Unusual association of diseases/symptoms

Obsessive compulsive disorder with psychosis NOS, in an asexual male: a diagnostic challenge

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Correspondence to Professor Amin Muhammad Gadit, amin.muhammad@med.mun.ca**Summary**

A 28-year-old asexual Malaysian male presented for emergency assessment with suicidal thoughts, paranoid delusions and increasing time spent on ritualistic behaviours that included hand washing, door checking and religious chanting. His obsessions were primarily related to counting, perfectionism, contamination and chanting. The patient found himself compelled to complete numerous rituals including chanting religiously to 1000, having to restart in the event of an error during such and also described delusions of being followed by a woman who was analysing his life pattern in order to steal from him. He then started to proclaim himself to be Buddha as he believed this would keep his dead grandmother away from him, thus avoiding supposed persecution from her. Following optimisation of both escitalopram and olanzapine, a slight reduction in the patient's ritualistic behaviour and psychotic phenomenon were witnessed.

BACKGROUND

We believe this case is relevant due to its uniqueness in terms of co morbid psychiatric disorders and the dilemma concerning correct treatment of such mental illnesses. Furthermore, we deem this patient's presentation to be interesting due to his lack of desire to have sexual relations with another individual, irrespective of sex or gender. His treatment regimen included olanzapine and escitalopram, which were used concurrently with improvement in his symptoms. Medication compliance was difficult due to poor insight as well as family discouragement due to cultural stigma surrounding mental illness. This case report is interesting for readership because of its complexity and challenge that it pose in terms of management. It will also generate debate about the asexuality issue that is a rare but interesting finding in an individual who is already facing a number of mental health issues.

CASE PRESENTATION

A 28-year-old Malaysian male was admitted to WF hospital short stay unit on June 28, 2011 and discharged on July 4, 2011. Initially he presented with dental pain. Through the course of his assessment the patient commented on suicidal ideation (SI) and was consulted to the psychiatry service with the complaint of feeling depressed and suicidal. He identified that he 'thinks (he) would like to die but not in pain'. The patient had contemplated taking all his medications to go to sleep and die, a quick and painless death. He dismissed such acts as jumping off a building, given they could result in extreme pain. The patient also denied past suicidal acts or engaging in self-harm behaviours. He identified SI dating back to his diagnosis of obsessive compulsive disorder (OCD) in 2008. His psychiatrist in Malaysia initiated a trial of antidepressant and antipsychotic medication (outlined in treatment section), which the patient claimed alleviated his SI at that time.

He complained of chronically poor sleep, and feelings of guilt regarding his grandmother since her death. When

alive, the patient convinced his grandmother that she had poisoned him. He now struggles with extreme guilt surrounding the same, due to his inability to retract such statements. Interest in the patient's usual activities was observed to be preserved during admission, including his continued Buddhist meditation; no complaints regarding appetite were noted during admission. He has the compulsion to count his chants to 1000 and was compelled to restart if he made a mistake, with chanting lasting for 4–6 h/day at its peak. At school, he was unable to tolerate imperfect test scores. According to the patient, chanting was related to guilt pertaining to his deceptive behaviour towards his grandmother. Other reported symptoms include checking behaviours (particularly in terms of frequent checking to see his door is locked; he would typically check 7–10 times per day). He also reported hand washing in excess of 30 times a day and checking for lost items, although he was well aware of their exact location at any given time. On discussion, the patient informed that people were watching him and that he needed to pour water himself because of fear of contamination or of being poisoned by others. If at a restaurant, he must eat large quantities of garlic, onions and vegetables to 'cleanse' himself thereafter.

Identified stressors include lack of local social supports, and minimal contact with his immediate family due to their continued residence in Malaysia. The patient lives alone, taking his medications every second day to save money and because he questions their efficacy and the need for him to be maintained on them. He receives his prescription medication by mail from his sister who resides in Malaysia (clonazepam 1 mg HS, olanzapine 2.5 mg HS, escitalopram 10 mg HS).

