OBSESSIVE COMPULSIVE DISORDER AND OPPOSITIONAL DISORDER
-CASE PRESENTATION-

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ABSTRACT

Obsessive–compulsive disorder (OCD) affects children and adolescents, as well as adults. OCD is an anxiety disorder characterized by intrusive thoughts that produce apprehension, fear or worry (obsessions), repetitive behaviors aimed at reducing the associated anxiety (compulsions), or a combination of such obsessions and compulsions. This paper presents a case of an eight year old patient admitted to the Child and Adolescent Psychiatry Clinic, “Prof. Dr. Al. Obregia” Psychiatry Hospital, Bucharest, for obsessive thoughts, compulsive acts, opposition, inflexible adherence to useless objects and angry fits after the parents interrupt the child’s unwanted behaviors. The data obtained from the family history, clinical examination, paraclinical investigations results and mental state evaluation were significant for DSM V–TR and ICD 10 diagnostic criteria for Obsessive Compulsive Disorder and Oppositional Disorder. Taking into account the case’s particularity, we speculate that the presence of comorbidities and the family history suggest chronicity of the disease and diagnosis stability in adulthood.

Keywords: obsessions, compulsions, opposition, family history.

INTRODUCTION

Everyone double checks things sometimes. For example, you might double check to make sure the stove or the iron is turned off before leaving the house. But people with obsessive-compulsive disorder (OCD) feel the need to check things repeatedly, or have certain thoughts or perform routines and rituals over and over again. In children the thoughts and rituals associated with OCD cause distress and hinder everyday life. Obsessions are involuntary, seemingly uncontrollable thoughts, images, or impulses that occur over and over again in the patient’s mind [1]. Compulsions are behaviors or rituals that feel driven to act out again and again. Usually, compulsions are performed in an attempt to make obsessions go away.

However, the relief never lasts. In fact, the obsessive thoughts usually come back stronger and the compulsive behaviors often end up causing anxiety themselves as they become more demanding and time-consuming [1].

CASE PRESENTATION

We report the case of an 8 year old boy suffering from Obsessive-Compulsive Disorder concomitant with Oppositional Disorder.

The patient D.T. accompanied by his parents, referred to our clinic in the first week of January 2015 for multiple obsessive thoughts (“He is afraid of time passage, because he will never again see the objects around him”, “He is always thinking of his special objects which he is afraid to lose”), compulsive acts (“He arranges objects in a certain order”, “He hides his special objects – leftovers or clothes lint, so we don’t throw them away”), opposition, inflexible adherence to useless objects (“He is searching in the trash for fear of throwing useless objects”) and angry fits after the parent interruption such behaviors.
His family history reveals:
- the mother aged 40, professor of Romanian language, rigorous, hiperprotective, she sets rules that all family must comply with.
- the father aged 42, engineer, obsessive thoughts and rituals in his youth, currently increased adherence to objects / locations ("I buy clothes, but I never wear them." “I always wear the same clothes, I hardly adapt to changes" "It’s very difficult for me to change jobs or to move in another house ").

His personal history reveals: only child, pregnancy and delivery had physiological evolution, normal psychomotor development in different stages of age, with no documented history of mental or somatic illness, he lives with his parents in an urban area and he is in II\textsuperscript{nd} grade, having very good academic results.

Information gathered from the family revealed that the apparent onset of the symptoms had taken place 3 months earlier, in the context of school change and the necessity of adapting to the new environment. The mother decided to change schools because she disagrees with the after-school system where “the child is forced to stay in the same clothes 8 hours / day”. Having a hiperprotective parenting style, the mother admits she has always had a critical behavior regarding both the child and the husband (“The child is not allowed to run in the park because he must not sweat”, in the clinic “He is not allowed to play with other children because he has to rest”).

