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Comprehensive multidisciplinary approach in the long-term hospitalization of a child with obsessive – compulsive disorder and autism spectrum disorder: Emphasizing nursing practice

Mami Ono[1], Ikuhiro Harada[2], Kotoe Itagaki[3], Masahide Usami[3,4,5]

[1] Department of Nursing, Kohnodai Hospital, National Center for Global Health and Medicine, Ichikawa, Japan;
[2] Department of Social Work, Kohnodai Hospital, National Center for Global Health and Medicine, Ichikawa, Japan;
[3] Division of Clinical Psychology, Kohnodai Hospital, National Center for Global Health and Medicine, Ichikawa, Japan;
[4] Department of Child and Adolescent Psychiatry, Kohnodai Hospital, National Center for Global Health and Medicine, Ichikawa, Japan;
[5] Clinical Center for Children's Mental Health, Kohnodai Hospital, National Center for Global Health and Medicine, Ichikawa, Japan.

Abstract: This article presents the case of a boy diagnosed with both obsessive–compulsive disorder (OCD) and autism spectrum disorder. Long-term hospitalization was required to improve the patient's OCD symptoms and family relationship. In his last year of compulsory schooling, a multidisciplinary team, led by a nurse, took various approaches to help him self-determine his pathway. In their role of assisting the patient with daily living, the nurses were at risk of becoming involved in his compulsive behavior and developing negative feelings. To support his self-determination, having a mutually supportive environment was essential between the multidisciplinary team and team members, which included discussing his daily living concerns and venting out negative feelings. In this case, ongoing dialog with the medical staff was important for the individual and parents to move forward positively within a supportive framework.

***Keywords*:** child and adolescent psychiatric nursing, self-determination, multidisciplinary team

Introduction

This article presents the case of a boy diagnosed with both obsessive–compulsive disorder (OCD) and autism spectrum disorder (ASD) without intellectual disabilities. We aimed to derive effective nursing interventions for the patient by reviewing the nursing process, symptoms, and treatment from admission to discharge in the Child and Adolescent Psychiatric Ward.

During the patient's third hospitalization, we focused on employing a multidisciplinary approach and nursing interventions related to self-determination and parent–child relationships, including his post-discharge life (Table 1). Furthermore, to ensure the confidentiality of individuals, some information was anonymized while retaining the content's integrity.

Clinical setting

The Child and Adolescent Psychiatric Ward at Kohnodai Hospital, National Center for Global Health and Medicine, featured 45 beds with an in-hospital school. The primary nursing system assigns one nurse to oversee each patient from admission until discharge. The unit comprises 11 four-bed rooms and seven private rooms and accommodates patients up to the third grade of junior high school.

Clinical case

Developmental and concurrent medical history

A 15-year-old boy was admitted to our unit because of severe OCD symptoms. The patient's medical history revealed signs of obsession with food and hypersensitivity to sound during infancy. Furthermore, the patient exhibited unusual behaviors, such as disrobing while urinating and changing clothes. In year X-7, the patient experienced bullying at school, leading to difficulties in eating. At home, the patient resorted to aggressive behaviors toward his family and spent nearly half a day in the bathroom because of anxiety. The patient was admitted three times due to deteriorating symptoms and family relationship disruptions.

Previous hospitalization

Table 1. Multidisciplinary approach led by nurses during the patient's third hospitalization

Time	*May, Year X*	*May to July, Year X*
His condition	- Overadaptation to hospitalization - Intense anger toward his parents for forcing him to be hospitalized	- End of overadaptation and relapse of compulsive behavior - Fear of excessive seclusion and need of assurance that he will not be secluded
Details of intervention	- Eased the tension of his parents and recommended rest - Communicated information about his hospitalization to the family under visitation restrictions - Assessed his readiness to meet with family members and informed him about their visits - Addressed the mother's concerns and challenges in interacting with her son	- Staff shared frustrations with him openly, rephrasing them into simple and polite language - Informed the patient that he was beyond the fear of isolation stage and encouraged him to focus on life after graduation
Time	*August to October, Year X*	*November, Year X to March, Year X+1*
His condition	- Began to talk about his worries and career path - Recognized and included by other hospitalized children - Reconciliation with parents	- Accepted the family's policy of not living together - Emergence of anxiety and frustration after discharge from the hospital - Increased burden on him and his parents due to unfamiliar high school entrance examinations and group home search
Details of intervention	- Listened to him and worked with him on how to respond about friendship problems - Encouraged him to plan and implement specific actions for his high school application independently - Helped him organize what he intended to communicate with his parents during their initial reconciliation - Established and supported a minimum in-hospital school attendance time collaborated with his HRT	- Collaborated with local medical and social services to initiate the search for a group home after discharge - Shared information with in-hospital classes to prepare him for the high school transition led by his family - Assisted him in developing strategies to maintain the schedule he established - Engaged in phone conversations with him and his parents to methodically discuss and prioritize specific actions

