Case Report

Early Onset Obsessive Compulsive Disorder with Obsessive Slowness: A Case Report and Demonstration of Management

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ABSTRACT

Obsessive slowness is a rare entity and is conceptualized either as primary psychiatric illness or as part of obsessive compulsive disorder (OCD). Often its outcome is frustrating even with treatment. We report a case of early onset severe OCD with obsessive slowness which showed good response to combined pharmacotherapy and behavioral therapy.

Key words: *Behavioral intervention, management, obsessive slowness,*

INTRODUCTION

The majority of cases of obsessive compulsive disorder (OCD) begin in childhood and adolescence; but in clinical practice, early onset OCD with slowness is rarely encountered. The obsessive slowness (OS) was first described by Rachman (1974) who documented ten cases of "primary obsessive slowness".[1,2] The literature on obsessive slowness is limited and primarily deals with the diagnostic criteria, neurobiology, along with some highlights on the management. We report a case of early onset OCD with obsessive slowness, which was satisfactorily treated with combined pharmacotherapy and behavioral therapy.

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CASE REPORT

Mr. M, a 15-year-old boy from middle socioeconomic status, Hindu, nuclear family, student of eighth class, without any past medical and psychiatric illness, with anankastic traits in parents as rigidity and stubbornness, and with slow to warm premorbid temperament; presented with 3 year history of insidious onset and progressively deteriorating course of symptoms characterized by repeated doubts (regarding locking and unlocking the door knobs, turning switches on and off), repeated fears (something bad would happen with him if somebody would touch him while performing almost all routine activities), magical thinking (roof falling on him if he would not stand properly from toilet seat), mental compulsion (counting) with progressive slowness in self-care behavior (brushing, bathing, changing clothes, walking, and eating), and avoidance of routine activities with academic decline. For 6 months prior to reporting to a tertiary level referral hospital in India, the patient started having anxious and low mood, loss of interest in all pleasurable activities, and stopped going to the school. He would remain confined to bed, would not speak and communicate mostly by gestures. He would spend 2-3 h

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in finishing his one meal, and similar time in bathing, changing clothes, etc., The mental status examination revealed obsessive slowness, obsessive doubts and fears, magical thinking, yielding, and mental compulsions. Yale-Brown Obsessive Compulsive Scale (YBOCS) score was 40 at the time of initial assessment. He was diagnosed as a case of OCD with slowness following International Classification of Diseases and Related Health Problems (ICD-10).[3] It was planned to manage him as inpatient with combined pharmacological and behavioral treatment. His relevant and routine investigations were within normal limits. He was started on fluoxetine 20 mg/day. After detailed behavior analysis, it was found that he had slowness and repetition in all routine activities with score of 9-10 for distress on a scale of 1-10. He would remain in bed throughout the day and would do all routine activities only on being coaxed by parents. Prompting, pacing, and shaping of routine activities were carried out daily. Exposure and response prevention sessions were conducted on alternate days. Also, fluoxetine was slowly titrated to 60 mg/day and was well tolerated by him. Initially, it was difficult to get him involved in the treatment as he would take several minutes while coming to interview room, starting conversation, and following instructions. It was decided to make individual sessions longer because the slowness and resistance made it difficult to achieve the individual session goals. The duration of sessions was increased to 90-120 min instead of usual 45-50 min. Also, psychoeducation for the family members was started. Initially, the parents had difficulty in accepting the fact that their son's problems were because of a psychiatric illness as they believed that M's problems were due to maladaptive behavior and he did it on purpose to annoy them. However, later on with psychoeducation, his mother understood the nature of his illness. She agreed to be cotherapist and her increased involvement and dedication made the therapy more intense and helped the team to achieve more and more cooperation from the patient. The two major hurdles in managing the case were difficulty in establishing rapport with the patient and retaining him in the therapy. After beginning of the combined therapy, he started showing improvement in almost all the problem areas (as tabulated below) and after 3 months, YBOCS score reduced to 25 with improvement in the time spent in getting out of bed, brushing, going to toilet, answering to questions, changing clothes, and eating. Post discharge from the hospital, he came regularly for follow-ups and his mother continued to be a cotherapist and would practice therapy at home. He maintained the improvement post 3 months of discharge [Table 1].

Table 1: Changes in his behavior which were noted during his hospitalization

	At the time of admission	In last 1 week
Affect	Anxious and depressed	Euthymic, smiled back to others
Interaction with family members	Absent, responded only with gestures	Started talking with family
Involvement in day care activities	Absent, remain seated on bed throughout the day	Started typing on computer 1-2 h daily, walking in ward, evening walk daily 1-2 h
Initiation of response to questions asked from him	10-20 min	1-2 min
Asking same question	3 times	Once
Wake-up	10 am	8 am
Brushing	30-60 min	20-40 min
Bathing	Once in a week, 2 h	Once in a week in 1 h
Changing clothes	Once in a week, 1 h	Daily in 10-15 min
Urination	1 h	5 min
Defecation	2 h	1.5 h
Meal	2 meals; breakfast and dinner and 2 h in each meal	3 meals; breakfast, lunch, and dinner; 30-60 min
Time taken while getting up from bed	20-30 min	Within 10 min
Weight	50 kg	54 kg
YBOCS score	40	25

YBOCS – Yale-brown obsessive compulsive scale

DISCUSSION

In our case, OCD had started at the age of 12 years with obsessive doubts and fears, magical thinking, mental compulsions, and slowness in self-care behavior. Slowness in his behaviors like brushing, getting up from bed, urinating and defecating, and responding to questions was not preceded by obsessive ideas, doubts or fears, or mental compulsions and was not accompanied by anxiety. The features like prominent slowness in self-care behavior, absence of an increase in anxiety, or discomfort either before or following the behavior corresponds to description of primary obsessive slowness by Rachman (1974).[1] However, some researchers (Veale, 1993) have suggested that the slowness is secondary to the recognized phenomena of OCD or anakastic personality disorder.[4] Our patient responded to combined therapy of fluoxetine along with behavioral therapy in the form of prompting, pacing, shaping for symptoms related to slowness, and exposure-response prevention directed for the repetitive behavior he improved considerably. In most of the interventional studies available for obsessive slowness, the interventions sped up specific target behaviors without affecting other areas of OCD.[5] In a case series of 11 Down's syndrome patients with obsessive slowness by Charlot *et al*., (2002),[6] good response to behavioral pacing and shaping was demonstrated. However, replicable details of the treatment were not provided by the authors. In our case, there was considerable improvement after 12 weeks of intervention; most of the studies reported that effect occurs over 6-16 weeks.

CONCLUSION

His case demonstrates a successful treatment of OCD with obsessive slowness and the challenges met during the course of treatment.

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