

The Course of Childhood OCD, Its Antecedents, Onset, Comorbidities, Remission, and Reemergence

A 12-Year Case Report

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Abstract: The precursors of obsessive compulsive disorder (OCD) and its course are described in a boy in our clinic. First seen at age 4 with choking phobia, OCD was first diagnosed at age 9, was remitted by age 12, and did not reemerge again until age 16. Consistent with Kovacs and Devlin, we propose the course is consistent with biologically driven processes for internalizing disorders for children. This 12-year case report provides for observation of the development and course of OCD. This case is unique in describing antecedent behavior to onset of OCD, which was early choking phobia or obsessions of swallowing large objects and compulsive reassurance seeking. It is unique in describing a single child patient who shows remission of OCD and later reemergence of OCD. Literature of an empirical and theoretical nature support what can be learned in terms of the course and treatment of this childhood condition.

Keywords: obsessive-compulsive disorder, comorbidity, symptom return, childhood, remission

1 THEORETICAL AND RESEARCH BASIS

The case we present in this report has afforded a unique opportunity to view the behavioral precursors, development, and course of obsessive-compulsive disorder (OCD) in a child followed for 12 years in our clinic in the Department of Psychiatry at the University of Florida. Nonsignificant details have been changed to protect the confidentiality of the patient and family. We have not seen a case report describing antecedents to development of OCD or a case report of a child followed for this duration. We

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believe the comorbidities and frequent exacerbations are consistent with the hypothesis that biologically driven processes influence the course of OCD in this youngster. Kovacs and Devlin (1998) have written that genetically driven biologic processes play an important role in the course of some children's internalizing disorders. We also believe environmental factors affect the psychopathology of the patient on whom we have reported.

Some retrospective studies (Flament et al., 1988; Keller et al., 1992) have suggested that childhood anxiety disorders may last for many years and may be comorbid with development of other psychiatric disorders. We briefly review four prospective studies on childhood OCD. Flament et al. (1990) followed clinically referred adolescents with OCD for 2 to 7 years and found that of those seen again, 68% or two thirds still had OCD. Leonard, Swedo, and Lenane (1993) followed a group of clinically referred children with OCD after a Clomipramine trial and found that 43% still met criteria for OCD at follow-up 2 to 7 years later, though many others still had subclinical OCD symptoms and only 6% met criteria for true remission. Thomsen and Mikkelsen (1995) followed a sample of children with OCD for 1½ to 5 years, and found that approximately one half retained their OCD diagnosis at follow-up. Berg et al. (1989) studied a community sample of nonreferred children and noted that of children with OCD or a related obsessive-compulsive spectrum disorder at the start of the study, a substantial proportion still had the disorder 2 years later. It is of interest that in the Thomsen and Mikkelsen study, of those who retained the diagnosis, one third had an episodic course and two thirds were considered chronic. Hence, these prospective studies suggest that a substantial portion of children with OCD—up to two thirds—still met diagnostic criteria at follow-up periods of 1½ to 7 years. This case shows behavioral precursors to OCD, onset of OCD lasting for several years during childhood, remission of OCD for several years, and its recurrence several years later. Remission and reemergence of OCD in childhood is suggested as a possible course in Thomsen and Mikkelsen (1995), though we have not seen this described in a case report.

Choking phobia appeared to play a critical role in the later development of OCD in the patient in our case study. Choking phobia is defined as a persistent fear and avoidance of swallowing solid foods, liquids, and/or pills (McNally, 1994). The literature on this disorder does not include published treatment outcome studies but rather a number of case reports (Zelikovsky, MacNaughton, & Geffken, 2001). Prevalence of choking phobia after choking is unknown. However, it seems reasonable to speculate that many individuals choke on foods without subsequently developing a choking phobia or solid food/swallowing phobia. An initial conceptualization of choking phobia may be understood with reference to the classical conditioning model. When choking is paired with an eating event, choking is the unconditioned stimulus and the accompanying anxiety is the unconditioned response, and eating becomes the conditioned stimulus to elicit the conditioned response of anxiety. Subsequently, the act of eating, or the conditioned stimulus, is avoided because of fear of a conditioned response of high anxiety associated with fear of choking while eating. It is our contention that although a behavioral conceptual-

ization of choking phobia parsimoniously explains onset of our patient's first antecedent to OCD characterized by fear of choking, recurrence of related symptomatology in our patient over 12 years also needs to make reference to Kovacs and Devlin's (1998) contention that biologic processes drive some children's internalizing disorders.

