CASE REPORT

CBT COMBINED WITH EMDR FOR RESISTANT REFRACTORY OBSESSIVE-COMPULSIVE DISORDER

REPORT OF THREE CASES

Gian-Paolo Mazzoni, Andrea Pozza, Carmelo La Mela and Isabel Fernandez

Abstract

Objective: Cognitive-Behavioural Therapy (CBT) with Exposure and Response Prevention (ERP) is the most studied and empirically validated form of treatment for Obsessive-Compulsive Disorder (OCD). However, this therapeutic modality can be extremely demanding and stressful for many patients, especially those with severe OCD symptoms and those who are particularly resistant to the usual therapies. Therefore, alternative forms of intervention - such as the Eye Movement Desensitization and Reprocessing (EMDR) - are of great therapeutic interest.

The present study describes a cases series reporting how the processing of traumatic memories and obsessive contents can facilitate the treatment of symptoms in resistant cases with OCD.

Method: Three cases have been described and analyzed in detail. Attention has been focused particularly on how to enable patients to regulate their emotions, and on the treatment of sensations and cognitions associated with traumatic memories. A hybrid intervention, composed of EMDR and CBT therapies, was administered. This involved three distinct ways to use EMDR through and combined it with CBT in the psychotherapeutic treatment. During the first phase of treatment with the first subject, EMDR was applied to contents related to the patient’s thoughts (obsessions of contamination), the residential context. The second patient (with obsessions of aggression) was treated with CBT and EMDR first administered in a day-hospital facility and subsequently as an outpatient treatment; with the third patient, EMDR was also administered as an outpatient, during a relapse prevention plan.

Results: All three patients showed a clinically significant reduction in symptoms.

Conclusions: These are only three case reports so we can draw only anectodal conclusions EMDR could be a useful method to implement current treatments when combined with CBT, also for OCD resistant patients; however, future randomized controlled trials would be needed to validate these findings.

Key words: cognitive-behavioural therapy, exposure and response prevention, resistant refractory obsessive-compulsive disorder, EMDR

Declaration of interest: none

Gian-Paolo Mazzoni[1,2], Andrea Pozza[3], Carmelo La Mela[1] and Isabel Fernandez[4]

[1] Unit for the Treatment of Resistant OCD, Poggio Sereno Clinic, Fiesole, Florence, Italy
[2] Postgraduate Program on Cognitive Psychotherapy - “Studi Cognitivi”, Florence, Italy
[3] Department of Health Sciences, University of Florence
[4] Psychotraumatology Research Center, Milan, Italy

Corresponding author
Gian-Paolo Mazzoni
mazzoni.psico@gmail.com

Introduction

Several studies have shown that cognitive-behavioural therapy (CBT) based on exposure and response prevention (ERP) is the most effective psychological treatment for Obsessive-Compulsive Disorder (OCD) (Dèttore et al. 2013, Pozza et al. 2016, Sanchez-Meca et al. 2014). However, 15-40% of patients do not fully respond to treatment for various reasons, including lack of motivation and intolerance of negative emotions (Taylor et al. 2012). In the recent decades, researchers and clinicians have defined the resistance to change in pharmacological and psychotherapeutic treatment of OCD and developed the concept of Resistant Refractory OCD (R-OCD; Pallanti & Quercioli 2006). After an adequate trial of evidence-based treatment (20-30 hours of ERP or 10-12 continuous weeks of serotonin reuptake inhibitors), Pallanti and Quercioli (2006) defined R-OCD according to the presence of one or more of the following criteria: (a) OCD symptoms on gold-standard self-report measures not being resolved to within normal limits, (b) the patient continuing to meet the diagnostic criteria for OCD, (c) the patient experiencing little or no symptom improvement.

OCD psychopathology shares many clinical aspects of Post-Traumatic Stress Disorder (PTSD) symptoms (Gershuny et al. 2003), including need for

Submitted March 2017, Accepted July 2017
© 2017 Giovanni Fioriti Editore s.r.l.

control and avoidance behaviours. Studies conducted on clinical samples suggested that symptoms of PTSD are relatively common among patients with OCD (Gershuny et al. 2008, Liotti 2001). The prevalence of PTSD in patients with OCD ranges between 10.2% and 75% (eg, Huppert et al. 2005), and the prevalence of OCD was found to be 41% in a sample of patients with PTSD (Nacasch et al. 2011). A study based on a series of cases suggested that the co-occurrence of OCD and traumatic clinical correlates could hinder the effectiveness of treatment with traditional CBT (Gershuny et al. 2003). Research on clinical samples exposed to trauma indicated that OCD symptoms can emerge after exposure to traumatic events, and also that the content of OCD symptoms could be associated to past trauma (Nacasch et al. 2011, Sasson et al. 2005). It has been hypothesized that traumatic episodes could contribute to complicate OCD severity in patients who have R-OCD (Dykshoorn 2014, Sookman & Steketee 2010). In fact, for patients with R-OCD, repetitive behaviours can reduce anxiety and can also function as a coping strategy to control memories and emotions related to traumatic events (Gershuny et al. 2002).

Eye Movement Desensitization and Reprocessing (EMDR) is a therapy centered on the elaboration of emotions and bodily sensations enclosed in the traumatic memories (Shapiro & Forrest 2001). The EMDR protocol consists of eight steps focusing on traumatic events in the patient's history and on the triggers of their symptoms (Shapiro 2001). The rationale for using EMDR for R-OCD is that processing of traumatic memories could facilitate treatment. In recent years, there has been preliminary evidence which suggests that EMDR could be effective in the treatment of anxiety disorders and OCD (Marr 2012, Böhm & Voderholzer 2010, Onofri 2010, Nazari et al. 2011). In the treatment of OCD, EMDR is reportedly viewed as a stand-alone therapy and a helpful adjunct in ERP (Marr, 2012). Both treatments are used in the target sequence according to the three-phased protocol: past memories are processed first, followed by current triggers, and then by future actions, and each target is fully processed according to the standard procedure (Marr 2012). Böhm and Voderholzer (2010) recommended the use of EMDR to assist patients in emotional mastery. De Jongh and Ten Broeke (2009) suggested EMDR treatment in order to resolve focus-disturbing or traumatic events and memories which can be the origin of the problem, or disturbing events which may have played a catalytic part in the onset of OCD. The literature provides less research on EMDR application with OCD, and much of it only refers to single cases in treatment or few participants (Tenore & Gragnani 2016).

