Case Report: Pharmacotherapy and EMDR Psychotherapy as an Effective Treatment for OCD Imagery in a Patient with a Psychotic Disorder

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ABSTRACT

Unlike compulsive symptoms, such as washing hands, or obsessive symptoms, such as recurring thoughts of contamination, the issue of obsessive compulsive disorder (OCD) imagery receives little attention in the literature. This article describes the case of a 28-year-old male who was referred to a psychiatric day care department following complaints of intrusive imagery which he had sustained for more than a decade. The symptoms started after watching a video clip of decapitation on the internet. He also complained of intrusive thoughts with both aggressive and sexual contents. The Yale-Brown Obsessive Compulsive Scale and the Impact of Event Scale-Revised were used to assess his mental distress. During his stay in the day care department, he was diagnosed with a schizoaffective disorder and OCD. The patient was treated successfully with an antipsychotic medication for the psychotic disorder and concomitantly with selective serotonin reuptake inhibitors (SSRIs) and eye movement desensitization and reprocessing (EMDR) therapy for the OCD. This clinical case report supports the body of knowledge on the efficacy of EMDR as an adjuvant treatment to pharmacotherapy for OCD and, specifically, for OCD imagery. In addition, it supports the growing body of evidence of the beneficial effect of EMDR therapy among patients with psychotic disorders.

INTRODUCTION

Obsessive compulsive disorder (OCD) is one of the most prevalent mental disorders in high-income countries and a leading cause of disability worldwide (1, 2). The lifetime prevalence of OCD ranges from 2.3-3.8% in the general population (2-4), and it strongly affects the patient's marital and social functioning as well as quality of life (5, 6). Individuals diagnosed with OCD may have symptoms of compulsions, obsessions, or both. Obsessions are recurrent and persistent thoughts, impulses, urges, and images that are experienced as intrusive and unwanted. Those disturbing thoughts and urges provoke anxiety and distress, and lead to an individual's attempts to try to neutralize or suppress them by performing various actions (7). Those actions or behaviors are termed compulsions but often there is no realistic connection between the obsession and the compulsion (7).

In contrast to compulsive symptoms, such as washing hands, or obsessive symptoms, such as recurring thoughts of contamination, OCD imagery receives little attention in the literature. The persistence of images is one of the criteria of OCD, and patients with OCD complain about significant suffering which accompanies those images (8, 9). Most of the images are visual, but there are also reports about their having olfactory, auditory, and gustatory qualities (9, 10). OCD imagery has also been related to past memories (9), and the images were memories of earlier negative or unpleasant events among two-thirds of the patients with OCD mental imagery in several reports (11, 12).

Patients experience those images extensively and vividly similarly to the way posttraumatic stress disorder (PTSD)

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patients experience intrusive memories (12). The predominant content of the recurring images concerns harm to others and, in addition to the mental distress which those images cause, patients who suffer from such symptoms perceive themselves as being dangerous (8, 13, 14).

Clomipramine, a tricyclic antidepressant, was shown to be of benefit to OCD patients in the early 1980s, but side effects limited its use as a first-line treatment (15). Since then, many studies confirmed the efficacy of selective serotonin reuptake inhibitors (SSRIs) for the pharmacological treatment of OCD (16, 17). This class of drugs is the first-line pharmacological treatment of OCD because of proven efficacy and because of relatively benign side effects (18). Exposure and response prevention (ERP) and cognitive-behavioral therapy (CBT) comprise the recommended treatment for OCD by major health organizations (7, 19), and numerous studies support its efficacy (20-22). The combination of SSRIs with CBT is considered a first-line treatment for OCD (18). However, the studies which examined pharmacological and psychological studies did not include patients who suffer from OCD imagery, and there is currently no recommended psychological treatment for this type of OCD.

