EMDR
in Obsessive-Compulsive Disorder

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EMDR Brighton, 25.01.2019

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The disorder specific procedure is getting worked out.

Content

- Why EMDR?
  Potential advantages
- How can EMDR be applied?
  Sequence, Picture, Planning of therapy
- What is the value of EMDR?
  Costs and Benefits

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The differentiation between obsessions and compulsions is essential for therapy. Compul. can be overt or covert!

ICD-10: F42

Symptoms

1. Are own thoughts/ actions (not issuing)
2. Disagreeable and at least exaggerated and insane (ego-dystonic)
3. Abortive resistance is offered
4. Accomplishment is not agreeable/ enjoyable

Time

obsessions or compulsions
at most of the days from at least 2 weeks

Psychological strain or reduced social / indiv. achievement potential

Not in consequence of other psychological disorders

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You need to distinguish between obsessions and compulsions to be able to use EMDR correctly.

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What is the difference?

Obsessions

Create strain
and negative feelings

Are intrusive

Can be related
with intrusive pictures

Exp: „I am dangerous“
„I am in danger“

Compulsions

Actions that are used to
neutralize the obsession

Copingstrategy

Exp: Washing, Control;
Praying,
Reinsurance

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Many patients do not profit (enough) by present methods of treatment

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Why do we need new methods of treatment?

	frequent consequences
Therapy **resitent cases** 15 – 50% despite expositions lege artis	hopelessness
Emotional labor is often **problematic** Anxiety for loss of control, guilt, shame	Therapy stagnates
Expos are exhausting, incriminating, for some patients **too hard**	discontinuation of treatment

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Exposition exercises in vivo are rarely adopted
(Böhm, Voderholzer et al., 2008)

Reality in care:

Paper: Verhaltenstherapie

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EMDR can be used as a solution for these problems

Possible benefits of EMDR

- Therapy resitent cases despite expositions lege artis
- Hope: EMDR enhances ressources
- Emotional labor is often problematic
- Encouraging with EMDR
- Expos are exhasting, incriminating, for some patients too hard
- EMDR is experienced pleasantly

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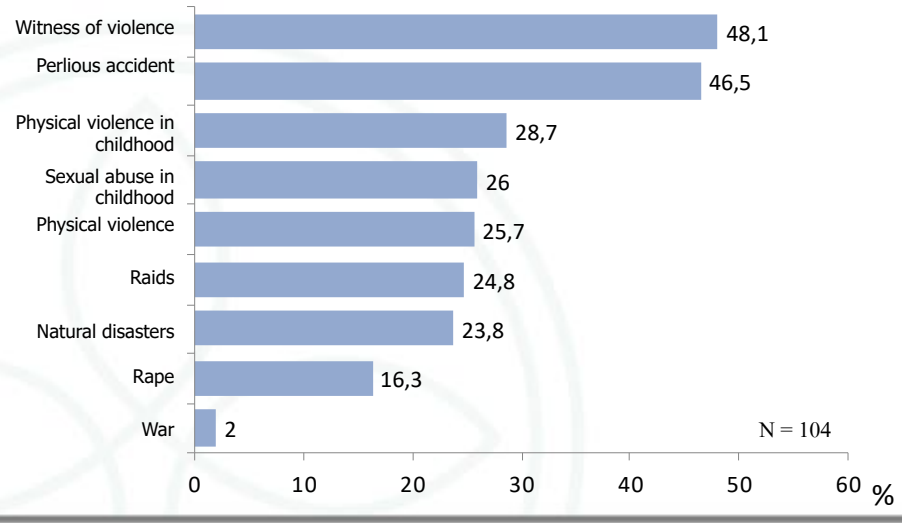
82% of therapy resistent OCD patients expierenced at least one trauma, 46% meet the criteria of PTBS



Gershuny BS et al.: Trauma and posttraumatic stress disorder in treatment-resistant obsessive-compulsive disorder. Depress Anxiety 2007, Feb 22

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6 months before OCD accomulation of critical life events is observed (sickness, birth)

Comorbidity		Literature
Trauma	inconsistent results No sig. increased prevalence	non: Grabe et al., 2008 light: Cromer et al., 2007 strong: Gershuny et al., 2007 Grabe, 2001: increased compulsive symptoms and –disorders in PTBS
Traumatization „minor traumatization“	increased	in time before disorder sign.: Khanna et al., 1988; Maina et al. 1998; McKeon et al., 1984 In general: inpatients: Fricke, 2007; Lochner, 2002 however not in outpatients: Lochner, 2007

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Learning-history seems to have the major impact on the development of OCD

Possible causes

Genetic

Is clarifying approximately 30% of variance

Learning-history

- Learning- and educationstyl (overprotecting, cleanliness, high claims for benefits, vicarious learning, minor attachment...)
- **Traumata**, losses, stress, interpersonal conflicts (as trigger)
- Personality factors (e.g. self- insecurity, self- doubt, catastrophic thinking, high moral standard, fear of denial)
- high religious / moral values & norms
- handling of negative emotions (guilt, worthlessness…)

Neurobiology

Transmitter: Lack of serotonin
Loop frontal brain – basal ganglia (striatum) – Thalamus: Dysfunction

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How can we use EMDR?

