Diagnostic Case Study: MP

Bio-Psycho-Social Assessment

Client (MP) is a ten-year-old, cisgender, female, elementary school student. An only child to her two, married, biological parents, and currently living in the same household as them. Client moved from Brooklyn to Westchester area in the midst of the pandemic, and started fifth grade in-person. MP's mother is of East Asian descent, Chinese, speaks Mandarin; MP's father did not disclose ethnic background, understands Mandarin (mostly); MP is mixed-race and speaks Mandarin. Client's mom reports no significant physical/mental health or substance abuse history on either side of MP's parents' family.

Client's protective factors include supportive family, parents that sought out help before potential onset, and parents that are willing to be in the therapeutic process. They also include potential early intervention, client shows positive affinity towards school and activities, is in a good education system with psychoeducation/awareness, and has cultural connection through language. However, MP's risk factors include difficult temperament, potential anxiety, potential parent attachment issues, is shy/socially anxious, and has increased parent-child conflict(s). Client also potentially shows addictive behavior and/or unhealthy coping via uninhibited iPad use, as well as potential hoarding tendencies (mom indicates client accumulates items with no sentimental value, and refuses to part with them).

During intake call, MP's mom reported client as having *anxious*, *compulsive*, and *rigid* behaviors. These behaviors *include but are not limited to*, a fear of insects, a fear of contamination by insects, being "triggered" or emotionally dysregulated by the mention of insects, and requiring mom to show proof and clean the entire area where the potential contamination took place. Germaphobia (increased since COVID-19), client has fear of contamination by "dirty" things (including insects), being "triggered" or emotionally dysregulated by the mention of "throw up" or "being sick." Trigger words are prohibited in the home as they "trigger" (upset/dysregulates) MP, but MP's mom is frustrated because the list is continuously growing.

MP's mom also reports client's inability to regulate anger, becoming hysterical, hitting herself on the door, locking herself in her room and making threats of self-harm when iPad might be taken away. Client (according to mom) will say, "The iPad is the only thing that comforts me. It makes me feel safe. It distracts me from my fears." In a family session with MP's mom and dad, client was described as rejecting help (for work she requested assistance for), insisting on doing it her way, often using, "you're not helping" or "you're doing it wrong" with little to no effort on MP's part. MP is also described as becoming hostile and inflexible when parents attempt to discipline or correct, saying, "you don't understand me."

MP's mom also expressed concern with client's bathroom compulsion, client insists on going to the bathroom at least three times in a row, despite having just gone. In family session with the parents, MP's mom disclosed that up until very recently, client refused to wipe herself after using the restroom out of fear of it being dirty; however, when client was invited to a sleepover, client was able to do so on her own (albeit with much effort and hand-holding).

Client will not admit that she has anxiety/phobias, and will not acknowledge these situations and behaviors significantly disrupting daily living and being cause for family conflict. Significantly, this situation affects home more than it does in other settings. It is currently inconclusive how client behaves in school settings aside from mom's speculations/viewpoints.

Diagnosis

F60.9 Unspecified Personality Disorder

This category applies to presentations in which symptoms characteristic of a personality disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the personality disorders diagnostic class. The unspecified personality disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific personality disorder and includes presentations in which there is insufficient information to make a more specific diagnosis.

According to the American Psychiatric Association (2022), the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM–5) requires the presence of four or more criteria out of

eight, in order to qualify for the Obsessive Compulsive Personality Disorder diagnosis—of which the client meets three out of eight. Client (as mentioned above) holds on to objects of zero attachment, is unable to receive help for work unless it is the client's way, and is rigid and inflexible (as in the words of MP's mom), (APA, p. 772, 2022). However, client does not meet *full* criteria for OCPD, and there is not enough information at this time to determine whether client's behaviors indicate meeting full criteria and diagnosis, hence qualifying her to have an initial diagnosis of F60.9 Unspecified Personality Disorder instead.

