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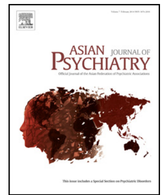

A study of phenomenology, psychiatric co-morbidities, social and adaptive functioning in children and adolescents with OCD

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ABSTRACT

Objective: To study the phenomenology, social, adaptive and global functioning of children and adolescents with OCD.
Background: Studies have shown varying prevalence of paediatric OCD ranging from 1% to 4%. Childhood-onset OCD have some important differences in sex distribution, presentation, co-morbidities and insight.
Materials and methods: 25 subjects (6 to ≤18 years) with a DSM-IV-TR diagnosis of OCD were included in this study. Subjects were evaluated using K-SADS-PL, Children's Y-BOCS, HoNOSCA, C-GAS and VABS-II.
Results: The mean age of the sample was 14.9 ± 2.2 years. Obsession of contamination was commonest (68%) followed by aggressive obsession (60%); commonest compulsions were washing and cleaning (72%) followed by checking (56%). Most distressing obsessions were obsession of doubt about their decision (28%), having horrible thoughts about their family being hurt (20%) and thought that something terrible is going to happen and it will be their fault (16%). Most subjects rate spending far too much time in washing hands (60%) as most distressing compulsion, followed by rewriting and checking compulsions (both 12%). 76% subjects have co-morbid psychiatric diagnosis. Anxiety disorders (24%), depression (16%), and dissociative disorder (16%) were common co-morbidities. Mean C-GAS score of the sample was 53.2 ± 9.9. 44% of subjects had below average adaptive functioning.
Conclusions: The study shows that, most frequent obsessions and compulsions may be different from most distressing ones and this finding might have clinical implication. Most of the children and adolescent with OCD have co-morbidities. Children also had problems in adaptive functioning.
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1. Introduction

Obsessive compulsive disorder (OCD) is characterized by the presence of obsessions and/or compulsions that reduce or prevent anxiety in response to the obsessive thought that cause distress, are time-consuming and interfere with age appropriate functioning (APA, 2000). The epidemiological studies in children and adolescents (hereafter referred to as children unless specified) have shown varying prevalence rates of OCD ranging from 1% to 4%. Indian studies reported, point prevalence of OCD as 0.1% (Srinath et al., 2005) and 1.45% (Kirthi Kumar, 1998) in children. Although childhood-onset OCD is generally similar to adult-onset OCD (Bloch et al., 2008), but there are important differences regarding gender distribution, symptom presentation, patterns of co-morbidity and degree of insight in both the groups.

Concerns about contamination, aggression, exactness or symmetry, repeating, ordering/arranging and counting is more common in this age group (Geller et al., 2001). Hoarding was found significantly more often as compared to the adolescents and adults (Geller et al., 1998). As a child ages, the type of obsession might alter to include obsessions of a sexual or religious nature. As a result, the rate of sexual obsession increases significantly from childhood to adolescents to a level similar to that of adult.

Abbreviations: OCD, obsessive compulsive disorder; TS, Tourette's syndrome; ADHD, attention deficit hyperactivity disorder; C-YBOCS, Children's Yale-Brown Obsessive Compulsive Scale; HoNOSCA, Health of the Nation Outcome Scales Child and Adolescent Mental Health.

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Religious obsessions are more frequent in adolescents as compared to either children or adults.

OCD in children is characterized by more parental involvement (Geller, 2006) and changing symptom clusters over time (Hanna et al., 1995). Children tend to hide their rituals for a long time and frequently display compulsions without well-defined obsessions, perhaps due to the limited cognitive ability to be able to articulate their cognitive processes (Swedo et al., 1989).

Children suffering from OCD show high rates of co-morbid psychiatric disorders, especially tic disorders, Tourette's syndrome, disruptive behaviour disorders, major depression and anxiety disorders (Chabane et al., 2005; Chowdhury et al., 2004; Do Rosario-Campos et al., 2005; Geller et al., 1996, 1998; Masi et al., 2006; Swedo et al., 1989). Eating disorders, body dysmorphic disorder, trichotillomania, impulse control disorders are also among common psychiatric co-morbidities in children with OCD (Garcia et al., 2009).

There are few Indian studies regarding co-morbidities in this group (Reddy et al., 2000, 2003; Jaisoorya et al., 2003) and these studies found rate of major depression, dysthymia and bipolar disorder as 14–23%, 0–2% and 0–2% respectively. Panic disorder, social phobia, specific phobia, overanxious disorder and separation anxiety disorder ranged from 0 to 6%, 0 to 13%, 5 to 7%, 0 to 7% and 5 to 7% respectively in these studies. Beside above, Tourette's syndrome (8–11%), tics disorder (2–23%) and attention deficit hyperactivity disorder (ADHD) (3–18%) were other co-morbid psychiatric disorders.