It is common for most children to display age-dependent behaviors that are obsessive and ritualistic in nature (Judd, 1965; March & Mulle, 1998). For example, some young children have complicated bedtime rituals or demand to have activities conducted "just so" (March & Mulle, 1998). Normally developing school-aged children often engage in compulsive or ritualistic behavior. For example, they may ritualistically run their hand along the wall or a fence post or avoid stepping on cracks in the sidewalk. Rituals that are seen as normal in the development of children are not excessive, nor do they interfere with the child's functioning. When asked to interrupt or stop a developmentally normal ritualistic behavior, the child will do so without significant and prolonged emotional distress. In addition, developmentally normal rituals typically abate by 8 or 9 years of age. Some authors (Leonard, Goldberger, Rapoport, Cheslow, & Swedo, 1990) have proposed that these normal developmental rituals involve mastery and control and can be distinguished from OCD on the basis of their content, severity, and timing. OCD symptoms are different from developmentally normal rituals, as they are often seen as bizarre, occur later in development, and are more time-consuming, distressing, and impairing. The case presented in this report illustrates the more bizarre, distressing, and ongoing nature of childhood OCD.

Incidence of OCD in youngsters is 1%, whereas the lifetime prevalence is estimated as 2% (Flament et al., 1988; March & Mulle, 1998). Swedo, Rapoport, Leonard, Lenane, and Cheslow (1989) have studied the age of onset of OCD. They found an earlier age of onset in males than females, though in older samples, the ratio between the sexes was relatively equal. Other researchers (Rasmussen & Eisen, 1990) have described a retrospective report of adults, which finds that between 33% and 50% had onset before adulthood. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (DSM-IV) (American Psychiatric Association, 1994) indicates that for boys, most have onset of OCD between the ages of 6 and 15, though for females, onset is most often between the ages of 20 and 29. Our case illustrates an example of early onset in a boy. Our patient had onset of his obsessions at age 8 but had antecedents in the form of different phobias years earlier. Given the pervasive and chronic nature of OCD, early onset in children and adolescents significantly contributes to developmental problems in daily, academic, social, and family functioning; the case presented in this report illustrates these issues.

One of the better studies of psychiatric comorbidity in children with OCD, to date, was conducted by Swedo et al. (1989). Their sample included 70 children and adolescents diagnosed with OCD. Those with an existing diagnosis of mental retardation, eating disorders, and Tourette's syndrome were excluded from the study. Remarkably, only

26% of the participants had OCD as their sole diagnosis. Tics (30% of the sample) were the most common comorbid condition. Other conditions that were comorbid with OCD included the following: major depression (26% of the sample), specific developmental disorders (24% of the sample), oppositional disorders (11% of the sample), attention deficit disorder (10% of the sample), and conduct disorder (7% of the sample). The patient described in this article presented with comorbid phobias, oppositional defiance disorder, attention deficit hyperactivity disorder (ADHD), and separation anxiety. In the prospective studies of the course of OCD referred to earlier (Berg et al., 1989; Leonard, Swedo, & Lenane, 1993), psychiatric comorbidity in childhood samples of OCD or subclinical OCD ranged from 56% to 96%, suggesting that the case in this report is fairly common in this respect.

There are two treatments demonstrated as effective for OCD. These include cognitive behavior therapy (CBT) and pharmacotherapy. CBT (March, Franklin, Nelson, & Foa, 2001) consists of exposure and response prevention. In exposure, patients are intentionally encouraged to face their fears. For example, in this case, the patient had an obsession related to swallowing large objects; in adolescence, exposure for our patient consisted of asking the patient to hold the feared objects in or near his mouth. With response or ritual prevention, the individual is asked to reduce or altogether do away with their compulsive behavior. In the case in this report, the patient compulsively sought reassurance. The patient was asked to intentionally reduce and then eliminate reassurance seeking. His family also was coached on how to respond to the patient's request for reassurance to reduce the family accommodation (Calvocaressi et al., 1995).

