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Short communication

"Rituals or rivalry?" The phenomenology and treatment of sibling specific obsessions in paediatric obsessive-compulsive disorder

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ABSTRACT

Obsessive-compulsive disorder (OCD) is highly heterogeneous, and can be difficult to assess and diagnose particularly when unusual symptoms are present. This case study ($n=9$) describes an under-reported presentation of OCD in youth, whereby the patient experiences an obsessional fear of a sibling. Clinical characteristics of this presentation are discussed and comparisons with sibling rivalry disorder are examined. Seven of the participants engaged in a standard treatment protocol for OCD (comprising cognitive-behaviour therapy with or without an SSRI medication); five achieved remission. This presentation of sibling obsessions should be recognised as OCD, and be treated with evidence-based interventions for OCD.

1. Introduction

Obsessive-compulsive disorder (OCD) is characterised by intrusive, unwanted thoughts which cause significant anxiety or distress, provoking urges to perform behavioural or mental rituals. The disorder affects approximately 0.6–2% of young people under the age of 18 years (Bolton et al. 2006; Rapoport et al. 2000), can be highly impairing (e.g. Piacentini, Bergman, Keller, & McCracken, 2003), and if left untreated can run a chronic course (Micali et al., 2010). Identification and diagnosis of OCD in youth is therefore of paramount importance so that effective interventions can be delivered. It has been noted that accurate diagnosis can pose a significant challenge to clinicians for a number of reasons (Glazier, Calixte, Rothschild, & Pinto, 2013). OCD symptoms have characteristic features (unwanted, distressing, repetitive and impairing thoughts and behaviours), however the nature and manifestation of obsessions and compulsions is highly heterogeneous (Summerfeldt, Richter, Antony, & Swinson, 1999). The content of obsessional thoughts can often appear bizarre in nature, particularly in paediatric populations where OCD is associated with greater levels of "magical" thoughts and lower levels of insight (Ivarsson & Valderhaug, 2006). Furthermore OCD is often characterised by high levels of embarrassment and shame, which can lead to reluctance in disclosing symptoms (Chung & Heyman, 2008). This combination of factors means that OCD can be difficult to assess and diagnose, particularly in the absence of classical, overt compulsions such as excessive washing or checking.

The current study describes an under-reported presentation of OCD in youth, where the prominent and most impairing obsession is fear related to a sibling. The patient is typically highly avoidant of their sibling, and may carry out related or magical rituals to 'neutralise' the fear relating to their sibling. When they are unable to avoid or ritualise, exposure to their sibling generally triggers extreme distress which can manifest as temper outbursts and lead to high levels of family conflict. It is important that clinicians are aware of these characteristics in order to aid accurate diagnosis. Given the focus of the OCD symptoms in these cases, it can be misinterpreted as stemming from dysfunctional family relationships or being indicative of sibling rivalry disorder. There is little empirical research characterising sibling rivalry disorder, its prevalence, co-morbidities, or effective treatment. However, diagnostic criteria from the International Classification of Diseases (ICD-10; World Health Organisation, 1996) states that sibling rivalry disorder is characterised by evidence of sibling rivalry and/or jealousy; onset during the months following the birth of the younger (usually immediately younger) sibling; and intense/persistent emotional disturbance. Interestingly, sibling rivalry disorder does not exist as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), although this presentation can be coded under relational problems, which are defined more broadly.

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In order to understand how sibling relational problems or sibling rivalry can be delineated from sibling specific obsessions in OCD, data on possible similarities and differences will be considered, for example age of onset of symptoms, impact on family, and relationship of affected sibling to the participant.

Differentiation of OCD from sibling jealousy or rivalry is of clinical importance, not least so that appropriate treatment can be delivered. Paediatric OCD has been shown to be highly responsive to cognitive behaviour therapy (CBT) with exposure and response prevention (E/RP) and serotonin re-uptake inhibitors (SSRIs) (Watsons & Rees, 2008), with CBT being the recommended first-line treatment in the majority of cases (National Institute for Clinical Excellence (NICE), 2005). In contrast, parenting or family-focused treatments are suggested for sibling rivalry (Wagner, Hunter, & Boelter, 1988), although a paucity of literature results in limited guidance on how sibling rivalry may be effectively treated. It is crucial that the correct diagnosis is made and appropriate treatment provided as symptoms which may be indicative of either diagnosis (e.g. aggression, avoidance, high impact family) may lead to future psychological and emotional difficulties for both siblings involved, and other family members (Whipple & Finton, 1995).

This paper documents a presentation of OCD characterised by an obsessional fear of a sibling as the dominant intrusion. The aim is to: (1) describe the phenomenology of sibling specific obsessions; (2) outline the clinical and demographic characteristics association with sibling specific obsessions in nine cases; and (3) report treatment outcomes for these nine patients following a course of E/RP based CBT for OCD plus SSRI medication in some cases.

2. Method

2.1. Case selection

Cases were identified from the register of the National Specialist child and adolescent Obsessive-Compulsive and Related Disorders Clinic at the Maudsley Hospital, London. All cases presented met ICD-10 diagnostic criteria for OCD as their primary diagnosis, as confirmed by the specialist multidisciplinary team during a detailed assessment. The assessment included an interview with parents to obtain a developmental history and an account of presenting difficulties, including evaluation of diagnostic criteria. A semi-structured interview (Children's Yale-Brown Obsessive-Compulsive Scale; CY-BOCS; Scahill et al. 1997) with the young person was conducted to obtain a detailed account of OCD symptoms. The assessments were conducted by trained clinicians under the supervision of psychologists or psychiatrists who were highly experienced in administering and rating the CY-BOCS. In addition, detailed information was collated about previous diagnoses and treatment. 697 cases of OCD were referred to the clinic between 1998 and 2012; case notes were reviewed using data from CY-BOCS assessment interviews to identify where sibling specific obsessions were the primary symptom reported by patients. Information was also elicited from clinicians who conducted treatment and assessment sessions to clarify the nature of the primary symptom. Sibling specific obsessions were classified as any fear specifically linked to a sibling (s) (see Table 2 for a description of obsessions in the included cases). Cases were excluded if it was not clear whether the primary symptom was related to a sibling obsession. In total, nine cases were identified with sibling specific obsessions as the primary symptom, a prevalence rate of 1.3% of referred cases with OCD in this clinic.

