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Mobile Stealing: A Rare Presentation of Pediatric Obsessive-Compulsive Disorder

Monirul Islam[1], Mohammad S. I. Mullick[1] and Tumpa Indrani Ghose[2]*

[1]*Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh*

[2]*Department of Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh*

Abstract

Obsessive-Compulsive Disorder (OCD) is a chronic and diversely presented psychiatric condition. Patients of this disorder, sometimes, present such an unusual way that diagnosis becomes very difficult. These patients, later, may face multiple consultations in different specialties or social and legal difficulties. This is the case of an adolescent boy who presented with stealing or pick-up mobile phone and facing social harassment. He was diagnosed as OCD after meticulous psychiatric assessment and treated with fluoxetine along with exposure and response prevention. Significant remission of symptoms of this adolescent was found with the intervention. Unusual presentations of OCD is not unexpected and early identification and treatment can reduce the huge burden of this troublesome psychiatric disorder.

Keywords: Unusual presentation; Obsessive-Compulsive Disorder; Mobile stealing

Introduction

Obsessive-Compulsive Disorder (OCD) is a very distressing psychiatric condition with waxing and waning course. According to DSM-5, the presence of obsessions, compulsions or both which are time-consuming and cause clinically significant impairment is called OCD [1]. In the Epidemiological Catchment Area Survey, OCD is the 4th most prevalent psychiatric condition, and in an early burden of disease study of all medical diseases, OCD ranked as 10th [2]. Among children and adolescents, the prevalence of OCD is 1% to 3% [3,4]. In the USA, one-year prevalence of adolescent's OCD is 0.7% [3]. Cut-off ages are 10, 14 and 18 years for early-onset OCD [5]. The fear of contamination (48%) is the most common obsession, succeeded by pathological doubt (47%), need for symmetry (36%), aggression (36%), somatic (33%), sexual (22%), and others (32%). Similarly, checking is the most common compulsion (62%), then, washing (36%), need to confess (41%), symmetry (40%), counting (30%), and hoarding (25%). Multiple obsessions (60%) and compulsions (48%) are present in most patients over time [6].

Like Developed countries, the prevalence of OCD is ranged from 1% to 2% in Bangladeshi children and adolescents [7.8]. Unlike children's age group, interference from obsessions, the mean obsession score, and extreme OCD are significantly higher in adolescents [9,10]. However, sometimes OCD patients present in an unusual way that their assessment and diagnosis become so difficult and they face legal issues or multiple consultations in different specialties. This unusual presentation is not uncommon among the children and adolescent's population as evident in the contents of the miscellaneous group of OCD [10]. Here we depicted a case of an adolescent boy presented with stealing and perfectionist behavior facing social harassment and legal difficulties later diagnosed and treated as a case of OCD.

Identifying Information

Tahsan (a pseudonym), a 15 years old boy, student of 9th grade, hailing from the semi-urban area of Cumilla, Bangladesh.

The main complaint "in his and mother words"

"Urge to pick-up mobile phone, tendency to complete every work in an unusually perfect way, repeated checking behavior, irritability for the last two years".

History of present illness

Tahsan was quite well two years back. Then he gradually developed to practice some behaviors symmetrically following the death of his uncle. He described an urge to repeat certain actions

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Correspondence:
Monirul Islam, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Room: 1208, 11th Floor, Block-D, Dhaka, Bangladesh, Tell: +8801711800297; E-mail: monirulbsmmu@yahoo.com

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until complete perfectly. He used to replace everything in the same places in the house. He wanted to get a "just perfect" feeling. If someone displaced household things he became angry with that person. He had repeated urges of certain motor acts, usually socially embarrassing ones, for example, and the urge to slap others. Tahsan also developed checking behaviors. He was unable to leave the house without lengthy repetitive checking of school bag, door locks, water taps, and electric switches. He took longer and longer so that he was often late for school. His mother gave him a mobile/cell phone so that she can contact him when he was outside the home. He used to carry the phone in his right pocket of the pant. Gradually he felt distressed that his left pocket was empty. So, he started to take his mother's phone and put it in his left pocket without noticing his mother. Then, his mother failed to connect him. So, she did not allow him to take her phone. But Tahsan felt severe distress without taking both phones into his pockets separately. For that, he went to a mobile shop in the local area and stole a phone. Shop keepers caught him with stolen mobile and beat him collectively. He was failed to explain the cause and injured badly. He hid the total incident from his mother. Tahsan also started to avoid wearing shirts that have a pocket so that he could avoid putting another phone into them. These types of incidents took place six times in the last year. He managed new places every time and shop keepers beat him every time but did not take any legal action except last time. He stole the last phone from a mobile repair shop and they took him to the local police station. Police called his mother and handed over him without taking any legal action after taking a written promise from his mother that it will not happen again. All these problems were associated with considerable impairment and disability in terms of role functioning, educational productivity, disability days as well as social embarrassment. After that incident, Tahsan convinced his mother that mobile stealing was not intentionally happened rather he had been suffering from a disease. They went for psychiatric consultation and wanted to know what was wrong with him.