Mental status examination: Patient was well-groomed, casually dressed, looking anxious, cooperative, had intense eye contact at times, English good enough to have a conversation, speech was normal in rate, rhythm, volume and tone, mood was 'ok' and 'sad', affect was anxious, suspicious, somewhat dysphoric and restricted. SI

were identified, there were no reports of hallucinations. Delusional themes thought secondary to his OCD symptoms. Insight was poor and it was felt that he took his suicidality very lightly.

Following admission, the patient's dose of olanzapine was increased to 5 mg one tablet every night (QHS) while his dose of escitalopram was maintained at 10 mg QHS. By the end of his hospitalisation, the patient was notably more optimistic and future oriented, while continuing to deny any associated side effect with his medication regimen. His obsessions were ongoing but he felt more in control of his thoughts. He had ongoing thoughts that the world would be a happier place without him, but denied an active plan of suicide. He was discharged home, with completion of an outpatient referral to psychology, and scheduled outpatient follow-up.

On subsequent follow-up with his psychiatrist and liaison nurse, he admitted to taking only half prescribed medications because of fear of side effects. He did not report any side effects. Escitalopram was increased to 20 mg daily. Follow-up 6 weeks after first presentation, he re-experienced thoughts of death and demonstrated additional symptoms suggestive of a concomitant anxiety and psychotic disorder. He believed that the psychologist interviewing him was his dead grandmother, and as such, the patient requested discharge from that particular psychologist's care. The patient said that he had not been medication compliant. He mentioned of seeing a lady across the street wearing always the same clothes and would watch him continuously. She was apparently following him around according to him. He mentioned of being afraid to go outside because he thinks people will notice his odd behaviour and think he was crazy. He agreed to be admitted voluntarily for medication optimisation.

Psychiatric history- the patient claimed that he has struggled with symptoms of OCD since his teenage years. However, he was only diagnosed with OCD in 2008 after seeing a psychiatrist in Malaysia. He has had no previous suicide attempts, self-mutilation or aggressive behaviours. He identified SI dating back even prior to the OCD diagnosis of 2008. His psychiatrist in Malaysia initiated a trial of medication which the patient claimed helped alleviate his SI. He described being controlled by 'the brain' and notes that there is a part of the brain that controls his thoughts and actions which he has no control of. He believed that the only way to end his difficulties would be to end his life as this would end 'the brain'. He also commented that he needs to save the world through his Buddhist chanting. He believed that if he chants perfectly then he will become Buddha so that his dead grandmother will cease to haunt him.

Medical history- he had a recent gingival infection treated with penicillin V in June 2011.

Substance history- he admitted having a glass of wine per month and denied illicit drug use or smoking. Family history was nil and collateral history was not possible to obtain.

Personal history- the patient was born in Malaysia and was raised with his four siblings. He completed high school and attended various universities, attempting several fields of study but ultimately failing to acquire a degree in any particular discipline. Ultimately, he discontinued his various academic pursuits because he could not tolerate less than perfect grades which made the exams exceedingly stressful and challenging for him to undertake. The patient

moved to the USA in 2008 for school, attempting two different degrees, however, not finishing either and moving back to Malaysia. He moved to Canada in April 2011 and is currently studying english as a second language with aspirations to pursue further schooling thereafter. The patient lives alone, has limited social interaction with his peers and denied any interest in being engaged in a sexual relationship with anyone. Culturally, the patient's family does not accept mental illness as a form of human pathology, and as such, refuse to validate the patient's supposed need for psychotherapeutic intervention. With respect to traumatic life events, the patient reported that he was nearly sexually assaulted by a group of men when he was 15 years old. They took off all his clothes, and hit him in the face. A librarian saved him before the actual assault could occur. The patient describes his religious identity as Buddhist, and has practiced this faith since 1986. Occasionally, he doubts his faith and admittedly prays to God.

INVESTIGATIONS

- August 29, 2011- Sleep deprived electroencephalogram-normal
- August 23, 2011- Urine drug screen-negative
- August 19, 2011- HIV 1 and 2- negative, syphilis-non-reactive
- August 18, 2011- CT head-normal
- June 29, 2011- B12, thyroid stimulating hormone, complete blood count and liver function test within normal limits.

DIFFERENTIAL DIAGNOSIS

- OCD with psychotic features
- Psychosis with OCD as a comorbid diagnosis
- Schizophreniform disorder
- Pervasive developmental disorder
- Cluster A personality: schizoid.

