Case Report

A unique case of OCD: Contamination of steamed rice (Bhater Ento)

Kaberi Bhattacharya[1]

[1] Department of Psychiatry, Midnapore Medical College and Hospital

Corresponding author

Kaberi Bhattacharya, Department of Psychiatry, Midnapore Medical College and Hospital,
Email: bkaberi.acharyya@gmail.com

Abstract: culture affects symptom, course and perception about any psychiatric disorder. This is a very common yet unreported contamination fear found in Hindu, Bengali population only.

Introduction: A unique type of contamination fear in Hindu Bengali population in West Bengal is noted by us and that is fear of contamination by 'steamed rice' or 'bhat'. Bhat or steamed rice is the staple diet of a Hindu Bengali. One is supposed to eat steamed rice in the designated place only (in specific dining area), wash hands thoroughly after eating and not supposed to touch anything other than eating utensils while eating steamed rice. Previously one had to wash his/her cloths after eating cooked rice. Brahmans were supposed to take rice only once in a day, not allowed to talk during that period and not allowed to leave seat too. Though that type of behavior is rare now. Raw rice, puffed rice and other type of cereals do not have that property. That contamination is called "Bhater ento". Dictionary is showing that the word "Ento" meaning in Bengali is 'leaving of a meal' which is synonymous with the hindi word 'Jutha' but in bengali life "ento' encompasses much wider area[1].

Very often we get patients who are obsessed to get contaminated by 'Bhat' to such an extent that they stop taking rice and other rice preparations which look like rice e.g. poha or chira. They often force other family members to follow the same behavior.

Following is the example of such a case:

Ms AB was brought to a psychiatrist with complaints of:

Not eating rice for last 5 years
Not allowing family members to eat rice for last 3 years
Not going out of house for contamination of the same.

History of present Illness:

Ms AB's family is a conservative Hindu Brahmin family. Both of her parents expired at an early age and she was living with her elder brother and younger sister for past 10 years. The elder two siblings are very religious in nature. The Brother who is 4years older than her, is a confirmed bachelor, works in a private firm, has taken 'Diksha" from a guru and prefers to wear saffron coloured clothing in home. He is a graduate. Ms AB didn't continue her study after a failure in class X board exam. She was accustomed to do all household chores as her mother had a poor health and remained bedridden most of the times.

After her mother's death with the help of her younger sister she was continuing well except that she was very particular about "bhater ento". So she allow everyone to take cooked rice only in dining area in kitchen and after eating meticulously cleaned the area and took a bath for 30 minutes after cleaning. As it was difficult to take bath 3 times a day, specially during winter, so they changes their diet from rice to 'chapati' in dinner. About 3 years back she and about 2 years back all of them all of her family members stopped to take rice to avoid her regular tantrums regarding 'bhater ento'. Coming to know about their present situation some distant relatives suggested that it may be a psychiatric problem which can be cured. So they have come to me.

Ms AB a saree clad thinly built lady, looked quite younger than her stated age 40 years, was poorly dressed compared to her younger sister. She stated that she cannot wear nice saree as she has to wash them in soap water every time she goes out. She apprehends that in road there is every possibility of contamination with steamed rice because people often feed stray animals on road and often through out left overs on roadside. So she has stopped going outside recently. She also stated that she has few pet kittens who share the same bed with her. She does not feel disgust in cleaning their excreta but whenever she thinks of cooked rice she feels extremely uncomfortable, nausea and anxiety. She also affirmed that most probably she wont be able to visit me in future for the same reason. Although she agreed to take few pills to relieve her behaviour which she considers abnormal but she refused psychotherapy for the same reason. She also agreed to do routine blood tests which came out to be within normal limit but she refused CT Scan brain. She was prescribed Fluoxetine, the dose was gradually escalated to 60 mg. Later on Risperidon 1 mg and Clomipranine 25 mg were added. Her compliance was poor, came only once after the first visit. Her Siblings visited me for her for a couple of times though. Last time her younger sister was very elated as recently she allowed her siblings to take cooked rice after almost 3 years, though she was reluctant to take at that time. After that they didn't come for consultation.

Discussion:

Culture may affect many clinical symptoms, the patient's own perception about it, and the way clinician understanding and interpretation of the clinical symptoms. So it can be assumed that culture may have an impact on different aspects of obsessive- compulsive disorder as risk factors precipitating the disease, variety of symptoms being experienced, prevalence, severity, and course of the disease.[2,3] However, there are those who believe that experienced symptoms are similar regardless of the cultural background.[4]

The type of obsessions seems to vary according to the cultural context. In Middle Eastern countries, religious themes prevail, while in Brazil, there is a predominance of aggressive obsessions[3] and in most countries, the issues of contamination are the most predominant, an example of this is the Indian population, where it has been described that the compulsions related to cleanliness and pollution are more prevalent in comparison with other types of compulsions.[5] It has been proposed that this phenomenon is linked to their religion, in which purification and cleansing rituals play an important role.[6]

High incidence of contamination OCD in Indian population may be due to their cultural background which has a great concern about purity and cleanliness. Hindu code of ethics provide us variety of purification rituals, celebration of which consists of bathing in certain place or manner.[5]

In India, the relationship between people and food relates to the caste system still prevalent in the region. These rules are driven by different ancient scriptures.The most famous one is 'Manusmriti' or 'Manusamhita'. According to 'Manusamhita' chapter 4 rule no 223: A Brahmana who knows (the law) must not eat cooked food (given) by a Sudra who performs no Sraddhas; but on failure of (other) means of subsistence, he may accept raw (grain), sufficient for one night (and day).[7] So from long back cooked food was not accepted from a lower cast person. But from when and why they gained this 'ento' or 'contamination' property in bengali hindu society is not clear. Though in many famous bengali literary works we get mention of 'bhater ento' (contaminated with steamed rice).[8]

So far this is the first reported case of contamination of steamed rice which is very unique of Bengali Hindu community. For a practicing psychiatrist in Bengal this is not an uncommon presentation of OCD.

References

1. https://sobdartho.com/bengali-to- bengali/%E0%A6%8F%E0%A6%81%E0%A6%9F%E0%A7%8B
2. Yorulmaz O1, Işık B. Cultural context, obsessive-compulsive dis order symptoms, and cognitions: a preliminary study of three Turk ish samples living in different countries. Int J Psychol 2011; 46(2): 136-43.
3. Fontenelle LF, Mendlowicz MV, Marques C, Versiani M. Trans cultural aspects of obsessive-compulsive disorder: a description of a Brazilian sample and a systematic review of international clinical studies. J Psychiatr Res 2004; 38(4): 403-11.
4. Matsunaga H, Maebayashi K, Hayashida K, et al. Symptom struc ture in Japanese patients with obsessive-compulsive disorder. Am J Psychiat 2008; 165(2): 251-3.
5. Akhtar S, Wig NN, Varma VK, Pershad D, Verma SK. Socio cultural and clinical determinants of symptomatology in obses sional neurosis. Int J Soc Psychiat 1978; 24: 157-62.
6. Khanna S, Channabasavanna SM. Phenomenology of obsessions in obsessive-compulsive neurosis. Psychopathology 1988; 21(1): 12- 8.
7. http://oaks.nvg.org/manu-samhita.html
8. Galpoguchchho, Rabindranath thakur: Saraswati Library, streer patro p 550