The selective serotonin reuptake inhibitors (SSRIs) are helpful in treating OCD. However, Clomipramine, which is not an SSRI, was the first medication found to be effective with OCD. However, with children and adolescents, Clomipramine is usually not used as a first line choice because of increased side effects such as gastrointestinal distress, orthostatic hypotension, dry mouth, and constipation. Our case illustrates such psychopharmacological treatment. Combinations of behavior therapy and SSRIs have been described with good outcomes (March et al., 2001), as they are in this case.

2 CASE INTRODUCTION

Marvin's case is remarkable, as his development of OCD was associated with orally related phobias, distressing oral obsessions and disruptive behavior disorders. There was clinical evidence to suggest that his disruptive behavior was exacerbated by his anxiety. At initial presentation at age 4, Marvin was diagnosed with choking phobia. Antecedents to this problem were episodes where he choked on a peanut butter sandwich and choked while swallowing a penny. As described in Section 7, the choking phobia quickly

resolved with behavioral treatment, although it was followed soon thereafter by problems with restricted eating. The problems with restricted eating resolved quickly with an operant treatment program.

Prior to our recognition of Marvin's OCD, he evinced a dental phobia, a bathroom phobia, contamination anxiety, and symptoms of ADHD. Eventual onset of OCD, characterized by obsessions of swallowing large objects, was striking in its oral focus given the history of choking phobia, related eating problems, and dental phobia. Marvin showed many of the comorbid psychiatric disorders described in the Swedo et al. (1989) study, and as has appeared to be common in large percentages of children in prospective studies of OCD by Berg et al. (1989) and Flament et al. (1990). Marvin showed positive responses to behavioral and psychopharmacological treatments over the 12-year course that he was followed in our clinic. However, following positive responses to treatment, OCD and other symptoms recurred on numerous occasions. This pattern likely related to the discontinuation of psychotropic medication, the difficulty the patient and his grandparents had in maintaining the behavioral family treatment principles of OCD, and the biologically driven nature of his disorders. However, with the remission of symptoms, intermittent treatment was understood in the context of the patient being a child and living in a low-income family.

It was after 4½ years of intermittently seeing Marvin that the diagnosis of OCD was made. This followed several episodes of Marvin experiencing intrusive worrisome ideas that he was swallowing large objects. It was clear early on that from ages 9 through 12, and again at 16 when seen in our clinic, there were intrusive obsessions and compulsive reassurance seeking present. The family response to compulsive reassurance seeking in Marvin's case is prototypic of family accommodation described by Calvocoressi et al. (1995). This is where the family engages in behaviors to attempt to neutralize the patient's distress that, in turn, actually reinforces the problematic behavior.

3 PRESENTING COMPLAINT

Marvin initially presented at age 4 with a choking phobia following two specific choking episodes after medical assessment. He had not eaten solid food for 6 weeks when we saw him. Over time, the youngster developed numerous disruptive behaviors both at home and at school; these behaviors often appeared to stem from a predisposition for anxiety. In elementary school, the child began to present with obsessions of an oral nature. Looking back across the 12 years of treatment, we were able to observe a pattern of anxiety that initially manifested as oral phobias and behavioral disturbance and finally emerged as OCD.

4 HISTORY

FAMILY

Marvin lived in a rural town with his maternal grandparents, who were his primary caretakers, and although it was rare that he lived with or stayed with his mother, she was a source of instability in his life. His grandfather was a gardener and his grandmother was a homemaker. Marvin did not have contact with his biological father. Marvin had a 3 years older half-brother with whom he was close. His brother also lived primarily at his grandparents'. Both children had brief periods when they lived with their mother and stepfathers. Marvin's mother had been married seven times by the time he was an adolescent. His mother was employed as an aide in a hospital. His mother had one psychiatric hospitalization during Marvin's childhood for a suicide attempt and some alcohol-related problems.

SOCIAL

Marvin's peer relations were disrupted by his psychiatric conditions as described in Section 7. His school was changed on numerous occasions because of behavior stemming from his psychiatric conditions. He was active in sports, which, at times, were disrupted by his psychiatric disorders.