Differential Diagnoses

F60.5 Obsessive Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. **Is unable to discard worn-out or worthless objects even when they have no sentimental value.**
2. **Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.**
3. **Shows rigidity and stubbornness.**

Diagnostic criteria for Obsessive Compulsive Personality Disorder (OCPD) includes reoccurring fixations on "orderliness, perfectionism, and control" (Corcoran & Walsh, p. 453, 2016). OCPD is primarily concerned with *control* to the point of extreme rigidity and inflexibility, and causes clinical stress in areas of necessary functioning (APA, p. 735). Which in this case, would be her home. As mentioned above, with the current information available to us, client only meets criteria for three (italicized).

F42.2 Obsessive Compulsive Disorder with absent insight

A. Presence of obsessions, compulsions, or both:

Obsessions:

1. **Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.**
2. **The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).**

Compulsions:

1. **The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.**

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

Criterion for diagnosis for Obsessive Compulsive Disorder can be categorized in two categories: obsession and compulsion (APA, p. 265, 2022). Obsessions are defined as unwanted, repetitive thoughts that cause stress; compulsions are the actions taken to mollify the obsessive thinking and thoughts (Corcoran & Walsh, p. 201, 2016). One or both must be present, they must be time-consuming/negatively impacting daily living, and unable to be explained by other diagnoses (unlisted above, but client meets criteria).

For MP, client shows obsessive-compulsive behaviors: including the fear of contamination requiring mom to assist her in the bathroom, and exhibiting strong emotional disturbance in regard to contamination via insects. However, at the current stage, it is unable to be determined whether the behaviors are in response to relieving the anxiety or if due to inflexibility; or potentially both. Should MP be diagnosed with OCD, the risk factors according to Corcoran and Walsh (p. 206, 2016) are that much higher, and has greater potential to be comorbidly occurring with personality disorder.

Z Codes: Z62.820 Parent-child relational problem, Parent–biological child.

Assessment Tools

**Currently, there is no specific assessment tool for Obsessive-Compulsive Personality Disorder. To rule out diagnoses or even to assess for comorbid OCD, this section will detail assessment tools used for OCD.*

Traditionally, to assess for OCD, the YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS) would be used. According to Rapp et al. in *Evidence-Based Assessment of Obsessive–Compulsive Disorder* (2016), the Y-BOCS is known as the "gold standard" for OCD assessment and OCD symptom severity measurement. There is also one adapted for children called the CHILDREN'S YALE-BROWN

OBSESSIVE COMPULSIVE SCALE (CY-BOCS) which is also known as the standard diagnostic tool for pediatric OCD assessment.

The CY-BOCS Severity score "[demonstrates] excellent to fair internal consistency, excellent interrater reliability, and good to adequate short-term test-retest reliability," the tool is reusable for long-term assessment and measurement of improvement (Rapp et al., 2016). However, in the case of MP who is in fifth grade, even the CY-BOCS assessment would not be an appropriate tool due to its extensive nature and because of the need for filtering through certain criteria/questions (such as sexual). The CY-BOCS is, "lengthy, clinician-administered, [an] interview-based instrument and…its self-report format is too lengthy" (Piqueras et al., 2015).

Another assessment tool is the Short Obsessive–Compulsive Disorder Screener (SOCS), particularly recommended for children and adolescents aged eleven to fifteen. (This screener was actually administered to client.) Similarly to the CY-BOCS, according to Piqueras et al., the SOCS is useful and repeatedly shows accurate readings, its strength lies in more accurately identifying first-time diagnostic cases of pediatric OCD, and is useful for general practice and community implementation (2015). Its weakness lies in the fact that its accuracy might derive itself from being too general, and is limited when accounting for severity and factor variability (Piqueras et al., 2015). Though self-report is easier for the SOCS, again, this tool would have to be provided to parents as well due to the complex nature of diagnosing pediatric OCD.