EMDR treatment of OCD has been receiving growing attention during the past decade, with EMDR therapists having reported successful treatment of obsessions and compulsions using adaptations to Shapiro's phobia protocol (23-25). Patients who received ERP combined with EMDR therapy reportedly showed a symptom reduction rate of 60%, revealing EMDR as being a useful and motivating treatment method (26). In a randomized trial, EMDR therapy was significantly more effective in improving OCD symptomatology in patients who concomitantly received citalopram in comparison to those who received 12 sessions of EMDR therapy alone (27). EMDR has also been found effective in the treatment of patients who had been previously treated with CBT but continued to suffer from OCD (28). The treatment targeted patients' past aversive life experiences or intolerance of uncertainty, and it was found to have led to significant symptom reduction of OCD, depression, dissociation, and generalized anxiety disorder at the three-month follow-up (28).

Strong support for EMDR treatment for OCD came from another randomized controlled trial in which patients received either EMDR therapy or CBT, both with comparable completion rates and clinical outcomes (29). The combination of EMDR therapy and CBT has also been used successfully for the treatment of obsessions of contamination and aggression (30). A combination of EMDR therapy, CBT, and psychodynamic psychotherapy was recently found to be effective for treating OCD imagery (31). Specifically, EMDR therapy was used to treat intrusive images which appeared following watching a brutal scene on TV, cognitive therapy was used to treat cognitions of violent behavior, and ERP was used for reducing avoidance of sharp objects (31).

However, in none of those papers describing EMDR treatment of OCD were patients diagnosed concomitantly with a psychotic disorder. The purpose of the current work is to describe the treatment of a psychotic patient referred to a day care psychiatric department in a general hospital following complaints of recurrent and disturbing violent images.

PATIENT INFORMATION

Ben (pseudonym), a 28-year-old single male, was referred to a day care psychiatric department because of resistant OCD. He was born in an Eastern European country and immigrated with his family to Israel when he was 10 years old. He described having experienced bullying from his peers and violence by his parents. At the age of 16 years, following a friend's recommendation, he watched a movie clip of beheading on a horror website and reported feelings of anxiety and flashbacks in addition to panic attacks whenever he recalled that video. Ben managed to graduate from high school despite being undiagnosed with learning difficulties and was drafted into the army. He served as a truck driver and finished the three-year compulsory service with only a few behavioral incidents of arguments with his superiors.

After his demobilization, he studied applied engineering during which he was diagnosed again with learning difficulties. After graduation, he worked in a factory and, at the age of 25, he sought consultation with a psychologist with complaints of panic attacks, flashbacks, and aggressive thoughts that led him to minimize his social interactions. Ben thought that his co-workers and the people he saw on the street may suddenly attack him or that he may attack them, and he missed many working days as a result. The psychologist used prolonged exposure (32) that led to some improvement in Ben's mental condition; however, he continued to suffer from flashbacks and aggressive thoughts, but he felt that he could talk more openly about the video. He then turned to a psychiatrist who prescribed 10 mg of aripiprazole that helped him feel more relaxed but provided no relief from the mental distress.

CLINICAL FINDINGS

Ben resigned from his job since he felt that he was not competent enough to hold down a steady job. He felt stressed when sharp objects, such as scissors or knives, were around him. Still looking for an effective psychological treatment, he turned to a psychological clinic of a local university where he was treated for one month without any improvement. He was then referred to our psychiatric day care department. Ben's sexual obsessions were about attraction towards adolescent girls in tight clothing. He reported that he had never tried to force himself on women. His aggressive thoughts were about possible violence that may suddenly erupt with strangers he saw on the street: he thought that they may suddenly attack him or that he may suddenly attack them. His thoughts were ego-dystonic.

