



Short communication

A case of an unusual presentation of obsessive compulsive disorder in an adolescent

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ABSTRACT

Children and adolescents with Obsessive Compulsive Disorder (OCD) can present in atypical and unusual ways. We present the case of a 13 year old boy with an unusual presentation of OCD. He presented with irritability, aggression, poor sleep, reduced attention, hyperreligiosity, social withdrawal and disinhibition (i.e. inappropriately touching females) for 1 week and was found to have obsessional thoughts and impulses related to sex and the compulsion of seeking absolution from lord buddha. He was diagnosed as OCD after excluding organic causes, manic episode, acute psychotic episode, drug induced psychosis and sexual abuse. He initially responded to fluoxetine 20mg, olanzapine 2.5 and a short course of lorazepam. He was functioning well for 2 weeks and thus olanzapine and lorazepam were tailed off. A week later he presented with similar symptoms with the added symptoms of singing, masturbating in public and talking excessively to his mother about sex. He was found to have obsessional thoughts, impulses and images and the compulsions of reassurance seeking from his mother and seeking absolution from lord buddha. He responded to an increase in fluoxetine to 40mg and olanzapine 2.5mg. He has now remained in remission for 4 months with good functioning. This case shows that in contrast to adults, children may not recognize that their obsessional thoughts are irrational and may not be able to resist the obsessions as a result. It stresses the importance of being mindful of the atypical presentations of OCD in children to avoid misdiagnosis.

1. Introduction

Obsessive Compulsive Disorder (OCD) is characterized by repetitive thoughts, impulses, doubts or images, associated with rituals or compulsions. For a definitive diagnosis the obsessional symptoms should be (a) recognized as the persons own thoughts or impulses; (b) there must be at least one thought or act that is still resisted; (c) the thought of carrying out the act must not in itself be pleasurable and (d) the thoughts, images or impulses must be unpleasantly repetitive (World Health Organization, 1993). OCD has an estimated prevalence of 0.25–4% among children and adolescents (Heyman et al., 2003; Douglass et al., 1995; Geller and March, 2012).

There is a great deal of heterogeneity in the presentation of OCD symptomatology (Sarvet, 2013). OCD in children and adolescents differ from adults in that children do not show egodystonicity, rarely have pure obsessions without compulsions, and commonly have pure compulsions often with hidden or poorly articulated obsessions (Geller et al., 2001; Williams and Shafran, 2015). Furthermore, children are less likely to have insight into the irrationality of their obsessions and

compulsions presumably due to underdeveloped meta-cognitive skills (Geller et al., 2001; Hanna, 1995; Krebs and Heyman, 2015). The common obsessions described in children and adolescents include a fear of a catastrophic family event, fear of contamination, sexual and somatic obsessions, and excessive scruples/guilt (Geller et al., 2001). Washing, repeating, checking and ordering are described as common compulsions (Geller et al., 2001). Rituals such as verbal checking with parents to gain reassurance are also frequent (Geller and March, 2012). The presentation can be so atypical and unusual in children and adolescents that it may lead to misdiagnosis or delay in diagnosis (Mohapatra and Rath, 2016). Previous literature described OCD in children and adolescents being misdiagnosed as schizophrenia and treated with antipsychotics leading to unwarranted side effects (Mohapatra and Rath, 2016; Marsanić et al., 2011). Fireman et al has reported that diagnosis is on average, delayed for 3 years since the onset of symptoms (Fireman et al., 2001) which lead to greater functional impairment and poorer outcomes (Westwell-Roper and Stewart, 2019). Therefore, being aware of the atypical presentations of OCD in children and adolescents is critical in ensuring optimal outcomes for

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children and adolescents.

We present a case of OCD with an unusual presentation in an adolescent, which not only posed a diagnostic challenge but was also difficult to differentiate from other causes of acute behavioural disturbances.