Despite these preliminary contributions, little attention has been dedicated to the use of EMDR combined with CBT in the treatment of refractory cases with OCD. The current study presents three patients with R-OCD treated with an intervention based on CBT (ERP and cognitive therapy) combined with EMDR. It was hypothesized that this type of treatment could target both primary outcomes in OCD (OCD symptoms and beliefs) and secondary outcomes (anxiety, depression, and dissociation symptoms) (Ponniah et al, 2013). Researchers have supposed that the presence of dissociative symptoms in OCD patients is a negative predictor of response to only CBT treatment (Rufer et al. 2005, 2006; Liotti & Costantini 2011) at immediate post-treatment and follow-up. The participants were three Italian patients with R-OCD (two women and a man), who had been unsuccessfully treated through medication and CBT alone. The first patient was treated in a first stage with EMDR and then with CBT. It was agreed to start working with EMDR on her worst experiences, namely the sense of loneliness during her childhood and her mother's death. After two months of EMDR on past memories, we worked on the onset of the sensation of "feeling dirty" and then on the triggers which currently disturb her. The patient said that she became more resistant to feeling exposed and to taking risks, therefore we started working on the installation of a safe place and of resources to reduce the tendency to avoid dealing with anxiety-producing stimuli. Subsequently, as indicated by certain authors (Böhm et al. 2010), we continued working with EMDR therapy on the content of the obsessions of aggression, starting from the past memories from which they originated.

Lastly, given the severity of symptoms of the third patient, the usual CBT protocol was used in a preliminary phase, after which weekly sessions of exclusively EMDR therapy were used to work on episodes of family aggression and on the patient's feelings of anger and guilt originated in his past.

Case 1 – Inpatient treatment with CBT combined with EMDR

Anna, a 43-year old woman, accessed our Unit after 10 years of repeated pharmacological and psychotherapeutic treatments. She currently lives with her father and sister, has a degree in Literature and is unemployed. Anna presents extremely severe OCD symptoms, characterized by obsessions about dirt (dust, blood, oil and food residues) which cause frequent and prolonged washing rituals (lasting about 30 times a day), and a variety of avoidance and safety behaviours (eg, use of plastic gloves at home). She is currently being treated with Venlafaxine (150 mg/die) and Risperidone (2 mg/day).

History, onset, precipitating events and present symptomatology

She remembers always being "a little squeamish" in touching objects for fear of dirt. In July 1994, after eating a sandwich prepared by her mother, she felt an acute urge to "wash her hands frantically". From then, the frequency and duration of the washing became incongruous. At home, she was afraid of making her things "dirty" (eg. clothes), but also of being "contaminated" by non "clean" objects. The clinical course of these compulsive symptoms manifested stages of improvement and deterioration. The patient reports that a marked deterioration in the severity of her symptoms followed her mother's death. From 2003 to 2005 she used drugs (SSRIs), and, subsequently, she continuously underwent CBT sessions for about one year, which she then interrupted because of poor results.

Assessments

We conducted the assessments through a set of tests, including questionnaires and interviews, which included the Structured Clinical Interview for DSM-IV-TR axis I disorders (SCID-I; Mazzi et al. 2000) and SCID-II (Mazzi et al. 2003), the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al, 1989), Padua Inventory (PI; Sanavio 1988), Obsessive Belief Questionnaire-87 (OBQ-87; Obsessive Compulsive Cognitions Working Group 2005), Beck Anxiety

Inventory (BAI; Beck et al. 1988), Beck Depression Inventory-II (BDI-II; Beck et al. 1996), and the Dissociative Experiences Scale (DES; Bernstein & Putnam 1986). The assessment's findings indicated the presence of sub-threshold depressive symptoms, a comorbid Obsessive-Compulsive Personality Disorder and an Avoidant Personality Disorder. Pre-treatment scores were 34, 11, 25, and 15,72 on the Y-BOCS, BAI, BDI-II, and DES, respectively. Clinical evaluations were carried out by clinical psychologists during three- and six-month follow-up assessments.

Treatment

The patient underwent a 4-week inpatient intensive treatment in a psychiatric unit for R-OCD in a residential clinic, using CBT and EMDR combined with pharmacotherapy, using a protocol presented elsewhere (Pozza et al. 2014). The EMDR protocol has been divided into the following steps (**table 1**):

1) The reconstruction of the patient's history, identifying traumatic episodes, the so-called *T* (t = great single episodes considered as traumas by the DSM-5), and *t* (t = small interpersonal traumas), that may have contributed to the development of the disorder (Shapiro 2001).
2) After having identified the history of OCD, we worked on traumatic memories isolated by the standard EMDR protocol (Gonzalez & Mosquera 2012).
3) We worked on the history of the disorder, focusing on the first times obsessive thoughts and rituals appeared (Miriam et al. 2012, Marr 2012, Böhm 2010, Böhm & Voderholzer 2010).
4) Finally, we identified activating situations through diaries, self-monitoring and functional analysis sheets. Triggers can reactivate the development of scenarios which the patient found intolerable and emotionally activating and disturbing memories identified in the history of her life. This therapeutic procedure can prepare the patient to confront with these feared situations (Böhm 2010).
5) The last phase of the treatment combined EMDR with response prevention by exposing the patient to the previously mentioned intolerable scenarios without performing compulsive behaviours.

Each session consisted of a treatment with CBT+EMDR (**table 1**). During the first 20 minutes of the session, the clinician evaluated the levels of obsessions and compulsions and the patient's mood. In the subsequent 60 minutes, ERP (Foa et al. 2012), cognitive restructuring (CR) or re-elaboration of a traumatic target was delivered. In the final ten minutes of the session, homework was assigned. Finally, flash cards and psychoeducation materials were used, in order to consolidate the work done during the session (Fernandez 2011).

After having installed the *safe place* (the room of a house where she spent her holidays, associated with the word "respect") and a *resource* (the figure of Mrs. Gloria, a family friend) (Korn & Leed 2002), Anna received five sessions of EMDR on traumatic episodes. After session 6, she began working on past memories, such as: "the quarrels between her parents and the tense atmosphere", "the death of her grandmother, "the Latin test in secondary school", "schoolmates' criticisms for being very Catholic, and the sense of isolation and loneliness". Subsequently, the number of compulsions remained unchanged; however, the feeling of being contaminated diminished ("I feel a little less squeamish and dirty"). Later, the episode when OCD symptoms appeared for the first time ("the snack prepared by her mother") was elaborated. The memory elicited a Subjective Unit of Disturbance (SUD) of 7 associated to a feeling of sadness and the negative cognition (NC) "I am imperfect". The Validity of Cognition (VOC) was 3. This phase was followed by the exposure to one of the last episodes, "the contact with her sister which caused feelings of anxiety and disgust" (SUD= 8), which was associated to a NC "I am a prisoner of the OCD". Other incidents related to the symptom were processed, such as the "adventure bath", when the patient had a three-hour long shower and washed her teeth for about 70 minutes. After this, working on future episodes by combining EMDR with response prevention (Böhm & Voderholzer 2010), the patient was asked to identify potential situations, such as: "she washes and rinses her hands once and well". This was associated to a feeling of panic and NC "I'm lost". We chose to introduce an integrative cognitive intervention (ICI) such as "do so once and well" (Sturpe & Weissman 2002, Whisman 2000). In order to facilitate the emotional processing, ICIs were used according to guidelines (Whisman 2000), such as summary sentences or direct questions referred to the body (eg. "What do you feel in your body?", "If your body could talk, what would it say?"). In addition, the therapist used progressively longer sets of stimulations (eg. 35-40 stimulations), and the processing of the episode was repeated for various sessions. During this intervention, traditional CBT techniques were used (psychoeducation, daily in vivo ERP, and cognitive restructuring with disputing). Pre-post-treatment, and follow-up scores on OCD symptoms, obsessive beliefs, depression, anxiety and dissociation are presented in **table 2**. OCD symptoms, obsessive beliefs, anxiety, depression and dissociation levels decreased after treatment. At three- and six-month follow-up assessments, clinical evaluations were independently carried out by clinical psychologists. Overall, both the symptoms of anxiety, depression and OCD beliefs were found to be stable at six months after the end of treatment in some cases (eg. beliefs and dissociation), indicating that results consolidated or even improved over time.

