

Preschool Onset of Obsessive-compulsive Disorder: A Case Report

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ABSTRACT

Preschool onset of obsessive-compulsive disorder (OCD) is rare with limited studies on it and with multiple diagnostic and treatment quandaries. We report a case of 5-year-old girl who had obsessive-compulsive symptoms since 4 years of age. She was diagnosed based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria after eliminating other potential diagnoses. She showed good response to a combination of parent-assisted exposure and response prevention therapy and fluoxetine. This case brings into focus the distress associated with very early onset of OCD and discussion of differential diagnoses and treatment options for it.

Keywords: Differential diagnoses, Exposure and response prevention therapy, Obsessive-compulsive disorder, Preschool onset.

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INTRODUCTION

Pediatric obsessive-compulsive disorder (OCD) is a chronic and disabling disorder with impact on social, familial and academic functioning.¹ Estimated prevalence of OCD in 5–7 years is 0.3% with male preponderance.² Recent studies show that younger age of onset is associated with more symptom severity and poorer outcomes.^{3–7} Preschool onset of OCD is rare and existing literature mainly comprises case reports.^{8,9} No specific diagnostic or management guidelines exist and long-term course and outcomes in pediatric OCD are unknown.

We described a case of preschool onset of OCD in 5-year-old girl with good initial response to interventions used. Informed consent was obtained from the patient's parents and informed assent taken from the patient and her parents regarding the publication of this case report. The reporting of the case was approved by the Institute Ethics Committee.

CASE DESCRIPTION

The case report is of a girl aged 5 years and 4 months old brought for psychiatric consultation for temper tantrums when her mother did not comply with her wishes for performing certain repetitive behaviors for one and half years. The girl's symptoms had started abruptly after bout of fever associated with a sore throat. The fever was low-grade, intermittent and responded to paracetamol. It was not associated with rash, cold, cough, and altered cognitive status.

The child insisted on her clothes being worn just right. She would make her mother undress and again dress her nearly six to seven times until she felt satisfied that she was dressed properly. If her mother tried to refuse to dress her repeatedly while reassuring her that her clothes were proper, the child would start crying, screaming, and hitting her mother with her hands until mother gave in her wishes. The child would be late for school and frequently miss school as a consequence of her behavior. The child would also avoid going to the toilet because she was apprehensive that she would spoil the arrangement of her dress, or that her dress would inadvertently touch somewhere and become dirty. She also did not like anyone touching her for the same reason. Apart from this, the child also spent up to around 30 minutes each time washing her

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hands with soap and water up to 3–4 times a day as she complained that they were dirty, especially after going to the toilet, or returning home. The child also responded with tears and shouting whenever asked to go anywhere without mother as she needed her mother to rearrange her dress. The child acknowledged her behavior and admitted to the disruption of her daily schedule and activities by it but did not consider her behavior to be unreasonable and said that she has to remain clean and properly dressed to be good. Patient's behavior was reflective of obsessive symptoms regarding symmetry and contamination. Her symptoms had been consistent and progressive over time. Her symptoms were not associated with repetitive involuntary movements, hyperactivity or neurological abnormalities.

Child was born as a nonconsanguineous marriage after an uncomplicated pregnancy, full-term normal delivery at hospital with no antenatal, perinatal, or postnatal complication either in child or in the mother. Regular immunization was carried out. At birth, her weight was reportedly normal. Medical records and history suggested normal development. There was no history of neurotic behavior such as thumb sucking, nail biting, head banging, or bed wetting. The child's physical and psychological development was otherwise normal. There was no apparent family or interpersonal conflicts, which could have had an influence on the patient. There was no family history of seizures or other abnormal movements/psychiatric complaints or neurodevelopmental disorders.

Initial Assessment

Comprehensive clinical interviews were carried out with the patient and her parents. On examination, the child was well oriented and higher mental functions were age appropriate. Mini International Neuropsychiatric Interview for Children and Adolescents,¹⁰ a short structured diagnostic interview for Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) and International classification of disease- 10th edition (ICD-10) psychiatric disorders in children and adolescents was administered. Vitals were within normal limits. Her height and weight were age appropriate. Neurological and systemic examination showed no abnormalities. Children's Yale-Brown Obsessive-compulsive Scale (C-YBOCS)—parent version¹¹ and Children's Global Assessment Scale (CGAS)¹² were administered. Score on C-YBOCS was 30 with rating on most items being severe. On CGAS the score was 47, i.e., moderate degree of interference in functioning. Wechsler Preschool and Primary Scale of Intelligence—4th edition¹³ was used for formal intellectual assessment and child's composite and quotient score was 105, which is in the average range.