According to Corcoran and Walsh, pediatric OCD cases are more difficult to diagnose, as "parent–child agreement about symptoms is often low, and many children lack insight as well as attempt to conceal their symptoms" (p. 203, 2016). Which is why the CY-BOCS is best administered with the child and parents simultaneously, which currently would not be an option for MP and her family. Though SOCS was administered to MP via semi-structured interview, it yielded little to no positive result —also that OCD has to be monitored way past ages eleven to fifteen which is what the SOCS assessment

is geared to. Given that MP recently became a fifth grader, as in she is closer to elementary-age than middle school-age, there are more cautionary steps to take.

Clinical Interventions

**Currently, there is little to no specific research for interventions regarding pediatric Obsessive-Compulsive Personality Disorder. To rule out diagnoses or even to assess for comorbid OCD, this section will detail interventions used for pediatric OCD, and utilize data from related clinical research on non-pediatric OCPD.*

According to Corcoran and Walsh (2016), some of the most effective clinical interventions for OCD includes, "exposure response-prevention, other behavioral interventions, and cognitive-behavioral therapy (CBT) that emphasizes cognitive restructuring" (p. 206). Lewin et al. predicates research on an intensive CBT treatment model, a, "program [involving] training in behavioral principles (e.g., exposure, response prevention, extinction), parent training, and cognitive restructuring (when appropriate)" (2005). Research by Peris et al. reports that CBT "exercises are intrinsically anxiety provoking for children and frequently for their parents too, and they require family members to manage and tolerate emotional distress while simultaneously dealing with potential resistance" (2012). This is significant because more often than not, family intervention and treatment regarding pediatric OCD requires the direct opposite of accommodation.

According to Merlo et al. "Clinical experience suggests that parents believe family functioning is facilitated by accommodating the child's OCD behaviors. Unfortunately, accommodating symptoms maintains or exacerbates symptoms by providing short-term relief, which negatively reinforces the behaviors and prevents habituation" (2009). In cases of pediatric OCD, Corcoran and Walsh (2016) report that families often accommodate or adapt to the obsessive compulsive behaviors, and should be assessed as part of intervention and treatment plan. Lewin et al. utilizes these interventions, and addresses the OCD through a structured, systematic approach involving not the just the client, but the client's family/caretakers, and providing a means of continual graduating in beliefs and behaviors (2005).

Currently, (as this is a real client), three individual assessment phases have been completed, with the diagnoses/need to rule out diagnoses of ***F60.9 Unspecified Personality Disorder***, ***F60.5 Obsessive Compulsive Personality Disorder***, ***F42.2 Obsessive Compulsive Disorder with absent insight***. Given that the client is only ten years old, assessment and intervention requires parent-involvement, and the initial family session was what revealed the OCPD symptoms. However, in order to gain a therapeutic alliance, play (art) therapy will be utilized, and has already proven to be effective (Myrick & Green, 2012).

Treatment Plan

Client MP's treatment plan must include her family, CBT, as well as a form of play/art therapy/CBT. Family involvement, exposure therapy, and cognitive restructuring, all of which are components of CBT is critical for OCD treatment—they start in a treatment center, with a clinician, but must ultimately be implemented by the client and family. Play therapy allows a pediatric client to express in less rigid boundaries, and assists with "externalizing" the OCD making the obsessions/thoughts/patterns easier to contextualize for the client (Myrick & Greene, 2012). According to Landreth (2002), "Play therapy operates under the belief that children fare better in treatment when permitted to express their thoughts and feelings nonverbally" (as cited in Myrick & Greene, 2012).

In the next three months, MP and MP's parents will work towards effective OCD treatment implementation at home, reducing accommodations, and working with MP for exposure therapy. Simultaneously, MP will be working on two things every week, over a bi-weekly course timeframe. MP will identify an obsession, compulsion and/or point of rigidity (trigger) with parents if necessary, and use art/play therapy to externalize the object of anxiety, and utilize the externalization as part of therapy. This will continue until client and/or parents are able to reach a healthy equilibrium, and be reviewed as required.

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