Obsessive Compulsive Disorder in a 4-Year-Old Child

Harish Kulkarni, Sudarshan C. Y.

ABSTRACT

Obsessive-compulsive disorder (OCD) is a very distressing disorder for both patient and caregiver. Usual onset of the disorder is in late second or early third decade of life. It is diagnosed in children but rarely before 5 years. A case of OCD in a 4-year-old girl is reported here. Diagnostic and therapeutic dilemmas in such a situation are discussed.

Key words: Child, obsessive-compulsive disorder, very young onset

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a disabling and distressing disorder, beginning in late second decade or early third decade of life. However, symptoms can appear in first decade sometimes as early as 2 years.

Estimated prevalence of OCD in very young children (5-7 years of age) is 0.01%, which is much lower than in general pediatric patients (0.5-4.0%). Pre-pubertal onset is more common in boys than girls, in the ratio of 2:3:1.

A case of OCD in a 4-year-old child is reported here and related diagnostic and therapeutic dilemmas are discussed.

CASE REPORT

The present case report is about a 4-year-old female child with normal physical and psychological development until date and no family history of significant physical or psychiatric illness was brought for psychiatric consultation, for excessive anger in the child when her mother did not comply with her wishes of performing or not performing certain acts, since last 2 months. Child insisted on being bathed by mother repeatedly, up to 5-6 times successively. After bathing, towel had to be wrapped symmetrically over her. She insisted on dressing herself and denied any assistance/advises in dressing up (even though she had not yet learnt to dress herself properly). She insisted on climbing or walking in a particular way; climbing each step with one foot not missing any step. She refused to be helped to climb taller steps or to cross hurdles while walking. While returning from school she had to enter the house first, followed by mother. If not she used to return and repeat it from the beginning. Only mother was allowed to touch child’s belongings with her permission. Child restrained all family members, from speaking to her unless she speaks to them. She restrained mother from speaking to anyone else apart from her, not even over telephone. Mother was also restrained from doing household work. Mother had to carry out only her instructions and activities. Child did not wish her behavior to be reported to others and sought repeated reassurance from mother about it. Mother had to describe the child’s behavior to the doctor secretly to avoid child’s anger. Child also sought repeated reassurance about her behavior not being abnormal. Any noncompliance would result in instantaneous anger which was acted upon by crying, yelling, beating-up mother, scratching mother or herself, pulling her hair and throwing things accessible at the moment like cell-phone, remote-control of television.

Department of Psychiatry, J.J.M. Medical College, Davangere, Karnataka, India

Address for correspondence: Dr. Harish Kulkarni
Department of Psychiatry, J.J.M. Medical College, Davangere - 577 004, Karnataka, India. E-mail: harish.mbbs@gmail.com
Nail-biting was also observed during such situations, which she did not have earlier. Mother had no option than following the child’s wishes, to escape from her anger. Mother was unable to adhere to all the child’s orders and felt very sad and frustrated.

There was no history of fever prior to onset of symptoms or repeated involuntary movements of face/vocal utterances. No abnormal behavior was reported in school. Biological functions were unaffected.

It took three-four visits to out-patient department to establish rapport with the child. During the interview, child expressed that her mother makes mistakes in bathing her/dressing her and hence it should be redone correctly. Her book should not be touched as some papers may fall-off from the book. She should climb steps or walk in a particular manner in order to avoid slipping into the dirt or else she has to clean herself. Morbid-preoccupation with contamination (bathing), symmetry (dressing) and pathological-doubt (reassurance-seeking) were predominant in her behavior.

Her height and weight were appropriate to age and physical examination was unremarkable. Investigations revealed a normal hemogram. ASLO titer was 5.93 IU/ml (normal levels up to 100 IU/ml). As child was unable to answer the questionnaires, mother was administered parent-versions of Children Yale-Brown Obsessive-Compulsive Scale (CYBOCS). Child OC-impact scale-revised parent-version (COIS-RP) and Problem-Behavior Checklist (PBCL). Score on CYBOCS was 34. On most of the items rating was “severe” to “extreme.” On COIS-RP score was 55 and on PBCL was 107, which was in moderate problem-behavior range.

Diagnosis of OCD was made using Diagnostic and Statistical Manual of Mental Disorders, 4th Edition criteria. Child was started on tablet escitalopram 1.25 mg/day and dose was escalated to 2.5 mg over a period of 2 weeks. Child tolerated the drug well. After 2 months of treatment above scales were re-administered to mother. Score on CYBOCS was eight. On most of the items rating was “mild” to “none.” On COIS-RP score was 10 and on PBCL child scored 90 which is in low problem-behavior.