The mean age of patients at initial assessment was 12.6 years (range 9–16; S.D.=2.3). Six out of nine (67%) were male. In one case (P1), CBT sessions were conducted in parallel to parent management training for Oppositional Defiant Disorder. Four patients (P2, P3, P4, P8) were taking SSRI medications at the start of CBT, two augmented with risperidone (P2, P8). Changes in medication are noted in Section 3 when considering treatment outcomes.

2.2. Measures

2.2.1. Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)

The CY-BOCS is a clinician-administered measure that assesses the frequency, interference, levels of resistance and control, and distress associated with obsessions and compulsive behaviours experienced by the young person. It yields a total score ranging from 0 to 40 where a score over 10 indicates the presence of clinically diagnosable OCD symptoms (Micali et al., 2010). It has been shown to have good reliability and validity (Scahill et al., 1997; Storch et al., 2004). The CY-BOCS was completed at initial assessment and post-treatment where possible (P7 completed treatment sessions with a clinician at his local Child and Adolescent Mental Health Service, and P9 moved out of the country prior to the end of treatment).

The following measures were administered at the initial assessment only:

Children's Global Assessment Scale (*CGAS*): The CGAS is a clinician scored measure of overall functioning on a scale of 0–100. It has been found to be reliable and valid across a wide clinical population (Bird, Canino, Rubio-Stipec, & Ribera, 1987; Shaffer et al. 1983).

Beck Depression Inventory-Youth (*BDI-Y*):The BDI-Y is a 20-item, self-report measure of depressive symptoms. Total raw scores range from 0 to 60, and can be translated into a *t*-score based on the age and gender of the young person. It has good internal consistency and test-criterion validity (Beck, Beck, & Jolly, 2001). A *t*-score of 65 or above suggests moderately elevated depression and a *t*-score of 80 or above suggests severe depression.

Family Accommodation Scale (*FAS*):The FAS-PR (adapted from Calvocoressi et al. 1995) is a parent-report assessment of the degree to which family members have accommodated the child's OCD symptoms and the level of distress or impairment that the family members and patient experience as a result. The FAS-PR has good reliability and adequate validity (Merlo, Lehmkuhl, Geffken, & Storch, 2009). Total scores range from 0 to 48; with a cut-off score of 13 or above indicating clinically meaningful levels of family accommodation (Merlo et al., 2009).

Strengths and Difficulties Questionnaire Parent Version (*SDQ-P*): The SDQ-P is a widely-used measure of psychological adjustment for children and adolescents. It is a clinically valid and reliable measure (Goodman, 2001); consisting of 6 subscales which measure emotional symptoms, conduct problems, hyperactivity, peer problems, pro-social behaviour and impact. Cut-off scores indicating clinical difficulty for each subscale are 4 for emotional symptoms, 3 for conduct problems, 6 for hyperactivity, 3 for peer problems, 5 for pro-social behaviour and any score above 0 for impact. A total score is derived from adding scores of each subscale, excluding the impact score, with a score of 14 or above indicating significant difficulties.

2.3. Treatment

Treatment at the National and Specialist OCD and Related Disorders Clinic consisted of 5–20 weekly sessions of protocol-driven CBT for OCD, incorporating psycho-education, E/RP and relapse prevention. Treatment was conducted by experienced therapists who received regular supervision; parents were included in sessions as appropriate. Siblings were not involved in sessions as routine, but were included in E/RP sessions as needed. Graded exposure to the sibling included for example writing the siblings name, looking at a photo of the sibling, looking at the sibling through a one way screen, wearing the sibling's clothes, and finally tolerating physical contact with the sibling. The decision to terminate treatment was made jointly by the therapist, patient and parents and was broadly determined by one of the following: (a) therapy goals had been achieved; (b) progress in therapy had plateaued; (c) no meaningful progress had been achieved after at least 7 sessions; or (d) the patient moved geographical area. The use of an SSRI medication was also considered or reviewed for each participant as part of treatment.

3. Results

3.1. Demographics and clinical characteristics

A brief summary of patient demographics, family structure, and symptom characteristics are shown in Tables 1 and 2. This information was obtained during the assessment interviews. The mean total CY-BOCS score at initial assessment was 29.8 (range 19–36), indicating relatively severe OCD symptoms. In addition to an ICD-10 diagnosis of OCD, two participants met diagnostic criteria for an additional axis 1 diagnosis at assessment: one participant (P1) had a comorbid diagnosis of Oppositional Defiant Disorder and Tourette Syndrome, and one (P2) had comorbid depression. In addition three participants (P3, P7, P8) had a specific learning difficulty, namely dyslexia.

The mean age at onset of OCD was 9.1 years (range 6–12; S.D.=2.3). In all cases the focus of the obsession was on a younger sibling, except P6 where the affected sibling was the participant's twin. At the point of onset of OCD, the mean age of the affected sibling affected sibling was 8.2 (range 5–13; S.D.=2.4).