PSYCHIATRIC

Onset of Marvin's psychiatric problems occurred early at age 4 beginning with choking phobia. Although his OCD was diagnosed at age 9, he had numerous outpatient contacts with our clinic prior to that age for restricted eating problems, contamination anxiety, dental phobia, bathroom phobia, and ADHD. Comorbid with his OCD were phobias, disruptive behavior problems, and anxiety. In early adolescence, he had a remission of psychiatric problems requiring clinical attention and it was not until age 16 that his OCD reemerged.

5 ASSESSMENT

Marvin's psychiatric history was unstable, with periods marked by exacerbations of numerous psychiatric conditions described in the section above. Marvin and his family responded well to a combination of behavioral, cognitive behavioral, family, and psychopharmacological interventions. However, there were numerous exacerbations often associated with environmental factors resulting in treatment throughout child-

hood and adolescence. The pervasiveness and repeated recurrence of his psychiatric problems was thought to be biologically driven.

6 CASE CONCEPTUALIZATION

The course of this case is interesting as the initial presentation of choking phobia seemed parsimoniously explained in terms of learning theory. In addition, learning-based treatment was immediately successful in treating the clinical problem. However, one must ask how many children have experiences where they choke on a peanut butter sandwich or swallow a coin and do not develop choking phobia or subsequent refusal to eat. Recurrence of orally related symptoms over the course of the 12 years that Marvin was followed in our clinic as well as the disruptive behavior disorders, many of which had an anxiety-driven basis, can be seen as consistent with a hypothesis that his psychopathology was biologically driven. The conclusion of Kovacs and Devlin (1998) that genetically driven biologic processes play an important role in the course of some children's internalizing disorders, at the very least, makes sense in the case of Marvin. Marvin's treatment was episodic in our clinic, and it would not be surprising if, in the future, he again presents for treatment with OCD-related symptoms. Over time, Marvin's symptomatology became more consistent with the diagnosis of OCD. At age 16, he had obsessive intrusive distressing ideas and excessive recurrent time-consuming and interfering behaviors. Although the prospective studies of childhood OCD report results on the percentages of children still having OCD at varying follow-up intervals, Marvin's case illustrates the occurrence, remission, and reemergence of OCD in a youngster. Thomsen and Mikkelsen (1995) describe that of one half of youngsters who maintained their OCD at follow-up after 1½ to 5 years, one third had an episodic course, and two thirds had a chronic course. The course of Marvin's condition over 12 years of treatment in our clinic describes the development of OCD and its course through midadolescence.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

AGE 4 TO 5 YEARS—CHOKING PHOBIA AND RESTRICTED EATING

Marvin was a 4-year, 11-month-old youngster when he first presented to our clinic with a primary complaint of refusal to eat solid food. Marvin had been on a liquid diet for 6 weeks when he was first seen in our clinic. Medical evaluation had failed to demonstrate any organic basis for his refusal to eat solid foods. Refusal to eat solid food was subsequent to a set of choking experiences, including choking on a swallowed penny and choking on a peanut butter sandwich. Several learning-based theories, including obser-

vational learning, operant theory, and classical conditioning, were used as the basis of a behavioral treatment for Marvin. In five sessions, Marvin was reliably eating solid foods. Several months later, Marvin was seen again in our clinic as he had significantly restricted the variety of foods he was eating. This was addressed through an operant program designed to extend the range of food that he ate. A positive outcome was achieved in three sessions.

AGE 7 YEARS—CONTAMINATION ANXIETY, DENTAL PHOBIA, BATHROOM PHOBIA, AND ADHD

It was not until age 7 that Marvin again appeared in our clinic. At that time, he had some school-related problems. Treatment addressed a problem where he had gotten some chalk on his clothes and became very anxious and disruptive around this event. A few months later, when Marvin was 7 years 6 months, he presented with dental phobia. He had several cavities and had been very disruptive in the dental office, biting and kicking the dentist. Within three sessions of graduated shaping and exposure to the dental setting, Marvin successfully achieved allowing the dentist to perform the dental fillings for his cavities.

At 7 years 8 months, Marvin presented to our clinic after having developed a phobia of the public children's bathroom at school. He limited his bathroom use to the adult single bathroom at school, where he refused to close the door. Again learning-theory-based behavioral interventions were used to successfully address this problem.