Treatment plan, Targets, Interweaves

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EMDR Treatment-Planning: 8 Stages

Phase 1: Anamnese	Client History and Treatment Planning
Phase 2: Preparation	Stabilization with Safe Place, Psychoeducation, Target Selection
Phase 3 bis 7	*Phase 3* Assessment (Reprocessing) *Phase 4* Desensitization *Phase 5* Installation *Phase 6* Body Scan *Phase 7* Closure (Therapist gives appropriate info and support, treatment planning continued)
Phase 8: Evaluation	Reevaluation

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EMDR should be applied as a feature of the overall treatment plan, including in-vivo interventions

Treatment plan

Use of EMDR only:
Up to now just
in individual cases
effectively
Bekkers, 1999; Whisman, 2000;
Schubbe, 2004; Hensel, 2006

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Treatment Planning in OCD

Phase 1: Client History	1. Therapy relationship 2. Motivation for change and target selection 3. Behavior analysis and search for underlying conflicts 4. Aims of treatment
Phase 2: Preparation	5. Stabilization 6. Psychoeducation
Phase 3 to 7	7. Intervention – working with targets a. In-vivo desensitization (with or without EMDR) b. EMDR
Phase 3 to 7	8. Intervention – working with underlying conflicts a. Imaginary work (with or without EMDR) b. EMDR
Phase 8: Evaluation	9. Evaluation 10. Optimize success – long term handling of upcoming obsessions

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Focus on:

What is **normal**?
How much **risk** can I take?
How much **control** do I need?

Phase 1: Client History	1. Therapy relationship 2. Motivation for change and target selection 3. Behavior analysis and search for underlying conflicts 4. Aims of treatment

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In EMDR worst situation are used, expositions start with 40-60%.

Hierarchy of situations

10	Use of lavatory, contact to pubic area without hand washing in the following
9	Washing of used underwear
8	Use of lavatory with normal hand washing
7	Touching abdominal area without hand washing in the following
5	Touching lavatory flush or toilet seat
4	Washing of used overgarment
3	Touching (cleaned) door pull in bathroom and lavatory
2	Entering kitchen or living room showered and in clean clothes
0	Lying showered and freshly dressed in bed

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Patient is getting well prepared for EMDR as well as expositions in vivo

Phase 2: Preparation

5. Stabilization
6. Psychoeducation

OCD

- accurate exploration, psychoeducation
- Behavior analysis: protocols of compulsion
- Explanatory model
- Hierarchy of causing situations

EMDR

- psychoeducation for EMDR
- Verifing Precondtions (Dissociation, PTBS, Depression etc.)
- Imparting EMDR- technique, e.g. absorption technique
- Dealing with negative emotions (guilt, worthlessness…)

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How to work on aims, if there are non?

Phase 1: Client History	1. Therapy relationship 2. Motivation for change and target selection 3. Behaviour analysis and search for underlying conflicts 4. Aims of treatment
Phase 2: Preparation	8. Finding Aims-Intervention – working with underlying conflicts a. Imaginary work (with or without EMDR) b. EMDR
	5. Stabilization 6. Psychoeducation
Phase 3 to 7	7. Intervention – working with targets a. In-vivo desensitization (with or without EMDR) b. EMDR
Phase 3 to 7	8. Intervention – working with underlying conflicts a. Imaginary work (with or without EMDR) b. EMDR

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Traumamap

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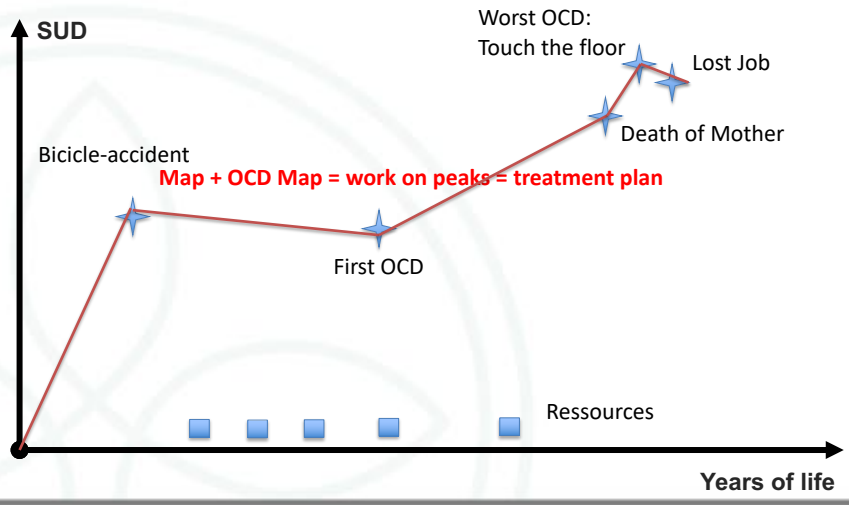
Traumamap to know how to handle affect-bridges.



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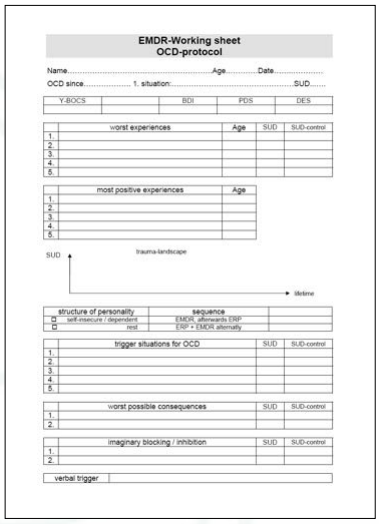
Working sheet gathers possible starting points for EMDR

Working sheet



EMDR-Working sheet
OCD-protocol

Name..... Age..... Date.....

OCD since..... 1. situation:..... SUD.....

Y-BOCS		BDI	PDS	DES

	worst experiences	Age	SUD	SUD-control
1.				
2.				
3.				
4.				
5.				

	most positive experiences	Age
1.		
2.		
3.		
4.		
5.		