Treatment

After having installed the safe place ("a mountain landscape in the trees, where you see the mountains, or by a stream") associated with the word "carefree" and a resource ("the image of my mother's side"), in order to improve self-efficacy to tolerate "painful" negative emotions, the CBT protocol was delivered, including psychoeducation, cognitive restructuring and intensive and daily ERP. It was decided to immediately start the ERP intervention with the use of "replacement tools", such as a plastic doll, and auxiliary tools (such as blunt objects), as the patient, at the time of starting the therapy, was unable to tolerate the presence of the child. For EMDR sessions, unlike what protocols in literature indicate (Sturpe & Weissman 2012, Whisman 2000), it was decided to start by traumatic episodes before the onset of OCD, in order to prepare the patient to work on the present eliminating the stress linked to her past. From session 6 we began to work on memories such as: "her mother slaps and punches her", "the finger operation when she was three years old", "a child gives her a kiss and she feels bad for not having shunned it" and finally the episode "of failing to do her homework even with the help of her father". The episode when OCD

Table 1. *Protocol of CBT+EMDR*

INTENSIVE TREATMENT PROGRAM CBT+EMDR
First week - Session 1
- Presentation of the staff and program of treatment - Interview: the patient explains why he/she joined the treatment program, assessment of motivation to treatment adherence - Administration of outcome measures
First week - Session 2
- An interview covering clinical symptoms (anxiety-evoking situations, meaning and content of obsessions, rituals, avoidance and other safety behaviours) - Delivery of self-monitoring sheets (ABC sheets) - Presentation and familiarization with the OCD model - Delivery of a self-help book - Engagement: presentation of the basic concepts of the Elaboration Adaptive Information Model and the principles underlying EMDR, delivery of a self-help book ("Trauma and psychological wounds of the soul") - Goal setting
First week - Session 3
- Case conceptualization - Presentation of the anxiety discomfort curve during ritual prevention - Motivating to ERP: blackmailer, advertisement on mobile phones and locked brain metaphors - Agreement on specific goals of therapy and restructuring unrealistic expectations of the patient - Construction and sharing of the work plan with EMDR
First week - Session 4
- Anamnesis, reconstruction of the patient's life history and identification of traumatic episodes that may have precipitated the onset of the disorder
First week – Session 5-7
- Identification and construction of the "safe place" - Construction of hierarchies and rules of response prevention - Psychoeducational intervention with family members
Second week - Session 8-11
- Work on traumatic memories (T and or t) using the standard EMDR protocol, divided into eight stages - Exercises of ERP
Third week - Session 12
- Work on the history of the disorder: the first time thoughts and compulsions appeared (failure) through the EMDR standard protocol + Response Prevention (RP) - Exercises of ERP
Third week - Session 13
- Work on the history of the disorder (on the worst episode in which symptoms appeared + RP) - Exercises of ERP
Third week - Session 14
- Work on the history of the disorder: on event generator of OCD by the floatback technique and bridge effect. - Exercises of ERP
Third week - Session 15
- Work on the history of the disorder (on the last episode in which symptoms appeared or c + RP) - Exercises of ERP
Fourth week - Session 16/18
- Process the current situations activator (triggers) identified + RP - Exercises of ERP
Fourth week - Session 19
- Work on the history of the disorder (the possible future episode, like in a movie + RP) - Exercises of ERP
Fourth week - Session 20
- Relapse prevention - Post-treatment assessments - Psychoeducational interviews with the family - Planning follow-up assessments

Table 2. *Assessments on outcomes as function of time-points for Anna*

Outcomes	Cut-off	Pre-treatment	Post-treatment	3-month follow-up	6-month follow-up
Y-BOCS total	17	34	18	17	22
Y-BOCS obsessions		17	9	9	11
Y-BOCS compulsions		17	9	8	11
BDI-II	20	25	15	17	14
BAI	16	11	6	5	6
PI total		Z =-0.33	Z= -0.65	Z= -0.87	--
PI Obsessional thoughts	z>1.50	Z= -1.42	Z= -1.14	Z= -0.95	--
PI cleaning		Z= 1.47	Z= 1.47	: Z= 0.63	--
PI checking		Z= -0.15	Z= -1.48	Z= -0.81	--
PI obsessional impulses		Z= -0.93	Z= -0.93	Z= -0.93	--
OBQ-87 intolerance for uncertainty	z>2	Z= 2.02	Z= 2.29	Z= 1.38	Z=1.22
OBQ-87 threat overestimation		Z= 0.41	Z= 1.56	Z= 2.14	Z=1.36
OBQ-87 control of thoughts		Z= 1.37	Z= 0.80	Z= 2.36	Z=1.22
OBQ-87 importance of thoughts		Z= 2.53	Z= 1.96	Z= 1.57	Z=0.80
OBQ-87 inflated responsibility		Z= 1.74	Z= 1.39	Z= 1.31	Z=1.83
OBQ-87 perfectionism		Z= 2.35	Z= 2.72	Z= 1.68	Z=2.58
DES	>20	15.72	14.35	12.2	11.07
DES-dissociative amnesia		7	7	6	5
DES- dissociative operation		18	17	17	16
DES- depersonalization/ derealization		20	18	16	15

Note. *BAI Beck Anxiety Inventory; BDI-II= Beck Depression Inventory-II; Y-BOCS=Yale-Brown Obsessive-Compulsive Scale; PI = Padua Inventory; OBQ-87= Obsessive Belief Questionnaire-87; DES = Dissociative Experience Scale.*

symptoms appeared for the first time was subsequently handled, when "the son did not want to take a bottle and she gave him two little spanks, which made him start to cry loudly". Straight after this episode she began feeling as if she were a mother unable to stay in control with her child. Initially, the memory elicited a SUD of 7 points associated with a feeling of being guilty located in the stomach and the negative cognition "I am bad". The VOC level was 3 points. Another recurring image processed was "her son covered in blood after she had killed him" (SUD = 6) with the NC "I am guilty". This was followed by one of the last episodes "herself in the kitchen with knives on the table next to the child" (SUD = 5), felt in the stomach and associated with the NC "I am a degenerate mother". Subsequently, combining EMDR with RP we worked on future episodes ("one time she'll wake up next to her son with her arm around his neck, ready to choke him").

Case report 2 – Outpatient's Treatment with CBT combined with EMDR

Katia is a 44-year old woman who lives with her partner, her two children had from a previous marriage and one she had from her current relationship. The patient, assisted during the second pregnancy, refers obsessive fears regarding the possibility of perpetrating impulsive and aggressive acts towards her one year old son. Her insight is good but high levels of anxiety are reported. Her mood is moderately flexed and no alterations in sleep and appetite have been noticed.

