CASE REPORT

Juvenile obsessive compulsive disorder in a paediatric dentistry set-up

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SUMMARY

Obsessive-compulsive disorder (OCD) is an anxiety disorder comprising uncontrollable thought processes and repetitive, ritualised behaviours that one feels compelled to perform. If an individual has OCD, he/she probably realises that his/her obsessive thoughts and compulsive behaviours are irrational but would still feel unable to resist them. Since a pedodontist's association with the child patient and parents is established at quite an early age, they should make good use of the opportunity to diagnose psychological disorders in child patients as well as adolescents. Prompt diagnosis in such cases would enable timely medical intervention and hence help in achieving a more cooperative dental patient to ensure instillation of a positive dental attitude. This endeavour highlights a case of a 10-year-old boy who had reported to a private dental set-up with dental problems and was concurrently diagnosed for OCD.

BACKGROUND

Obsessive-compulsive disorder (OCD) is an anxiety disorder comprising uncontrollable thought processes and repetitive, ritualised behaviours that one feels compelled to perform. If an individual has OCD, he/she probably realises that his/her obsessive thoughts and compulsive behaviours are irrational but would still feel unable to resist them. It encompasses 1% to 4% of children in the USA and the manifestation of OCD in children is very different from that in adults. The older the child grows, so does the urge to hide their behaviours due to embarrassment from peers. It is necessary that dentists along with caretakers in schools or activity classes are familiar with this condition and its symptoms to be able to counsel or refer appropriately to help students with OCD cope effectively.¹ Substantial research has been carried out in juveniles with OCD. There is a supposition that juvenile OCD could be a developmental subtype of the disorder. Juvenile OCD seems to have a favourable prognosis. In all the studies of OCD in children and adolescents reported from India, male subjects have outnumbered female subjects.^{2,3} Male predilection in juvenile OCD is consistent with the previous clinical studies of juvenile OCD justifying the argument that gender distribution in OCD is developmentally sensitive.⁴

CASE PRESENTATION

An 10-year-old boy (figure 1) reported to the paediatric dental office with chief symptoms of pain in tooth number 85 and the cariously decayed tooth number 75. Pulpectomy followed by a

Figure 1 Ten-year-old boy.

stainless steel crown was planned for 85 and glass ionomer restoration for 75. Dental treatment was planned in multiple visits as the patient had to be reassured time and again that the entire procedure would be carried out with the best of his consents (figure 2). However, a strange behaviour pattern was always noticed as the treatment visits went by. He would feel uncomfortable and irritated if the dental assistant did not assure him that he had cleaned the instrument tray and the dental chair handles in front of him. Whenever the treatment ensued, he would fold his legs in a typical manner one over the other and make sure that his bare feet did not touch the chair, insisted on not straightening his legs because his feet might get contaminated. He would also appear to be humming something which could not be deciphered but seemed like a counting pattern. The patient's parents confirmed that nobody else in the family had the same behaviour pattern. The mother stated that her son was not performing well in school too as he would be busy repeating rituals like putting books in his bag again and again, following a specific pattern or otherwise setting up his geometry box in a specific manner. She added that some counselling sessions were also being carried out for him in school but that she was not aware of the

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details in this regard. He also insisted on following and stepping only on the line between two tiles while climbing the stairs to his classroom in school.

INVESTIGATIONS

According to the clinical classification of OCD for a definite diagnosis, obsessional symptoms or compulsive acts or both, must be present on most days for at least two successive weeks and be a source of distress or interference with activities. The obsessional symptoms should have the following characteristics: (1) they must be recognised as the individual's own thoughts or impulses; (2) there must be at least one thought or act that is still resisted unsuccessfully, even in the presence of others whom the sufferer no longer resists; (3) the thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in this sense); (d) the thoughts, images or impulses must be unpleasantly repetitive. Though we could witness some of the aforementioned symptoms in the patient, a definite diagnosis for OCD could not be established in the dental office set-up. Therefore, we referred the patient to a paediatrician who with his team diagnosed his behaviour under the new upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which includes a new chapter on Obsessive-Compulsive and Related Disorders to reflect the increasing evidence of these disorders' relatedness to one another and distinction from other anxiety disorders, as well as to help clinicians better identify and treat individuals suffering from these disorders. The disorders included in this new chapter have enough similarities to group them together in the same diagnostic classification but enough important differences between them to exist as distinct disorders. There are certain specifiers for these disorders. The 'with poor insight' specifier for obsessive-compulsive disorder has been refined in DSM-5 to allow a distinction between individuals with good or fair insight, poor insight and 'absent insight/delusional' OCD beliefs (ie, complete conviction that OCD beliefs are true). Analogous 'insight' specifiers have been included for body dysmorphic disorder and hoarding disorder. These specifiers are intended to improve differential diagnosis

by emphasising that individuals with these two disorders may present with a range of insights into their disorder-related beliefs, including absent insight/delusional symptoms. This change also emphasises that the presence of absent insight/delusional beliefs warrants a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder. The 'tic-related' specifier for OCD reflects a growing literature on the diagnostic validity and clinical utility of identifying individuals with a current or past comorbid tic disorder, because this comorbidity may have important clinical implications.⁵