Other relevant history

Tahsan came from a middle-class family. He was the only son of his parents. His father, 46 years, lived in Saudi Arabia for a job for 14 years, and his mother, 38 years, was a housewife. Consanguinity of marriage was absent. His paternal uncle had been suffering from psychotic illness but could not mention the name of the disease. The patient was born and raised in the Cumilla district of Bangladesh. His birth and early development were uneventful. Tahsan first experienced obsessive-compulsive symptoms when he was at 10 years of age. He would tell his mother to repeat some words, like "Assalamualikum (Hello)" and "Ami Valo Achi (I am fine)". He also got into bed with a fixed way to avoid happening of bad things. These behaviors did not cause any significant impairment in his daily life. Mother was very strict and he was often physically punished by the mother. He was a good student since early childhood and had very few friends due to his mother's strict rules and they were not allowed to his place. Tahsan never took any substance and never fell in trouble with the law. He had no psychiatric disorder and his medical history was uneventful particularly before the present problems. His predominant mood used to be within normal range with a good attitude to seniors and juniors though he was relatively less sociable with poor peer relationships. He passed his COVID-19 related leisure period by learning to drive a motorcycle and Facebooking.

Mental status and other relevant examinations on the first visit

An adolescent boy with an average body built and nutritional status was sitting on a chair. He put on a T-shirt without any pockets and a pant which was culturally and seasonally accepted. His skin, clothes, and hair reflected that overall hygiene was maintained. He looked anxious a little. Though his gaze was forward, eye-to-eye contact was possible and maintained. Rapport was established and sustained. He was cooperative during the interview and aware about surroundings. There was no oddity of gesture, posture, and behavior.

The boy described his mood as irritable which was predominant, persistent, and pervasive in all situations. Affect was also irritable, moderate in intensity, appropriate to the settings, and congruous to the mood. He talked spontaneously; the answers were relevant. The rate, rhythm, volume, fluency, and tone of the speech were normal. There was no oddity of speech. There was no delusion, suicidal ideation. He had obsessive impulses and thought of doubt with themes of the need for symmetry. He, also, had compulsions in the form of checking and ordering/arranging things. However, he recognized that both obsessions and compulsions were of his own thought and action, intrusive in nature, senseless, definitely not true and tried to resist and control but failed, spending three to four hours per day which causes distress and severe functional impairment in daily life. His perception, cognitive function, and judgment were normal. His general and systemic including neurological examinations were normal. Routine and relevant special laboratory investigations were also within the normal range. For psychometric evaluation, we applied Bangla validated Children's Yale-Brown Obsessive-Compulsive scale [11]. His total, obsessions, and compulsions scores were 31, 14 and 17 respectively.

Differential diagnoses

We considered OCD, Kleptomania, Conduct Disorder, and normal stealing. Tahsan had persistent obsessions and compulsions. Though the boy failed to control his urge to steal mobile phones with the evidence that he did not do it for personal use or their monetary value. He was not a case of Kleptomania as he was predominantly distressed before the act and there was no pleasure or gratification after the act. Rather, he felt irritability, guilt, and remorse after taking the phone from the shop. Our meticulous history also revealed that Tahsan had no deceitfulness, aggression to people/animals, destruction of property, or serious violation of rules that excluded Conduct Disorder. In real theft, stealing occurs due to material value or personal benefits. Family history revealed that there was no financial crisis in his family that his parents could not fulfill his demand rather he had no demand for the Smartphone.

Diagnostic impression

From history, examinations, and investigations, Tahsan had been suffering from Obsessive-Compulsive Disorder with fair insight as he had both time-consuming obsessions and compulsions which causes severe distress with social and educational impairment and there was sufficient evidence that they were not due to any substance or another medical condition or another psychiatric disorder. Psychometric evaluation supported that his disorder was severe in intensity.

Treatment plan

a. Problems: Urge to pick up mobile phone, want to complete every work in a perfect way, repeated checking behavior, Irritability which results in educational and social problems.

b. Goals: Not picking up phone from shop, reduction of perfectionist behavior, reduction of checking behavior which was time-consuming, improvement of educational and social problems.

Interventions

a. Child Focus: Explanation, advice, and support to Tahsan. Psychological interventions included relaxation exercise, Exposure and Response Prevention (ERP), thought stopping, and daily work program. Pharmacotherapy provided by capsule Fluoxetine started with 20 mg titrated to 40 mg daily [12].

b. Family Focus: Psychoeducation, Family counseling with special emphasis on the role of the parents. Here, mother worked as a co-therapist.

c. School Focus: Liaison with school authority with providing a letter which described the disorder, current interventions, and asking help from class teachers and peer groups.

d. Social Focus: The psychiatrist gave a letter to the Police Station and Chairman of the Union Council (Local Government Body) describing the psychiatric problem that the boy had been suffered.

