Comprehensive Psychiatry 86 (2018) 25–30

Contents lists available at ScienceDirect

Comprehensive Psychiatry

journal homepage: www.elsevier.com/locate/comppsych

Atypical symptom presentations in children and adolescents with obsessive compulsive disorder

Rachel Porth [a], Daniel Geller [a,b,c,*]

[a] Department of Psychiatry, Massachusetts General Hospital, 185 Cambridge Street, Suite 2000, Boston, MA 02114, United States of America
[b] Harvard Medical School, United States of America
[c] Royal Australasian College of Physicians, Paediatrics, Australia

ARTICLE INFO

Article history:
Received 5 March 2018
Received in revised form 26 June 2018
Accepted 12 July 2018
Available online xxxx

ABSTRACT

Background: Common symptom presentations in youth with Obsessive Compulsive Disorder (OCD) are easily recognized and are included in the Children's Yale Brown Obsessive Compulsive Scale (CY-BOCS) symptom checklist. However, some youth may occasionally present with atypical or unusual symptoms that are less readily recognized as OCD and may be confused with other disorders that sometimes overlap, such as autism spectrum disorder or even psychosis.
Methods: Case synopses which are thematically linked and exemplify and illustrate two distinct types of unusual or atypical symptom presentations are described. These symptoms are embedded in the subjects' broader clinical picture, that more correctly identifies the atypical symptoms as a variant feature of OCD rather than some other diagnostic condition.
Results: We describe twenty-four children with OCD. Twelve children had obsessions related to adverse experiences of places, times or other people that were felt as horrific, abhorrent or disgusting. These obsessions led to contamination fears of any thoughts or actions associated with those places, events or people. In those whose OCD was a reaction to another person, the contamination obsession often took the form of fear of acquiring an unwanted trait or characteristic by association, which was then avoided. Twelve other youth had obsessions driven by a primary sensory experience that was intolerable, including tactile, olfactory, and auditory stimuli. These sensory experiences were sometimes linked to specific objects or people, driving time-consuming repetitive behaviors to avoid or alleviate the sensory discomfort.
Conclusion: Recognition of atypical presentations of OCD, such as fear of contamination by association with adverse experiences and primary sensory intolerance leading to OCD will help clinicians to better identify and treat these unique symptoms.

1. Introduction

Obsessive-compulsive disorder (OCD) is a common [1], often chronic disorder [2,3] in children and adolescents with significant associated impairment across multiple domains of functioning [4]. Pediatric OCD is typically characterized by well-recognized domains of symptoms, such as contamination, fear of harm or aggression, sexual/religious worries, or somatic concerns [5]. These domains are captured in the symptom checklist of the Children's Yale Brown Obsessive Compulsive Scale (CY-BOCS) [6] that is the gold standard of pediatric OCD assessment, is a variant of the adult Y-BOCS [7,8] and includes over 60 symptoms thematically organized into clusters or "dimensions". Factor and cluster analyses have identified a number of symptom dimensions with a fair measure of consistency in both adults and youth [5]. However, children and adolescents with OCD occasionally present with symptoms that do not fit easily into one of these categories. When symptoms appear as atypical, are not represented in the CY-BOCS or lead to behaviors that are bizarre, they may not be readily recognized as OCD- related and lead to diagnostic formulations or treatment that does not address underlying obsessions.

One example of an unusual presentation of OCD is a fear of contamination through exposure to, and association with, specific times, places or persons previously experienced as distressing, adverse and abhorrent. Obsessions include acquiring an unwanted trait or characteristic through association with someone who has the feared or undesirable trait or behavior, or a time or place in which the feared experience or behavior occurred. It may involve fear of a loss of status such as being "unpopular", "dumb" or "lazy" or antisocial such as a drug user or a "Goth" in appearance. These obsessions also represent a form of magical

* Corresponding author at: Department of Psychiatry, Massachusetts General Hospital, 185 Cambridge Street, Suite 2000, Boston, MA, 02114., United States of America.
E-mail addresses: rporth@mgh.harvard.edu (R. Porth), dan.geller@mgh.harvard.edu (D. Geller).

https://doi.org/10.1016/j.comppsych.2018.07.006
0010-440X/

thinking, inasmuch as there is clearly no logical or rational link between the feared outcome and the triggering source. This association is an internal, highly individual and idiosyncratic mental connection or memory that causes a feeling of horror around which there is frequently little or poor insight. In more severe cases, the obsession of contamination by association can lead to fear of actually becoming another person, reverting to a previous unwanted state (e.g. feeling rejected and unpopular at school) or being invaded/occupied by another, so called "transformation" obsessions [9,10]. Alternatively, the affect may be one of disgust and abhorrence rather than fear. Others, even immediate family members, may generate such disgust in the patient that it leads to severe family disruption as a result. These symptoms may or may not be accompanied by more typical OCD symptoms, that, when present, make the diagnosis more apparent and less likely to be understood as delusional or psychotic symptoms.

