

Case Report

A Rare Case of Very Early onset Obsessive Compulsive Disorder and Excessive Onanism in a 7 Year Old Son of a Don Juan

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Abstract

A case of hypersexual behavior occurring in association with obsessive-compulsive disorder (OCD) in a child and father is described. Both had non-paraphilic sexual addiction along with non sexual obsessions and compulsions diagnostic of obsessive-compulsive disorder. The case is presented for its clinical interest, because of familial pattern of sexual addiction in association with OCD. We intend to highlight the fact that hypersexual behavior in OCD patients could be part of impulsive end of obsessive-compulsive spectrum disorder.

ABBREVIATIONS

OCD -Obsessive-Compulsive Disorder

INTRODUCTION

The term hyper sexuality has three main contenders: sexual compulsivity, sexual impulsivity, and sexual addiction. The International Classification of Diseases (ICD-10) [1] of the World Health Organization includes "Excessive Sexual Drive" (coded F52.8), which is divided into satyriasis for males and nymphomania for females, and "Excessive Onanism/Masturbation" (coded F98.8).

Sexual compulsivity is the name given to this condition by investigators who believe that it should be classified as an obsessive-compulsive disorder (OCD). They argue that the sexual behavior in this condition is compulsive, since it functions to reduce anxiety and other painful affects. Perhaps because these sexual behaviors also provide gratification, they are more often ego-syntonic [2, 3]

Another way of understanding hypersexuality is with an addiction model. The concept of hypersexuality as an addiction was started in the 1970s by former members of alcoholics Anonymous who believed that their sexual behaviors meant the same thing as their alcohol use [4].

Barth and Kinder [5] argued against classifying hypersexuality as an addiction or as a compulsion, arguing instead for classifying it as an impulsivity problem. They argued that an addiction entails a substance and withdrawal states, whereas sexual behavior has neither, and that compulsive behaviors exclude intrinsically enjoyable activities, whereas sexual behavior is

intrinsically enjoyable. Hypersexuality does, however, contain the essential elements of an impulsivity problem: (1) It pertains to the failure to resist an impulse, drive, or temptation. (2) There is an increasing sense of tension before the behavior. (3) There is an experience of pleasure, gratification, or release at the time of committing the behavior.

The lack of an accepted term has arguably contributed to the relative paucity of research in this area. Hypersexual disorder is usually underreported even though it is commonly encountered in clinical practice. We are describing a case of excessive masturbation/onanism in a 7 year old child with obsessive-compulsive disorder in which careful evaluation revealed the presence of a psychopathologically similar spectrum of satyriasis with OCD in the father.

CASE PRESENTATION

A 7 year old boy was brought to the psychiatry OPD by his mother with the complaints of recurrent paraphimosis for past one year, which had to be reduced with lubricants, cold compression or by manual pressure. As the frequency of occurrence of paraphimosis increased, mother became suspicious and noticed the reason behind its recurrence was excessive and compulsive masturbation by the child. Child was indulging in masturbation once or twice per day since past two years but his frequency had increased gradually to several times in a day for past six months and it at times lead to paraphimosis. He was often thrashed and beaten up by his mother for the same, but he found it difficult to resist. He derived pleasure from the act and had no guilt feelings or anxiety concerning his behaviour. He expressed no ruminations or thoughts which were distressing to him.

In addition to this mother reported that child has a habit of maintaining excessive cleanliness since the age of one year. As he never defecated or urinated when he started walking, rather he started crying when he had the urge. He never soiled his clothes while playing or eating. He was toilet trained at the age of 15 months. As he grew up his preoccupation with cleanliness has increased, he doesn't play with children if they urinate or defecate in their clothes, and doesn't like dirty places. He washes his bicycle twice a day and takes bath around five times in a day himself during summers and 2-3 times in winters. He changes his clothes 5-6 times a day and often becomes anxious or irritable if he is not allowed to do the same. There was no other relevant past psychiatry or medical history and child has never taken the treatment for this problem. He was good in studies and his developmental history was normal.

The child's father 30 yrs of age had been diagnosed with non paraphilic sexual addiction with obsessive compulsive behaviour two years back from our hospital and is on treatment for the same. He was brought by his wife with a 9 year history of increased sexual activity. He reported having sexual intercourse 10-15 times in a day, with his wife, with prostitutes and at times even with any female acquaintance. According to him, he was unable to delay his sexual impulses and felt almost driven to commit sexual intercourse instantly. On most occasions, he would feel so overwhelmed by his compelling sexual needs that he would start sexual act without using condom, following which his wife had multiple abortions and later had to get the tubectomy done. He reported having non orgasmic sexual intercourse most of the time but there appeared to be little or no guilt or remorse concerning his behavior. The wife reported that he insisted for frequent sexual intercourses with her much against her will and if she would resist he would thrash her and threaten to abandon her. As he was a land owner and gives his land on lease for farming, he has no work to do and was free throughout the day. Whenever patient was stressed or had any problem he would resort to sexual intercourse, also he had recurrent thoughts about sexual activity during the day.