Follow-up and outcome

The boy was advised to follow up fortnightly for the first three months. Initial increment of anxiety and restlessness was successfully managed by short-term use of clonazepam. The patient's initial improvement was achieved after one month. CY-BOCS Bangla score was 26, 21 and 11 at the end of the 1st, 2nd and 3rd month respectively with regular ERP sessions and 40 mg of fluoxetine. At that time, the patient was distress-free and was able to do his daily works including education.

Discussion

Children and adolescents with OCD are typically presented with contamination, fear of harm, blasphemous, sometimes somatic thought [13]. However, Pediatric OCD occasionally presents in such a way that does not fall into one of these themes. When symptoms appear as atypical or unusual, they may not be recognized as OCD and lead to delay in diagnosis and treatment.

In one study of OCD in Bangladesh, patients presented with unusual presentations such as headache (56%), decreased sexual behavior (16%), chronic cough (9.6%), pain (8%), vomiting (8%), increase frequency of micturition (2.4%) and deliberate self-harm (1.6%) were later diagnosed as OCD [14]. In another study of pediatric patients, they describe 24 children with OCD. Twelve children had obsessions related to fearsome experiences of places or people and led to contamination obsessions. Twelve other children had obsessions of primary sensory experiences which later linked to objects or people, leading to compulsive behaviors to avoid that distressful sensory stimulus [15]. Rasmussen and Eisen described another case of a woman who was compelled to let the telephone ring continuously, sometimes up to 40 times, until she got the just-right feeling to her ear [16].

Our case, Tahsan, had prominent obsessions as well as compulsions. He discussed both his obsession and compulsions in the first visit, though many patients are less spontaneously revealing in early sessions. For that, an assessment of pediatric OCD requires specific questions that can allow different insights to discuss thoughts and actions which can be embarrassing. Tahsan reported multiple obsessions such as symmetry (Thought of exactness in arranging phone, household things), doubt (Uncertainty about previous actions of common daily activities), and repeated urges to carry out actions which were recurrent, persistent, intrusive, and unwanted thoughts, naturally induce anxiety or distress. He also had several compulsions such as checking behaviors, ordering/arranging things (All the pockets of the clothes should have mobile phones) which are repetitive behavior in response to obsessions. These behaviors were aimed at reducing distress and also excessive or realistically unconnected to the anticipated event. These symptoms were time-consuming (3 h to 4 h/day) and caused distress and impairment in Tahsan's educational, social and personal life. Not only his symptoms were time-consuming but he appeared to be a socially embarrassed, isolated adolescent whose life had been significantly ravaged by OCD. It is important to explore whether OCD symptoms can be attributable to a substance, medication, or other psychiatric conditions. From history, it appeared that Tahsan had no such history including Kleptomania and Conduct Disorder. To subcategorize OCD, Thasan had no history of Tic Disorder. Another specified related to insight, Tahsan appeared to understand his obsessional beliefs are untrue and so would fall into the insightful category.

Tahsan may be biologically vulnerable to develop OCD due to one of his paternal uncles had been suffering from psychotic illness. Furthermore, he appeared to have an anxious temperament. Stressful life events such as the current stressful COVID-19 situation, strict rules of his mother may have predisposed Tahsan to develop psychopathology. Compulsive symptoms of Tahsan linked to the mobile phone (Need for symmetry) may be due to easy availability of phone to child and adolescent students for attaining online class during COVID-19 related lockdown, passing leisure period by Facebooking during long school closure due to COVID-19. This symmetry phenomenology is commonly expressed by OCD patients and discussed in the literature on child and adolescents OCD [17,18]. Valleni-Basile et al. [4] described that the most common compulsion (Over 50%) in adolescent OCD patients was ordering and arranging things [19]. Pick-up mobile phone due to reducing distress was defined as 'Not Just Right Experiences' (NJREs) [20]. Though he had subclinical symptoms during middle childhood, Tahsan had gradual onset of OCD following the death of his relative. His illness was exacerbated by stressful conditions like upcoming school assignments, physical assault after pick-up the phone. Moreover, excitement related to learning to drive motorcycle was act as a salient trigger factor. Despite the vicious cycle of OCD, Tahsan had numerous protective factors including a supportive mother, well financial condition, achieving well at school, and average intelligence. So, if he continued his current intervention accordingly, he may lead a better life.

Conclusion

Obsessive-compulsive disorder is usually an easily diagnosable psychiatric disorder but not always and sometimes its presentation is atypical, especially, in children and adolescents. That may result in delayed diagnosis which causes long-suffering of the patient, sometimes after legal and social harassment. Awareness of mental health problems, meticulous clinical assessment can reduce over or under diagnosis of this high impacting psychiatric disorder.

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