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Suicidal Obsessions in a Patient with Obsessive Compulsive Disorder: A Case Report

Faten N. Al-Zaben, MD, FRCPC

Department of Medicine, Faculty of Medicine
King Abdulaziz University, Jeddah, Saudi Arabia
faten_zaben@yahoo.com

Abstract. Obsessive-compulsive disorder is a common psychological illness characterized by recurrent intrusive thoughts, often accompanied by uncontrollable behavior. This disorder carries its own risk for suicide; however, suicidal thoughts can be a form of an obsession content of this illness. Distinguishing the difference between suicidal obsessions and accurate suicidal ideations may be under-recognized, which contribute to unnecessarily rigorous risk assessment, and subsequent interventions. This report presents one of the very few cases in literature that describes suicidal thoughts as the obsession content of obsessive-compulsive disorder patients. The present study can assist professionals evaluate a better risk assessment, and implement suitable treatment methods for patients suffering from this particular form of obsessive-compulsive disorder. Paroxetine is the choice medicine recommended for this cognitive, restructuring in the treatment of this and similar condition illnesses.

Keywords: Obsessive-compulsive disorder, Suicide, Risk assessment.

Introduction

Obsessive-compulsive disorder (OCD) is a common mental illness that can be present in diversity forms. Suicidal obsessions have been documented previously[1,2], hence, under-recognized or under-diagnosed. This has significant clinical implications; patients often subjected to an inappropriate scrupulous risk assessment due to the inaccurate

Correspondence & reprint request to: Dr. Faten N. Al-Zaben
P.O. Box 80205, Jeddah 21589, Saudi Arabia

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differentiation between suicidal obsession and accurate suicidal ideation. Moreover, the treatment of these diverse conditions is different. Very few studies have discussed the risk assessment and management of suicidal obsessions in OCD[3].

The present OCD study case, which to the best of our knowledge is one of the very few that describes suicidal thoughts as the obsession component of OCD. Through this case study, it demonstrates suicidal thoughts as an obsession occurring over a period of 36 years in a patient with OCD who had no suicide attempts. It also illustrates the outcome after using paroxetine for treatment.

Case Report

A case study of a 54-year-old female, an only daughter has a history of four depressive episodes, including an 18-year history of suicidal thoughts with no actual suicide attempts. She received continuous treatment over this time-span.

In April 2009, her suicidal obsessions worsened in both, intensity and frequency. At that time, her depressive symptoms consisted of low mood, decreased appetite, diminished energy, and impaired concentration. She was socially withdrawn and her hygiene was dwindling. The patient was diagnosed with Major Depressive Disorder, and consequently, admitted for evaluation. Her medications during admission were: venlafaxine 150 mg per oz once per day, mirtazapine 40 mg per oz once per day, olanzapine 5 mg per oz once per day, and risperidone 2 mg per oz once per day.

A thorough assessment of her suicidal thoughts revealed persistent urges to jump off a balcony, as well as to stabbing herself with a knife. These thoughts were recurrent, persistent, and intrusive, which caused her considerable distress. She deems these thoughts to be excessive and time consuming, thus, interfered with her daily activities. Her level of function declined, causing her to describe the situation as her intrusive thought, “fighting a battle, trying to resist and ignore”. Her thoughts were ego-dystonic in nature, and she denied any intention of carrying them out or having any desire to die. Her suicidal thoughts tended to worsen with stressful events, also reported having intrusive sexual and aggressive thoughts. She expressed an obsessive urge to look at female chests and male genital areas. Her aggressive obsessions were to hurt

people by throwing rocks or by stabbing them. These thoughts were quite distressing for the patient; however, they were not as intense and recurrent as her suicidal obsession.

The patient also reported having motor and vocal tics. The motor tics took the form of involuntary hand movements and eye blinking. The vocal tics consisted of making strange sounds. Hence, she was unclear about the exact time she started experiencing the vocal tics or their duration. Some of the medications given at the time of hospital admission (venlafaxine, mirtazapine, and olanzapine) were gradually reduced and discontinued. Risperidone was reduced to a dose of 1.5 mg per day and Paroxetine was introduced gradually and later increased to a dose of 50 mg once per day. After a careful risk assessment, cognitive restructuring sessions were conducted, and the patient was gradually exposed (with close monitoring) to the feared situations (*i.e.,* balconies and knives). Medication and continuous sessions gradually improved the patient's depressive state and intrusive suicidal thoughts over a period of approximately 2 months. Moreover, a significant reduction in the intensity and frequency of her suicidal thoughts, and other sexual and aggressive thoughts were diminished.

Discussion

This case study reports on a patient who ostensibly had depression with suicidal thoughts, but after a careful review, using diagnostic statistical manual IV-TR diagnostic criteria, she was diagnosed with OCD. The patient suffered with persistent symptoms of OCD, despite not being properly treated. Suicidal thoughts are described in literature as a variety of obsession content[1,2], thoughts of this type of obsession is not widely recognized. Suicidal obsessions can take different forms[2]. In this case, the authors believe it is in the form of an obsessive impulse, which is reported to be infrequently acted upon[4,5].