He also had compulsive need to maintain cleanliness and had some other compulsive rituals, counting compulsions and ritualized eating behaviour. His premorbid personality was described as introvert, obsessive and anxious. He had limited peer group as he was preoccupied with his thoughts and acts for most of the time. There was no history of drug abuse in the father.

Mother had brought the child with the fear of her son becoming a sex addict like his father.

On MSE child appeared to be anxious, revealed no evidence of a persistent mood change or psychotic feature. He expressed a feeling of helplessness at his failure to control his sexual behaviour but also defined the act to be pleasurable. Other obsessions of contamination were present and compulsive rituals. There were no motor tics and no symptoms of bipolar affective disorder in the child.

Physical and neurological examination was normal. Endocrinological assessment was within normal limits. An MRI scan of the brain was normal. A diagnosis of obsessive-compulsive disorder with hyper-sexual behavior was made. A score of 29 of

a maximum total of 40 was noted on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) (Goodman et al., 1989), with a score of 14 on obsessive symptoms and 15 on compulsive symptoms. He was started on clomipramine 25mg per day slowly escalating it to 50 mg per day. The patient and his family members were psychoeducated about the nature of patient's illness. The patient exhibited significant improvement in the fourth week of treatment with respect to OCD and hypersexual symptoms. The patient scored a total score of 13 on Y-BOCS with a score of 8 on obsessive symptoms and a score of 5 on compulsive symptoms. However there were discrete episodes of masturbation present when the child failed to resist an impulse and experienced pleasure and gratification after the act. He was started on tab olanzapine 2.5mg/day and there was significant decrease in the activity noted within three weeks. Currently, the patient is maintaining well on clomipramine 50mg/day and olanzapine 2.5mg/day and weekly CBT session

DISCUSSION

The child had non-sexual obsessions, compulsive rituals, and avoidance behaviour for past 5 years, thus he was diagnosed with obsessive-compulsive disorder. However, the predominant presenting complaint was excessive masturbation for past two years. It could be argued that this behaviour was symptomatic of OCD as it was repetitive and the patient felt it was beyond his control even though it was harmful for the patient as it lead to recurrent paraphimosis, but the child did not experience his repetitive sexual behaviour as distressing, repugnant or unreasonable, neither did he made any attempt to resist the behaviour. Also he experienced pleasure and gratification at the time of committing the act, which makes it more likely to be an impulse. Since both compulsive and impulsive aspects are present in the child with respect to hypersexuality, thus it seems more to be on the impulsive end of OCD spectrum.

Also the fact that his father had satyriasis with obsessive compulsive disorder makes the case unusual. Hyper sexuality in both father and child, does seem to be a part of spectrum of obsessive compulsive disorder. Thus the possibility of genetic linkage of hypersexuality and ocd with possible coinheritance arises.

It may be useful to think of at least some OC spectrum disorders as falling on a continuum anchored by two poles, with classic compulsive OCD at one end and with tourette syndrome and tic related behaviour at other end. The dimension seems to range from compulsive behaviour to tics, with impulsions being in between. OC spectrum disorders like excessive masturbation, problem gambling, bulimia nervosa and compulsive buying, could be viewed as addictive disorders in which mesolimbic dopamine pathway is dysfunctional. Also it seems likely that serotonergic and nor-adrenergic mechanism play an important role of affect regulation in maintaining addictive behaviours. Thus there is role of SSRI with neuroleptics in treatment of impulsive end of OC spectrum disorders [6].

Kafka et al. [7], in three outpatient males samples (total n=240) reported a lifetime co morbidity of hypersexual behaviour with obsessive-compulsive disorder ranging from 0-11%.

Langstrom et al [8] in 2002 in a study on same sex teens

reported that heredity and environment influenced the problematic masturbatory behaviour among children. The degree of problematic child masturbatory behaviour resemblance was higher within MZ twin pairs as compared to DZ same-sex twin pairs. Model fitting indicated that genetic factors substantially influenced the studied behaviours (77%, 95% CI = 9-96%), although family environment also played a role.

In a recent study, Reid et al. [9] (2009) studied 59 males seeking psychological help for nonparaphilic hypersexual behaviours and compared their clinical sample to a control group of 54 college age men. The hypersexual sample reported more interpersonal sensitivity/depressive (neuroticism) symptoms, obsessive characteristics, social alienation, and preoccupation than the sample norms of the scale.

CONCLUSION

This case has no similarity in the literature and this report of OC spectrum disorders, i.e. OCD and hyper sexuality in both father and child encourages the interested clinician to think beyond the 'chicken bones' of patterns of co morbidity. Certainly the field needs more clinicians and researchers to test various models of OC spectrum based on consideration of ethology, neurobiology and treatment response.

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