The patient's first hospitalization occurred during elementary school (year X-5 to year X-3). Before admission, the patient experienced a life-threatening decline in food intake. Upon admission, behavioral restrictions and nutritional management were imposed. As the patient recovered, he attended an elementary school in the hospital. After his initial hospital discharge, the patient gradually became unable to attend school and exhibited destructive behaviors again in the house. Consequently, the patient was re-hospitalized (year X-3 to year X-1). Hospital staff encouraged the patient to become more independent in his daily routines, including commuting to school and attending structured interview sessions. Family support efforts aimed at easing the mother's burden, promoting family reunification, and introducing home nursing care upon discharge were administered.

After the previous discharge, the patient's life deteriorated rapidly. The patient became fixated on mirrors and could no longer attend in-hospital classes. Family accommodation became severe, and the patient's parents were exhausted. The patient repeatedly sought assurances from his parents that he would not be hospitalized again and insisted on providing promises. The home nursing service introduced upon discharge from the hospital was discontinued after 2 months. The patient and his parents also refused home visits by the homeroom teacher (HRT).

Third Hospitalization: Year X to X+1

May, Year X

The patient was hospitalized for the third time during ninth grade. Upon hospitalization, the patient exhibited remarkable adaptability, attending in-hospital school daily and participating in various activities. Despite not bathing for several months at home, the patient began to bathe once a week following admission. However, the patient remained isolated from other children in our ward and school. The patient harbored resentment toward his parents, often repeating, "My parents promised not to hospitalize me, but they did". The patient refused visits from his parents, and his mother also hesitated and dreaded seeing him. The patient's father was the sole visitor responsible for exchanging daily items with the nurses. Simultaneously, the parents maintained regular meetings with the attending physician. The multidisciplinary team, led by nurses, provided information about his daily life in the hospital to his parents. In particular, the nurses approached the parents in an atmosphere of informality and small talk. They attended to the mother's psychological anxieties when dealing with her son and encouraged her to rest. Furthermore, they assessed the patient's readiness to meet with family members and informed him about their visits.

May to July, Year X

After 2 months of hospitalization, the patient experienced challenges with daily activities. Over time, the patient struggled with timed activities, such as bathing and attending school; when the patient could not perform well, he placed the blame on medical staffs. The patient developed an intense fear of seclusion and attempted to elicit the word that he would not be isolated by hounding the medical personnel. The patient found it challenging to cope with the various limitations of infection control prevention measures during his hospitalization. The patient's unmet wishes fueled frustration and anger. Furthermore, his autistic tendencies not only prevented him from understanding what the other person was warning him about but also risked contributing to panic by focusing only on the angry expression on the other person's face: This had been observed many times in previous interactions with his mother. Some staff nurses were unpleasant because of his way of treating them as if nothing had happened the day after an intense outburst. The multidisciplinary team, led by nurses, shared staff frustrations about the patient openly. The primary nurse, who carefully watched her tone and facial expressions, then rephrased their frustrations into simple and polite language to the patient. The medical staff also informed the patient that he was beyond the fear of isolation and encouraged him to focus on life after graduation. Furthermore, the primary nurse and HRT had frequent contact and exchanged information about hospitalization and school life.

August to October, Year X

The patient began to talk about his age-related friendship problems as he made friends in the hospital. The medical staff listened to the patient and worked with him on how to respond. The patient gradually began to discuss his career path concerns and expressed a desire to attend high school. However, the patient still refused to see his family. The patient's psychiatric social worker (PSW) continued to work with him to reunite him with his parents in preparation for his discharge and career path. The patient organized his interactions with the PSW by talking to his nurse. During this period, the patient often used the term "first reconciliation with his parents". The patient always felt that his parents were deprived of making decisions for him. Therefore, the patient decided to reconcile with his parents for now as a means of gaining access to higher education, although the patient still felt resentful toward them.

The multidisciplinary team helped him organize what the patient intended to communicate to his parents. Furthermore, they encouraged him to plan and implement specific actions for his high school application independently. Furthermore, they collaborated with the patient's HRT and supported minimum in-hospital school attendance to encourage consistent school attendance. After the initial reconciliation, the patient resumed communication with his parents as if nothing had happened. He had a haircut and shave, which he had not done for years, in preparation for the examination.