History, onset, precipitating events and present symptomatology

In 2004 the patient started to present obsessive thoughts of varied content, such as the fear of being homosexual and the fear of being forced to return to her husband (from whom she has now been separated for 4 years). In the same period she began a pharmacological treatment, which, following improvement in her conditions, was ended in May 2006. In the same year, Katia begins a new relationship with a divorced man, with whom she has a son in 2010. In July 2010, a few months after giving birth, new obsessive fears of losing control and harming her child or strangers in the street begin: "When I went out on the street I felt terrible, I had panic attacks". In September 2010, during a period of strong tension and agitation, while she was at home with her parents she wrapped a chain around her neck; this act is explained in the following words: "I did not want to die, but it was more of a sign which proved I was too unwell". Following this episode Katia asked to be admitted to hospital; after 18 days of hospitalization, she

was discharged with a diagnosis of Major Depression, Obsessive Compulsive Disorder and Panic Attacks (the diagnosis was only made by psychiatric interviews). After drug treatment, her condition improved, and the patient could function satisfactorily, though an important obsessive fear of being responsible of harming her child still remained; thus, her psychiatrist recommended a specific psychotherapy for OCD.

Assessment

We conducted the diagnostic study of this case using a wide range of measures, such as the SCID-I, Y-BOCS, PI, OBQ-87, BDI-II, BAI and DES for Axis I assessment. Moreover, for personality evaluation, we used SCID-II and MMPI-2. On the MMPI-2, the following scales showed clinically significant T scores: Depression (D) 66, Psychasthenia (Pt) 71, Psychopathic Deviation-impulsivity (Pd) 73 and Paranoia (Pa) 68. These scores seem to indicate an insecure and worried attitude, with a fear of failure and with spans of rigid morality, meticulousness and strong indecision. Signs of intense anxiety with obsessive-compulsive aspects also emerged (**table 3**). Furthermore, the patient clearly came across as a solitary individual, shy, with little energy, unable to concentrate, with physical and sleep disorders, little self-confidence, feelings of inadequacy and sad and dysphoric moods. The SCID-II suggested Obsessive Compulsive Personality Disorder (OCPD) and Dependent Personality Disorder (DPD), while the SCID-I revealed an OCD associated with a Unipolar type Major Depressive Disorder. Y-BOCS scores were 14 and 11 for the obsessions and compulsions scales, BAI and BDI-II scores were 25 and 36. The OBQ-87 scales with significant scores were Perfectionism (Z = 2.26) and Importance of thoughts (Z = 2.67). The DES placed a mean value of 25.8. A reduction of obsessions, compulsions and depression emerged (**table 3**). Anxiety, conversely, was not affected by the treatment. Beliefs related to perfectionism and the intrusiveness of thoughts were reduced.

Treatment

The first step of the treatment was the installation of the safe place ("a mountain landscape in the trees, where you see the mountains or by a stream", associated with the word "carefree") and of a resource for Katia ("the image of my mother's side"). Then, after an improvement of the self-efficacy to tolerate the emotion "painful", the usual protocol of CBT based on psychoeducation, cognitive restructuring associated with intensive and daily in vivo ERP was applied.

It was decided to start with the ERP intervention immediately, with the use of "replacement tools", such as a plastic doll, and auxiliary tools (such as blunt objects), as the patient, at the time of starting the therapy, was unable to tolerate such objects in presence of the child. This caused her problems in handling her child, and possible complications in the mother-child attachment relationship. For the EMDR sessions, once we identified what the most traumatic memory for the patient was, unlike the protocols in literature suggest (Böhm 2010, Böhm & Voderholzer 2010), we decided to start with traumatic episodes before the onset of OCD, in order to prepare the patient to work on the present, eliminating the stress linked to her past. From the sixth session, therefore, we started working on the memories such as: "The mother pulls, slaps and beats", "the operation on his finger at three years of age", "a child gives her a kiss and she feels bad for not having shunned it "and finally the episode of "failing to do their homework even with the help of his father", when "the son did not want to take a bottle and she gave him two little smacks, which made him start to cry loudly". Straight after this episode, she began feeling as if she were a mother unable to stay in control when with her child. The memory elicited a SUD of 7, associated with a feeling of guilt felt in the stomach, and the Negative Cognitions (NC) was "I am bad". The VOC was 3. We also processed a recurring image "the son covered in blood after she had decapitated him" (SUD = 6) with the Positive Cognitions (PC) "I am guilty". This was followed by one of the last episodes, "the woman in the kitchen with knives on the table next to the child" (SUD = 5), which the patient felt in her stomach and which was associated with a NC "I am a degenerate mother". Later, working on future episodes, we combined EMDR with ERP. The patient was asked to draw up situations such as the following: once she wakes up next to her son with her arm around his neck. The image was associated with a feeling of anxiety and NC "I am vulnerable". Katia's symptoms were monitored during the course of treatment and at the end of each hospitalization through questionnaires, as shown in **table 1**. The work done on processing the incident-related symptoms allowed a weakening of the perception of feeling bad and guilty. After the cycle of day hospital during which she continued drug treatment and CBT module + EMDR treatment, OCD symptoms (assessed by the Y-BOCS) were significantly reduced (Y-BOCS = 10).

Case report 3 – Sequential outpatient treatment with CBT with EMDR.

Luca is 29 years old, single and unemployed, and has a severe form of OCD characterized by superstitious and aggressive obsessions, which cause him strong feelings of guilt. For example, obsessions included fear and doubt that some numbers could predict his death during plane flights, or that he could become an aggressive man. Comorbid depressive and paranoid traits emerged during personality evaluation. Despite the patient's excellent compliance, both psychotherapeutic and pharmacological interventions produced poor improvements, and the patient continued to report symptoms, which also made him unable to begin working and having social interaction.

Assessment

Assessment were conducted through symptom questionnaires such as the SCID-I, the Y-BOCS, the PI, the OBQ-87, BAI, BDI-II, the DES, the SCID-II and MMPI-2 as personality instruments. Pre-treatment, BAI and BDI-II scores were respectively 26 and 38. The patient had a severe level of OCD symptoms (Y-BOCS Total= 29; Y-BOCS obsessions= 16; Y-BOCS compulsions= 13). With regard to obsessive beliefs, threat overestimation (z score = 3.26) and need to control thoughts (z score= 3.05) were the most significant ones. On the MMPI-2 significant scores emerged on the Depression (D= 81), Paranoia (Pa= 81), Psychasthenia (Pt= 75) and Schizophrenia (Sc= 73) scales (**table 4**), suggesting depressed mood, fatigue and abulia, serious symptoms of anxiety and tension with frequent somatic problems, ruminative ideation, persecutory ideation, derealization/depersonalization feelings.

