British Journal of Psychiatry (1989), **155**, 116–117

Obsessive–Compulsive Disorder in a Mentally Retarded Woman

RICHARD J. McNALLY and JOHN E. CALAMARI

Obsessive–compulsive disorder is extremely rare among mentally retarded people. We report here a case of a mildly mentally retarded woman who exhibits contamination obsessions, compulsive hand-washing rituals, and avoidance.

Obsessive–compulsive disorder (OCD) is extremely rare among mentally retarded people (Novosel, 1984; McNally & Ascher, 1987). Although 'compulsive' stereotypical behaviour (e.g. body rocking) is common in this population, it is clearly distinguishable from compulsive rituals triggered by anxiety-based obsessions (Rachman & Hodgson, 1980, p. 96). Indeed, as Matson (1982) notes, many clinicians doubt whether OCD occurs in persons with subnormal intelligence. Consistent with the notion that intellectual handicap protects against OCD, obsessive–compulsives often have above average intelligence (Rasmussen & Tsuang, 1984).

Matson (1982) published the only detailed report of OCD in mentally retarded people. He treated three mildly retarded men whose concerns with personal tidiness led them repeatedly to check their clothes and personal appearance, which interfered with their performance in a sheltered workshop. Treatment included exposure to situations that triggered checking, differential positive reinforcement for not checking, modelling of appropriate on-task behaviour, performance feedback, and overcorrection for violations of response prevention of rituals. Treatment reduced checking and self-reports of anxiety.

We describe here a mentally retarded woman with OCD. She had been discharged from our facility and was living in a group home when we obtained permission from her legal guardian to interview her.

Case report

Ms D is a 51-year-old single, white woman with mild mental retardation of unknown aetiology (WAIS-R full scale IQ = 54). She lives in a group home for mentally retarded people, and attends a work activity centre.

Ms D is the oldest of three children born to Scottish immigrants to the USA. Of her two sisters, the older is intellectually gifted, whereas the younger is mildly retarded. Except for her alcoholic grandfathers, there is no family history of psychopathology.

Ms D's records indicate an uncomplicated, full-term birth following a 12-hour labour. At six weeks of age, she developed a high fever requiring her admission to hospital. No further information was available regarding this illness. She began to walk at 13 months, and to talk when three and a half years old. Her language delay prompted an evaluation, resulting in a medical diagnosis of mental retardation. Ms D's formal education was terminated after her first day at school because of the severity of her tantrums. According to her mother, Ms D became anxious before school age whenever deviations from the family routine occurred (e.g. changes in seating arrangements at the dinner table). When anxious, Ms D would compulsively arrange objects.

When eight years old, Ms D was institutionalised at a state school for the mentally handicapped. According to her mother, Ms D's 'mental problems' made her unmanageable at home. These problems ranged from disruptiveness to mutism, which lasted three months. Institutional records describe Ms D's social withdrawal, periodic polydipsia, and hoarding of various objects. Her OCD emerged during early adolescence, and has remained essentially unchanged for the past 35 years. In response to contamination obsessions triggered by 'dirty' objects, she would compulsively wash her hands and face, sometimes for hours. She always carried a towel to decontaminate herself should she become dirty. When asked why she washed so much, Ms D would cry out, "Clean! Clean! I want to be clean! I don't want to be dirty!"

When 42 years old, Ms D was transferred to a smaller state facility, where efforts to reduce her obsessive–compulsive behaviour began. She received amitriptyline with little benefit. Several behaviour-modification procedures were implemented that produced minimal change in her OCD symptoms. She participated in a token economy on her living unit, where she received positive reinforcement for completing pre-vocational tasks, and for appropriate socialisation with peers. She also received tokens for refraining from ritualising for specified periods of time (differential reinforcement of other behaviour), and was fined tokens for engaging in compulsive rituals (response cost). Graduated exposure *in vivo*, consisting of having staff stand near her and touch her appropriately (e.g. attempts to shake hands) was ineffective. She also failed to benefit from progressive muscle relaxation. Physical attempts to prevent excessive hand-washing produced extreme anxiety, and the patient would hit herself and bang her head. Thioridazine (25 mg t.i.d.) reduced the severity of her rituals somewhat.

