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OBSESSIVE COMPULSIVE DISORDER: REPORT OF SIX CASES

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SUMMARY

Obsessive-compulsive disorder (OCD) refers to interloping and interactive thoughts, ideas, images, fantasies, impulses and actions accompanied by feelings of distress and declarations of resistance. It is assumed that OCD is rare among black Africans. This paper reports six cases from Uganda. The report indicates that OCD exists among black Africans and that those affected experience considerable amounts of emotional, social and occupational distress. It is suggested that OCD should be taught adequately to medical students to enable future general-duty medical officers to recognise and manage it appropriately. The names that appear in the text are pseudonyms.

INTRODUCTION

The term obsessive-compulsive disorders (OCD) refers to interloping and interactive thoughts, ideas, images, fantasies, impulses and actions accompanied by feelings of distress and "declarations of resistance". Descriptions of behaviours akin to OCD under social religious labels appeared in literary works as early as 1500, and the term exists in the autobiography of Ignatius of Loyola, the Founder of the Society of Jesus(1). Perhaps the best known character with the disorder was Shakespeare's Lady Macbeth. The term obsession acquired its medical meaning in French psychiatry in the work of Falret in 1866, but the term "obsession" was adopted in the *Lancet* and the *British Medical Journal* at the beginning of the twentieth century following a description of the natural history of the condition in France by Legrand du Saulle in 1875(1).

The chief features of OCD include repetitive involuntary, impulsive and irresistible thoughts, ideas, images, impulses and activity in clear conscious; absence of hallucinations and illusions; presence of insight; the experience of OCD phenomena as foreign and unacceptable to oneself; associated irrational fear and insidious onset, fluctuating course and a tendency to change. However, OCD does not appear to present as a pure clinical entity and the condition may accompany major depressive disorder, be a significant feature of schizophrenia and certain degenerative neurological conditions. Although OCD is a common disorder in Europe and North America, a recent Medline literature search revealed only four papers that addressed the condition in Africa(2-5) in the last 15 years. This paper reports further clinical material from the African continent with a suggestion that OCD may not be a rare condition among black Africans. Reasons for the apparent rarity of the condition among Africans are discussed.

CASE REPORTS

Case 1: Namukasa, a 24 year old female, sought professional help because of a history of having been depressed from childhood. Namukasa felt worthless and had great fear of each day. "Each day is like a trial for me. I force myself to do everything. If I had a choice I would not want to do anything, or even to live. ... I try to appear perfect, and the experience is trying, a burden. I do not feel free. I do not trust anyone. I fear rejection. I fear that people do not accept me for what I am. All this is difficult. I feel imprisoned. I believe that no one really cares for me. What they do for me does not really get inside me. This is worse with my (biological) father." Namukasa often mistrusted the intentions of others. She doubted her own capacity and "do not give credit to myself. I always find excuses for my achievements."

During the third therapy session, Namukasa revealed that she had lived with "fear of dirt" from the age of eight years while she was in the third year of primary education. The constant fear of dirt led to unacceptable repeated hand-washing, avoiding touching door knobs, carefully inspecting and cleaning where to sit and avoiding greeting by shaking hands. The fear of dirt made it difficult for her to participate in the activities of her present professional training. In addition she used to experience an "internal voice in my head. The voice used to tell me to do something, for example, get out of the class". However she denied the experience of any type of hallucination.

"I thought I was making the other person. I created company. I did not wish to be alone. I had erected an impervious barrier around myself. The voice represented an opening for company. The barrier was to protect myself from being hurt. I always severe relations when I sense that someone else is taking control of me. I felt comfortable with the created person. Later I evicted him because I feared discovery and because I thought I was losing control. I became afraid because I could not understand his nature, and what he wanted." She explained that the external visible person she had was false and that she created the external Namukasa to protect the real hidden Namukasa from hurt and rejection. Repeated hand washing by the external Namukasa protected the hidden dirty real self from being injured, yet protected the false external self from the danger of contamination.

Case 2: Twelve year old Okello was referred for consultation with history of an epileptiform disorder of an unspecified duration.