Table 3. *Assessments on outcomes as function of time-points*

Outcomes	Cut-off	Pre-treatment	Post-treatment
Y-BOCS total	17	25	10
Y-BOCS obsessions		14	10
Y-BOCS compulsions		11	0
BDI-II	20	36	12
BAI	16	25	24
PI total	z>2	Z = 3.04	Z =-0.02
PI obsessional thoughts		Z = 3.83	Z =-0.20
PI cleaning		Z = -2.14	Z = 0.51
PI checking		Z= 2.59	Z= 0.66
PI obsessional impulses		Z = 3.59	Z =0.18
OBQ-87 intolerance for uncertainty	z>2	Z= 1.28	Z=-1.06
OBQ-87 threat overestimation		Z=1.6	Z=-0.07
OBQ-87 control of thoughts		Z=1.81	Z=-0.33
OBQ-87 importance of thoughts		Z=2.67 Critico	Z=-0.45
OBQ-87 inflated responsibility		Z=0.75	Z=0.02
OBQ-87 perfectionism		Z= 2.26 Critico	Z=0.6
DES	>20	23.85	11.08
DES-dissociative amnesia	--	7.5	5.2
DES- dissociative operation	--	39	16
DES- depersonalization/Derealization	--	20.2	11.3
MMPI-2 (D)	>65	66	---
MMPI-2 (Pt)	>65	71	---
MMPI-2 (Pd)	>65	73	---
MMPI-2 (Pa)	>65	68	---

Note. BAI=Beck Anxiety Inventory; BDI-II=Beck Depression Inventory-II; MMPI-2=Minnesota Multiphasic Personality inventory-2; Y-BOCS=Yale-Brown Obsessive-Compulsive Scale; PI=Padua Inventory; OBQ-87=Obsessive Belief Questionnaire-87; DES = Dissociative Experiences Scale.

History, onset, precipitating events and present symptomatology

At the age of seven, the patient was victim of a car accident which lead him to be hospitalized for a fracture of a lower limb. This episode triggered in Luca constant thoughts of being "unlucky", and this belief remained constant during the following years. In 2007, following an argument with his mother, he lost control and showed aggressive behaviour towards her (eg. he pulled her hair), which triggered deep feelings of guilt in Luca ("maybe God wants me to pay for something that I did, and I want to die"). Thus, early obsessions related to the idea of becoming "aggressive like his father", emerged. In 2010 he enrolled in a parachuting school and, after only one launch from a very high altitude, he reported early fears of empty spaces ("the parachute will not open, I will die "). The patient identified the onset of his OCD in the death of the newest recruit of the 13 paratroopers, caused by parachute malfunctioning. His symptoms seemed to worsen after he broke up with a girl he had started dating. The patient interpreted this episode as a confirmation of the beliefs of his bad luck and destiny of death.

Treatment

The patient underwent a 4-week intensive inpatient treatment with CBT combined with EMDR therapy, associated with pharmacotherapy according to the protocol previously exposed. Given the severity and pervasiveness of symptoms, which called for rapid improvement, in a first step the usual protocol of CBT was used for four weeks, after which weekly outpatient sessions of only EMDR were used for a period of 15 months on an outpatient basis. After having installed the safe place ("In his room, in his bed under the covers, safe, warm and protected"), linked to the keyword "blanket" and a resource ("the presence of the therapist"), Luca received 14 sessions of EMDR treatment on traumatic episodes before the onset of his OCD. Given the traumatic nature of the patient's history, Luca began working on past memories, such as: "his mother's screams at her husband's beatings", "the traction orthopaedic surgery in the operating room after the car accident", and finally "an episode in which he is alone in a club, derided and dismissed by his friends because he is limping", which Luca entitled ("my worst nightmare"). All three memories always elicited

Table 4. *Assessments on outcomes as function of time-points for L*

Outcomes	Cut-off	Pre-treatment	Post-treatment
Y-BOCS total	17	29	1
Y-BOCS obsessions scale		16	1
Y-BOCS compulsions scale		13	0
BDI-II	20	38	9
BAI	16	26	6
PI total	1.50	Z = 4.57	Z = -1.89
PI obsessional thoughts		Z = 3.44	Z = -2.03
PI cleaning		Z = 2.74	Z = -1.15
PI checking		Z= 2.81	Z= -0.93
PI obsessional impulses		Z = 3.49	Z = -1.73
OBQ-87 intolerance for uncertainty		Z=1.45	Z=-0.2
OBQ-87 threat overestimation		Z=3.26	Z=-1.82
OBQ-87 control of thoughts		Z=3.05	Z=-0.32
OBQ-87 importance of thoughts		Z=1.99	.Z=-0.21
OBQ-87 inflated responsibility		Z=2.19	Z=-1.33
OBQ-87 perfectionism		Z=1.94	Z=-0.23
DES total	20	15.3	7.14
DES dissociative amnesia scale		6	2
DES dissociative functioning scale		25	12.3
DES depersonalization and derealization scale		14	6
MMPI-2-D scale	T>65	82	____
MMPI-2-Pa scale	T>65	81	____
MMPI-2- Pt scale	T>65	75	____
MMPI-2- Sc scale	T>65	73	____

Note. BAI=Beck Anxiety Inventory; BDI-II=Beck Depression Inventory-II; MMPI-2=Minnesota Multiphasic Personality Inventory-2; Y-BOCS=Yale-Brown Obsessive Compulsive Scale; PI = Padua Inventory; OBQ-87=Obsessive Belief Questionnaire-87; DES = Dissociative Experiences Scale**.**

a feeling of sadness with a SUD of 7-8, associated with the constant NC "I only deserve bad things" and "I am so unlucky". Subsequently, we worked on episodes directly linked to OCD symptoms such as "the death of the new paratrooper" and "the death of an actor in a parachute launch", which elicited a strong state of anxiety causing repeated rituals (eg. seeing a necrology on the seventeenth day of each month, which he considered an unlucky number) and a neutralization behaviour (eg. either smoking a specific number of cigarettes in a day other than 17 or having to cease all remaining activities for the day).

Post-treatment assessments suggested the effects of the treatment of Luca evidencing a significant reduction of obsessions and compulsions, anxiety and depression (**table 4**). Beliefs related to OCD and dissociative symptoms were reduced.

Discussion

Despite CBT having been proven to be the first-line psychological treatment for OCD (Mancini 2016), a noticeable proportion of patients does not fully respond to this type of treatment or prematurely drop out, showing a Resistant-Refractory OCD. The presence of comorbid dissociative experiences may be a predictor of negative response after CBT for OCD (Rufer et al. 2006, Onofri 2010).

EMDR, which has been demonstrated to be an effective treatment strategy for dissociation and trauma (Gonzalez & Mosquera 2012), might be a useful treatment strategy in addition to CBT for OCD. Despite some preliminary contributions (Nazari 2011, Marr 2012), poor attention has been dedicated by researchers and clinicians to the use of EMDR in the treatment of OCD. In contrast with previous studies, the current study presented three cases with R-OCD treated with an intervention based on CBT (ERP and cognitive therapy) combined with EMDR. Intervention was conducted in an inpatient or outpatient setting and also included a long-term follow-up assessment for one patient. During the treatment, CBT and EMDR were combined differently (**table 5**).

In the first case, we worked with the EMDR and then with CBT. For the second case, we combined the two therapies, while for the third patient, we employed ERP and subsequently EMDR treatment.

