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CASE REPORT/CASO CLÍNICO

Co-occurring Obsessive-compulsive Disorder, Autism Spectrum Disorder and Intellectual Disability: A Case Report

A Perturbação Obsessiva-compulsiva em Comorbilidade com a Perturbação do Espectro do Autismo e a Perturbação do Desenvolvimento Intelectual: Caso Clínico

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Abstract

Autism spectrum disorders encompass a wide range of clinical presentations, including obsessive-compulsive symptoms. The comorbidity between these disorders is significant, and it has therapeutic and prognostic implications. While there are a few references on the approach of such comorbid presentations, the literature is even scarcer when this co-occurrence is superimposed on individuals with intellectual disability. We present the case of a 43-years-old male patient with comorbid treatment refractory obsessive-compulsive disorder, autism spectrum disorder and intellectual disability, exhibiting subacute symptomatic recurrence including hetero-aggressive outbursts and contamination obsessions. The phenomenological features and therapeutic strategies are discussed, highlighting the centrality of a patient-centered and methodologically pluralistic approach. Symptomatic remission was achieved employing high end doses of fluvoxamine and haloperidol, alongside daily psychotherapy involving both symptom-directed behavioral therapy and supportive psychodynamic techniques. An integrative approach may be the best option in the stabilization of complex cases as the one presented.

Resumo

A perturbação do espectro do autismo abrange uma ampla gama de apresentações clínicas, incluindo sintomas obsessivo-compulsivos. A comorbilidade entre estas patologias é significativa e tem implicações ao nível do prognóstico e terapêutica. Existem poucas referências bibliográficas sobre a abordagem a este tipo de comorbilidade, sendo a literatura ainda mais escassa quando a esta comorbilidade se sobrepõe uma perturbação do desenvolvimento intelectual. Apresentamos o caso de um doente do sexo masculino de 43 anos com perturbação obsessiva-compulsiva refratária ao tratamento, comórbida com perturbação do espectro do autismo e compromisso intelectual concomitante, exibindo recorrência sintomática com heteroagressividade e obsessões de contaminação. As características fenomenológicas e estratégias terapêuticas são discutidas, destacando uma abordagem metodologicamente multidimensional e centrada no doente. A remissão sintomática foi alcançada recorrendo a altas doses de fluvoxamina e haloperidol, juntamente com psicoterapia diária envolvendo terapia comportamental e técnicas psicodinâmicas. Uma abordagem integrativa pode ser a melhor opção na estabilização de casos complexos como o apresentado.

Palavras-chave: Perturbação do Desenvolvimento Intelectual; Perturbação do Espectro do Autismo; Perturbação Obsessiva-Compulsiva

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INTRODUCTION

Obsessive–compulsive disorder (OCD) is associated with chronic disability and is often reported in individuals with autism spectrum disorder (ASD).[1,2] ASD, besides deficits in social communication and social reciprocity, is characterized by repetitive behavior and restricted interests which may be apparent in OCD as well.[1,3,4] In both disorders, a fixation on routine, ritualized patterns of behavior, resistance to change, and restrictive interests of disproportionate intensity may appear.[5] In individuals with ASD, comorbid anxiety disorders can exacerbate ASD symptoms and aggravate behavioral problems.[6,7]

There is evidence supporting pharmacological interventions with selective serotonin reuptake inhibitors and cognitive-behavioral therapy in the cases where OCD and ASD are comorbid.[8-10] However, in the cases where both OCD and ASD occur in comorbidity with intellectual disability, the literature is scarce.[10-12] We report a case of a male patient presenting OCD in comorbidity with ASD and Intellectual disability, highlighting the clinical manifestations, diagnostic approach and therapeutic strategies applied in the management of this comorbid presentation.

CASE REPORT

A 43 year-old man was hospitalized in our department from the emergency unit, where he was taken by the authorities in the context of reiterated aggressive behavior towards his father. In the psychiatric emergency unit, he presented hostile and irritable contact and it was possible to identify contamination obsessions driving to compulsive washing. He lived with his father and used to integrate a Day Care Unit which was temporarily closed due to the SARS-CoV-2 pandemic. He was a tall ectomorphic man, with no obvious physical abnormalities, other than the reddish plaques on his hands, compatible with dermatitis associated with compulsive hand-washing. His initial complaints focused on the fact that he "had to clean all the spermatozoa from the hands". He described having to "press the soap dispenser three times in every hand-wash", and lately he had to shower up to ten times a day. In between washings, he would confirm with his father if he was sufficiently clean. It was clear that the aggressive outbursts arose when the father refused to collaborate with his compulsive behaviors. The obsessions and compulsions occupied most of his time, every day, aggravating for at least 3 months prior to admission.