SUD → lifetime

trauma-landscape

structure of personality	sequence
☐ self-insecure / dependent	EMDR, afterwards ERP
☐ rest	ERP + EMDR alternatly

	trigger situations for OCD	SUD	SUD-control
1.			
2.			
3.			
4.			
5.			

	worst possible consequences	SUD	SUD-control
1.			
2.			

	imaginary blocking / inhibition	SUD	SUD-control
1.			
2.			

verbal trigger

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Target selection

Use the highest utility

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Standard protocol can also be used in OCD, but is slightly modified: use these targets!

Procedure I

	Picture
traumatic memory	
Imaginary Trigger Situation of Obsession	Compulsion triggering situation / stimulus
Real Trigger Situation	Compulsion triggering situation / stimulus
worst scenario/flashforward	underlying validation / catastrophe
Automatic and Intrusive Mental Images	Worst image
blocking compulsion imaginary cognitive interweave	Compulsion can not be executed

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Traumatic Memory: Patients with OCD often report that they experienced traumatic life events that can, but do not have to be, linked to their OCD. The specific traumatic memory can be used as a target.

Imaginary Trigger Situation of Obsession: The obsessive trigger situation or stimulus itself is imagined here. The image can be a representation of a past memory or an anticipated event as a future template. Patients are therefore asked to imagine a real-life situation that triggers their obsessions and arouses their distress and anxiety. Patients are then asked to resist the compulsion to perform rituals. The most difficult picture would be used in Phase 3.

Real Trigger Situation: Trigger situations can also be produced in real situations with real stimuli. As a result, patients experience the urgent need to neutralize the obsession. The resulting pressure (SUD) can be used as a way to access the target for Phase 3. Patients who suffer from contamination fears, for instance, may touch the door handle as a trigger.

Worst Case Scenario/Flashforward: Another target could be the worst scenario that could occur when the patient is in an obsessive situation and nothing can be used to handle the emotions, including a compulsive behavior. It is helpful to ask for short and long term consequences. The picture/catastrophe is the patient's flashforward. These consequences can extend to after death preoccupations, such as, "God will punish me for that." For example, the patient might be asked about the potential consequences of not engaging in compulsive washing for a contamination fear. The patient might also imagine an anticipated disastrous event or even facing death scenarios, such as, "What will happen afterwards? What will happen after death?" It is helpful to use the worst part of that sequence as the target in Phase 3.

Automatic and Intrusive Mental Images: Special kinds of worst case scenarios are automatic and intrusive mental images. They can occur without obsessive thoughts and can cause severe distress. Often, they are connected to aggressive obsessions, such as an image of "how I am going to stab my baby to death." The image could be a future template, a flashforward or an occurrence in the past or a trigger in the present.

Imaginary Blocking of Compulsive Action: This is a type of cognitive interweave where patients are asked to imagine that the compulsive action cannot be executed. For example, the patient imagines an object or situation that triggers obsessions that arouse severe anxiety. The therapist then asks the patient to stay in contact with the obsession trigger and an external event that prevents engaging in the ritual behaviors (e.g. the patient cannot engage in hand-washing rituals as the water tap is not working). The worst part of that scenery in used as the target in Phase 3. This kind of a target is rarely used because the other types of targets usually have higher SUDs.

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EMDR is very good in combination with classical Exposure with response prevention (ERP) in vivo

Phase 3 to 7

7. Intervention – working with targets
   a. In-vivo desensitization (with or without EMDR)
   b. EMDR

Phase 3 to 7

8. Intervention – working with underlying conflicts
   a. Imaginary work (with or without EMDR)
   b. EMDR

Phase 3 **Assessment (Reprocessing)**

Phase 4 Desensitization

Phase 5 Installation

Phase 6 Body Scan

Phase 7 Closure (Therapist gives appropriate info and support, treatment planning continued)

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In imagination visible or cognitive ***compulsions*** are **not** the aim

Compulsions are not accomplished in EMDR, too.

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What can we learn about Negative and Positive Cognitions in OCD-Patients?

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Negative Cognition...

Central obsessions can be used as negative cognitions:
I am in danger! // I am dangerous!

- Avoid long discussions around cognitions
- Keep it simple: use the central obsessions, which has been worked out in the preparation phase
- If the neagtive Cognition doesn‘t seem to be connected with the OCD-situation, but the target is – reflect that to your patient
- Use simple sentences!
- Is your patient able to take the risk for it?

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Positive Cognition...

Follow the standard procedure

- Once more: Avoid long discussions around cognitions
- Use a trick: after the Negative Cognition is once fixed, you find yourself the opposite (just turn it around in your mind) without telling your patient
- If your patient doesn‘t find a good Positive Cognition, use a short Socratic Dialogue to make him/her find your PC
- Result: a new perspective. (even if it is just very cognitive so far)

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Treatment Planning in OCD

Phase 1: Client History	1. Therapy relationship 2. Motivation for change and target selection 3. Behaviour analysis and search for underlying conflicts 4. Aims of treatment
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Phase 8: Evaluation	9. Evaluation
	10. Optimize success – long term handling of upcoming obsessions

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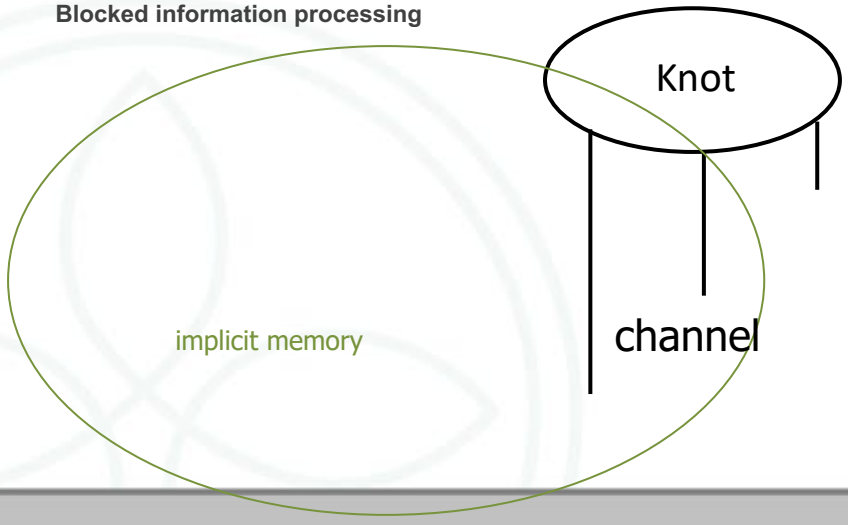
Emotional experiences (trauma) can not be assimilated in OCD