The first two patients were treated with CBT combined with EMDR. The use of EMDR may have allowed the reduction of emotion dysregulation symptoms, thus possibly facilitating the patients' habituation process during exposure therapy. Accordingly, the patients reported that they felt "more strengthened" by the preparatory work with EMDR and were able to do the homework alone. Based on Marr (2012) and Böhm (2010), EMDR work also allowed them to identify their "deep and unexpressed desires" at non-verbal level, coming into contact with new bodily sensations ("despite years of psycho-analysis, I never actually realized I have a body, if not

in the context of feeling dirty"). This work allowed the patient Anna to accept for the first time the risk of experiencing anxiety and emotions of disgust, which she had previously perceived as intolerable. Katia was able to process the content of the obsessive thoughts and frightening images which previously she had not been able to fully face with usual ERP exercises. Thus, she felt "free" and less burdened by "having to be a good student" in performing the usual daily exercises. Post-treatment assessments suggested that the combined treatment enhanced a significant reduction in compulsive symptoms and also produced improvement in dissociative symptoms (Rothbaum et al. 2005).

The CBT treatment for Luca consisted of in vivo exposure, which was subsequently strengthened by working with EMDR (**table 5**). This therapeutic approach offered him an effective way to bring out feelings related to past episodes, in which emotions of "bad luck", sadness and sense of responsibility were trapped. Moreover, the work on traumatic memories related to observed violence on behalf of the patient allowed Luca to process the theme of his father's aggressions and violence. Post-treatment assessment indicated that Luca endorsed lower levels of inflated responsibility, threat overestimation and control of thoughts and beliefs. This achievement seemed to be relevant since the patient had shown sub-threshold psychotic symptoms indicated by MMPI-2-Pa and MMPI-2-Sc scores which were greater than the clinical cut off at a pre-treatment stage.

Conclusions

Up to 50% of OCD patients resistant to CBT treatment have experienced traumatic events in their past (Dykshoorn 2014, Gershuny et al. 2002). Some research showed that CBT alone can be insufficient with this particular kind of OCD patients.

The use of EMDR has proved to be a flexible and very effective tool with patients with R-OCD (Onofri 2010, Marr 2012). This point raises the question of whether patients with OCD and PTSD symptoms may respond better to CBT combined with EMDR, as suggested by the cases of Anna, Katia and Luca. The clinical presentations of OCD and PTSD (**table 5**) could share common underlying mechanisms, such as trauma and dissociation (Nacasch et al. 2011, Liotti & Costantini 2011), which could play a role in the development of obsessions.

After the therapeutic work with these patients, their levels of SUD dropped below the value of 0,5-1, but it did not reach the requested level of 0 and the VOC level of 6-7. This aspect could be explained by the fact that for complex cases with traumatic symptoms the SUD and the VOC level cannot reach said levels since the processing is more difficult, as suggested by Marcus et al. (1997)).

Overall, the findings suggested that EMDR is a useful therapeutic tool, which can be included as an additional module (Nazari et al. 2011, Böhm & Voderholzer 2010) to improve the outcome of CBT. The timing of the delivery of the two forms of treatment seems particularly important, to help patients in regulating emotion or to promote the use of homework of ERP, also autonomously.

However, regardless of the combination and the time during which EMDR was used with the three patients, the post-treatment test results and the therapist's clinical evaluation employed in this study seemed to suggest the usefulness and effectiveness of EMDR therapy in treating individuals diagnosed with OCD.

Several limitations in the interpretation of the findings should be carefully pointed out. First, the results were based on self-report instruments. In addition, the three patients had different types of medications and pre-treatment comorbidities, which could have played a role in their response to treatment. Studies with large

Table 5. *EMDR and ERP treatment in the three OCD patients*

Case	Treatment method	Complaints	Trauma's/ life events	Number of sessions	Results
Anna	EMDR+ERP	Obsessions about dirt Washing rituals Avoiding activities Social withdrawal	- Memories of emotionally distant parents - Repeatedly critical by parents - Painful death of a grandfather - Repeated memories of loneliness - Painful rejection at school	20	Disturbing Thoughts Reduced Rituals deduced
Katia	I) EMDR II) ERP	Fear/avoidance Obsessions and worry about harm to the child Severe depressive mood	-Domestic violence and fear of a separation -Mom beats her -Repeated memories of home loneliness -Witnessing her mother's car accident -Physical violence by her husband - Unexpected pregnancy of a lover	42	Disturbing Thoughts Reduced Depressive symptoms disappeared
Luca	I) ERP II) EMDR	Aggression and superstitious disturbing thoughts Feelings of guilt Depressive mood Persecutory ideation	-Depressed mother -Repeatedly witnessing domestic violence -Incurable broken leg in an accident five years old -Emergency admission -He attacks the mother with guilt	45	Disturbing Thoughts Reduced Depressive symptoms disappeared

sample sizes would be desirable for the purpose of improving the integration mode between the EMDR module and CBT (Tenore & Gragnani 2016, Böhm, & Voderholzer 2010).

Importantly, future research with a randomized controlled design should evaluate the effectiveness of the treatment by comparing a group assigned to solely CBT and another assigned to CBT+EMDR. Another limitation concerned the lack of follow-up assessments for two of the three patients. Thus, future studies should further assess whether the combination of EMDR and CBT has a sustained effect in the long-term.

The point regarding what phase of the treatment it could be useful to introduce EMDR and CBT in, appears interesting. It could be held that the order of each type of treatment could depend on the type of OCD symptoms and other clinical considerations related to the patient's life history and symptom onset, degree of treatment compliance and therapeutic alliance.

In conclusion, additional studies are needed to examine how, when and why EMDR works in addition to other treatments helping clinicians in decision-making with patients with R-OCD.

References

Abramowitz JS, Deacon BJ, Olatunji BO, Wheaton MG, Berman NC, Losardo D et al. (2010). Assessment of obsessive-compulsive symptom dimensions: development and evaluation of the Dimensional Obsessive-Compulsive Scale. *Psychological Assessment* 22, 180-198.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). American Psychiatric Association, Washington, DC.

Baer H, Kim D & Ahn J (2006). A case series of post-traumatic obsessive compulsive disorder: a six month follow-up evaluation. *Journal of Korean Neuropsychiatric Association* 45, 476-480.

Beck AT, Epstein N, Brown G & Steer RA (1988). An inventory for measuring clinical anxiety: psychometric properties. *Journal of consulting and clinical psychology* 56, 6, 893.

Beck AT, Steer RA & Brown GK (1996). *Beck Depression Inventory-Second Edition Manual*. The Psychological Corporation, Harcourt Brace & Company, San Antonio, TX.

Bernstein EM & Putnam FW (1986). Development, reliability and validity of a dissociation scale. *Journal of Nervous and Mental Disease* 174, 727-735.

Bisson J & Andrew M (2007). *Psychological Treatment of Post-traumatic Stress Disorder (PTSD)* (Review). Wiley & Sons, Chichester.