In addition to the symptoms described above, the patient presented with ongoing delusions of reference and grandiosity, along with depressed mood, low interest, low energy, feelings of hopelessness, and suicidal ideation. Upon questioning, he revealed that those symptoms have been present throughout the past decade. He also noted that he had experienced delusions of persecution lasting for about six months prior to the treatment with aripiprazole. He also suffered from severe depressive symptoms as well as hypomanic episodes during that period. There were periods of time during which ideas of reference and grandiosity were present, without significant affective symptoms, throughout the patient's history and during the time he was under our supervision and treatment. Based on these findings, a diagnosis of schizoaffective disorder was made in addition to the diagnosis of OCD.

DIAGNOSTIC ASSESSMENT

The following questionnaires were administered at the beginning of the treatment, at the end of the treatment, six months posttreatment, and one year after the end of treatment. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (33) is considered the "gold standard" for measuring both OCD symptomatology severity and treatment response (34, 35). This questionnaire includes five rating dimensions for compulsions and obsessions, and each item is scored on a 4-point Likert scale from 0 = no symptoms to 4 = extreme symptoms. The total sum of the first five items comprises the severity index for obsessions, and the total sum of the last five items comprise the index for compulsions. Ben scored 19 (out of 20 possible points) on the obsessions scale (indicative of moderate OCD) and 3 on the compulsions scale.

The Impact of Event Scale—Revised (IES-R) (36) is a self-report questionnaire that assesses various PTSD symptoms experienced in the past seven days. This measure consists of 22 items rated on a 5-point scale, which ranges from 0 (not at all) to 4 (extremely). The IES-R is composed of three subscales, which relate to the different posttraumatic stress symptomatology clusters of avoidance, hyperarousal, and intrusion. Several studies report a high degree of intercorrelation (37), high levels of internal

Table 1. *Patient's reports and therapeutic interventions during the treatment in the day care department*

Time	Intervention type	Patient's reports
Week 1	Clinical interview, diagnosis of schizoaffective disorder and OCD	Complaints about intrusive imagery, obsessive and aggressive thoughts, reference and grandiosity delusions, hypomanic episodes, depressive symptoms
Week 1	Diagnostic assessment	Y-BOCS=19, IES-R=65
Week 2	Fluoxetine 40 mg/d, aripiprazole 15 mg	
Week 3		Reports notable improvement of the OCD and affective symptoms
Week 4	Fluoxetine 30 mg/d	Sexual dysfunction, relief of psychotic symptoms and bothering OCD imagery
Week 5	EMDR (preparation phase)	
Week 6	EMDR (processing of disturbing image)	The patient does not see the disturbing image any longer
Week 7	EMDR (processing of disturbing image)	The patient sees a part of the disturbing image
Week 8	EMDR (processing of disturbing image)	The image does not bother the patient
Week 9	EMDR (future work)	Significant decrease in aggressive obsessions
Twelve weeks in the department (treatment completion)	Diagnostic assessment	Y-BOCS=7, IES-R=11
Six-month follow-up assessment	Diagnostic assessment	Y-BOCS=4, IES-R=6
One-year follow-up assessment	Diagnostic assessment	Y-BOCS=4, IES-R=6

consistency (36, 37), and high test-retest reliability (36). At the beginning of the treatment, Ben's total score was 65 (avoidance = 24, hyperarousal = 15, intrusion = 26). An IES-R score of 33 or more signifies the likely presence of PTSD (36, 37).

THERAPEUTIC INTERVENTION

The patient was started on 40 mg of fluoxetine with a notable improvement of the OCD and affective symptoms. The aripiprazole dose was increased to 15 mg as treatment for the psychotic features and for the possible effect of mood stabilizing after establishing the diagnosis of schizoaffective disorder. He was fully compliant throughout follow-up. After a few weeks of therapy, he complained about difficulty in reaching orgasm, and the dosage of fluoxetine was decreased to 30 mg, with partial improvement in sexual performance and to the patient's satisfaction. There were no other side effects.