**DISCUSSION**

While diagnosing OCD in children certain issues have to be considered. Repetitive behaviors and magical thinking which can be part of normal child development occur between age 3 and 6 years. They are self-limiting and rarely time-consuming or distressing.\(^5\) In this child the behaviors were time-consuming, interfered with her daily activities and caused distress to child and mother. Distress in OCD could be due to characteristics of the symptom such as irrationality, content, ego-alieness, social acceptability, efforts to resist and associated disability or secondary to being prevented from carrying out compulsive acts. Perception of irrationality of the symptom is associated with presence of insight. As a child’s appreciation of these features is inadequate, they may not evoke the same degree of distress as in adults. Even if appreciated, their objective elicitation is difficult. This raises the question, whether it is tenable to diagnose OCD in the absence of above features. But diagnosis of OCD can be reliably made from the age of 4-5 years.\(^6\) It is possible that a child’s perception about a given behavior being “wrong” can be equated with irrationality and inferred indirectly. This child repeatedly asked the mother “my acts are not wrong, is it?” Child also repeatedly sought reassurance about non-divulgence of her behavior and got angry whenever it was discussed with others. This indicates child’s awareness of the social unacceptability of her behavior. Hence, the diagnosis of OCD was made. Extensive literature review did not yield any reports of OCD in very young children, though children as young as four can develop full-blown OCD.\(^6\)

Children having OCD rely on their caregivers for symptom execution as they are dependent on them for physical and emotional needs. Coercive/disruptive behaviors refer to imposing rules and prohibitions on family members by the patient, due to the disorder. Coercion includes forced participation in compulsive rituals, demands to perform actions instead of the child or to refrain from certain behaviors, to avoid distress to the child and compulsive behaviors on the part of the child that negatively impact on others.\(^7\) Accommodation refers to family members’ actions to facilitate rituals, acquiesce to the child’s demands, provide reassurance, decrease child’s responsibility, assist with or complete tasks for the child.\(^8\) Parents are willing to sacrifice in order to avoid children’s anger, distress or to restore the peace to the home.\(^9\) Most parents report physical violence and/or threat by these children. The primary targets of the coercive/disruptive behaviors were mostly mothers.\(^8\)

Family members often report associated distress and impaired daily functioning. Distress is correlated with the degree to which family members are involved in the patient’s symptoms.\(^9\) Mother of this child was forcibly and extensively involved in doing the compulsive activities for the child. Any noncompliance by mother was met with verbal and physical abuse, who felt depressed. Father of this child was not targeted as he stayed away most of the time.
Cognitive-behavior therapy (CBT) is the first-line treatment for OCD in children.[10] Normal children aged 5-11 year can engage in tasks required for cognitive therapy. This is yet to be demonstrated among children with OCD.[11] The abstract concepts of CBT are difficult to communicate to a child, but children with early-onset OCD having good insight benefit from CBT.[12]

CBT was difficult in this child. She was too young to understand the concepts of CBT. Establishment of rapport was difficult in the initial visits. Even in subsequent visits, communication was restricted to areas not concerned with psychopathology. Any effort to discuss psychopathology was met with resistance in the form of deviating from the topic of discussion.

Though selective serotonin reuptake inhibitors such as fluvoxamine, sertraline and fluoxetine have been successfully used in childhood-onset OCD, there is lack of literature about dosage schedule.[13] This child was started on tablet escitalopram in very low dose which was titrated gradually. Choice of drug was based on the author’s experience with the drug as antidepressant. This resulted in significant improvement. Child continued to maintain remission for 4 months with treatment. Childhood-OCD carries poorer prognosis. Poor insight carries poor prognosis.[12] It is intended to follow-up this child to observe the long-term course and outcome.

CONCLUSION

OCD in very young children though rare and fraught with diagnostic and therapeutic dilemmas, can be reliably diagnosed. Though CBT is proposed as the first-line treatment, there are practical difficulties in administering it. Pharmacotherapy in very young children is beset with lack of literature regarding type and dose of medication. Caregivers of childhood-OCD undergo significant psychological distress due to coercion by the child and the need to accommodate for the child’s obsessive-compulsive behavior. Though this child remitted well in short-term, only continued follow-up will reveal long-term course and outcome of her illness.

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