

Genital Self-Mutilation and Psychotic Disorder: Case Report

Genital Self Mutilasyon ve Psikotik Bozukluk

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ABSTRACT Self-mutilation against external genitalia in psychiatric patients is known as Klingsor Syndrome. Major self-mutilations against ocular, genital and larger body organs are rare. These cases are more frequently seen in young men. The role played by conflicts about “the male role”, problems of identification about male role, and feelings of guilt on sexual aggression were frequently mentioned. A case of genital self-mutilation who had negative symptoms of psychosis will be reported in this paper, and genital self-mutilation is discussed as a probable strong predictor of following suicide.

Key Words: Psychotic disorders; suicide; castration; schizophrenia; self mutilation

ÖZET Psikiyatrik hastalıklarda dış genitallere yönelik self mutilasyon Klingsor sendromu olarak da bilinir. Bu olgularda erkek rolü ile ilgili çatışmalar, erkek rolü ile ilgili özdeşim problemleri ve cinsel saldırganlıkla ilgili suçluluk duygularının rol oynadığından sıklıkla bahsedilmektedir. Okuler, genital ve vücudun büyük uzuvlarına yönelik major self mutilasyonlara nadir rastlanır. Daha çok genç erkeklerde görülmektedir. Bu yazıda negatif psikotik belirtiler ile başvuran genital self mutilasyon olgusu ve bunun gelişebilecek intiharın bir öngördürücüsü olabileceği tartışılmıştır. Olgumuz, negatif belirtili bir psikoza olan genç, erkek genital self mutilasyon vakasıdır.

Anahtar Kelimeler: Psikotik bozukluklar; intihar; kastrasyon; şizofreni; kendini sakatlama

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Self-mutilation is defined as damaging or changing body parts purposely, in order to commit suicide. Minor self-mutilation is considerably common, generally does not cause a major disability, and even be a part of the accepted cultural practice. Major self-mutilation is rare; is seen generally only in association with a severe mental illness and frequently result in a permanent organ or function loss.¹ The three main forms of major self-mutilation are ocular, genital and organ mutilation.² Patients with a history of eye or testicle mutilation, penile amputation or amputation of part of a joint were diagnosed as having “psychosis of schizophrenia spectrum”. Acute psychosis and especially the first episode of schizophrenia is found to be the most important cause of major self-mutilation in a systematic review of case reports.³

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Self-mutilation against external genitalia in psychiatric patients is also known as “Klingsor Syndrome”. These patients have a strong inclination to aggressive behaviors to themselves.⁴ This condition is rare and young male patients. The role played by conflicts about “the male role”, problems of identification about male role in childhood, and feelings of guilt on sexual aggression were frequently discussed in the literature.⁵

Formerly, investigators had accepted these individuals “psychotic”, due to the nature of their behavior. It was shown in studies later that most of these persons were not actually psychotic during self-mutilation.⁶

Cases of auto-castration were reported among schizophrenic patients with religious delusions. A young male patient had castrated himself as a response to Matthew 19:12 from the Bible.⁷ Self-castration is generally seen in transsexualism, serious character disorders and psychosis.⁸

Considering auto-castration cases, Greilshaimer and Groves have determined 3 general classes of patients: Psychotic individuals, non-psychotic persons with major personality pathologies, and persons affected by socio-cultural factors and religious believes.⁹

Schweitzer observed four generalized pre-morbid features in these cases: specially religious hallucinations, themes of guilt and sexual conflicts, history of depression and frequency of past suicide attempts, and severe deprivation in childhood.¹⁰

Rates of suicide is 20 times higher in schizophrenia, in comparison with the general population. Twenty to 50 percent of patients with schizophrenia attempt suicide, and 10% of these lose their lives as a consequence.¹¹

CASE REPORT

HISTORY

N. K. 28 years old, unmarried, male, high school graduate; completed his military duty, living with his family. He had closed himself to his surroundings a few weeks before his penile amputation, started putting a distance between himself and

other people, and not talking with anyone, he had quit talking to others, started laughing by himself, and neglected himself. Insomnia and impassivity had occurred. A few weeks later, he did a complete amputation of his penis with a knife. He was taken to the emergency department by his father, and was hospitalized. An urethro-cutaneous reconstruction was done at the hospital, and the department of psychiatry was consulted. He was given some medications, which his next of kin did not remember by name, and was discharged. The patient had discontinued his medications a few days later.

After discharge from the hospital, withdrawal, shrinking from people and not talking to others had become more severe. He had started speaking to himself, laughing, and he would not sleep in the nights. He also would not having a bath. After 8 months, he was convinced by his father’s hard toil to be admitted at our hospital.