The therapeutic conceptualization of this case was based on the adaptive information processing (AIP) model, which is the theoretical basis of EMDR therapy (23, 38). According to this model, life events are processed by a physiologically based information processing system and stored as memories. Those memories are linked in memory networks that contain related emotions, images, sensations, and thoughts. Experiences that cannot be processed are stored in a raw and unprocessed form. Various internal and external stimuli can trigger these unprocessed memories and thus bring about psychopathological symptoms (23, 38).

According to the AIP model, Ben's intrusive images can be understood as stemming from the inability to process the horrific video clip, as well as from earlier traumatic experiences. Based on recent reports about the effectiveness of EMDR therapy and CBT in the treatment of intrusive imagery and obsessive aggressive thoughts (30, 31), the staff considered treating him with this combination.

Following the pharmacologic treatment, Ben reported relief in his mental distress, but he still complained of the disturbing obsessive thoughts and the vividness of the intrusive imagery. The therapist described the EMDR + CBT treatment plan to him and suggested using EMDR therapy. Ben replied that he had undergone that treatment a few years earlier. He added that he underwent eight sessions of EMDR therapy and recalled that the therapist had used tappers. Following that treatment, he felt some relief, but it lasted only for a few days. The therapist suggested trying EMDR therapy again, using eye movements this time, and Ben agreed. The first phase of EMDR therapy included history taking and treatment planning, and it had already been completed earlier, so the treatment continued with the second phase of EMDR therapy, namely, preparation.

The patient received an explanation about EMDR therapy and was taught a self-relaxation technique to help him with self-regulation during the treatment (23). The preparation phase also included psychoeducation about OCD and, especially, about aggressive thoughts. Ben, like many patients with similar symptoms, was terrified that he was insane and never told anyone about his thoughts (39). He learned that having aggressive and sexual thoughts indicates that he is only human, and that individuals who pass him every day may also have the same thoughts. An important part of this treatment included reading from Baer's (39) seminal book about obsessive thoughts. When Ben read about the sexual and aggressive thoughts that other people have, he said with great excitement: "Wow! What thoughts these people have! I'm normal! All those years I thought that I'm crazy and I was ashamed of those thoughts." The therapist emphasized to Ben that he had never acted upon his thoughts, in contrast to individuals who do act upon their thoughts.

The therapist considered starting EMDR therapy with the processing of an earlier traumatic but not highly disturbing event. Ben was asked to relate a disturbing traumatic experience from his past. He had suffered from abuse at home and from bullying from his peers, but he did not see those events as disturbing. He said that he was a child and thought that those bullies are now sorry for their actions. He rather preferred to focus on the disturbing memory of the horror video at age 16, since it was the major source of distress in his life.

Assessment is the third phase of EMDR therapy, during which the therapist identifies the components of the targeted memory (23). The image which had represented the hardest moment for Ben was the one in which one man cut the throat of another man and blood spurted all over the place. On the Subjective Units of Disturbance (SUD) scale of 0–10, Ben ranked this memory as SUD = 6, and the Negative Cognition (NC) associated with this memory was "I'm helpless." The Positive Cognition (PC) was "I survived," and the Validity of Cognition (VoC) was 7. PC is an empowering self-assessment that incorporates the same theme as the patient's negative issue, and they should be related to the same thematic domains (23). However, in this case, the patient's NC was related to the control domain, whereas the PC was

related to the safety domain. In this context, Shapiro (23, p. 128) notes that "exceptions to this guideline may be made when the overriding feeling of fear in regard to a traumatic incident is the primary manifestation of the dysfunction. In this case, an appropriate positive cognition might simply place the incident firmly in the past, since the constant intrusions and current state of fear are the most troublesome aspects of the event." She also adds that useful positive cognitions in such cases might be: "It's over, I'm safe now" (23), which, in this case, was indeed Ben's positive cognition.