The Mental State Examination: The patient is cooperative, self-conscious, oriented, visual and psychic contact are easily obtained, mimics and gestures mobile, consistent with his disposition. The patient doesn’t have qualitative perception disorders at the present examination, he has a normally spontaneous speech, he is centered on discussions with his mother, he has a constant tendency to contradict his parent’s replies. The obsessive thoughts and the compulsive behaviors (“He arranges objects in a certain order – the Lego game must necessarily stay on the left corner of the table”, “Our home is full of apple tabs and he knows every corner of the house where they are hided”, “He doesn’t want me to clean the house lest I Hoover the lint”, “I started hiding lints in books, so my mother can’t throw them away”) are exacerbated in the family environment; meanwhile school activities are not affected. The patient experiences irritability, oppositionist behavior especially towards his mother, constantly criticizing her imposed rules. The characteristic of a very early onset of the symptoms is the complete lack of insight of unwanted behaviors: the patient considers that obsessions are intrusive but not exaggerated, and finds an explanation for each unreasonable act.

Clinical somatic and neurological examinations were normal, laboratory tests (CBC, transaminases, ESR, CRP, TSH, T4, anti TPO, fecal exam, pharyngeal exudate, EKG) were normal. EEG line performed while the patient was awake – without pathological graphic elements. The patient performed cerebral imaging (brain MRI) which has not detected any space replacement process or abnormalities. The patient benefited from a psychological evaluation regarding his cognitive capacity (IQ=126). We didn’t consider this reassessment necessary because the school results were good and our clinical evaluation excluded a possible mental retardation. In order to assess the severity of the symptoms we applied the Children’s Yale–Brown Obsessive Compulsive Scale, which revealed a total score of 22 (moderate severity of family and occupational functioning).

The positive first axis diagnosis was set to Obsessive–compulsive Disorder and Oppositional Disorder. No data was presented to sustain a second or a third axis diagnosis. Parental Hyperprotection was set on the fourth axis The Global Assessment of Functioning scale was rated at 60/100 (moderate difficulties in family and occupational functioning).

The practitioner could potentially diagnose OCD as a somatic or neurological disease (Epilepsy, frontal tumors, intestinal parasitosis, Hypoglycemia, Hyperthyroidism, pheochromocytoma, cardiac arrhythmias, autoimmune diseases, infection with Streptococcus) but the normal laboratory tests exclude this diagnosis. OCD should be differentiated from early onset psychosis (which can begin as OCD, but bizarre compulsions and ideas are not testing reality), depressive disorders (the patient didn’t experience depression or loss of interest and joy, he continued his social and school activities), adjustment disorder (the patient did not express concern about the new school’s environment,
he did not consider his attempts to integrate in the new environment a burden, school performance has not changed), generalized anxiety disorder - exaggerated preoccupation for real life events), tics, stereotype movements (are not intended to neutralize an obsession). Oppositional disorder may be mistaken for mental retardation, behavioral disorders or ADHD but regarding the present case our assessment excluded these alternative conditions [2].

The psychopharmacological treatment that was established in the first days of hospitalization was meant to diminish obsessions and compulsions. Therefore, small doses of an atypical antipsychotic were used together with a selective serotonin reuptake inhibitors antidepressant.

During hospitalization, psychological intervention was based on teaching the patient several techniques to reduce anxiety, to block unwanted behaviors and to help him have normal thoughts. In addition, family education was performed including measures to decrease familial rigor and to encourage the child’s empowerment and accountability. [3].

At discharge, recommendations also were made in favor of cognitive behavior therapy sessions in order to help alleviate the patient’s discomfort therefore improving social and family functioning.

Evolution and prognosis. The patient’s evolution can be maintained as favorable given good compliance with the recommendations, the fact that school performance was not affected and that unwanted behaviors have been kept under therapeutic control. However, given comorbidity with oppositional disorder, the existence of a family history and the mother’s constant tendency to impose strictness, a negative outcome is expected [4].

CONCLUSIONS

The management of Obsessive–compulsive Disorder is multifaceted and coping with its symptoms can be challenging. Treating patients with Obsessive–compulsive Disorder should be a collaborative effort. In this respect, the neurologist, psychiatrist, psychologist, family members, and school professionals should be involved in therapeutic process. We believe that the present case demonstrates that it is possible to obtain an improvement of obsessive symptoms at a young age by acting in favor of psychotropic medication accompanied by psychotherapy which is an important and necessary step in the therapeutic process.

In view of case particularity, we speculate that the presence of comorbidities and loaded family history suggest chronicity of the disease and diagnosis stability in adulthood.

REFERENCES


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