Blocked information processing



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Often long channels occur, emotional involvement is not always visible

Interweave

Pat. switches within stimulations between different emotions/ pictures **[Looping]**

Very slow alteration of the picture, very long channels

When switching occurs, go directly back to initial event;
Weaving in empathic-directive: please, stay just at the picture, remember your image description
no cognitions, emotions etc.

Channels are getting shorter
picture is changing;
reinforced / faster emotioninduction

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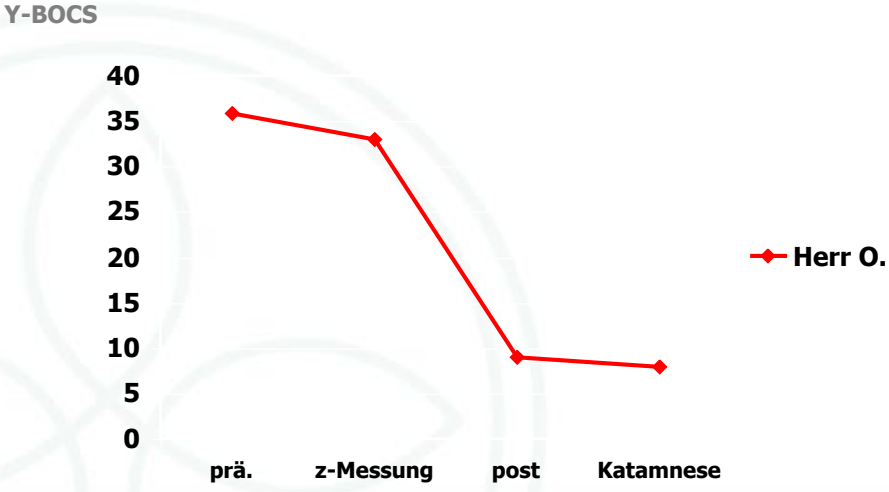
Only experiences in vivo are leading to obvious reduction of symptoms (75% pre-post)



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Problems with emotion regulation are usually central upholding factors of OCD

Functionality: shelter from…

Emotions

Anxiety, shame, guilt, failure, loneliness, temper, anger, disgust

intrapsychological

- Compensation of general lack of self-worth
- Search for control and orientation
- Assumption of responsivility for step in development
- Fulfill high moral/ ethical standards
- Boredom, inner emptiness

interpersonal

- Regulation of closeness and distance
- Outlet for suppressed aggressions against others
- Difficulties in conflict resolution
- Avoidance of life-task
- Dysfunctional regulation of social deficites
- Admiration

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Generating hypothesis, verifying in expositions and make it to come alive with EMDR

Functionality: perspective of conflict

- Support of distancing from compulsive system by increased understanding of biographic coherences
- OCD **protects** against experiencing sharp aversive emotions
- **Closeness-/ distance regulation**
- Frequent **early bonding experiences** of loss, lack of concealment, faint and humiliation

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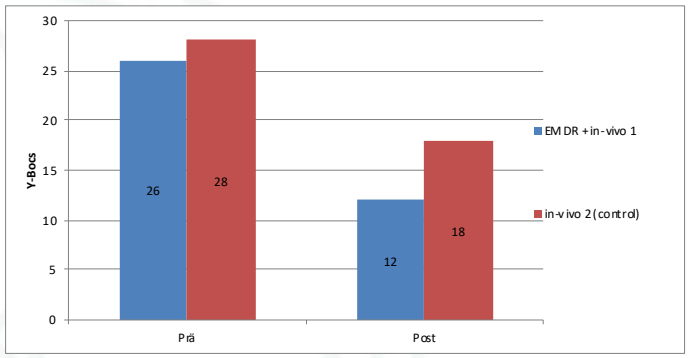
First data about our RCT (still on duty! N=13)



Up to now 54 OCD patients got treated with EMDR in our pre-study – 11 out-, 43 inpatients

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Papers

Böhm K, Voderholzer U (2010). **Use of EMDR in Treatment of Obsessiv-Compulsiv Disoders: A Case Series.** Verhaltenstherapie; 20: 175-181 (DOI: 10.1159/000319439)

Böhm K (2011). **Die Therapiemethode EMDR bei Zwängen.** Z-aktuell; 4: 6-7.

Böhm, Karsten (2015). **Obsessive Compulsive Disorder and EMDR**. In Luber, Marilyn (Hrsg.): Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summery Sheets: Treating Trauma, Anxiety and Mood-Related Conditions, Springer New York, 2. Edition, Chapter 13.

Böhm, Karsten (2014). **EMDR bei Zwangsstörungen**. In Hofmann, Arne (Hrsg.): EMDR: Praxishandbuch zur Behandlung traumatisierter Menschen, Thieme, 5. Auflage, 156-157.

Böhm, Karsten (2016). **EMDR in der Psychotherapie der PTBS**, Springer, 1. Auflage, Heidelberg.