When 50 years old, Ms D was transferred to a community residential home for mentally retarded adults, where she was observed and interviewed by the authors. Currently, she is particularly obsessed about contamination from

other people. For example, when one of us extended his hand to shake hers, she became visibly anxious, recoiling and crying out that he was 'dirty'. She became increasingly anxious during the interview, and eventually ran into the bathroom to wash her hands. Interestingly, she did not respond to objects we had touched as dirty. Hence, 'contamination' did not generalise as easily as it often does for obsessive–compulsives of normal intelligence.

Although staff members report a high frequency of hand-washing, washing episodes now last only about ten seconds. Indeed, she limits her ritualising through avoidance. She minimises contact with objects by grasping them with her thumb and fingertips, and holds her hands close to her chest to prevent contact with contaminants.

Ms D takes a daily 30-minute shower, during which she washes herself in the same sequence. If her shower is interrupted, say, by a staff member calling to her, she becomes anxious and begins all over again.

Her OCD has prevented her from making friends, as she maintains a physical distance from others. Although she attends a work activity centre during the day, her productivity is minimal.

Discussion

Ms D exhibits classic OCD. Perhaps due to her limited intelligence, she does not exhibit any apparent subjective resistance to her obsessions and compulsions, nor does she seem aware that her behaviour is abnormal.

Behavioural treatment with mentally retarded obsessive–compulsives is likely to be difficult if they do not recognise the abnormality of their behaviour, and if they do not wish to overcome their fears. As exemplified by the present case, non-compliance undermines exposure and response prevention treatments that are otherwise highly effective (for a review, see Marks, 1987). Perhaps such patients would respond to clomipramine (Christensen *et al*, 1987) or fluvoxamine (Perse *et al*, 1987), either alone or in combination with behaviour therapy.

References

CHRISTENSEN, H., HADZI-PAVLOVIC, D., ANDREWS, G., *et al* (1987) Behavior therapy and tricyclic medication in the treatment of obsessive–compulsive disorder: a quantitative review. *Journal of Consulting and Clinical Psychology*, **55**, 701–711.

MARKS, I. M. (1987) *Fears, Phobias, and Rituals*. New York: Oxford University Press.

MATSON, J. L. (1982) Treating obsessive–compulsive behavior in mentally retarded adults. *Behavior Modification*, **6**, 551–567.

MCNALLY, R. J. & ASCHER, L. M. (1987) Anxiety disorders in mentally retarded people. In *Anxiety and Stress Disorders: Cognitive-Behavioral Assessment and Treatment* (eds L. Michelson & L. M. Ascher), pp. 379–394. New York: Guilford.

NOVOSEL, S. (1984) Psychiatric disorder in adults admitted to a hospital for the mentally retarded. *British Journal of Mental Subnormality*, **30**, 54–58.

PERSE, T. L., GREIST, J. H., JEFFERSON, J. W., *et al* (1987) Fluvoxamine treatment of obsessive–compulsive disorder. *American Journal of Psychiatry*, **144**, 1543–1548.

RACHMAN, S. J. & HODGSON, R. J. (1980) *Obsessions and Compulsions*. Englewood Cliffs: Prentice-Hall.

RASMUSSEN, S. A. & TSUANG, M. T. (1984) The epidemiology of obsessive–compulsive disorder. *Journal of Clinical Psychiatry*, **45**, 450–457.

*Richard J. McNally, BS, MA, PhD, *Associate Professor of Clinical Psychology, Department of Psychology, University of Health Sciences/The Chicago Medical School, Building 51, North Chicago, IL 60064, USA*; John E. Calamari, BA, MA, PhD, *Clinical Director, Waukegan Developmental Center, Dugdale Circle, Waukegan, IL 60085, USA*

*Correspondence

British Journal of Psychiatry (1989), **155**, 117–119

Mania in a Five-Year-Old Child with Tuberous Sclerosis

RAKESH KHANNA and MILIND BORDE

A five-year-old girl presented with mania and adenoma sebaceum. Later she developed grand mal seizures, and EEG revealed a prominent right temporal focus. It is important to consider tuberous sclerosis as aetiologically related to mood disorders.