A Report of Sado-Masochistic Behavior in a 7-year-old Child

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Abstract:
Sado-masochistic habits are those in which the patient enjoys inflicting damage to himself. It occurs among globally developmentally delayed individuals, psychotic patients, and individuals with severe personality disorder. Often, these habits pass unnoticed. As dentists, we should be aware that self-injurious behavior occurs in children and should be a part of any differential diagnosis involving soft tissue or dental trauma. In most of the instances, the general physical lesions get unobserved and neglected at times with prime concentration only to the oral region. The aim of this study is to present such a case of a 7-year-old child who actually reported for the dental problem, and sado-masochistic behavior was identified, and appropriate referrals and treatment was provided.

Key Words: Burn marks, psychiatric, scratch marks, sado-masochistic behavior, self-injurious behavior, teeth

Introduction
“Sado-masochistic behavior is also known as masochistic habits, self-injurious behavior (SIB), self-mutilation.” Sado-masochistic behavior has been defined as the deliberate destruction or alteration of body tissue without conscious suicidal intent and occurs in conjunction with a variety of psychotic disorders as well as various developmental anomalies and some syndromes. It occurs among globally developmentally delayed, psychotic patients, and individuals with severe personality disorder. This study presents a case report of sado-masochistic behavior exhibited in a 7-year-old child and highlights the importance of identifying it by discussing in detail.

Classification
Sado-masochistic behavior may be classified as either “organic” or “functional”. In organic mutilation, the person injures himself unknowingly, unintentionally, and compulsively. This includes hereditary disorders, in which genetic, biochemical, or enzymatic deficiencies have been identified. Examples are Lesch-Nyhan syndrome, global developmental delay associated with congenital toxoplasmosis, congenital indifference to pain, Tourette’s syndrome, de Lange syndrome, schizophrenia, borderline personality disorder, pervasive developmental disorders, and stereotypic movement disorder. Functional mutilation is performed as a response to certain stimuli and may or may not serve as a cognitive purpose. It is generally divided into three subcategories: (1) Mutilation motivated by and sustained by secondary gain, (2) factitial or neurotic self-excoriations, and (3) self-mutilation during psychotic episodes.

Etiology
Many causes have been suggested.1
- Sensory neuropathies may lead to sado-masochistic behavior. This includes sensory loss of pain sensation in anesthesia dolorosa. Many other diseases have also been associated with SIB.
- Loschen and Osman2 suggested that anything that causes discomfort such as sinusitis, headaches, and painful dental conditions could precipitate this behavior.
- Auto-additive mechanism where the physical pain results in raised levels of endogenous opiates or the opiate system is abnormal resulting in elevated pain thresholds.

Several investigators have suggested a behavioral etiology to SIB or a behavioral reason for the maintenance or continuation of the behavior.

Case Report
A 7-year-old boy reported with his mother to the Department of Pedodontics and Preventive Dentistry, Ambedkar Dental College and Hospital, Bengaluru, with the chief complaint of missing teeth. History revealed that he had difficulty in eating food and was unhappy with his appearance. Family history revealed that his parents had a consanguineous marriage. Medical history was not remarkable. The patient was shy, submissive, and not socially interactive.

Extraoral examination revealed multiple scars over his hands, legs, and face (Figures 1, 2 and 5). Detailed history from his mother revealed apparently reduced pain sensation, which induced the patient to hurt himself by falling, banging his head, peeling the skin of his fingers (Figure 3), scratching his hands (Figure 5), and burning his fingers by lighting matchsticks (Figure 4). She also reported that despite having lost some primary teeth, due to caries, he had extracted the lower molars himself.
Intraoral examination revealed the presence of a few permanent teeth with pulpal involvement in 46. Orthopantomograph revealed three congenitally missing permanent teeth (21, 45, and 41). Therefore, we planned root canal treatment (RCT) in 46 and prosthesis for missing teeth. While anesthetizing for RCT patient could feel the needle prick but was co-operative in taking injection. He was referred to a neurologist who carried out nerve conduction tests, but the reports were normal.

Additional scratch marks over the patient’s ears and burn marks over his hands were noticed during the subsequent appointments. He closed his fingers around the flame of the Bunsen burner, used for border molding.

Based on these findings and the history given by the mother, a diagnosis of sado-masochistic behavior was made. After initial dental treatment, he was sent for psychological counseling. After 3 months at his recall visit, it was observed that his scars were healing, and his attitude had changed. His self-esteem was further increased by the improved esthetics achieved by prosthetic dental treatment.

**Discussion**

Sado-masochistic behavior is any behavior, initiated by the individual, which directly results in physical harm to that individual. Physical harm will include bruising, laceration, bleeding, bone fractures and breakages, and other tissue damage.\(^1\)

Plessett\(^5\) observed a 9-year-old girl of apparently normal intelligence who worked her maxillary primary canine and mandibular permanent incisors loose from their supporting tissues and removed them; this is consistent with the history that our patient had extracted his lower molars himself.
Common sado-masochistic behavior includes skin picking, scratching, eye rubbing, head banging, nail biting, craniomandibular dysfunction, and dental disorders. In our patient, multiple scars, scratch marks, burn marks, skin picking were seen. The self-inflicted injury may be incorrectly diagnosed. These findings and others include bruising, welts, fractures, burns, and lacerations are also consistent with non-accidental injury. The importance of accurate diagnosis lies in careful history taking and examination of the patient. In this case, a diagnosis of sado-masochistic behavior was made on the basis of our observation and the parent’s history. The management of patients exhibiting sado-masochistic behavior includes psychotherapy and psychiatric counseling and adjunctive therapy in the form of bandages, facilitating wound healing.

Awareness of this condition is important among all health professionals and should be included in the differential diagnosis of facial and oral trauma.

Conclusion
As dentists, we should have a thorough knowledge of SIB and should include sado-masochistic behavior in the differential diagnosis of any traumatic injury. Following diagnosis, a multidisciplinary approach along with appropriate referrals psychiatrist services is recommended.

References