Bohart AC & Greenberg L (2002). *EMDR and experiential psychotherapy. Experts of diverse orientations explore the paradigm prism*, pp. 239-261. American Psychological Association, Washington, DC, US.

Böhm K & Voderholzer U (2010). Use of EMDR in the treatment of obsessive compulsive disorders: A case series. V*erhaltenstherapie* 20, 175-181.

David B, Olatunji BO, Armstrong T, Ciesielski BG, Bondy CL & BromanFulks J (2009). Incremental specificity of disgust sensitivity in the prediction of obsessive-compulsive disorder symptoms: Cross-sectional and prospective approaches. *Journal of behavior therapy and experimental psychiatry* 40, 4, 533- 543.

De Jongh A, & Ten Broeke E (1998). Treatment of choking phobia by targeting traumatic memories with EMDR: A case study. *Clinical Psychology & Psychotherapy* 5, 264-269.

Dell'Anna A (2015). *Stress post-traumatico: diagnosi e psicoterapia di urgenza*. Psychofenia XVIII, 32, 183-208.

Dèttore D, Pozza A & Coradeschi D (2013). Does time-intensive ERP attenuate the negative impact of comorbid personality disorders on the outcome of treatment-resistant OCD? *Journal of Behavior Therapy and Experimental Psychiatry* 44, 411-417.

Dorz S, Novara C, Pastore M, Sica C & Sanavio E (2009). Presentazione della versione italiana dell'obsessive beliefs questionnaire (OBQ): Struttura fattoriale e analisi di attendibilità. *Psicoterapia Cognitiva e Comportamentale* 15, 139-170.

Dykshoorm KL (2014). Trauma-related obsessive-compulsive disorder: a review. *Health Psychology and Behavioral Medicine* 2, 517-528.

Fensterheim H (1996). Eye movement desensitization and reprocessing with complex personality pathology: An integrative therapy. *Journal of Psychotherapy Integration* 6, 27-38.

First MB, Gibbon M, Spitzer RL, Williams JBW & Benjamin LS (1997). *Structured Clinical Interview for DSM-IV Axis II personality disorders* (SCID-II). American Psychiatric Press, Washington, DC.

Fernandez I, Maslovaric G, & Galvagni MV (2011). *Traumi psicologici, ferite dell'anima: il contributo della terapia con EMDR*. Liguori, Napoli.

First MB, Spitzer RL, Gibbon M & Williams JB (1995). *Structured Clinical Interview for DSM-IV Axis I disorders-Patient edition* (SCID-I/P, version 2.0). Biometrics Research Department, New York.

Foa EB, Yadin E & Lichner TK (2012). *Exposure and Response (Ritual) Prevention for Obsessive-Compulsive Disorder*. Oxford University Press, New York.

Gershuny BS, Baer L, Parker H, Gentes EL, Infield AL, & Jenike MA (2008). Trauma and posttraumatic stress disorder in treatment-resistant obsessive-compulsive disorder. *Depression and Anxiety* 25, 69-71.

Gershuny BS, Cloitre M, & Otto MW (2003). Peritraumatic dissociation and PTSD severity: do event-related fears about death and control mediate their relation? *Behaviour Research and Therapy* 41, 156-166.

Ghisi M, Flebus GB, Montano A, Sanavio E & Sica C (2006). *Beck Depression Inventory-Second Edition.* Adattamento italiano: Manuale. Organizzazioni Speciali, Firenze.

Gonzalez A & Mosquera D (2012). *EMDR and Dissociation: the progressive approach*. Second edition (revised). Ed Pléyades, Madrid.

Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, Heninger GR & Charney DS (1989). The Yale-Brown obsessive–compulsive scale, I: development, use and reliability. *Archives of General Psychiatry* 40, 1006-1011.

Grimmet J, Galvin DM (2015). Clinician Experiences with EMDR: Factors Influencing Continued Use. *Journal of EMDR Practice and Research* 9, 1.

Huppert JD, Moser JS, Gershuny BS, Riggs DS, Spokas M, Filip J, ... & Foa EB (2005). The relationship between obsessive–compulsive and posttraumatic stress symptoms in clinical and non-clinical samples. *Journal of Anxiety Disorders* 19, 127-136.

Korn DL & Leeds AM (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *Journal of Clinical Psychology* 58, 12, 1465-1487.

Kozak MJ & Foa EB (1997). *Mastery of obsessive-compulsive disorder: A cognitive-behavioural approach.* The Psychological Corporation, Hartcourt Brace Company, San Antonio, TX.

Liotti G (2001). *Le opere della coscienza*. Cortina, Milano.

Liotti G & Costantini M (2011). La dissociazione nel disturbo ossessivo-compulsivo: una rassegna critica. *Cognitivismo Clinico* 8, 1, 47-59.

Lochner C, Seedat S, Hemmings SM, Kinnear CJ, Corfield VA, Niehaus DJ ... & Stein DJ (2004). Dissociative experiences in obsessive-compulsive disorder and trichotillomania: clinical and genetic findings. *Comprehensive Psychiatry* 45, 384-391.

Maffei C, Fossati A, Agostoni I, Barraco A, Bagnato M, Donati D, Namia C, Novella L, & Petrachi M (1997). Interrater Reliability and Internal Consistency of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), Version 2.0. *Journal of Personality Disorders* 11, 279-284.

Mancini F (2016). *La Mente Ossessiva.* Raffaello Cortina Editore, Milano.

Marcus SV, Marquis P, & Sakai C (1997). Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy* 34, 307-315.

Marr J (2012). EMDR Treatment of obsessive-compulsive disorder: Preliminary research. *Journal of EMDR Practice and Research* 6, 2-15.

Mazzi F, Morosini P, De Girolamo G, Lussetti M & Guaraldi GP (2000). SCID-I—*Structured Clinical Interview for DSM-IV Axis I Disorders* (Italian Edition). Giunti OS: Firenze.

Mazzi F, Morosini P, De Girolamo G, & Guaraldi GP (2003). *SCID-II-Structured Clinical Interview for DSM-IV Axis II Personality Disorders, Italian Version*. Organizzazioni Speciali, Firenze.

Nacasch N, Fostick L, & Zohar J (2011). High prevalence of obsessive–compulsive disorder among posttraumatic stress disorder patients. *European Neuropsychopharmacology* 21, 876-879.

Nazari H, Momeni N, Jariani M & Tarrahi MJ (2011). Comparison of eye movement desensitization and reprocessing with citalopram in treatment of obsessive-compulsive disorder. *International journal of psychiatry in clinical practice* 15, 270-274.

Neborsky R & Solomon MF (2001). *The challenge of short term psychotherapy*. Short-term therapy for long-term change, 1-15.

Obsessive Compulsive Cognitions Working Group (2005). Psychometricvalidation of the Obsessive Belief Questionnaire and Interpreta-tion of Intrusions Inventory–part 2: factor analyses and testing of a brief version. *Behaviour Research and Therapy* 43, 11, 1527-1542.

Onofri A (2010). Pensare la mente del padre. Psicoterapia Cognitiva orientata dalla Teoria dell'Attaccamento e approccio EMDR: un caso clinico di Disturbo Ossessivo Compulsivo. In Luigi Onnis (a cura di) *Attaccamento. Una teoria ponte per la psicoterapia*. Bollati Boringhieri, Torino.