He was admitted at our institution with complaints of decrease in conversation, closing inward, decrease in personal care, impassivity about disease, and insomnia. He was hospitalized and treatment with olanzapin 10 mg, aripiprazol 15 mg and quetiapine 100 mg was started. A prominent clinical improvement was observed after 4 weeks of hospitalization and he was discharged with an appointment for follow-up. He did not show up at the scheduled control and it was heard that he had committed suicide with a firearm. Genital self-mutilation (GSM) and following mortal suicide was discussed in this paper.

CLINICAL EVALUATION AND FOLLOW-UP

The patient was silent at admission, did not answer to questions, and only told that he did not want to stay at the hospital, and he did not have any illness. He was convinced to stay, was hospitalized and hardly convinced to ingest his medications.

A brain computerized tomographic imaging (CT) was ordered, and biochemical and hematological routine tests were done. All test results were in the normal range. He got a score of 26 from a Brief Psychiatric Rating Scale (BPRS), of

which 24 points were from items about schizophrenia.

In his psychiatric interview, eye contact was diminished, his personal care was seemingly neglected, he was indifferent and his affect was dull. Production and flow of speech and thoughts were diminished. Thought contents were diminished; he only told that he was not ill and he wanted to go away. Especially, he was angry at questions about his penile amputation of 8 months before, and denied the occurrence of such an incident. His memory and orientation was intact. Psychomotor activity was retarded, and initiation of purposeful behavior was restricted. There was only the penile amputation in his medical history, and his family history was uneventful. His personality before this illness was reported as a quiet, introverted person with strong religious beliefs. Treatment with Olanzapin 10 mg, Aripiprazole 15 mg and quetiapine 100 mg was initiated with a working diagnosis of psychotic disorder.

The patient's sleep and self-care improved after 4 weeks; he started communicating with other patients; and he was discharged with an appointment for a control examination. He did not show up at that time. His father was called, and he reported that the patient was in good condition, and taking his medications. He was given a new appointment for control examination. He did not come to the second appointment, and his father was called again. This time, he told that the patient had quit taking his medications. He was reminded that control examinations were really necessary, and the patient would have to be brought to the hospital by law enforcement. He still did not show up for a control examination. It was heard 2 months later that the patient had committed suicide with firearm, and had died.

When the history, examination and psychometric evaluation of the patient, deterioration of functioning, duration, denial of the illness and premorbid personality characteristics are considered together, he was considered to be in a process of psychotic disorder, and especially a process of schizophrenia with predominant negative findings.

DISCUSSION

Our aim in this paper is reporting of a case of GSM who had died at a suicide attempt with a firearm after initiation of a psychotic process, who had also amputated his penis 8 months before he was admitted at our hospital. GSM is done by individuals from all races, religions and cultures, and the first case was reported in 1901 by Strock at the English literature.¹²

It is very hard to predict GSM before it actually is done. Motivations for GSM are multifactorial.¹³ In a case of male auto-castration who had recovered from a psychotic attack with probable sexual guilt, religious personality and hostility against women are rare one of antecedents of GSM behaviors, and a careful search for a probable post-psychotic depression may be beneficial in preventing this self-destructive behavior.¹⁴ A religious personality was present as a premorbid lifestyle in our case. Presence of religious psychotic experiences is one of the symptoms associated with GSM.¹⁰

Although self-castration is seen very infrequently, it generally occurs in male patients with schizophrenia and feelings of sexual guilt, with delusions about having a relief only with self-castration.⁷ These patients are strongly inclined to repeat self-aggressive behaviors, especially when medical therapy is stopped.⁴

Order hallucinations, drug abuse and presence of depressive periods play an important role in the high rate of suicides in schizophrenia patients. Also, demographic characteristics such as younger age, being at earlier stages of the illness, being unmarried and male were found to be associated with suicide, all of which are present in our patient.¹⁵ There are six important risk factors for GSM in schizophrenia: a) Psychotic experiences; b) Presence of personality disorder; c) Past history of GSM, d) alcohol or drug addiction, e) feelings of sexual guilt, f) early loss of father.¹⁵

Although major self-mutilations such as self-castration are very rare, these may decrease the rate of early treatment of psychotic disease. Manage-

ment of these patients should include long-term pharmacotherapy, personal and family therapies. Psychotherapy should be utilized in the solution of developmental conflicts in young schizophrenic patients.⁵

Although there were no clear delusions and hallucinations in this case, clinical features indicate the negative signs of schizophrenia, according to DSM-IV-TR. Our case lost his life as a result of suicide with a firearm, approximately 1 year after self amputation. The significant improvement of the

signs and symptoms of our patient, after being admitted at the hospital, and being hospitalized, indicate the importance of pharmacotherapy and also importance of psychotherapy in these patients. On the other hand, withdrawal of this treatment by the patient and his family, and breaking off of the relationship between hospital and patient was effective in the patients suicide. For this reason, this case is important in that it shows that self-castration in young male patients may help us in predicting a completed suicide.

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