An electroencephalogram was normal with a well-developed alpha of 11-13 hertz and random moderate theta waves. Clinical evaluation revealed an anxious and worried boy who was afraid of heights, of being alone in rooms and of handling ropes or sharp objects such as knife. "If I climb a tree it means I will jump down to my death. If I am left alone in a room, it means dead bodies will enter the room. If I play with a rope, it means I will use it to hang myself." Mr Okello was tormented by repeated fear of failing examinations, of dying, of being sick with AIDS, or of suffering from his mother's condition (Bipolar Affective Disorder, currently depressed). He repeatedly saw images of a dead body dressed in green, of his parents being run over by a car, and of himself being knocked down by a motor vehicle. "Sometimes I see myself standing alone in a room and I keep pulling myself away from that room. If I do not pull myself away the image will appear," He described the images as "foreign and unpleasant", and he did not want to see them. Thus, he developed a variety of coping strategies to prevent the images from appearing to him. He repeatedly yelled out a gasping shrill sound to prevent the intrusive image of the dead body appearing. Sometimes he would shut his eyes forcibly and tightly with associated pursing of the lips and oro-masticatory movements of his jaws and lips. "I keep seeing dead bodies dressed in green. I do not want to see them. I bite my teeth repeatedly five times to prevent the images appearing. I wash my hands five times. If I wash twice it means we are two people, the other person being the dead body. If I wash five times it means there are four people with the dead body but excluding myself. By the fifth time of hand washing I bite my teeth very hard. If I do not do this in time, the image will appear. I perform many abnormal things to prevent the appearance of the images. I bite my teeth, shut my eyes, shout and say some words five times, such as Jesus, Jesus I shake my fist at the image to chase it away and bite my teeth to change the dress of the dead body from green to red When I am eating it means I must very quickly chew the food five times and then swallow it in time to prevent the image from appearing. When I enter a room I bang the door shut to prevent the images following me into the room. If I close the door gently it means the dead body will follow me into the room."

Mr Okello felt sorry for himself, and he described himself as being unhappy with poor comprehension and memory. He had lost interest in school and in social contact. He felt he was a total failure in life. He was tired of life and he had communicated his intention to commit suicide by hanging to his mother. Apart from fear and depression, Mr Okello had experienced two episodes of elated mood with excitement and over-activity necessitating treatment with chlorpromazine.

Mr Okello was the second of dizygotic twins. His twin sister was robust in physique and she enjoyed good health. His mother suffered from bipolar affective disorder. His father had a history of treatment for an anxiety disorder and he currently stammered in speech.

Case 3: Mr Male, a fifty year old catholic priest, presented with a persistent belief that he emitted a foul odour from his perineum, arm-pits and the shoulder region whenever he was in a company of people. Due to the offensive odour, he believed, people always coughed, sneezed, shifted positions and finally moved away from him. Mr Male believed that he was prompted to seek counselling because people had begun to avoid him and he too began to stay away from people due to the inconvenience he caused them. The episodes of bad odour were typically triggered by his constant preoccupation with imaginary smell, impending encounter with the public and whenever he sat close to people.

Case 4: Mr Semakula, a 24 year old university student was preoccupied with a senseless fear of sharp instruments, polythene bags, broken pieces of glass, drugs and chemicals for fear that these items might cause his death. The constant threat of danger led Mr Semakula to avoid these and other potentially dangerous situations in order to keep alive. Mr Semakula constantly reassured himself of the harmlessness of the situations he was afraid of and he wondered why he always forgot that the situations had always been harmless previously.

Case 5: Forty four year old Ms Akumu presented with the recurrent feeling of self-doubt, ideas of worthlessness, belief that she had lost shape and was ugly, fear of the public and nervousness over a period of four months. Ms Akumu's relations with workmates at the office deteriorated markedly as a result of her belief that people talked about her. In order to cope with her experiences, Ms Akumu began to: rebuke people whom she believed were laughing at or talking about her; pray more often than usual in order that her experiences would end; work harder at the office than anyone else; leave the office much later than others to avoid attracting attention; forgive those who talked about her or despised her and; repeatedly looked into the mirror to disconfirm her disfigurement.

Ms Akumu reported that her feelings and actions were unpleasant and untrue, but kept intruding into her consciousness against her will, thus resulting into the restriction in her social life.

Later Ms Akumu developed complete ptosis of the left eye. Plain skull radiograph and CT scan revealed no structural abnormality despite Ms Akumu's experience of intense throbbing headache in the left temporal region. Cerebral angiography revealed the presence of an aneurysm of the left posterior communicating artery. Surgical removal of the aneurysm alone did not provide relief from OCD phenomena.

Case 6: Kirunda, an 11 year old school-boy in primary five in rural Uganda, presented with a history of episodes of seeing dark with tics affecting his lips and peri-orbital muscles bilaterally. He had associated ritualistic behaviour and he often retraced his steps as he walked, put his right foot at a particular spot three times in response to an internal voice telling him that "you have not stepped at that spot."