Pallanti S & Quercioli L (2006). Treatment refractory obsessive compulsive disorder: methodological issues, operational definitions and therapeutic lines. *Progress in Neuopsychopharmacology and Biological Psychiatry* 30, 400-412.

Parnell L (2007). *A therapist's guide to EMDR.* Norton & Company, New York.

Pinto A, Pinto AM, Neziroglu F & Yaryura-Tobias JA (2007). Motivation to change as a predictor of treatment response in obsessive compulsive disorder. *Annals of Clinical Psychiatry* 19, 83-87.

Pollard CA (2007). Treatment Readiness, Ambivalence, and Resistance. In MM Anthony C Purdon & L Summerfeldt (eds) *Psychological treatment of OCD: fundamentals and beyond.* APA books, Washington DC.

Ponniah K, Magiati I, & Hollon SD (2013). An update on the efficacy of psychological treatments for obsessive–compulsive disorder in adults. *Journal of Obsessive-Compulsive and Related Disorders* 2, 207-218.

Pozza A, Mazzoni GP, Coradeschi D & Dèttore D (2016). Immediate outcomes after inpatient intensive CBT for severe, resistant OCD. *BPA-Applied Psychology Bulletin (Bollettino di Psicologia Applicata)* 64, 15-24.

Pozza A, Mazzoni GP, Neri MT, Bisciglia R, La Mela C, Fernandez I & Dèttore D (2014). "Tackling Trauma to Overcome OCD Resistance" (The TTOOR Florence trial) Efficacy of EMDR plus CBT versus CBT Alone for Inpatients with Resistant Obsessive Compulsive Disorder. Protocol for a Randomized Comparative Outcome Trial. *American Journal of Applied Psychology* 2, 114-122.

Rasmussen SA & Eisen JL (1997). Treatment strategies for chronic and refractory obsessive compulsive disorder. *Journal of Clinical Psychiatry* 58, 9-13.

Rothbaum BO, Astin MC, & Marsteller F (2005). Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. *Journal of Traumatic Stress* 18, 607-616.

Rufer M, Fricke S, Held D, Cremer J & Hand I (2006). Dissociation and symptom dimensions of obsessive–compulsive disorder. *European Archives of Psychiatry and Clinical Neuroscience* 256, 146-150.

Rufer M, Held D, Cremer J, Fricke S, Moritz S, Peter H & Hand I (2005). Dissociation as a predictor of cognitive behavior therapy outcome in patients with obsessive-compulsive disorder. *Psychotherapy and Psychosomatics* 75, 40-46.

Sánchez-Meca J, Rosa-Alcázar AI, Iniesta-Sepúlveda M & Rosa-Alcázar Á (2014). Differential efficacy of cognitive-behavioral therapy and pharmacological treatments for pediatric obsessive–compulsive disorder: A meta-analysis. *Journal of Anxiety Disorders* 28, 31-44.

Sanavio E (1988). Obsessions and compulsions: the Padua Inventory. *Behaviour Research and Therapy* 26, 169-177.

Sasson Y, Dekel S, Nacasch N, Chopra M, Zinger Y, Amital D, & Zohar J (2005). Posttraumatic obsessive–compulsive disorder: A case series. *Psychiatry Research* 135, 145-152.

Schimmenti A, Craparo G, Caretti V (np). Reliability and validity of the Revised Dissociative Experience Scale (DES-II) in an Italian sample. *Faculty of Human and Social Science*, Kore University of Enna.

Semiz UB, Inanc L & Bezgin CH (2013). Are trauma and dissociation related to treatment resistance in patients with obsessive–compulsive disorder?. *Social Psychiatry and Psychiatric Epidemiology* 1-10.

Shapiro F (2001). The challenges of treatment evolution and integration. *American Journal of Clinical Hypnosis* 43, 3-4, 183-186.

Shapiro F & Forrest MS (2001). *EMDR: Eye movement desensitization and reprocessing.* Guilford, New York.

Shapiro F & Solomon RM (1995). *Eye movement desensitization and reprocessing.* John Wiley & Sons, Chichester.

Sica C, Coradeschi D, Ghisi M & Sanavio E (2006). *Beck anxiety inventory*. Adattamento italiano: Manuale. Organizzazioni Speciali, Firenze. Cerca con Google.

Skarphedinsson G, Hanssen-Bauer K, Kornor H, Heiervang ER, Landro NI, Axelsdottir B, Biedilae S, Ivarsson T (2015). Standard Individual Cognitive Behavior Therapy for pediatric obsessive compulsive disorder: A systematic review of effect estimates across comparisons. *Nordic Journal of Psychiatry* 69, 81-92.

Socci C (2015). *Trauma, Cura e Protezione. Modelli interpretativi sulle esperienze traumatiche infantili intrafamiliari.* Dipartimento di Scienze Politiche, Università di Pisa.

Sookman D & Pinard G (1999). Integrative cognitive therapy for obsessive compulsive disorder: A focus on multiple schemas. *Cognitive and Behavioral Practice* 6, 351-362.

Sookman D & Pinard G (2007). Specialized Cognitive Behavior Therapy for Resistant Obsessive-Compulsive Disorder: Elaboration of a Schema-Based Model. In LP Riso, PL du Toit, DJ Stein, JE Young (eds) *Cognitive*

schemas and core beliefs in psychological problems: A scientist practitioner guide, pp. 93-109. American Psychological Association, Washington, DC, US.

Sookman D & Steketee G (2010). Specialized cognitive behaviour therapy for treatment resistant obsessive compulsive disorder. In D Sookman & RL Leahy (eds) *Treatment resistant anxiety disorders. Resolving impasses to symptom remission*, pp. 31-74. Routledge, Taylor & Francis Group, New York, London.

Sturpe DA, & Weissman AM (2002). What are effective treatments for panic disorder? (Clinical Inquiries: from the Family Practice Inquiries Network). *Journal of Family Practice* 51, 743-744.

Taylor S, Abramowitz JS & McKay D (2012). Non-adherence and nonresponse in the treatment of anxiety disorders. *Journal of Anxiety Disorders* 26, 583-589.

Tenore K & Gragnani A (2016). Il lavoro sulla vulnerabilità storica. In F Mancini (ed) *La mente ossessiva*, pp. 386-394. Raffaello Cortina Editore, Milano.

Vogel PA, Hansen B, Stiles TC & Götestam KG(2006). Treatment motivation, treatment expectancy, and helping alliance as predictors of outcome in cognitive behavioral treatment of OCD. *Journal of Behavior Therapy and Experimental Psychiatry* 37, 247-255.

Whisman M (2000, May). Treatment of obsessive compulsive disorder (OCD) with EMDR. *Presentation at the 1st EMDR Europe Association Conference,* Utrecht, The Netherlands.

Zabukovec J, Lazrove S & Shapiro F (2000). Self-healing aspects of EMDR: The therapeutic change process and perspectives of integrated psychotherapies. *Journal of Psychotherapy Integration* 10, 189-206.