TREATMENT

Medication on admission-clonazepam 1 mg HS, olanzapine 2.5 mg HS, escitalopram 10 mg HS.

On discharge- August 31, 2011- olanzapine 20 mg PO daily, escitalopram 20 mg PO daily, clonazepam 0.5 mg PO twice daily as needed.

OUTCOME AND FOLLOW-UP

The patient expressed great displeasure surrounding his status as an inpatient on the psychiatric ward, and was adamant about being discharged swiftly. No safety concerns were identified towards the end of his hospital stay, and on review of the patient's mental status, he was not deemed to be certifiable. He did agree to be compliant with his medication as prescribed, and follow-up with the psychosis intervention and early recovery (early psychosis program) program. He described his mood as good with less intrusive thoughts and compulsions.

The patient continued to chant on discharge; counting each time, he repeated: 'the mantra'. He believes that if he is distracted, his 'enemy', 'brain' will command him to start from zero. The patient finds obeying his 'enemies' commands' to be calming, and further explains that if he did not obey such commands, then his day would be 'disorganised'. He said his medications make it more

comfortable for him when he disobeys. His mood was somewhat improved on discharge but his convictions surrounding being followed by a woman persisted.

DISCUSSION

Compared with OCD, patients without psychosis, patients with OCD and psychotic features were more likely to be male, single, have a deteriorative course and have had their first contact with a mental health professional at a younger age.¹ With respect to our patient, such facts would imply that he is at risk for a particularly poor prognosis, if not treated and followed up with appropriately.

Results indicated that individuals who reported fear of harming self or others via overwhelming impulse or by mistake—as well as those with religious obsessions—had poorer insight and more perceptual distortions and magical ideation than other types of obsessions.² Such appears to be the case with this particular patient, as his symptomatology was evidently ego-syntonic. Nonetheless, he struggled a great deal with the fact that he was mentally ill at all.

Our patient's insight was poor and correlates with our observation as well. Although the comorbid diagnosis of schizophrenia and OCD, or of OCD and psychotic features, seems to predict a worse prognosis than for either illness alone, the available data suggest that some patients with schizophrenia and OCD symptoms may improve with traditional antiobsessional treatment.³ With the use of escitalopram at its maximum dose, obsessions and compulsions continued with unwavering frequency and intensity. During the course of outpatient follow-up, we will be able to see if other interventions are necessary or if pursuit of alternate interventions are warranted.

The patients with OCD-schizophrenia were more likely to have a previous history of suicidal attempts and ideations. The number of previous suicidal attempts were significantly higher in patients with OCD-schizophrenia than in patients with non-OCD schizophrenia. The patients with a history of previous suicide attempts were more likely to have a comorbid diagnosis of OCD. Compulsive symptoms were significant predictors of suicide attempt among patients with schizophrenia. Our preliminary findings may suggest that obsessive compulsive symptoms may account for the emergence of suicidality in patients with OCD-schizophrenia.⁴ These findings might very

well correlate with this patient and hence the patient's SI/ thoughts must be followed closely.

Asexuality in this patient is also an interesting observation. It has been described that 'person with schizoid personality disorder sustain a fragile emotional equilibrium by avoiding intimate personal contact and thereby minimising conflict that is poorly tolerated'.⁵ Their sexual experiences are sporadic and limited and may cease altogether. This may explain the asexuality of our patient to some extent. Our patient however, denied the existence of any sexual interest at all. We wish to further work on this issue with our patient in the follow-up clinical settings.

Learning points

- ▶ OCD type symptoms with the use of escitalopram in combination with olanzapine resulted in improvement in this patient's symptoms.
- ▶ Medication compliance is essential in order to ensure an adequate trial of medication prior to alterations in dosing or consideration of alternate interventions.
- ▶ OCD ought to be addressed in the setting of psychosis based on the likely relation between these disorders.
- ▶ Religious beliefs with psychosis and concomitant OCD are difficult to treat when they are so strongly believed and valued by the patient.
- ▶ Cultural stigma of mental illness and the need for psychoeducation in such cases is important.

Competing interests None.

Patient consent Obtained.

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