At his first visit to a child and adolescent psychiatry at the age of 11, he was diagnosed with ASD and Intellectual disability. His OCD diagnosis had been established from the age of 14, and the usual themes revolved around contamination and sexuality.

The symptomatic course of obsessive-compulsive symptoms had been one of frequent relapses and occasional partial remissions. There was also history of prescription of high doses of clomipramine, co-prescription of clomipramine and fluvoxamine, in concomitance with several first and second generation antipsychotics as well as mood stabilizers. At admission, physical and systemic examination were normal. His complete blood count, liver function tests, kidney function tests, thyroid function tests, urinalysis, were all within normal range. Computed tomography (CT) scan was not performed, but previous brain images had no relevant changes.

We decided to treat the patient with fluvoxamine 200 mg/day, haloperidol 10 mg/day and lorazepam 5 mg/day in order to stabilize his behavior, considering previous prescriptions. After 2 weeks there was minimal improvement in the patient's rituals with continuous and excessive hand washing behavior. As fluvoxamine and haloperidol were titrated, these ideas got progressively more egodystonic and he kept asking how to "delete" his thoughts and doubts about cleaning and sexuality. We also applied behavioral techniques directed to compulsions and performed supportive practices.

Improvement started after 4 weeks, and despite keeping his own routines of washing his hands in specific periods and during a rigorously determined amount of time, we could manage an improvement with substantial reduction of the excessive washing and rubbing. His baseline interests and concerns - sports videogames - became the main topic of conversation.

At discharge, 6 weeks after admission, the patient was prescribed with the following pharmacological treatment: fluvoxamine 300 mg/day, haloperidol 30 mg/day, ciamemazine 200 mg/day and lorazepam 5 mg/day. At 2 months follow-up visit, significant improvement was reported in his daily functioning and the social center the patient used to go before SARS-CoV-2 had reopened.

DISCUSSION

It is described in the current literature that around 25% of people with OCD are also diagnosed with ASD.[2] Of those with a diagnosis of ASD, approximately 5% also have an OCD diagnosis.[2] It is likely that OCD is underdiagnosed in ASD because ASD associated problems outshine OCD symptoms, or since OCD symptoms overlap with ASD phenomena. Also, there may be an erroneous over-diagnosis of OCD in individuals with ASD if the nuclear symptoms of the last, such as resistance to change, highly restricted interests/routines and ritualized patterns of behavior, are misunderstood and erroneously considered as obsessions or compulsions.[5] There is no doubt that managing OCD and ASD in intellectually disabled individuals is difficult, because symptoms are predominantly behavioral rather than the classical anxiety spectrum presentation. The egodystonic quality that lead OCD-only patients to report their behaviors as excessive, are rare in the ASD population, and even rarer when intellectual disability is

present.[5] In this case, OCD presented not only as sexual obsessions and excessive cleaning, but also as behavioral problems in the form of aggression. To establish a differential diagnosis, it is important to evaluate the experience of anxiety in relation to the obsessive thought and compulsions. In OCD, obsessions are reported as intrusive, unacceptable and egodystonic.[1,14] This is not characteristic in ASD, except of course in the cases in which there is comorbidity. Our patient initially showed an egosyntonic quality in his obsessions and compulsions. However, he manifested anxiety in what concerns sexual thoughts and obsessions which conditioned his aggressive behavior directed to his father. The assessment of observable behavior has reliability in diagnosing OCD in such patients, with emphasis on externally observable components of the disorder, rather than on inner conflicts and anxiety.[15,16]

Our strategy was based on pharmacological optimization and psychotherapy, including behavioral techniques. Also, it must be acknowledged that external precipitants, such as routine alteration, may play a critical role in clinical destabilization and symptomatic course.

Responsabilidades Éticas

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