the proposed EMDR protocol adapted for OCD to large samples.

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Data Availability

Not applicable

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