November, Year X to March, Year X+1

The parents complained to the doctor that they could not live with their son. The patient expressed, "at this point, I don't think he would do well back home". The patient admitted that he was not sure. As a result, it was decided to look for a group home as a place for the patient to live after discharge from the hospital. Throughout the patient's examination preparation and housing search, he experienced multiple challenges with deadlines, which triggered frequent outbursts; however, the patient never stopped attending his in-hospital classes.

The multidisciplinary team, led by nurses, provided information about the patient's concerns or considerable points regarding communal living, and the patient continued to work with staff from the local mental and welfare services through his PSW. Furthermore, they assisted him in developing strategies to maintain the discharge schedule he established. In particular, the PSW followed the patient on his frequent outings to taking his examinations and finding a group home, gradually delegating this role to his parents. The patient's HRT also continued to meet with his parents. Nurses confirmed the appropriate use of abortive medication when going out or staying overnight. Furthermore, they engaged in calmed conversations to prevent arguments between the patient and his parents from developing to methodically discuss and prioritize specific actions.

The patient successfully gained acceptance into high school and celebrated with friends at the ward's farewell party. However, due to his age and medical condition, the patient could not find a suitable group home during his hospitalization. Consequently, the patient was discharged home temporarily, which his parents accepted. His mother, who had been stubborn toward him, was pleased with the progress that the patient had made during this hospitalization. The patient remained at home without causing inconvenience to his family while awaiting placement in a group home.

Medication

Pharmacotherapy included paroxetine (50 mg), levomepromazine (50 mg), and haloperidol (9 mg).

Discussion

Early intervention for OCD in children is important not only to reduce the duration of untreated psychosis but also to prevent the loss of important opportunities for growth and development, including school life (*1,2*). This case was accessed at an early stage in a

child psychiatry outpatient clinic, and treatment was initiated; however, the long-term intervention by a multidisciplinary team continued until the end of the patient's compulsory schooling year. The prolonged duration of child psychiatric hospital stays influenced the severity of the patient's psychiatric issues and family functioning challenges, such as limited community resources and low child-rearing capacity (*3*). However, note that during extended hospitalizations, children often experience improvements in life functioning through group activities and school life (*3*).

This hospitalization was also crucial for him to explore self-determination and his chosen way of life. The medical staff pulled the patient out of a stalemated family relationship and provided him with an environment conducive for integration with his peers, which he had been prevented from doing due to the intensity of his severe symptoms. The patient's experience of recognition from other children provided him with a sense of belonging and self-affirmation. In particular, the nurses provided unwavering support to rebuild his disordered lifestyle and self-esteem while focusing on developmental milestones.

Nurses in child psychiatry play a vital role in offering support while striking a balance between adhering to the therapeutic structure of the ward and nurturing the child's autonomy (*4*). However, because of the nurses' role in assisting with daily living, they were at risk of becoming involved in the patient's intense compulsive behavior and developing negative feelings. Child psychiatric nurses have been reported to be more exposed to occupational stress and are at higher risk of burnout (*5-7*). Therefore, a multidisciplinary team and an environment conducive for mutual support among team members, including sharing of concerns and venting out of negative emotions, were essential for the nurses to remain calm and provide the patient with consistent care.

In Japan, parents are usually expected to continue caring for their children after compulsory education ends. However, family involvement in children with OCD or ASD disrupts and exhausts the family's daily life (*8-11*). The patient's parents expressed difficulties in living with their son again. Therefore, medical personnel had to find not only a place for the patient to go to school but also a group home; however, finding a residential facility that accepts young individuals with mental illness or disabilities is challenging (*12*). Although the medical staff encouraged the family to take a break, they continued to support the family initiative during this important phase of the patient's career decision-making. The nurses assessed the parents' readiness to engage with their child and empathized on the burden of supporting their child's life.

The roles of child psychiatric nurses were to share information about hospital and school life with other staff members and the patient's parents to maintain daily activities after discharge. The ongoing dialog with the medical staff was important for the patient and his parents to move forward positively within a supportive framework.

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*_Address correspondence to_:
Masahide Usami, Kohnodai Hospital, National Center for Global Health and Medicine, 1-7-1 Kohnodai, Ichikawa, Chiba 272-8516, Japan.
E-mail: usami.masahide@hospk.ncgm.go.jp