2. Case presentation

A 13 year old boy was brought to the Child and Adolescent Mental health Services by his mother, complaining of irritability, poor sleep and aggressive behaviour for 1 week, which were progressively worsening. He had no history of disruptive behaviour in the past but had punched a classmate two days back over a trivial matter, and had not been to school since. His teacher had complained that he was inattentive. He had also started worshipping the Buddha frequently and had left the classroom on several occasions to worship. Mother reported that he became withdrawn and hardly spoke to anyone else other than her. He had been repeatedly questioning his mother about sexual activities, also for the same duration. He was noted to be restless and walking about in the house at night. The child had an uneventful antenatal history and normal development. There was no history of past psychiatric illness. He had average academic performance. There was no family history of mental illness. On mental state examination, he was restless and verbally abusive. He was agitated and was pacing about, stopping to worship at times. He was disinhibited and was touching female staff inappropriately. It was difficult to build a rapport. His speech was increased in rate and volume, but was coherent and relevant. His mood was irritable. When inquired the reason for worshipping the Buddha excessively he replied that he wanted to be a “good boy”. When asked for the reasons why he felt that he was not a “good boy”, he claimed that he was having recurrent thoughts about sex and having impulses to touch females. He described these as his own thoughts and impulses that he could not resist. Due to the egodystonic nature of the thoughts, it was decided that he was having obsessional thoughts and impulses with the compulsion of repeatedly worshipping the Buddha. He denied having any delusions or perceptual disturbances. His behavioural changes were believed to be a manifestation of distress associated with obsessional thoughts.

He was managed as an inpatient and manic episode, organic causes, acute and transient psychotic episode and drug induced psychosis were considered in the differential diagnosis. Basic investigations including an EEG and urinary drug screen were done, which were normal. A possibility of sexual abuse was also entertained but there was no forthcoming evidence. He was commenced on Fluoxetine 20 mg, and a short course of lorazepam 0.5 mg bd and olanzapine 2.5 mg to manage his agitation. Within 2 days of starting on medications his sleep, irritability, agitation and disinhibition improved and by the end of 1 week, his mood was euthymic. He reported a reduction of repetitive thoughts and also stopped worshipping. He was discharged home on fluoxetine 20 mg and olanzapine 2.5 mg while lorazepam being tailed off. At the 2 week review he functioned well with minimal symptoms. Thus olanzapine 2.5 mg was stopped and he was continued on fluoxetine.

7 days later, he presented with irritability, repeated singing and describing about sexual activities to his mother. He was readmitted and was observed to be restless, pacing about, repeatedly singing, and engaging in masturbating in the ward. He did not speak to anyone other than his mother. He had poor eye contact, poor rapport, had no spontaneous speech and gave one word answers to questions. His mood was dysphoric. He reported that he had recurrent thoughts of sexual activities and impulses to masturbate. He also described repeatedly seeing images of people engaging in sexual activities, which he kept describing to his mother. He could not elaborate further about the nature of these thoughts or images. It became clear that he was experiencing obsessional thoughts, impulses and images, which he was not able to resist and the associated irritability and poor sleep were manifestations of his distress. His fluoxetine was increased to 40 mg and olanzapine 2.5 mg

and lorazepam 0.5 mg bd was again added. Due to the acute and severe nature of his obsessive symptoms, an Anti Sterptolysin O Titre (ASOT) was done with the Paediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infection (PANDAS) in mind, which was normal. He showed marked improvement with the increase in medication. Within the next 5 days he was free of obsessional symptoms and his irritability reduced. Once his distress was reduced, he admitted that he engaged in repetitive singing as a method of distraction from his thoughts and talking to his mother about sexual activities was a form of reassurance seeking.

During follow-up lorazepam was tailed off. He has remained in remission for 4 months with good functioning with fluoxetine 40 mg and olanzapine 2.5 mg.

