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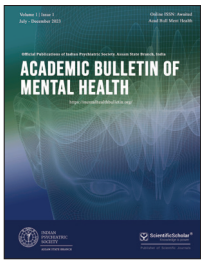

Case Report

From Childhood Bullying to Hidden Battles: Unraveling the Link Between Obsessive Compulsive Disorder (OCD) and Childhood Trauma

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ABSTRACT

Bullying is defined as violent, recurrent behavior amongst peers that entails an imbalance of power and is intentional harm. Contrary to popular belief, some people still see bullying as a normal part of growing up. Here we have described a young man who as a result of peer victimization of bullying had later developed obsessive compulsive disorder. Reports of childhood bullying are common among people with obsessive compulsive disorder(OCD).

Keywords: Bullying, Obsessive compulsive disorder(OCD), Childhood trauma, Peer victimization

INTRODUCTION

Peer victimization is almost a regular occurrence during childhood and adolescence that negatively impacts young people's social and psychological well-being. Thankfully, educators and mental health professionals have recognized the negative effects of peer victimization. Consequently, professionals and scholars have turned their attention to the growing problem of bullying in both therapeutic and educational settings.[1,2] Self-critical attitudes increase suffering when aggressive peers' negative criticism is internalized. This process can lead to poor self-perceptions and social scenario avoidance, which in turn can lead the child to develop social anxiety, depression symptoms and generalized anxiety.[3,4] It makes sense that obsessions and compulsions would develop as a result of being victimized by peers. The young person may have uncontrollably obsessive and upsetting obsessions with bullying events. When a youngster identifies particular rituals as a means of regulating or avoiding triggers connected to teasing, compulsions may arise.[5] Peer victimization and other unfavorable features of peer interactions are associated with negative results for mental health.[6]

Social functioning is difficult for people with obsessive-compulsive disorder (OCD); these difficulties include making and keeping friends and engaging in peer activities that are acceptable for their age.[7,8] Children's prosocial behavior was found to decrease with more victimization.[9] When compared to younger OCD sufferers, older OCD sufferers typically report higher degrees of social impairment.[10] A child's externalizing and internalizing behaviors may be observed by parents as a result of OCD symptoms, which can also cause more victimization by peers and exacerbate symptoms of despair and loneliness. When OCD youngsters stop performing compulsions, some of them get a second chance from their peers, but others still get rejected by the peers.

We have described a situation in which our patient was the target of peer bullying because of a single incident of unresponsiveness. The state of affairs was made worse by this harassment, which resulted in the emergence of OCD and attempt of suicide.

CASE REPORT

The Assam Medical College and Hospital's Department of Psychiatry received a referral call from a private psychiatrist for a 23-year-old male who needed further consultation. His family was nuclear middle class and he had just received his engineering degree. His father was a businessman by profession, and his mother was a homemaker. He belonged to a family environment of strict parents regarding his academics. They had high hopes from him and when he would not score up to the mark, he was criticized. On further query about his family environment , he revealed his parents frequently fought, which would hamper him. He arrived with a history of depressive symptoms, frequent intrusive thoughts involving the word "psycho," which were typical of OCD symptoms. But after looking more into his background, it became clear that he had experienced bullying in the past. His symptoms were associated with bouts of dyspnea and palpitations on and off.

The sequence of events started in the sixth grade when he passed out and a doctor determined that he had conversion disorder. After that, his mother informed the teacher about his health and he was able to take a few days off from school. However, his pals started tormenting him by calling him "psycho" once they found out about his illness. He started to feel more and more depressed in the seventh and eighth grades since he was having trouble controlling his recurring thoughts of being called "psycho" by bullies. He turned to self-harming behaviors as a coping mechanism, such as harming himself in secret places on his body to evade attention. This action gave him some momentary respite from his repetitive and intrusive thoughts. He attempted to commit suicide by jumping into a pond, but luckily, his father saved him. On asking why he would do so, he replied that he would feel lonely and misunderstood. It served as a means of dealing with his intrusive thoughts of anxiety, which he was facing as a result of bullying.

He was sent to a private psychiatrist and given a daily sertraline dosage of 50 mg. While in his twelfth year of high school, he was doing well in his studies and started dating. But after four months the relationship ended and he again attempted suicide by taking 500 mg of sertraline. After this incident, he started having new intrusive thoughts that suggested he was gay, which made him feel obligated to constantly tell himself that he was attracted to females by stating, "No, I am attracted to girls."

On examination

There were cut marks near the elbow joints of both hands. Other areas of the body did not reveal any scar marks. On assessing the premorbid temperament, it was found that he was an attentive, active and energetic child. However, he could not adapt easily to changes in his environment and would easily become upset. Also, he did not feel at ease with a new setting/person. He is shy and anxious about certain people/places. He was emotional in his reactions to pleasant/unpleasant situations. He would respond even to minor changes in the environment. Premorbidly, he was seen as an easygoing child. On mental status examination, he was guarded initially and rapport was established with difficulty, in possession of thought there was an obsession and he had insight regarding his illness and wanted help for the same.

Management

He was diagnosed with OCD with good insight according to DSM 5 (diagnostic and statistical manual of mental disorders fifth edition) and YBOCS (Yale Brown Obsessive Compulsive Scale) score was 18, which indicated moderate OCD.

