Sexual Obsessions in Mental Retardation: A Case Report

To the Editor: Although obsessive-compulsive disorder (OCD) in mental retardation was earlier considered rare,[1] recent research has sufficiently dispelled this belief. Prevalence of ritualistic behavior is reported to be 3.5% in individuals with mild to profound mental retardation[2] and 40% in severe to profound mental retardation.[3] In Down syndrome, prevalence of compulsive behavior ranges from 0.8%[4] to 4.5%.[5] Notably, much of this literature reports compulsions or rituals, and rarely have obsessions been described. We report the case of a girl with mild mental retardation with sexual obsessions.

Case report. Mary, a 17-year-old girl with diagnosed mild mental retardation (IQ = 53), presented in September 2009 with 6-month history of progressively withdrawn behavior, poor personal hygiene, lack of interest in housework, irritability, and aggression directed toward her mother. There was no history of fever with rash, seizures, or medication use. Personal history revealed delayed language acquisition, though she had achieved a satisfactory level of speech before the current illness. She was able to perform activities of daily living independently and helped her mother in housework. She discontinued schooling after 5th grade due to learning difficulties.

Physical examination findings were unremarkable. Mental status examination (MSE) revealed an agitated and disheveled adolescent girl displaying hostility toward her mother. No hallucinatory behavior was observed. She was hospitalized, and her liver and kidney function, blood glucose, electrolytes, and hematologic indices were found to be within normal ranges. Head computed tomography (CT) scan and electroencephalography (EEG) revealed no abnormality. A provisional diagnosis of unspecified non-organic psychotic disorder was made (*ICD-10*). She was prescribed risperidone 3 mg/d and trihexyphenidyl 4 mg/d, which reduced her aggression. On follow-up MSE, she was calm but was reluctant to be interviewed. She was discharged after 2 weeks.

On follow-up a week later, her parents reported improvement in aggression but not in personal hygiene and interaction. This time, Mary was cooperative and admitted having repetitive, uncomfortable, and persistent thoughts of touching male genitalia for 6 months. She considered them "bad" and tried to resist them. Rarely, however, she touched her father's genitals while he was asleep. During one such attempt she was witnessed by her mother, who reprimanded her. Though Mary never repeated the act, she developed irritability and hostility toward her mother. She disclosed that she was embarrassed to reveal these thoughts to her mother or to us during hospitalization. There were no additional obsessions, compulsions, or psychotic symptoms. Her diagnosis was revised to OCD, predominantly obsessions. Her Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score was 19, corresponding to moderate impairment.[6]

After discussion and informed consent from Mary and her parents, we discontinued risperidone and trihexyphenidyl while watching out for reemergence of behavioral problems and initiated clomipramine at 25 mg/d, which was increased to 75 mg/d over 2 weeks. Assessments were conducted independently by the authors both initially and at follow-ups. After 4 weeks, her Y-BOCS score came down to 10 and she reported substantial reduction in obsessions while her parents reported improvement in her mood, interaction, and self-care. Her Y-BOCS score was 4 at week 8, which did not change significantly on subsequent follow-ups. She remained well for the next 10 months, after which she stopped coming.

Review of the literature shows that compulsive or ritualistic phenomena are the dominant presentations of OCD in mental retardation.[2,3,7] This observation could be partly due to the study design whereby emphasis is on observable repetitive behavior rather than inner conflicts in diagnosing OCD[2,7] and partly due to the underlying intellectual impairment, which prevents formation and expression of obsessions.[7] However, the present case along with other case reports describing mixed obsessions and compulsions in mild mental retardation[8,9] illustrate that some of these individuals might possess sufficient cognitive resources to form obsessions and acknowledge their unreasonableness. This report is especially noteworthy as it reports sexual obsessions as the sole presentation of OCD in mental retardation, which has not been described so far.

Despite the initial diagnosis of unspecified non-organic psychosis, our patient did not exhibit hallucinations, delusions, or thought disorder throughout the course of illness. It is conceivable that risperidone, given initially, calmed her down to enable evaluation. Moreover, the fact that she responded completely to and remained well on treatment with clomipramine alone suggests that she was suffering from a primary obsessional illness rather than OCD comorbid with psychosis. Hence, careful assessment is required in patients with mental retardation for whom aggression could be secondary to underlying obsessions.

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