

Adolescent Onset Obsessive Compulsive Disorder Presented as Dissociative Disorders: Role of Drug Assisted Interview

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Abstract

Paediatric Obsessive Compulsive Disorder (OCD) is still under-diagnosed, despite significant advances made in identifying obsessive-compulsive symptoms. The authors report a case of adolescent-onset OCD presenting as a mixed dissociative disorder. The drug assisted interview provided a breakthrough in revising the correct diagnosis of the clinical condition. The psychopathology of the patient contains sexual and aggressive obsessions without any compulsions. Adolescent OCD can present as dissociative disorders and a thiopentone interview can be helpful in revealing the distress associated with OCD.

Key Words: *Obsessive Compulsive Disorder, Dissociative Disorder, possession disorder.*

INTRODUCTION

Obsessive Compulsive Disorder (OCD) is a well-recognized anxiety disorder in adults and children (Srinath & Janardhan Reddy, 2007). The ages of onset of OCD in adults and children are 20-25 years (Karno et al., 1988) and 7.5-12.5 years (Geller et al., 1998) respectively. Knowledge of symptom presentation in paediatric OCD is scarce, which is attributed to (a) poor recall of onset (Arnold et al., 1996); (b) limited insight (Geller et al., 2001); (c) concealment of obsessive symptoms; (d) prevalent subclinical symptoms (Geller et al., 2001) and (e) long duration of untreated/unrecognised OCD (Geller et al., 2001) in this age group.

Paediatric OCD is often characterised by multiple obsessions and compulsions and its content changes over time (Swedo et al., 1989; Flament et al., 1988). Compulsions without well-defined obsessions and with poor insight are commoner in children and adolescents than adults (Rettew et al., 1992; Geller et al., 1998; Khanna, & Srinath, 1989), while mental rituals, religious, sexual, and aggressive obsessions are more common in adolescents than children and adults (Mancebo et al., 2008; Geller et al., 2001).

Furthermore, dissociative experiences are commonly reported in OCD without syndromic dissociative disorder (Lochner et al., 2004; Wolańczyk, & Bryńska, 1998). Conversely, both compulsive symptoms (Agarwal, 2006; Bieniecka, & Sulestrowska, 1982) and psychogenic seizures (Wolańczyk, & Bryńska, 1998) have also been reported in dissociative disorders. The authors of this paper report a case of adolescent-onset OCD presenting as mixed dissociative disorder (dissociative convulsions and possession attacks), which, to the best of existing knowledge, is the first case of adolescent OCD presenting as mixed dissociative disorder.

DETAILS OF THE CASE

A 17-year old-male student of class-XI, from a middle socio-economic, semi-urban area, with slow-to-warm-up temperament, and with negative past and family history, was admitted with a two-month period of complaint of abrupt onset and episodic attacks of abnormal behaviour. The first attack started with the sudden onset of anxiousness, palpitations, sweating and abdominal discomfort, followed by bizarre cyclical movements of all limbs for 10-minutes with complete awareness and

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responsiveness during the attack. A similar attack of 25 minutes occurred two weeks later along with a possession phenomenon (by a lady) lasting another 30-40 minutes, during which he did not speak, but acted like a lady, with subsequent complete recall. These dissociative episodes continued for next two months with a frequency of 2-3 attacks per week. The patient was noted to be irritable, withdrawn and avoiding college during this period. Routine haemogram, biochemical parameters and scalp electroencephalograph showed no abnormality. The patient was diagnosed with Mixed Dissociative Disorder (ICD-10).

Initial management was focussed on symptom removal and the reduction of secondary gain. In individual therapy sessions, the patient was largely un-cooperative, avoiding eye-to-eye contact, maintaining an expressionless face and therapeutic rapport was difficult to establish. The use of sertraline was initiated and gradually increased to 100 mg over two weeks. In these two weeks, the patient had four dissociative attacks without possession symptoms.

Due to unsatisfactory progress in therapy sessions and the inability of the patient to express his feelings, a drug (thiopentone)-assisted interview was planned and informed consent taken from both the patient and his father. A Few minutes before the administration of the thiopentone, the patient confided that he had been getting 'bad' sexual thoughts. Anticipating further information on bad thoughts, the thiopentone interview was aborted. Subsequently, in the next week, the patient continued to have dissociative attacks, giving no further information on bad thoughts. The thiopentone interview was therefore carried out one week later, which was successful. The patient reported having repeated sexual thoughts and images of females involving his mother over a period of 13 months, becoming distressing in the last 2 months. He also had repeated urges to kill his father, and impulses to jump down from tall buildings during the same period, all of which had an obsessive quality. Interestingly, the patient had no associated compulsions. He also reported an uncontrolled anxiety associated with these obsessions leading to the above-mentioned dissociative attacks in the last 2 months.

Following the receipt of the above-mentioned information, the diagnosis was revised to OCD - predominantly obsessions (ICD-10). The Yale-Brown obsessive-compulsive severity (Y-BOCS) scale scoring (Goodman et al., 1989) was 15/40 (15/20 in obsessions and 0/20 in compulsions).

Subsequent management was aimed at making an overt link between the dissociative attacks and the distress of the obsessions. At the end of 4 weeks, sertraline was increased to 200-mg/day and risperidone-4 mg added as an augmenting agent. At the end of the 6th week, the patient reported a significant improvement in distress and had infrequent dissociative attacks. At the end of 2 months, the patient was discharged with a Y-BOCS score of 7/40 and an absence of dissociative attacks. The patient maintained about 60 to 70 % improvement over the next two follow-ups after 2-months with sertraline and risperidone and reported no further dissociative attacks.

DISCUSSION

The onset of OCD was correlated with the onset of dissociative attacks in the last two months, despite obsessive symptoms having been present over the previous 13-months. The patient also acknowledged the same during the thiopentone interview.

The authors wish to highlight the secretive nature of these obsessions in this patient. The socio-cultural taboo of sexual obsession with the mother and aggressive obsession with the father, together with distressing thoughts of obsessive urges may explain why these obsessions are kept so secret.

Since patient initially presented with dissociative disorder, the management was aimed at dissociative attacks. When there was no improvement with this supportive approach, thiopentone interview (used as diagnostic tool) was conducted which gave a breakthrough in revising the diagnosis to OCD and resulted in paradigm shift in management plan. Drug assisted interview done on third week helped both patient to talk about stress related to secretive obsession and treating team to make definitive diagnosis and in turn directed to choose treatment modalities (in this case, directed to wait for 6-8 weeks of anti-obsessive action of sertraline). Even though psychotherapy was attempted initially for tentative diagnosis of dissociative disorder, authors feel that patient showed improvement only with pharmacotherapy despite changes occurred in definite diagnosis as OCD (because of complexity during initial presentation).

The influence of dissociative symptoms from the available literatures in the course of OCD is yet to be explored. The role of thiopentone interview in adults may be useful in dissociative disorders, but it has definitive diagnostic implication in adolescent children.

CONCLUSION

Distress associated with adolescent OCD can present as dissociative disorders. Thiopentone interview can be

helpful in revealing the distress associated with OCD, especially when there is no improvement in dissociative symptoms.

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