

SERIOUS BODILY HARM RELATED TO OBSESSIONS FROM SRI LANKA

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INTRODUCTION

An obsession is a thought that persists and dominates an individual's thinking despite the individual's awareness that the thought is either entirely without purpose or else has persisted and dominated their thinking beyond the point of relevance or usefulness (Fish & Hamilton 1985). Obsessions occur in many psychiatric disorders such as Obsessive Compulsive disorder (OCD), Major Depressive disorder and Schizophrenia (APA 2013, Bahceci et al. 2014, Doyle et al. 2014). In certain patients medication such as clozapine may induce obsessions (Doyle et al. 2014).

In the 5th edition of the Diagnostic and Statistical Manual of mental disorders (DSM 5), OCD has been categorized together with few other related disorders (APA 2013). Among these disorders there are several disorders with direct physical self-harm. They include Trichotillomania and Excoriation disorder which are presumably related to OCD in terms of a range of diagnostic validators (APA 2013).

There have been case reports on patients with OCD who presented with self-injurious behaviour. A description of an older male presenting with late onset OCD and genital self-mutilation has been published from India, the closest neighbour to Sri Lanka (Pandit & Vardhan 2013). There are cases of Tourette's disorder with comorbid OCD presenting with severe self-injurious behaviour (Krüger & Müller-Vahl 2015). In a series of patients with self-injurious skin picking, 52% of them was found to be suffering from comorbid OCD (Wilhelm et al. 1999). We could not find any larger studies on OCD and bodily harm.

Sri Lanka is an island in the Indian Ocean with a multi-ethnic population of about 21 million (World Bank 2015). The psychiatrist to patient ratio is low and in 2012 there was approximately one consultant psychiatrist per 500,000 persons (Jenkins et al. 2012). Only 1.6% of the total health budget is spent on mental health (Jenkins et al. 2012).

We describe two Sri Lankan patients presenting with significant bodily harm related to their obsessions. There is very few published data regarding bodily harm

in relation to obsessions. Therefore we hope this description of two patients would be valuable to other clinicians treating patients with similar presentations.

CASE PRESENTATION: PATIENT A

Patient A was a 52 year old right handed male. He complained of fearfulness to open a bandage on his right middle finger for two years duration. Two years before he obtained a small abrasion on his finger and bandaged it using a cotton cloth. After few days he was concerned to open the bandage as he feared the wound would have worsened and the finger would be unusable. This thought was repetitive, highly unpleasurable, resisted and believed to be his own. He slowly trained himself to use the left hand for important activities.

He frequently repeated the same Buddhist stanza 21 times at a stretch mentally. He believed this mental act would help to protect his finger from possible harm. If he could not complete the repetition for 21 times, he would restart from the beginning and would do it until he 'feels right'.

Patient A claimed that he at times knew that keeping the bandage on the finger and repetition of the stanza was highly irrational. But he did not have the will to go ahead and remove the bandage despite the family members pleading to do so.

On the initial mental state examination, patient A appeared anxious and distressed. The mood was euthymic and he had obsessive thoughts and mental rituals. There were no delusional beliefs and cognitive functions were normal with good insight. According to the Yale Brown Obsessive Compulsive Scale (YBOCS) he scored in the severe range for symptoms (Goodman et al. 1989).

Patient A was treated with Clomipramine and at the end of 12 weeks he was significantly better clinically and by the YBOCS scores. After improvement of obsessive symptoms he voluntarily removed his bandage on the right middle finger and it was found to have an ulceration. He was referred for plastic surgeon's opinion and required inpatient admission for skin grafting. Patient A was later referred to the occupational

therapist for functional improvement of the right hand. According to the surgical opinion further delay in presentation to psychiatric services could have led to far more serious damage to his finger culminating in possible amputation.

CASE PRESENTATION: PATIENT B

Patient B is an 11 year old boy presenting with recurrent thoughts about looseness of his teeth. He states that he is doubtful that whether his teeth are loose or not. These thoughts are recurrent, resisted and unpleasurable to him. The boy says at times he feels the irrationality of the thoughts and believes these thoughts are of his own.

In order to clear his doubt he would engage in repetitive checking of the fixity of the relevant tooth to the jaw. The boy would pull mainly the lower incisors to check their fixity. If he feels them to be loosely fixed, he would be in significant psychological distress even affecting his daily activities. If a particular tooth is felt to be loose he would pull it out completely and he had pulled off three during a period of one month. After the third tooth removal he developed profuse gum bleeding from the site of extraction and needed admission to the emergency dental care unit. The parents later revealed that they have used restraining to stop the boy from removing his own teeth.

On mental state examination the mood was euthymic and the boy had obsessional doubts, without any delusional beliefs. The YBOCS scores were in the severe range and he was treated with cognitive behaviour therapy (CBT) with exposure and response prevention (ERP) and Sertraline antidepressant therapy. He appeared much better at 12 weeks clinically and according to YBOCS scores. He had not removed any teeth afterwards. The boy was also referred to the Paediatric Dental Surgeon for follow up care.

Informed written consent was obtained for assessment and publication from patient A, the mother and father of patient B and the assent from the child.

DISCUSSION

The two patients were Sri Lankan males in two different age groups. Patient A presented with late onset OCD associated with an obsession on a catastrophic outcome of his wound. Due to avoidance behaviour he kept his bandage for a long time. This led to significant tissue damage to the right middle finger and functional impairment due to difficulty in using the dominant right hand. He was commenced on pharmacotherapy as he declined to come regularly for CBT. At present the Serotonin Reuptake Inhibitors (SSRI) are usually the first line pharmacological treatment (Baldwin et al. 2014). Clomipramine was selected based on the availability of medication at the treatment setting he was seen and affordability of other options. The serotonergic

tricyclic antidepressant Clomipramine is found to be more effective than SSRIs in certain studies in patients with OCD (Ackerman & Greenland 2002). Patient A's distress related to the bandage significantly reduced with the improvement of his obsessional symptoms.

Patient B is an adolescent with early onset of OCD which is known to be associated with more severe symptoms and poorer prognosis (Dell'Osso et al. 2013). He had obsessional doubts related to his teeth which caused loss of three. According to the parents he has been previously seen by dental and medical doctors who failed to identify the possibility of OCD in him. The failure of treatment of obsessions may have led to further loss of teeth and lifelong difficulties in chewing. In severe OCD combination of psychological and pharmacological treatment is warranted for better outcome (Baldwin et al. 2014). In this 11 year old boy reduction of symptom scores were seen after treatment. This was accompanied by stoppage of tooth removal by the patient.

Both patients presented with bodily harm related to their psychiatric presentations. Considering their history, mental state findings the injurious behaviour was most probably related to their obsessions. These case examples highlight the possibility of obsessional thoughts, doubts and associated avoidance leading to serious bodily harm.

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Contribution of individual authors:

Miyuru Chandradasa: Design of the study, literature searches and analyses;
Layani Champika: Literature searches and analyses, Clinical evaluations;
Darshani Hettiarachchi: Literature searches and analyses, Clinical evaluations
Swarna Wijetunge: Design of the study and interpretation of data, Clinical evaluations;
Jayan Mendis: Design of the study and clinical evaluations.

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