A second interesting point relates to the high rating of the VoC. Patients usually report a VoC lower than 6 or 7, and Ben reported a VoC of 7. As such, the therapist followed the recommendation that appears in the EMDR literature and asked about the gut-level feeling of the PC (40, 41). Ben explained that any remembrance of the traumatic event has for years been associated automatically with a physical feeling of fear. He said that he becomes highly anxious when he watches TV and the broadcaster suddenly begins to talk about decapitations and terror organizations. He also avoids reading newspapers and fears seeing disturbing images of executioners with swords or prisoners. Ben added that he feels proud of himself because he thought many times of suicide but managed to survive despite the intrusive image. He was asked several more times to think of the image and pay attention to the gut-level feeling of the PC, although he insisted on a VoC of 7.

During desensitization, the fourth phase of the standard EMDR protocol for a single traumatic event, the therapist leads the person in eye movement sets until his SUD are reduced to zero (SUDs of 1 or 2 can sometimes be more appropriate). After the first two sets of bilateral stimulation (BLS), Ben reported feelings of pressure in his chest. After two additional BLS sets, he had difficulty in visualizing the disturbing image. During the ensuing sets, he reported experiencing headache, nausea, and, relaxation, and after a dozen BLS sets, he suddenly moved away from the therapist and asked him "what had just happened."

The therapist did not understand and asked Ben to explain. Ben said that he was shocked since all he can see of the disturbing image is a stain. He asked to stop the session, not because of distress, but because he wanted some time to understand what had just happened. The therapist explained that patients report on similar experiences during EMDR therapy, and reflected that he understood that Ben needed sometime to process his experience. At the end of this session, the SUD was 3, and Ben was commended for the effort he had made. In addition, he was told that the processing may continue after the session, and he was instructed to notice new insights, thoughts, memories, or dreams, and to report them during the next session.

At the beginning of the second session, Ben reported that he felt encouraged to continue. The picture that had represented the hardest moment continued to be in the form of a stain, and that the PC and the NC were also the same. The VOC of the PC was 7, and he ranked this memory as a SUD of 5. During the desensitization phase, he again reported various physical sensations and, at the end of the session, he reported that all he could still see of the threatening image was the hand of the executioner. The session ended with a SUD of 2, and, as in the previous session, the procedure for closing down an incomplete session was performed.

At the beginning of the third session, the image that had represented the hardest moment was the same, as were the PC and the NC. The VOC of the PC was again 7, and he ranked this memory as a SUD of 2. During this session, the image sometimes appeared more clearly and sometimes became blurred. After 20 minutes, Ben reported that he could look through the image as though it were transparent, and that it did not bother him. After a few additional sets, he reported the same results, and the session ended with SUD of 0. This session continued with the installation of the PC (the fifth stage of EMDR therapy), body scan (sixth stage), and closure (seventh stage).

In the next session, the therapist continued with the eighth stage of the protocol, re-evaluation, to check whether the positive results had been maintained. Ben said that he did not suffer from intrusive imagery anymore, and the therapist switched the focus to a future concern. The aim of future work in EMDR therapy was to prepare patients for confrontation with anxiety-eliciting situations, and Ben chose to work on a hypothetical situation in which a person who enters a bank and pushed in front of Ben who has been waiting patiently in line. Ben feared that any possible comment towards people who go ahead of him will lead to violence and therefore avoided making any comment in such situations and even avoided waiting in line.

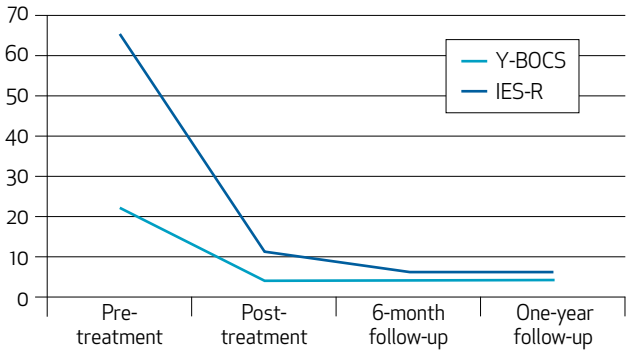
In the subsequent session, the therapist wanted to start the preparation for ERP. However, Ben reported that the amount of the aggressive thoughts decreased significantly and that they did not bother him at all. He said that he rarely feels that the situation may turn aggressive when he stands next to people, but when he does, the feeling lasts

for only a few seconds and that it does not bother him. He also commented that he feels "like a human being again" and that he feels competent to work again. He was advised to work on his checking compulsions, but he declined the offer saying that they do not bother him very much.