Shortly before Marvin's eighth birthday, our clinic had contact with Marvin's school regarding his disruptive behavior in class. Our assessment confirmed that Marvin met diagnostic criteria for ADHD. After involving a child psychiatrist, a trial of Ritalin was begun. Marvin's grandmother, who was the primary caretaker, was very resistant to the medication and discontinued Ritalin soon after it was started. The problems seen during the time the patient was 7 illustrate the problem of psychiatric comorbidity even prior to his diagnosis with OCD. More important, the oral phobia represents behavioral antecedents to the development of OCD not described in other case reports.

AGE 8 YEARS—ADHD AND UNDIAGNOSED OCD SYMPTOMS

The school's concerns about Marvin's hyperactive and disruptive behavior persisted when he returned to our clinic at age 8 years 3 months. A Ritalin prescription of 5 mg bid (twice per day) was reinitiated with the new school year. Marvin had some adverse reactions, including a decreased appetite and "scrunching up" of his nose, which were viewed as stimulant-induced side effects and resulted in the decision to discontinue the Ritalin. At age 8 years 5 months, hyperactivity at school worsened and Marvin was prescribed Clonidine 0.05 mg qid (four times per day). Marvin had adverse reactions to Clonidine, including depression, crying, headaches, and sleep problems. The Clonidine then was discontinued.

At 8 years 7 months, Marvin presented again to our clinic. His grandparents related that he had been displaying oppositional, noncompliant, hysterical, and manipulative behavior in the preceding weeks. Of particular concern was a report that Marvin misplaced a drinking glass and expressed concern that he had swallowed it. In retrospect, this was interpreted as Marvin's first intrusive obsession. This obsession was the first sign of emerging OCD, though it was not diagnosed as such at that time. This event occurred simultaneously with the stress that Marvin was having at school. He was again put on Ritalin 5 mg and additionally Imipramine 25 mg qhs. Marvin and his grandparents were adherent with the medication for several months and no problems or side effects were noted.

AGE 9 YEARS—PANIC, PHOBIAS, OCD, AND DISRUPTIVE BEHAVIOR

At 9 years 2 months, Marvin presented to our clinic again. This was after he had returned from football practice and stated that he was worried as he experienced difficulty breathing, dizziness, nervousness, and "feeling funny." This episode was conceptualized as a panic attack. Around the same time, Marvin had concerns that he swallowed a misplaced fork at mealtime. Concurrently, Marvin was experiencing difficulty sleeping alone as he was fearful at night. He frequently managed his fear by sleeping with his older brother.

At 9 years 4 months, Marvin had peer-related issues that escalated to the point of him being involved in a fight at school. At this time, he was threatened with suspension from school. He was maintained on 25 mg of Imipramine. When Marvin was 9 years 5 months, while visiting his mother and stepfather, his stepfather dropped a flashlight and Marvin feared he had swallowed some of the batteries and became quite panicked. At this point in treatment, these symptoms were conceptualized as symptoms of OCD. Marvin's obsessions also included fearing that mud on his hands would act like battery acid. He compulsively drenched his hands with soap and began his ritualized washing behavior. At this point, Imipramine was stopped and Clomipramine 25 mg qhs was started, thus initiating the psychopharmacological treatment of his OCD.

Still in treatment at age 9 years 7 months, Marvin's disruptive school behavior continued to escalate. During the same time period, Marvin's mother made a suicide attempt and was psychiatrically hospitalized. Marvin's grandmother attributed this event to the mother's alcohol problem. Marvin was very upset by his mother's hospitalization and the events precipitating the hospitalization. Marvin's difficulties continued: He was fearful of sleeping alone at night, was disruptive at school, and had an episode where he feared he had swallowed a knife. At age 9 years 10 months, we again had contact with Marvin's school in response to his disruptive behavior, including fighting and name calling. Events described while Marvin was ages 8 and 9 illustrate the problems of comorbid psychiatric diagnoses with childhood OCD.