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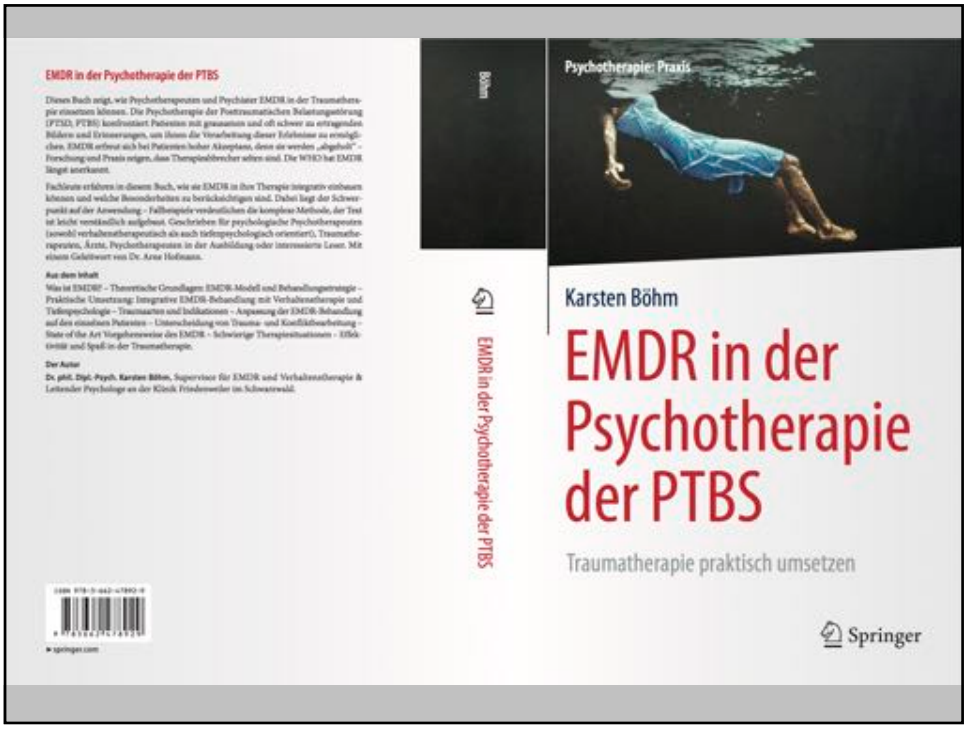
EMDR in der Psychotherapie der PTBS
Diesen Buch zeigt, wie Psychotherapeuten und Psychiater EMDR in der Traumatherapie einsetzen können. Die Psychotherapie der Posttraumatischen Belastungsstörung (PTSD, PTBS) konfrontiert Patienten mit grausamen und oft schwer zu ertragenden Bildern und Erinnerungen, um ihnen die Verarbeitung dieser Erlebnisse zu ermöglichen. EMDR erfreut sich bei Patienten hoher Akzeptanz, denn sie werden „abgeholt" – Forschung und Praxis zeigen, dass Therapieabbrecher selten sind. Die WHO hat EMDR längst anerkannt.
Fachleute erfahren in diesem Buch, wie sie EMDR in ihre Therapie integrativ einbauen können und welche Besonderheiten zu berücksichtigen sind. Dabei liegt der Schwerpunkt auf der Anwendung – Fallbeispiele verdeutlichen die komplexe Methode, der Text ist leicht verständlich aufgebaut. Geschrieben für psychologische Psychotherapeuten (sowohl verhaltenstherapeutisch als auch tiefenpsychologisch orientiert), Traumatherapeuten, Ärzte, Psychotherapeuten in der Ausbildung oder interessierte Leser. Mit einem Geleitwort von Dr. Arne Hofmann.
Aus dem Inhalt
Was ist EMDR? – Theoretische Grundlagen: EMDR-Modell und Behandlungsstrategie – Praktische Umsetzung: Integrative EMDR-Behandlung mit Verhaltenstherapie und Tiefenpsychologie – Traumaarten und Indikationen – Anpassung der EMDR-Behandlung auf den einzelnen Patienten – Unterschätzung von Trauma- und Konfliktbearbeitung – State of the Art Vorgehensweise des EMDR – Schwierige Therapiesituationen – Effektivität und Spaß in der Traumatherapie.
Der Autor
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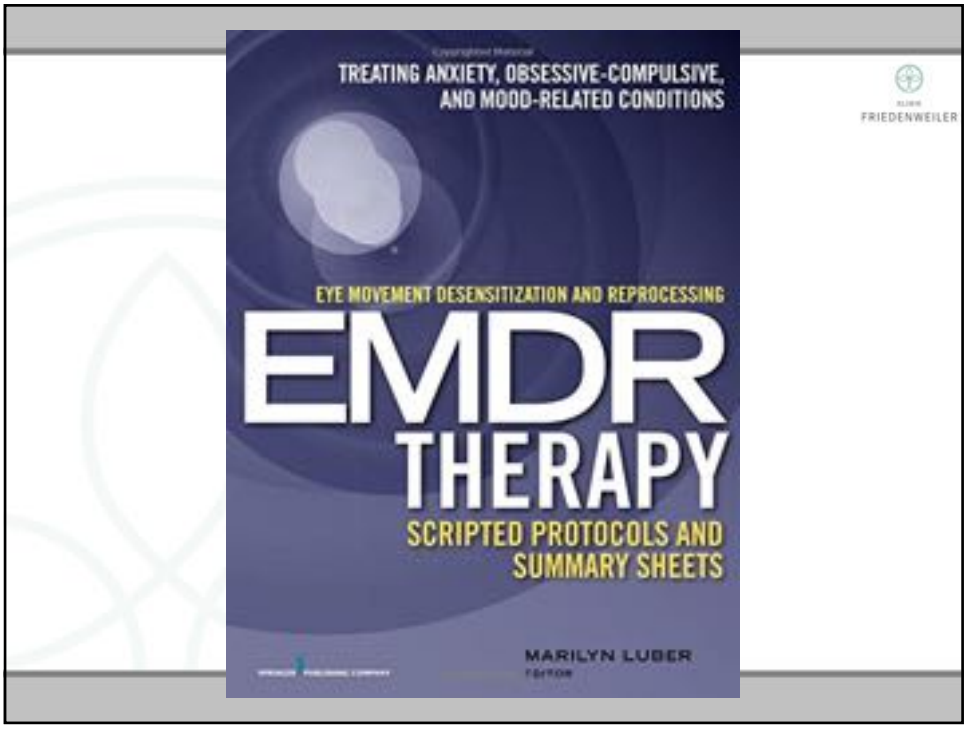
TREATING ANXIETY, OBSESSIVE-COMPULSIVE, AND MOOD-RELATED CONDITIONS
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EMDR THERAPY
SCRIPTED PROTOCOLS AND SUMMARY SHEETS
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Exkurs: Trichotillomania