Obsessions are defined as "persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate, and cause marked anxiety or distress"[6]. Patients acknowledge them as unreasonable or excessive. Descriptions of obsessions stress their intrusive and egodystonic nature[4], which is consistent with this case. The more enjoyable the act, the less likely it is to become an obsession[4]. Obsessive ideas are thoughts that repeatedly intrude into consciousness,

while ruminations are defined as prolonged inconclusive thinking about a subject[1,7]. Furthermore, one dictionary definition of obsession implies a volitional control that is absent in obsessive phenomena.

The patient also reported other ego-dystonic, intrusive sexual thought, which would favor the diagnosis of OCD, since many obsessions can exist in the same individual. Factors suggesting OCD in thoughts of violence as reported[3] as:

A. Ego-dystinicity
B. Absence of past behavior consistent with the thought
C. Presence of avoidance behavior (*e.g.,* avoiding knives or sharp instruments)
E. Frequent thoughts
F. High degree of distress and strong motivation to seek help

This unique case report on OCD symbolized by suicidal and sexual thoughts accompanied by vocal and motor paroxysm has significant clinical implications. Violent obsessions, including suicidal obsessions, are documented in the literature[8,9], though they are often are under-recognized. These themes are common in people with OCD at any age and often misinterpreted as an indicating risk to self-harm or others[3]. Professionals presented with individuals describing thoughts of violence or suicide may be tempted to focus primarily on safety concerns when conducting a risk assessment. However, a person with OCD can be harmed by unduly lengthy risk assessments, responding with increased doubts and fear about the implications of their intrusive thoughts. These can lead to greater distress, compulsive behavior, avoidance and the mistrust of health professionals[3].

Differentiating between genuine suicidal desires and suicidal obsessions is crucial, as the treatment approach will differ depending on the diagnosis. In Veale *et al.*[3], the authors stress the importance of an accurate assessment of suicidal thoughts in patients suffering from OCD; thus, sub-classifying them in two types of risks. The first primary risk is apparent and rises only from an obsession; the risk that the patient will act on the obsession (*e.g.,* suicide or sexual thoughts). The authors lessen the clinical concern by indicating that obsessions by definition are unacceptable, that ego-dystonic fears and worries that the patient does not wish this to happen, and to avert at all cost. Of much greater concern is the secondary risk, where patients may act on compulsions and urges

to avoid anxiety-provoking incidence. An example would be a person with contamination fears in relation to eating or drinking who may severely restrict food and fluid intake, leading in some cases to malnourishment or dehydration[2]. In the case of genuine suicidal desires, prevention of the act is the primary goal, whereas in obsessive suicidal ideation, exposure therapy is the most suitable approach, much like the treatment of other symptoms of OCD.

A similar case was reported in Wetzler *et al.*[10], where the patient's depressive symptoms were accompanied by suicidal thoughts initiated from obsessive symptoms of OCD rather than a true wish to die. The patient expressed suicidal thoughts of drinking detergent. She gradually started on exposure therapy, and following seven sessions, there was an improvement in her symptoms.

In the present case, one could argue that OCD was part of her depressive disorder. However, when the patient achieved remission of her depression symptoms, she continued to have suicidal obsessions. In addition, she had never acted on her suicide or sexual and aggressive obsessions.

It is widely known that unresolved OCD may lead to depressive episodes. Therefore, the assessment of the secondary suicide risk becomes more complicated if the individual becomes more depressed and hopeless, or has a co-morbid personality disorder that is associated with impulsive behavior[3]. In addition, OCD itself carries its own risk of suicide, which has to be distinguished from ego-dystonic obsessions of suicide. However, both conditions can coexist, making the diagnosis more challenging.

Conclusion

This case report stresses and supports the need to differentiate between suicidal obsessions and factual suicidal ideation. Careful assessment of patients with OCD experiencing suicidal thoughts needs to be considered bearing in mind that suicidal thoughts can be part of OCD. In addition to the appropriate treatment of exposure to therapy or other established interventions for OCD. This case also supports the use of Paroxetine and cognitive restructuring in patients with Obsessive-Compulsive Disorder.

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الوساوس و الأفكار الانتحارية في مريض الوسواس القهري

فاتن نبيل الزبن

قسم أمراض الباطنة، كلية الطب

جامعة الملك عبد العزيز

جدة – المملكة العربية السعودية

المستخلص. يعتبر اضطراب الوسواس القهري من الأمراض النفسية المنتشرة. ومن خواصه الأفكار الدخيلة المتكررة، يصاحبها اضطرابات سلوكية قهرية قد تعرض المريض لمخاطر انتحارية. مع ذلك قد تكون الأفكار الانتحارية من محتوى الوسواس القهري. من المهم التمييز بين الرغبة الجادة في الانتحار وبين الوساوس الانتحارية حيث أن الخطأ في التشخيص يؤدي إلى عدم تقييم المخاطر والعلاج غير الصحيح. تعتبر هذه الحالة من الحالات النادرة التي تصف الأفكار الانتحارية كجزء من الوسواس القهري، والتي ستساعد الأطباء في التشخيص والعلاج الصحيح. وتؤيد هذه الحالة استخدام العلاج النفسي السلوكي ودواء باروكستين في علاج حالات مماثلة.