Laboratory tests/investigations revealed complete hemogram, blood sugar, thyroid, renal, and liver function were within normal limits. Hemoglobin (13.6 g/dL), total leukocyte count (7,800/mm³), differential leukocyte count (P60 L28 M5 E2) were within normal limits. Other blood investigations revealed normal sugar, electrolytes levels, and liver function tests. Anti-streptolysin O (ASO) titer was negative and C reactive protein (CRP) (quantitative) was 1.5 mg/L, i.e., within normal limits.

Intervention

Diagnosis of OCD with poor insight was made based on DSM-5. Parents were psycho-educated about OCD, its likely course and prognosis as well as treatment options. Treatment was started with fluoxetine 5 mg once daily and titrated gradually to 15 mg once daily over a period of 3 weeks. Once child's symptom severity had come down and C-YBOCS score had come down to 22, she was started on exposure and response prevention therapy conducted by clinical psychologist with active participation of parents. Parent management techniques were also employed.¹⁴ The patient was reexamined at 8 weeks. The patient was reassessed at 8 weeks on the scales and score on CYBOCS had come down to 14 and rating was mild on most items. The CGAS score was 65, i.e., some difficulty in a single area, but generally functioning pretty well.

Discussion

Certain differentials have to be considered before reliably diagnosing OCD in children. Children are prone to repetitive behavior and magical thinking as part of their normal development.¹⁵ They are characteristically self-limiting and nondistressing in nature. In the present case, the repetitive behaviors and underlying thoughts caused significant impairment in child's daily activities and were persistent and distressing to child and parents.

A child is not able to adequately understand the irrationality of their obsessions and compulsions. Even if appreciated it is difficult to elicit it. Degree of distress and insight may not be the same as adults. This might lead to difficulty in making a reliable diagnosis of OCD.¹⁶ Mohapatra et al. had reported a case of atypical presentation of OCD in a child that was misdiagnosed initially as psychotic disorder.¹⁷ In the present case, although the admission of irrationality could not be elicited, child showed an understanding of the harm her behavior was causing her, and demonstrated willingness to try to stop it.

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection was excluded on the basis of absence of tics, choreiform movements, and typical relapsing remitting course.¹⁸

Some degree of preoccupation with their concerns is present in anxiety disorders. Children with social anxiety disorder might be excessively concerned with their appearance due to their fear of negative evaluation and extreme scrutiny but usually the response is avoidance of situation rather than engaging in ritualistic behaviors as seen in this child. Children with separation anxiety will cling to parents, might not leave home and have a habit of reassurance seeking as seen in this child but generally themes are of fear separation or fears of harm to self or loved ones.¹⁹

Currently there are two approaches to the treatment of pediatric OCD—cognitive behavioral therapy (CBT) and pharmacotherapy with selective serotonin reuptake inhibitors (SSRI).²⁰ Family-based ERP has shown favorable outcome in some studies conducted in very young children with OCD.^{21,22} American Academy of Child and Adolescent Psychiatry treatment guidelines consider CBT or CBT + SSRI medication the first-line treatment of pediatric OCD. Cognitive behavioral therapy was not feasible in this child due to inadequate abstract development because of her young age. However, over time once rapport had been established with the child, behavioral therapy using exposure and response prevention techniques could be successfully implemented with both child and mother's cooperation.

Efficacy of SSRIs in treating pediatric OCD has been clearly established in various trials but there are no clear guidelines regarding dosage initiation, schedule and duration of treatment. In this case, the child was started on fluoxetine initially at low dose, which was later increased. The child showed initial response on this combination, indicating that preschool onset of OCD is treatable although long-term follow-up will be required to assess the long-term course and psychosocial outcomes.

CONCLUSION

Diagnosis of preschool onset of OCD requires adequate ruling out of other differential diagnoses. Early detection along with adequate and timely treatment may lead to more favorable prognosis. The development of psychotherapies molded to preschoolers and further clarification of pharmacotherapy guidelines can assist in better management of very early onset of OCD.

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