1. Cognitive behavioral therapy (CBT) was started and psychoeducation was done. A total of 7 CBT sessions were done. Each CBT session was for the duration of 20–30 minutes and the entire CBT session was carried out for a period of 2 months weekly. The CBT session focused on problem-solving and changing negative thought patterns. It included the behavioral management of his symptoms. Good sleep hygiene was explained to him, along with digital well-being. He was asked to stop excessive reassurance-seeking by staying with the anxiety, using mindfulness and self-soothing techniques. Also, he was asked to engage in distraction if ruminations disturb. He was also given a self-instruction to follow like, "this is OCD, not me. This anxiety is temporary. This is not real and I don't need to do anything about it." For his self-harming behaviors, he was asked to use distress tolerance techniques like holding ice cubes, snapping rubber bands on the wrist and if not working, then to go and approach someone who is helpful.
2. Along with that psychotherapy, he was started with a cap. Fluoxetine 40 mg with Aripiprazole 15 mg once daily. His intrusive thought improved but self-harming behavior continued, for which he was started

with Tab. Oxcarbazepine 300 mg which caused skin reactions and then it stopped. He was continued then with Tab Divalproex 1 gram in two divided doses due to his increased aggression directed mainly towards family members. His symptoms improved with these treatments.

DISCUSSION

An increasing amount of studies has shown links between both direct and indirect stressful and traumatic life experiences and symptoms of OCD.[11] Often trauma and OCD are overlapped.[12] The way that trauma was experienced—direct vs. indirect—as well as its type—interpersonal versus non-interpersonal—are crucial factors in determining how OCD symptoms could manifest. Research indicates that specific OCD symptoms, such as symmetry/ordering and obsessions/checking, may be connected to traumatic experiences in the past, such as bullying as a youngster.

Additionally, trauma might affect the obsessive behaviors that OCD sufferers exhibit. These actions might be coping strategies to establish control over one's life or prevent reliving traumatic events. For instance, after experiencing trauma, some people may acquire compulsions to bring back a feeling of predictability and order, while others may get fixated on repetitive actions like counting in an effort to filter out intrusive memories of the horrific incident.[13] An individual may experience uncontrollable and intrusive distressing thoughts related to specific bullying experiences. Compulsions might arise from coincidental or perceived connections between carrying out a ritual and stimuli related to teasing. Our patient serves as a case of how internalizing unfavorable peer criticism can result in the emergence of OCD.[5]

CONCLUSION

Bullying may serve as a primary cause in the development of OCD, causing the condition to manifest. After experiencing anything unpleasant, like bullying, our patient reacted in ways that worsened his symptoms, as it was a significant stress factor. He started to analyze intrusive thoughts excessively or engage in extensive avoidance behaviors, which resulted in the development of severe OCD symptoms.

Ethical approval

Institutional Review Board approval is not required.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Nil.

Conflicts of interest

There are no conflicts of interest.

Use of artificial intelligence (AI)-assisted technology for manuscript preparation

The authors confirm that there was no use of AI-assisted technology for assisting in the writing of the manuscript and no images were manipulated using AI.

REFERENCE

1. Hawker DSJ, Boulton MJ. Twenty Years' Research on Peer Victimization and Psychosocial Maladjustment a Meta-analytic Review of Cross-sectional Studies. J Child Psychol Psychiatry 2000;41:441-55.
2. Drake RE, Goldman HH, Leff HS, Lehman AF, Dixon L, Mueser KT, *et al.* Implementing Evidence-based Practices in routine Mental Health Service Settings. Psychiatr Serv Wash DC 2001;52:179-82.
3. Storch EA, Masia-Warner C. The Relationship of Peer Victimization to Social Anxiety and Loneliness in Adolescent Females. J Adolescence 2004;27:351-62.
4. Storch EA, Phil M, Nock MK, Masia-Warner C, Barlas ME. Peer Victimization and Social-psychological Adjustment in Hispanic and African American children. J Child Fam Stud 2003;12:439-52.
5. Storch EA, Heidgerken AD, Adkins JW, Cole M, Murphy TK, Geffken GR. Peer Victimization and the Development of Obsessive-compulsive Disorder in Adolescence. Depress Anxiety 2005;21:41-4.
6. Rudolph KD, Troop-Gordon W, Hessel ET, Schmidt JD. A Latent Growth Curve Analysis of Early and Increasing Peer Victimization as Predictors of Mental Health Across Elementary School. J Clin Child Adolesc Psychol 2011;40:111-22.
7. Langley AK, Falk A, Peris T, Wiley JF, Kendall PC, Ginsburg G, *et al.* The Child Anxiety Impact Scale (CAIS): Examining Parent- and Child-reported Impairment in Child Anxiety Disorders. J Clin Child Adolesc Psychol 2014;43:579-91.
8. Piacentini J, Bergman RL, Keller M, McCracken J. Functional Impairment in Children and Adolescents with Obsessive Compulsive Disorder. J Child Adolescent Psychopharmacology 2003;13(Suppl 1):S61-9.
9. Schwartz D. Subtypes of Victims and Aggressors in Children's Peer Groups. J Abnorm Child Psychol 2000;28:181-92.
10. Piacentini J, Peris TS, Bergman RL, Chang S, Jaffer M. Functional Impairment in Childhood OCD: Development and Psychometrics Properties of the Child Obsessive-compulsive Impact Scale Revised (COIS-R). J Clin Child Adolesc Psychol 2007;36:645-53.

11. Mathews CA, Kaur N, Stein MB. Childhood Trauma and Obsessive Compulsive Symptoms. Depress Anxiety 2008;25: 742-51.
12. Wadsworth LP, Van Kirk N, August M, Kelly JM, Jackson F, Nelson J, *et al*. Understanding the Overlap between OCD and Trauma: Development of the OCD Trauma Timeline Interview (OTTI) for Clinical Settings. Curr Psychol 2023;42:6937-47.
13. Pinciotti CM, Fisher EK. Perceived Traumatic and Stressful Etiology of Obsessive-compulsive Disorder. Psychiatry Res Commun 2022;2:100044.

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