Use of EMDR

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CASE REPORTS

Trichotemnomania: Obsessive-compulsive habit of cutting or shaving the hair

Rudolf Happle, MD
Marburg, Germany

J Am Acad Dermatol 2005;52:157-9

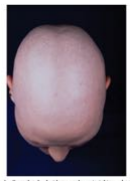

Fig 1. Completely hairless scalp mimicking alopecia areata totalis.

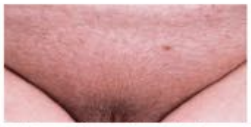

Fig 3. Pubic area showing hair stubs of same length, providing proof that it has been shaved.

Fig 2. Close-up view showing that all follicle openings are filled with hair. Note subtle signs of shaving trauma.

A 28-year-old woman presented with a completely hairless scalp. The disorder had started 1 year ago, and at the same time she had developed dysphonia. During the past year, her hair disease had been diagnosed as alopecia areata totalis by many specialists, including several dermatologists. A close inspection of her scalp, however, revealed that no alopecia was present, because all infundibula were filled with a hair shaft that, on microscopic examination, showed cleanly cut surfaces. A scalp biopsy specimen showed completely normal structures. The pubic area was found to be covered with hair stubs of the same

length. Therefore, a diagnosis of trichotemnomania was made. This term is derived from Greek thrix (hair), temnein (to cut), and mania (madness). After a stressful life event, the patient had developed both psychogenic dysphonia and the compulsive habit to remove the hair of her scalp, eyebrows, and axillary and pubic areas by shaving. Trichotemnomania is a distinct obsessive-compulsive disorder that should not be confused with trichotillomania. The condition should be taken into account when a supposed alopecia areata looks somewhat unusual.

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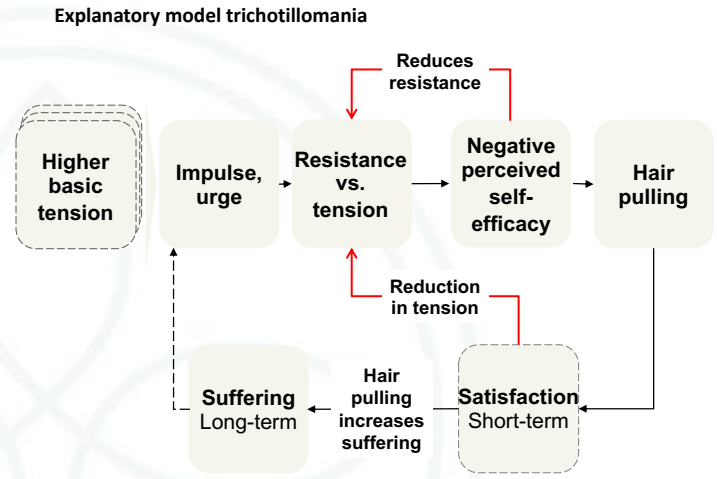
A trigger of the impulse to pull out hair can be a higher basic tension



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Trichotillomania is treated in the following steps

Treatment Procedure I

- Understanding of Symptoms
- Understanding of Underlying Conflicts → Hypothesis of Causes
- Mind Fullness + PMR → Preparation
- Habit Reversal & Confrontation & EMDR → Reduce Trich-Habits
- Work on Underlying Conflicts → EMDR & Imagination
- Stress-Tests → In daily life

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Treatment Planning in Trich

Phase 1: Client History	1. Therapy relationship 2. Motivation for change and target selection 3. Behavior analysis and search for underlying conflicts 4. Aims of treatment
Phase 2: Preparation	5. Stabilization – Mind Fullness - PMR 6. Psychoeducation
Phase 3 to 7	7. Intervention – working with targets a. In-vivo desensitization (with or without EMDR) b. EMDR
Phase 3 to 7	8. Intervention – working with underlying conflicts a. Imaginary work (with or without EMDR) b. EMDR
Phase 8: Evaluation	9. Evaluation
	10. Optimize success – long term handling of upcoming impulses

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Patients focus on these aims:

- Reduce Trich
- Develop Personality and Self-esteem!