FOLLOW-UP AND OUTCOMES

Questionnaires were administered again at the end of treatment, six months posttreatment and one year after the end of treatment. At the end of the three month treatment in the day care department, Ben's total score on the Y-BOCS was reduced to 7 from his pre-treatment score of 19. His total score on the IES-R was 11 (intrusion = 2, avoidance = 5, hyperarousal = 4). The results were comparable at six-month and one-year follow-up assessments: Y-BOCS = 4 and IES-R = 6, indicative of subclinical OCD and minimal symptoms of posttraumatic stress (Figure 1).

Figure 1. *One-year follow-up of Ben's Y-BOCS and IES-R scores*



DISCUSSION

A major concern before administering EMDR therapy was the "harm hypothesis," which is the assumption that talking about their traumatic experiences will most likely result in adverse events among patients with severe mental disorders (42). The day-care staff decided to proceed with EMDR therapy based on a number of reasons. First, the "harm hypothesis" is not supported empirically (43-46). Second, there is a growing body of evidence of EMDR therapy's beneficial effect among patients with psychotic disorders (45-47). Third, the patient was seen on a daily basis by various staff members in the department, whereupon pharmacological and psychotherapeutic interventions could be promptly provided if needed.

This case description demonstrates how combined pharmacological and psychotherapeutic interventions can be implemented in various stages of treatment of a complex disorder. Systematic reviews of randomized controlled trials emphasized that the combination of pharmacological and psychotherapeutic interventions is likely to be more effective than psychotherapeutic interventions alone in severe OCD (48, 49). A combination of pharmacological intervention and EMDR therapy had been found useful in OCD treatment (27), and clinicians who look for a psychotherapeutic intervention to combine with the pharmacological one should consider integrating EMDR therapy to the treatment since EMDR therapy and CBT have comparable completion rates and clinical outcomes in treatment of OCD (29).

Following the EMDR therapy intervention, the patient described here reported a sharp decrease in the severity and the disturbance level of his obsessive thoughts, and reported that those thoughts no longer bother him. This article contributes to the body of knowledge that emphasizes the significant role of traumatic experiences in the etiology of OCD (9, 50-53). Similar to this case, two studies that dealt with OCD imagery and obsessive aggressive thoughts found that the patients had suffered from physical abuse or bullying as children (30, 31). The current case also provides additional support to reports that suggested that eye movements are superior to other bilateral stimuli (54, 55).

Clinicians who treat OCD patients should inquire about traumatic experiences in the patient's history since they may play a significant role in the development of the disorder. Once such memories have been identified, they can be targets for processing, in addition to the memories of the current complaint (in the current case, watching a horrific TV scene or a frightening video clip on the internet). Since EMDR therapy can be useful in both reducing OCD imagery and obsessive thoughts, clinicians should consider combining it with pharmacological treatment. Randomized controlled trials on EMDR therapy among OCD patients with OCD obsessions in general and OCD imagery in particular are warranted.

PATIENT PERSPECTIVE

Following the pharmacologic treatment, Ben reported relief in his mental distress, but he still complained of the disturbing obsessive thoughts and the vividness of the intrusive imagery. Following the EMDR therapy intervention, the patient described here reported a sharp

decrease in the severity and the disturbance level of his obsessive thoughts, and reported that those thoughts no longer bother him.

Informed Consent

Informed consent was obtained from the patient included in the study.

Conflicts of Interest and Source of Funding:

All three authors have nothing to declare.

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