3. Discussion

The patient we presented was unusual as he acted on his obsessional thoughts and impulses. On the first presentation he was inappropriately touching females and on the second occasion he was masturbating in the ward. Previous literature has described that the risk the patient will act on an obsession is not a concern as there are no recorded cases of persons with OCD carrying out their obsession, due to the unacceptable and ego-dystonic nature of the obsession (Rothenberg, 2003). However, children and adolescents are known to lack insight into their obsessions and that may have led our patient to act on his thoughts and impulses.

Differentiating OCD from a manic episode was another challenge we faced. He presented with irritability, aggression, agitation, poor sleep, hyper-religiosity, singing and disinhibition, all of which were consistent with a manic episode. Nevertheless, previous literature has described that anxiety has a unique presentation in children and adolescents (Siegel and Dickstein, 2012) and that adolescents are more likely to present with behavioural manifestations of anxiety such as defiant behaviour (Frick et al., 1999). In addition, there is evidence that rage attacks (i.e. recurrent episodes of explosive anger or aggression triggered by minor provocations) can accompany OCD in children and adolescents (Storch et al., 2011, 2012). A study carried out in Sri Lanka has found that 53.1% of adolescents who assaulted their parents had obsessional thoughts (Perera, 2006). Youth with OCD who exhibited rage episodes were found to experience greater obsessive compulsive symptom severity, increased frequency of sexual, religious, and aggressive obsessions, as well as checking rituals relative to those without rage (Storch et al., 2011), which was consistent with the theme of obsessions in our patient. Rage attacks are thought to provide distraction from OCD-related stimuli or reduce internal distress (Storch et al., 2012).

Similarly, although hyper-religiosity occurs in manic episodes, it is also described in OCD where prayers and rituals for purification and absolution occur as a compulsion with obsessions related to forbidden thoughts of sex and violence (Sarvet, 2013).

The possibility of sexual abuse in this patient was also considered due to the sexualized behaviours. However, there was no history suggestive of sexual abuse. Earlier studies have suggested that when assessing children with sexual obsessions, clinicians should be aware about the possibility of sexual abuse (Rothenberg, 2003). It has been described that in contrast to adolescents with sexual abuse, those with pure obsessions did not show affective change when discussing this possibility or seem burdened by a ‘secret’. In addition, family relationships of children with sexual obsessions were good, unlike those commonly seen with abuse. Furthermore, symptoms of OCD improved quickly when the children received appropriate treatment (Healy et al., 1991), in contrast to children who have suffered sexual abuse, which was also the case in our patient.

Previous literature has shown that up to two thirds of children and adolescents with OCD meet criteria for at least one additional diagnosis (Peris et al., 2017). However, the adolescent we presented did not have any other comorbid mental illness. Recent studies have shown that the

presence of comorbidities were related to the age of the child, with adolescents (14–17 years) having more comorbidities compared to preadolescents (10–13 years) and children (7–9 years) (Peris et al., 2017). The younger age may be the reason for the adolescent we discussed to have no comorbidities.

Treatment of OCD in children and adolescents is also a challenge faced by clinicians. Lack of insight about the OCD symptoms in children and adolescents makes parental involvement essential in the management (Neziroglu and Fruchter, 2018). Parental involvement is particularly important for younger children who have unique developmental needs and rely heavily on their caregivers. As children lack insight into the nature of their symptoms, they are more likely to comply with therapy when external reinforcers are added. Therefore, parents need to be trained on behavioural management strategies such as implementing reward systems, modeling and ignoring behaviours that are reinforced by attention (Freeman et al., 2014). With regard to pharmacological treatment, unlike in adults, the available data on management of refractory OCD in children and adolescents is limited and augmenting and alternative treatment strategies have less evidence in children than in adults (Geller and March, 2012).

This case report highlights that diagnosing OCD in children and adolescents can be challenging due to the unusual presentation. Clinicians should be mindful about the atypical presentations of OCD in this population to avoid misdiagnosis.

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Conflict of interests

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