Clinical accounts often show that children with OCD have problems in various areas of life which includes daily routine, emotional adjustment, family and peer relationships, and academic performance (Albano et al., 1995; Piacentini et al., 2003; Valderhaug and Ivarsson, 2005).

Most of the Indian studies were from one centre. Studies have not systematically assessed impairment and adaptive functioning of these children as well as the distress level associated with the obsessive compulsive symptoms. Therefore, this study was planned to look in to if there are differences in phenomenology cross culturally as well as to study social, adaptive and global functioning of children and adolescents with OCD.

2. Materials and methods

2.1. Study sample

This cross-sectional, clinic based study was carried out at Department of Psychiatry, King George's Medical University, Lucknow from August 2009 to September 2010. The study was approved by the Institutional Ethics Committee. All old and newly registered patients at child and adolescent psychiatry out-patient department between ages of 6 years to ≤18 years with a DSM-IV-TR 2000 diagnosis of OCD together with the availability of at least one informant were included. Informed consent of the parent/guardian and the patient were taken. Patient with mental age 6 years or less and those with a severe physical disorder/condition requiring priority medical management were excluded from the study.

Information of the subjects regarding identification data, demographic profile, history of present illness and past history along with treatment history (detailed time-line), family history, personal history was obtained on the semi-structured Performa. The children were assessed on Kiddie-Schedule for Affective disorders and Schizophrenia – present and lifetime version (K-SADS-PL; Kaufman et al., 1997), for diagnosis and co-morbidities. Co-morbidities not covered by K-SADS-PL were assessed clinically. Children's Yale-Brown Obsessive Compulsive Scale (Scahill et al., 1997) was used to assess phenomenology and severity of OCD. Diagnosis was made as per Diagnostic and statistical manual of mental disorders fourth edition, Text Revision (DSM-IV-TR) criteria (APA, 2000). Children were specifically asked to rate most distressing obsession and compulsion. Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA; Gowers et al., 1999) was used to assess health and social functioning as well as the knowledge of parents about difficulties of the child and availability of services. Children's Global Assessment Scale (C-GAS; Shaffer et al., 1983) and Vineland Adaptive Behavior Scale-II (VABS-II; Sparrow et al., 2005) were used to assess impairment and adaptive functioning respectively.

3. Results

3.1. Socio-demographic profile

25 subjects (18 male, 7 female) were included in the study. The mean age of the sample was 14.9 ± 2.2 years. Majority of the subjects were currently studying (88%), from urban area (64%) and belong to low socio economic status family with monthly income <6000 INR (56%). The mean IQ of subjects was 91.3 ± 10.7.

3.2. Phenomenology

As per C-YBOCS most common obsession was of contamination (68%) and compulsion was of washing and cleaning (72%) (Table 1). Subjects had moderate to severe OCD (mean score 25.0 ± 4.2). Mean duration of illness was 27.5 ± 23.9 months. Only 2 (8%) subjects had episodic course, rest had chronic course of illness. There was family history of OCD in 2 (8%) subjects. The most upsetting obsession in the study sample is "I often have doubt whether I have made right decision" and the most upsetting compulsion is "I spend far too much time in washing hands" (Table 2).

3.3. Psychiatric co-morbidity

Most subjects (76%) had co-morbid psychiatric diagnosis (Table 3).

3.4. Social and adaptive functioning

Mean C-GAS score of the subjects was 53.2 ± 9.9. Majority of the subjects (52%) had some noticeable problems in more than one area on C-GAS (score 60–51). About 16% of the subjects had obvious moderate problems/impairment in most areas or severe problems/impairment in one area (score 40–31) and another 12% had serious problems/major impairment in several areas or unable to function in one area (score 40–31) been found.

Majority of the subjects (56%) had composite adaptive behaviour that is average for their age but still 44% of subjects had below average adaptive functioning on VABS-II. This data

Table 1
Obsession and compulsions in the subjects as per C-YBOCS checklist.[a]

Obsession (*N* = 25)		Compulsion (*N* = 25)	
Contamination	17 (68%)	Washing and cleaning	18 (72%)
Aggressive	16 (64%)	Checking	14 (56%)
Religious	10 (40%)	Repeating rituals	12 (48%)
Magical thought/ superstitious	8 (32%)	Ritual involving other person	11 (44%)
Sexual	6 (24%)	Excessive game and superstitious belief	8 (32%)
Hoarding/saving	4 (16%)	Ordering and arranging	7 (28%)
Somatic	0 (0%)	Hoarding and saving	4 (16%)
Miscellaneous	6 (24%)	Counting	4 (16%)
		Miscellaneous	20 (80%)

[a] Data not mutually exclusive.

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