DIFFERENTIAL DIAGNOSIS

Tic disorders, trichotillomania, generalised anxiety disorder (GAD), Schizophrenia, autism spectrum disorders, etc could be enlisted as the differential diagnosis for OCD.⁶

TREATMENT

Pulpectomy followed by a stainless steel crown for 85 and glass ionomer restoration for 75, as was planned, was carried out in multiple visits (figure 2).

OUTCOME AND FOLLOW-UP

The patient was recalled for dental follow-up every 3 months and the integrity of the restorations was checked.

DISCUSSION

The thought processes and manner of behaving linked to OCD is often puzzling to parents. Deciphering signs and symptoms of OCD can be difficult as one may perceive the child's actions to be purposely disrespecting or reluctance to perform. The child may try to conceal their symptoms or may not be able to express their worries. The spectrum of symptoms may alter with time and their appearance may change too, which in turn makes it more difficult to establish the right diagnosis. If a dentist encounters such a case and appropriate referral is made in the proper frame of time, the child can benefit from prompt diagnosis and treatment. The symptoms may exaggerate in a stressful situation. If treatment is neglected, the condition may

Figure 2 Pulpectomy and stainless steel crown placement with 75 and glass ionomer restoration with 85.

worsen and reflect in the form of limitations and withdrawal in other areas of the child's life. Relationships with family, friends, at school and during evening sports may all be affected.

Chansky⁷ reports that OCD affects at least 1 in 100 American children and that the average age of onset is 10.2. Children may be unaware, or unwilling to admit, that their behaviour may indicate the symptoms of a disorder. Families may need to be taught and trained about what they can reasonably expect from their child. Parents need to understand that therapy and medicines may reduce but not cure the symptoms.

The available literature indicates that OCD affecting children and adolescents is highly prevalent. Once believed to be relatively rare in children and adolescents, OCD is now thought to affect as many as 2–3% of children. Among adolescents with OCD, the literature indicates that very few receive an appropriate and correct diagnosis, and even fewer receive proper treatment. Paediatric-onset OCD or Juvenile OCD seems to share important similarities with the adult disorder but also shows important differences in the clinical expression of OCD, as these expressions may be actually driven by the age-dependent development of the patient. Children and adolescents with OCD typically first try to ignore, suppress or deny obsessive thoughts and may not report the symptoms as egodystonic or senseless. However, by trying to neutralise excessive thoughts, individuals with OCD very quickly change their behaviours by performing some type of compulsive actions, which are repetitive, purposeful behaviours carried out in response to the obsession. Usually, these repetitive actions follow certain rules or are quite stereotyped. Paediatric patients frequently demonstrate a poor understanding of their obsessions, and the added limited verbal expression usually makes diagnosis more difficult. Obsessions involving fear of harm and separation from the parent and caretaker, compulsions without obsessions and rituals involving family members are commonly seen.

There seems to be a bimodal distribution of age of onset of OCD, with one peak in preadolescent childhood and another in adulthood. Another distinction between child and adult OCD is gender representation. Whereas adult studies report either gender equality or a slight female predilection, paediatric clinical samples are clearly predominantly male. Family studies indicate that the disorder is highly familial and that a childhood onset of the disorder seems to be associated with a markedly increased risk for familial transmission of OCD, tic disorders and ADHD; however, in the present case, no such family history could be elicited.

The so-called 'spectrum disorders' related to OCD are less prominent in children and adolescents than in adults. Often, cognitive antecedents to these behaviours are less well developed than in more typical OCD, and behavioural interventions are the mainstay of treatment but with more variable success.⁸

In a dental set-up, dealing with patients with OCD may frequently be cumbersome for the operator as he would have to succumb to the pattern in which such children demand that the

treatment should be carried out. Treatment procedures and the entire chair side time may be unnecessarily prolonged due to the ritualistic repetitions of every act that these children usually indulge in.

Patient's perspective

The patient was happy to be relieved of dental pain and a positive dental attitude in the patient was successfully instilled, which was obvious as the visits went by.

Learning points

A pedodontist must gauge peculiar behavioural patterns in children so as to help diagnose obsessive-compulsive disorder at the earliest stage possible:

- ▶ Child being very fussy and determined about outdoing things in a particular manner only.
- ▶ Annoyance and reluctance to do things if activities around the child are not being performed in the manner the child wants them.
- ▶ Patients may be too conscious about personal hygiene so very selective and protective about making bodily contact with others and accessories.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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