AGE 10 YEARS—OCD AND DISRUPTIVE BEHAVIOR

For several months, Marvin's fear of swallowing objects appeared to remit; thus the Clomipramine was discontinued. Given all the problems that Marvin was having at school, he was transferred to a new school. Shortly after his 10th birthday, and 1 month following discontinuation of the Clomipramine, Marvin had a resurgence of obsessions regarding swallowing large objects. In this episode, he had seen some small animals and thought he had swallowed them. Furthermore, he had an episode where he thought he had swallowed a toy. The grandparents were coached to use responses that did not accommodate to Marvin's requests for reassurance, illustrating behavioral family treatment principles for not responding to compulsive reassurance seeking. Clomipramine 25 mg qhs was resumed. The prescription was taken for 2 months and discontinued. At age 10 years 3 months, Marvin had gone to live with his mother, which continued until he was 11 years 7 months, though he still frequently visited his grandparents. There was no clinical contact with Marvin and the family for the time Marvin lived with his mother, at which point Marvin was 10 years 10 months.

At 10 years 11 months, when seen again in our clinic, Marvin was found with a knife at school and he was subsequently recommended for placement in a classroom for behavior-disordered children. The school was very concerned about the incident with the knife and asked if his medication could be reinitiated. However, as it was almost summer and his guardians were not in favor of this, it did not occur.

AGE 11 YEARS—OCD, ANXIETY, PHOBIAS, AND DISRUPTIVE BEHAVIOR

At age 11 years 4 months, Marvin presented to our clinic after he was beaten by some older adolescents in the school bus. At this time, Marvin was in the sixth grade and was behind academically. He had not had recent symptoms of obsessions related to swallowing objects or other indicators of OCD. He was back living with his mother, though he had frequent contact with his grandparents.

At age 11 years 7 months, when seen in our clinic, Marvin was displaying disobedience and disruptiveness at school. Anxiety was underlying some of the conduct problems supported by symptoms Marvin was evidencing of phobic behavior at night and not sleeping alone. As well, he had many somatic complaints, including stomachaches and headaches. Furthermore, he was school avoidant in the morning. Moreover, at this time, it was learned that Marvin's stepfather frequently lost his temper with Marvin. This family dynamic appeared to significantly affect Marvin's emotional functioning. As Marvin was not receiving pharmacological treatment, he was prescribed Prozac 10 mg. Subsequently, many of these problems began to fade. During this phase of treatment, Marvin also disclosed phobias related to "bathroom doors and elevators." Once again, Marvin's living situation was disrupted as his mother and her seventh husband were going through a divorce. Marvin and his brother returned to live with their grandparents.

Over the next months, with the change in residence and the start of Prozac, problems decreased for Marvin in all settings. However, Marvin was having mild to moderate appetite loss coincident with the Prozac. At age 11 years 9 months, Marvin was having frequent fights at school. He was temporarily put on homebound instruction and plans were made to transfer him to another school for the next year. During the summer, his grandparents discontinued the Prozac. Marvin's problems did not reach levels requiring clinical attention again until he was age 16.

8 COMPLICATING FACTORS

Marvin's case clearly illustrates how OCD disrupts functioning across all spheres. OCD is a mental health condition affecting several million Americans. It adversely affects functioning across a broad range of spheres including family, social, work, and academic functioning (Adams, Waas, March, & Smith, 1994; Flament et al., 1988; Last & Strauss, 1989; Leonard, Lenane, & Swedo, 1993). As described previously, Marvin had numerous psychiatric conditions and a mother whose instability affected him. Marvin had problems in school with disruptive behavior that were contributed to by underlying anxiety as well as ADHD. His problem with using public children's bathrooms and only using the adult bathroom with the door open at school was but one illustration of this issue. Problems with social and academic functioning also were evident, as Marvin frequently got into fights at school and was transferred to two different schools owing to his behavior. He also disrupted his family by keeping them up at night and involving them in ritualistic behaviors surrounding his obsessions. Again, we believe the pervasive and recurring nature of Marvin's anxiety was biologically driven.

9 MANAGED CARE CONSIDERATIONS

Marvin's grandparents had a low socioeconomic status background. They showed a pattern of discontinuation of psychotropic medication, and the grandparents had difficulty with Marvin in maintaining the behavioral family treatment principles of OCD. However, with remission of symptoms, intermittent treatment was understood in the context of the patient being a child and living in a low-income, less educated family. Their managed care plan was not generous and contributed to the intermittent nature of care, as well as discounted treatment fees at times.