Phase 1: Client History	1. Therapy relationship 2. Motivation for change and target selection 3. Behavior analysis and search for underlying conflicts 4. Aims of treatment
Phase 2: Preparation	5. Stabilization 6. Psychoeducation

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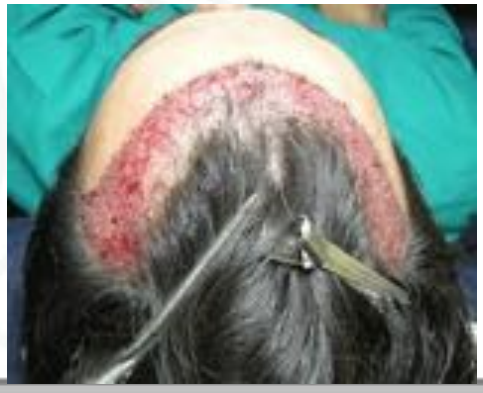
Understanding the symptoms

Where?	When?	How long?	Which feelings are there? (Severity of the feeling or the urge)



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Touching is not allowed! Hands off!

I should push this button?! Why not?

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Preparation: stabilisation includes the use of mindfulness and PMR

- Learning mindfulness + PMR
- Goal is to notice how the hand is raised above the eyes
- Or if other areas of the body are affected to find a point somewhere in the body, which is noticeable
- Practicing mindfulness + PMR

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What is Mind Fullness?

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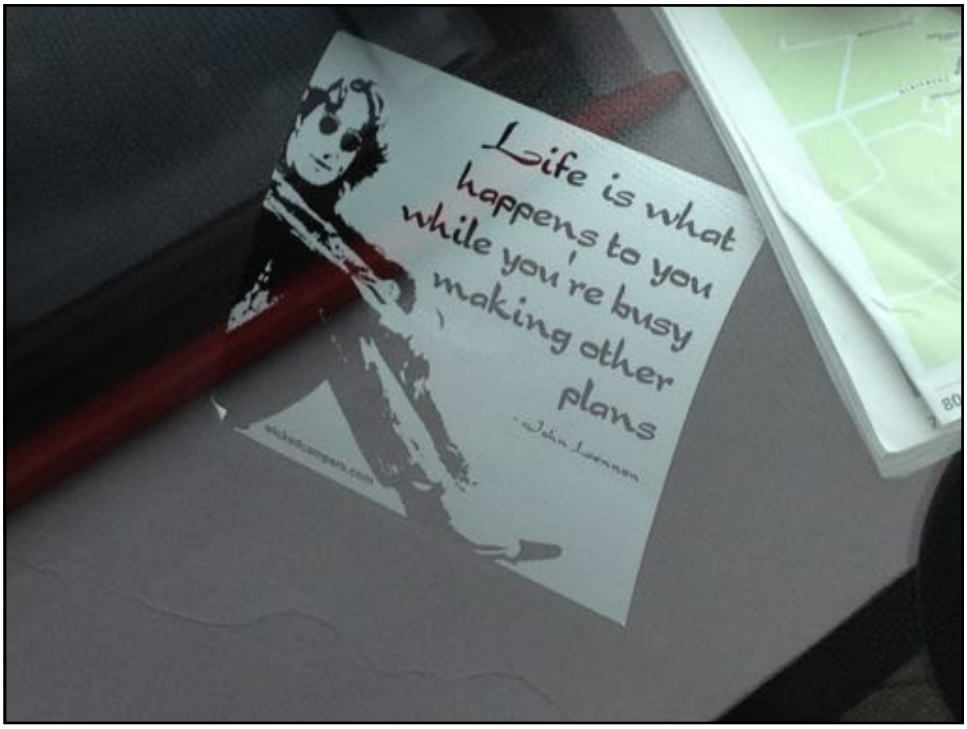

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Mindfulness

Kabat-Zinn, 1990: **"in the present moment, on purpose and non-judgementally"**

- ✓ **in the present moment** (vs. „automatic pilot")
- ✓ **on purpose** (vs. "self-forgetfulness")
- ✓ **non-judgmentally** (no categorization of the perception)

It has its roots in eastern meditation traditions (esp. buddhism), but it can also be found in western traditions. The awareness returning to the here and now is central to mindfulness.

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Focus of mindfulness

- During the first sessions typically on the breath sensation; later on body sensations
- Body sensations about hearing, seeing, emotions, thoughts
- For advanced people there is the so called „effortless mindfulness“, where being mindful by itself is the focus. Thus, the focus of attention is not on an object anymore.

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Principles of mindfulness

- Openness
- Acceptance
- Curiosity

Without judgment (not categorizing in „right“ or „wrong“, without interpretation and conclusion)

„Interested“ attention of feelings to the outside and to oneself

To the practice of mindfulness belongs a wandering off to daydreams and memories. Central to the practice, then, is a returning of the attention to the object (e.g. to the breath or to the particular body region)

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Focus II of the mindfulness intervention

- **Mindfulness of present preceptions**
  - Inner way of coping: Looking at, consciously laying aside and returning to the here and now
  - E.g.: Habit reversal, archery, skills-training
- Mindfulness of earlier experiences
  - „deep mindfulness“ follows a way back to the past, often childhood
  - Imagination technique

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Focus III of the mindfulness intervention

- **Mindfulness to the inside**
  - Thoughts, Emotions, Body sensations, mental images
- **Mindfulness to the outside**
  - 5 Senses:
    Seeing, Hearing, Smelling, Tasting, Groping

Mindfulness is an attitude & a strategy.