Another example of an atypical presentation are symptoms driven by a primary sensory discomfort in one or more sensory modalities that leads to avoidance, an above-threshold amount of time occupied in dealing with the sensory discomfort, compulsions, and impairment in daily life functioning, i.e., OCD. Sensory sensitivity has been shown to frequently occur in children with OCD, especially in younger children and those with depressive disorder, ADHD, and disruptive behavior disorder [11]. While sensory integration difficulties are not uncommon in children and may represent a "soft" neurological or developmental sign, their confluence with other more typical obsessional fears and behaviors and the compulsions they drive suggest they are a variant of OCD and not part of another disorder. For example, sensory integration difficulties may be noted in children with autism spectrum disorders but their behaviors are more stereotypic, self-stimulating or self-soothing, and ego-syntonic. It has been shown that prodromal sensory experiences often occur before the motor behaviors seen in chronic tic disorders [12–15]. Similar prodromal sensory experiences have been reported in children and adults with OCD and have been well documented in the University of Sao Paulo Sensory Phenomena Scale (USP-SPS) validation study [16]. Olfactory, tactile (including food texture), taste, touch and sound may all be involved. In these cases, sensations can lead to avoidance or rituals or even aggressive reactions. These symptoms represent a broader set of sensory phenomena than the more limited, recently coined "misophonia" ("hatred of sound") associated with trigger sounds, which is not a recognized DSM 5 or ICD 10 disorder. Sensory processing disorder or sensory integration disorder is characterized by difficulties organizing environmental sensations coming from the body's sensory organs and is manifest by adverse rather than adaptive responses and disruption in one or more domains of daily activity [17]. These may underlie or trigger the OCD behaviors (intrusive unwanted fears, anxiety and rituals) but are not sufficient to explain the behavioral phenotype alone, as most children with sensory processing disorders do not develop OCD. Sensory processing disorder is not a recognized DSM5 or ICD10 diagnosis.

In general, sensory phenomena are poorly understood, especially in children with limited verbal abilities, and are uncommonly used in diagnostic schema. We have previously described cases of sensory intolerance in OCD in youth [18], who do not seem to have the ability to inhibit sensory input and fail to habituate normally [19]. Because these symptoms are less frequently seen by clinicians, they may be misdiagnosed.

2. Methods

Children were evaluated clinically by the last author (DG) with extensive expertise in assessment of youth with OCD [20] using a standardized psychiatric history questionnaire and mental state exam. Open ended inquiry to ascertain the presenting set of symptoms and functional limitations were followed by standardized scalar assessment. All cases met DSM IV diagnostic criteria for OCD.

Measures: CY-BOCS [6]. The CY-BOCS is a psychometrically-sound clinician-rated interview that inventories symptoms and assesses OCD symptom severity. Over 60 symptoms clustered into obsession and compulsion categories are included for both past (ever) and current (last week) symptoms. Included in the CY-BOCS are sections recording contamination, somatic and miscellaneous obsessions with areas for narrative descriptions of individual obsessions and behaviors. From this expanded symptom checklist, we derived our data regarding atypical contamination and sensory-driven symptoms. A five-point Likert scale anchored by a zero score (no time, impairment or distress reported) is scored for the last week with a range of 0–40. All cases had at least a score of 16 on this scale, mean score in assessed cases was 23.

3. Results: case descriptions

Table 1 describes the sample demographics.

Table 2 describes twelve children and adolescents with obsessions of contamination by association with a time, place or person previously experienced as fearful or disgusting, leading to avoidance and compulsions.

Table 3 describes twelve children and adolescents with obsessions driven by primary sensory phenomena and intolerance.

Table 1
Demographics.

	Overall sample (n = 24)	Atypical contamination OCD Cases (n = 12)	Sensory phenomena OCD Cases (n = 12)
Age	11.71 (3.51)	12.92 (2.27)	10.50 (4.17)
Gender (Female)	15	6	9
Race			
White	21	11	12
Asian	1	1	0
Ethnicity (Hispanic)	1	1	0
Comorbid axis I diagnoses			
Agoraphobia	5	2	3
Attention deficit hyperactivity disorder	4	4	0
Generalized anxiety disorder	3	3	0
Learning disability (Not Specified)	3	3	0
Major depressive disorder	5	3	2
Oppositional defiant disorder	4	3	1
Separation anxiety disorder	1	0	1
Social anxiety disorder	1	1	0
Specific phobia	1	0	1
Tic disorder	2	1	1
Tourette syndrome	4	2	2