10 FOLLOW-UP

AGE 16 YEARS—OCD

There was a 4-year period when Marvin was not seen in our clinic. However, approximately once per year, his grandmother called to our clinic to say he was doing well. When he did return to our clinic at age 16, he was having problems with OCD and panic. He was started on Celexa and Xanax. At this time he was described as having an adverse reaction to the medicine, including being “spaced out, eyes glazed, and making funny noises like gasping.” His symptoms included generalized worry, poor appetite, disrupted sleep cycle, and worries that he would stop breathing. Marvin also experienced obsessions related to swallowing large objects and fear of illnesses. Marvin’s main obsessions were fear of choking on spoons, plastic bags, bottle caps, and socks. These symptoms of OCD were interfering with the family routine and Marvin’s daily functioning. Thus, CBT (March et al., 2001) was implemented for the fear of swallowing objects and disruption of family activities.

Because of the reported adverse medication reaction, his medication was changed to Remeron 15 mg qhs, and CBT with exposure and response prevention was implemented. CBT involved developing a hierarchy of feared events approximating placing large objects in and around Marvin’s mouth. For example, we began by having Marvin place a plastic bag at decreasing distances from his mouth. Eventually, he was able to hold a spoon and a sock in his mouth. Both Marvin and his grandparents had little insight into the diagnosis of OCD and thus had difficulty appreciating the cognitive behavioral treatment approach. Notwithstanding, the grandparents were coached, as they had previously been, to use responses that did not accommodate to Marvin’s compulsive reassurance seeking. The combined treatments of Remeron and CBT were associated with a remission of Marvin’s OCD symptoms and the family discontinued treatment. At the time of this report, Marvin had not been seen for 2 years, at which point he was 18 years old.

11 TREATMENT IMPLICATIONS OF CASE

Marvin’s presentation at age 4 for choking phobia and the subsequent course of treatment demonstrate that the clinician does not know how a case will develop. His choking phobia was treated successfully with a learning-based treatment. We believe Kovacs and Devlin’s (1998) conclusion—that genetically driven biologic processes play an important role in the course of some children’s internalizing disorders—makes sense

in the case of Marvin. We would not diminish the role of environmental instability contributed by his mother. The adult caretaker's limited ability to maintain responses that did not accommodate the patient's OCD symptoms likely contributed to the lack of extinction of his symptoms and their recurrence. It is also likely that Marvin's symptoms served both escape and attention-getting functions that contributed to the regular emergence of his symptoms. Limited familial resources and managed care coverage contributed to an episodic treatment that at the time were less-than-optimal treatments. Marvin's numerous psychiatric comorbidities to his OCD were often as much the focus of treatment as his OCD. The combined psychological and psychopharmacological treatments were both seen as therapeutic in his treatment.

Marvin's early entry into treatment and the 12-year duration of treatment are seen as providing an unusually long observation of one child's psychiatric conditions. The opportunity to follow Marvin's choking phobia, restricted eating, dental phobia, and panic over difficulty breathing provide anecdotal evidence consistent with conceptualizing early symptoms as antecedents to the development of his OCD related to swallowing large objects. Reemergence of OCD at age 16 after a 4-year hiatus provides an example of where clinicians must be ready to resume treatment for OCD when it had previously resolved.

12 RECOMMENDATIONS TO CLINICIANS

A combination of CBT and psychopharmacological treatment were successful in managing OCD and Marvin's numerous psychiatric symptoms. There is a good empirical basis for this statement. However, this was in the context of waxing and waning symptoms of OCD and other psychiatric conditions. It involved a flexible approach to treatment, as the family was in and out of treatment over the course of Marvin's childhood and adolescence. We believe the case of Marvin is consistent with the hypothesis that an interaction of environmental and genetic, biologically driven processes contributed to the course of childhood OCD and comorbid psychiatric disorders. We think that in Marvin's case, environmental events and experience influenced how OCD was manifested. Early choking phobia and oral phobias developed into OCD as an irrational fear of swallowing large objects. Marvin's course illustrates that OCD may remit and reemerge at a later date. On reemergence, OCD had the same oral focus. Clinicians may need to resume treatment when problems have resolved for years. This condition contributes to a pervasive disruption of functioning. Early in Marvin's treatment, behavioral approaches were most appropriate given his developmental level and his disruptive behavior problems; more cognitive behavioral approaches were not appropriate until he grew older. The case illustrates how learning-based treatment and contemporary psychotropic approaches can be combined in the treatment of OCD with its onset in childhood.

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