Young Kirunda reported that he continuously spat saliva in response to his recurrent belief that he felt dirty in his mouth each time he saw someone else spit saliva, and when he saw early morning dew, faecal matter, urine, house-flies and whenever he experienced foul smell nearby. He repeatedly experienced the thought of dying against his will and he saw the images of leopards and robbers come to kill him. Mr Kirunda also experienced difficulty with breathing while in crowded places, and always moved away from other people in order to avoid experiencing his symptoms. Mr Kirunda also coped with his problems by deliberate distractions ("having other thoughts"). Young Kirunda reported that he had ever experienced episodes of excessive happiness and that he suffered from the intrusive images, beliefs and internal voice whenever he felt unhappy and fearful. Routine scalp electroencephalogram was normal and other laboratory tests revealed no abnormality.

Health history revealed that Mr Kirunda was hospitalised for the treatment of tuberculosis at the age of 18 months and he developed measles and bacillary dysentery in the process. He was also reported to suffer from episodes of bronchial asthma on hot dusty days. Mr Kirunda had a strong family history of affective disorder involving his maternal aunt and uncle and the daughter of the aunt who suffered from bipolar disorder.

DISCUSSION

Obsessive compulsive disorder (OCD) is one of the four leading causes of psychiatric morbidity. It is assumed that (OCD) is rare among Africans. Indeed in a proportion of the sufferers of this disorder, the condition may be associated with neurologic disorder or a major psychiatric disorder such as schizophrenia or severe depressive disorder. The condition gives rise to significant psychosocial distress and morbidity leading to interference with socialisation, work and academic performance(4). OCD may co-exist with other major psychiatric disorders such as depressive disorder, anxiety disorder and alcohol use disorder.

A number of common differential diagnoses need to be kept in mind in considering a diagnosis of OCD. As reported in this series the clinical condition could pass for specific social or situational phobia. However, OCD differs from phobia in that the experience of OCD phenomena persist even in the presence of significant other persons. In the presence of significant others, phobic symptoms resolve and the affected person becomes symptom-free. The symptoms of social phobia arise in response to fear of anticipated public scrutiny or ridicule whereas the symptoms of OCD are related to perceived threat to personal security but not to fear of making mistakes or failing to perform in a public situation. The experience of internal voices in this series and which has been reported to be a feature of OCD among children(6), smacks of a diagnosis of multiple personality disorder (dissociative identity disorder). However, a diagnosis of multiple personality disorder is not likely due to the fact that the experience of the reported internal voices in this series took place in the full knowledge of the patients concerned. In multiple personality disorder, the different personalities that exist in an individual take full control of the person's behaviour in turn and without the awareness of the alternate personalities. The associated motor manifestations of OCD could be mistaken for tics or epilepsy. Pure tics are involuntary purposeless movement disorder of muscle groups and most commonly involve the head and neck muscles without accompanying obsessions. Tourette's syndrome comprises obsessions, motor tics and vocalisation of obscenities. In non-convulsive and unusual forms of epilepsy careful history taking will reveal episodes of impairment of consciousness and amnesia. An electroencephalogram may be required to confirm a diagnosis of epilepsy though this may not be conclusive in 15-20% of cases.

The clinical picture in all the patients comprised at least six of the constant features of OCD; namely: interativeness; impulsiveness; presence of insight; experience of the phenomena as foreign and unpleasant; associated irrational fear; clear consciousness; avoidance of situations or objects with trigger obsessions and a belief by each of the patients that their experiences were unreasonable and distressing. In addition each of the

subjects was involved in attempts to distract themselves from experiencing OCD phenomena and in performing actions to disconfirm the reality of their experience.

These cases appear to contradict the view that OCD is rare among black Africans(2,3). Reasons which might account for the relative rarity of OCD among Africans in the international literature include misdiagnosis or underdiagnosis(3); belief by African patients that physical symptoms only need to be reported to western-trained health workers; probable denial and somatisation of emotional symptoms; the belief that emotional symptoms can only be caused by witchcraft and are not to be reported to western-trained health workers; the possibility that patients with OCD do not present for treatment and the relatively low level of psychological sophistication among rural communities in Africa.

Before the nineteenth century, obsessions were believed to be the work of the devil. Freud suggested that obsessions represented regression to the anal phase of development and signified conflict between opposing tendencies, such as aggression and submission; dirt and cleanliness and order and disorder(7). OCD is now believed to arise in response to the threat of harm to, or death of oneself or other persons(8). In the present series, three features stand out as a possible psychodynamic basis of the disorder; namely: perceived threat of rejection; fear of injury and fear of death.

OCD phenomena are a universal human condition. This report indicates the need for health workers to recognise OCD patients as doing so facilitates the early relief of distressing symptoms. It is recommended that medical students should be adequately trained to recognise and manage the condition at primary care centres as most patients in rural areas will remain unlikely to ever see a psychiatrist or clinical psychologist.

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