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Intervention-phase in EMDR

EMDR is very good combinable with habit reversal and classical expositon with response prevention (ERP) in vivo

Phase 3 to 7	7. Intervention – working with targets a. In-vivo desensitization (with or without EMDR) Habit reversal - Confrontations b. EMDR
Phase 3 to 7	8. Intervention – working with underlying conflicts a. Imaginary work (with or without EMDR) Emotion-Regulation – Schemtherapy - Personality b. EMDR

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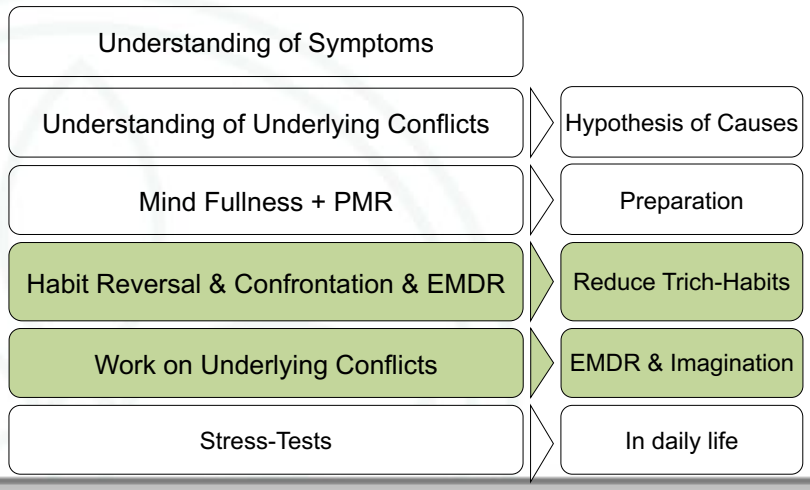
Trichotillomania is treated in the following steps

Treatment Procedure I



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Habit Reversal

- Mind Fullness is basis
- First: recognize the start of the Trich-behavior
- Second: take the problematic hand by the other
- Third: Press the hands together for 1 minute, than relax and check your strain
- If your strain is over your limit (e.g. 60%), press again for one minute and check again
- If your strain is below, continue your daywork without hair tearing

- Do it always!

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Confrontation - ERP

- First: find a good stimulus of the Trich-behavior
- Second: bring up that stimulus (e.g. look in the mirror)
- Third: Go for the strain! (How much can you take?)
- Stay in that position without tearing your hair – unless the strain lessens to about 30%. If the strain is under that limit, refect what has been done and how it feels
- The habituation can be fastened by the therapist (cognitive tricks) after the peak has been reached

- Do it every day once!

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EMDR

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- Second: bring up that stimulus (e.g. look in the mirror)
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- Stay in that position without tearing your hair – unless the strain lessens to about 30%. If the strain is under that limit, refect what has been done and how it feels
- The habituation can be fastened by the therapist (cognitive tricks) after the peak has been reached

- Do it every day once!

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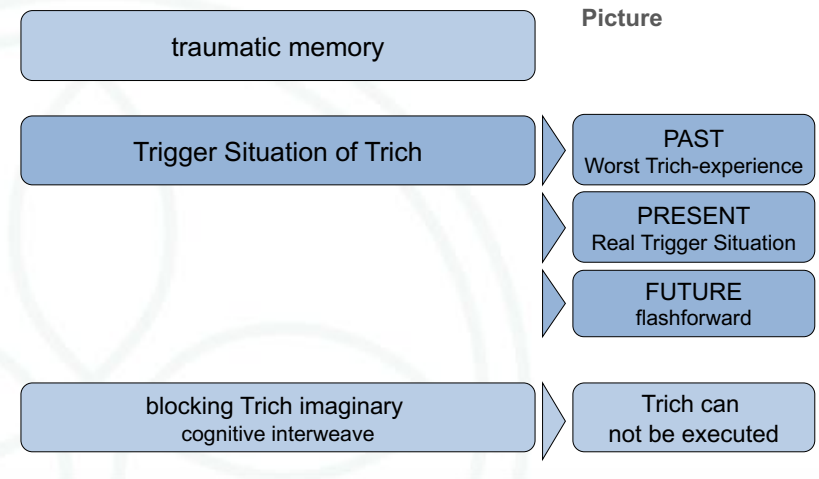
Targetselection in Trich-Patients for EMDR



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EMDR – standard protocol 3 to 7

- Follow the EMDR standard protocol
- Make sure: sign how to stop, safe place
- Target – Negative and Positive Cognitions
- Use Cognitive and Imaginary Phases in EMDR
- Stimulation by eye movements is stronger
- SUD should be really Zero and not One!
- Use interweaves

- Reduce Trich images and targets!

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Underlying Conflicts

- Hypothesis of Conflicts – no knowledge!
- Lack of Self-esteem
- Emotionregulation: how to go along with strain and pressure
- Focus on inner conflicts (past and present)
- Use imaginations and EMDR to work with them

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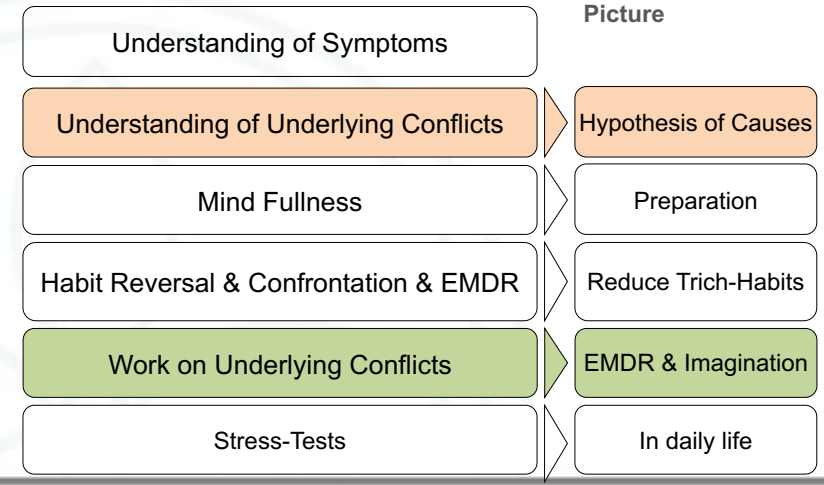
Trichotillomania is treated in the following steps

Treatment Procedure I



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