Reprinted from the German Journal of Psychiatry · http://www.gjpsy.uni-goettingen.de · ISSN 1433-1055

CASE REPORT

Genital Self-mutilation and Erotomania

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Abstract

The case of a 28-year-old woman with paranoid schizophrenia is reported who presented with erotomania and who had injured her external genitals in an attempt to stop coenaesthetic dysaesthesias. The implications of the symptoms are discussed with reference to relevant literature (German J Psychiatry 2005:8:38-41).

Key words: erotomania, genital self-mutilation, psychosis, female

Received: 6.7. 2005
Revised version: 12.7.2005
Published: 13.7.2005

Introduction

Psychiatric case reports of female genital self-mutilation (GSM) in the literature are rare and mostly anecdotal (Alao et al, 1999; French & Nelson, 1972; Simpson, 1973; Ziolko & Hoffmann, 1977). Most of them are connected with personality disorders (Goldfield & Glick, 1970; Wise et al, 1989). To our knowledge, there are only three reports of female patients with genital automutilation in connection with a psychosis to date (Krasucki et al, 1995; Standage et al, 1974; Wise et al, 1989). In men psychosis is an important cause for GSM, causing up to 80% of automutilations (Eke, 2000; Greilsheimer & Groves, 1977; Nakaya, 1996). We report a patient with paranoid psychosis (F20.0) who first presented with erotomania and who had injured her external genitals in an attempt to stop coenaesthetic dysaesthesias.

Case report

The 28-year-old woman was admitted after being treated in the outpatient department for 1.5 years. She complained about genital dysaesthesias which she described as a kind of electric current and which had increased in the last two years.

Her development during childhood was unremarkable. Aged 10 she started to be more remote, had less contact with her peers and had sleeping disturbances so that her mother stayed with her most of the night. At school she had difficulties concentrating. At the age of 13 she developed anorexia, her weight dropping to 35 kg with a size of 158 cm. Later she developed a compulsive disorder with obsessive thoughts and behaviour. She spent several hours in the cold shower and repeatedly needed to clean her mouth and throat. In one of these attempts she swallowed a toothbrush which had to be surgically removed. Her symptoms lead to increasing conflicts with her mother. Her compulsions started to focus on self-punishment, with repeated attempts of automutilation, banging her head against walls and inflicting subcutaneous bleeding by hitting herself. She allowed herself to eat only food of certain colours and without taste, so that she would not have any pleasure while eating and started rigorous exercise. From the age of 16 to 20 she was hospitalised several times. During the last hospitalisation she stabilised and moved into assisted living. She finished school, completed a professional training, moved into her own flat and started a university course. She did well in the first year in university and made some friends. Up to this point she did not have any sexual relationships. She had fallen in love with men whom she felt were beyond her reach or had started relationships but withdrawn when her partners wanted to get more intimate.

During her second year in university she fell in love with a professor. She did not initiate any personal contact but felt

that he was sending her messages between the lines, for instance citing a letter she had written. She assumed that he was in love with her, too. She started to have genital sensations which she pleasantly experienced at first as being in love or being stimulated. After several months these feelings changed their character abruptly. She felt she was being penetrated. From this moment she had the impression that she was being controlled by her professor communicating with her through the dysaesthesias. In the following time she had the impression of getting messages through the radio and of being also controlled by other instances. She could not concentrate any more and dropped her university course, lost contact with her friends and could leave her flat only after long negotiations with the controlling instance. Her only social contacts were her parents and the treating psychiatrist. In the last months before hospital admission she felt that the dysaesthesias did not allow her to concentrate on anything else which included eating. She lost 10 kg weight in the 2 months before she agreed to hospital admission. She then reported, that she had been hitting herself repeatedly in the genital area in the attempt to stop the dysaesthesias.

Mental state examination on admission: alert and orientated, polite and appropriate in manner but seemingly withdrawn, speaking with a low voice. Concentration strongly impaired, making easy daily tasks difficult. No formal disturbance of thoughts. Delusional system with erotomanic features. Coenaesthetic hallucinations. Disturbance of self feeling influenced by others. Mood parathym and suffering, subdepressive, activity reduced.

The physical examination revealed a meagre patient (weight 43.5kg, height 158cm), an older superficial laceration (2 x 5 cm) at the right labia majora, with a safety pin being sticked through the wound. The gynaecological exam showed no further injuries.

Routine laboratory test, EEG, evoked potentials and MRI scan were without pathological results.

The patient was treated with risperidone up to 8mg/d. In the following weeks dysaesthesia improved remarkably but did not disappear completely. She could distance herself quickly form her delusional ideas and did not think, that she was actually loved by her professor or influenced by him or anybody else. Her main reasoning for this was, that she was so unimportant that nobody would cause so much trouble because of her. Her concentration improv ed considerably.

The remaining symptoms worried the patient so much that she was preoccupied by the idea that her symptoms would never disappear completely. She complied with the hospital setting, attended psychological and psychosocial therapies and avoided seeking attention. Yet she spent as much time as possible outside the ward, generally visiting her parents. She described her symptoms, the expectations of psychiatrists, staff and her parents and the neuroleptic therapy as multiple layers of pressure put on her. Sexuality would be her core problem which she could not solve this way. Her mother tried to involve herself in the therapy, demanding invasive treatment and initiating repeated gynaecological exams by suggesting that her daughter might have injured herself again.

Because of extrapyramidal side effects treatment was changed to 15mg olanzapine daily. This reduced side effects but did not lead to any further decrease of the symptoms. The patient then wanted to terminate the hospital stay and to start working again. Because inpatient treatment did not lead to any further improvement, we discharged her into outpatient treatment.

Discussion

Genital self-mutilation (GSM) has been described in several publications in men (Aboseif et al, 1993; Becker & Hartmann, 1997; Greilsheimer & Groves, 1977; Martin & Gattaz, 1991; Nakaya, 1996) in about 110 cases. In the earlier publications, the majority of these patients were either psychotic or intoxicated during auto-mutilation (Greilsheimer & Groves, 1977). In recent articles the number of psychotic patients was reported to be smaller (Becker & Hartmann, 1997). The authors discuss that this might be due to a double bias, as psychiatrists are more frequently involved when the patients are psychotic and these cases tend to be published more frequently.

Reports of female GSM are more scarce and consist of case reports and small case series. Goldfield and Glick (1970) first described a syndrome of dysorexia and GSM (Goldney & Simpson, 1975). Since then the majority of patients reported had personality disorder mostly of the borderline type and frequently a history of sexual abuse during childhood. Wise et al (1989) differentiated female GSM in three groups: 1. patients with personality disorders, 2. self-induced aborters and 3. psychotic patients. These aetiological assumptions differ considerably from those concerning men. The differentiation between self-induced abortion and GSM has been discussed by Reich and Wehr (1973). Since then, abortion laws are more liberal in many countries, so this differential diagnosis has become rare. Social and forensic reasons are expected to be more important in these cases than mental disorders. Up to now there have been two reports of female GSM in connection with a psychosis (Krasucki et al, 1995; Standage et al, 1974) and one report of female GSM in a patient with an isolated delusional system and dysmorphophobia (Wise et al, 1989). The cases reported by Krasucki et al and Wise et al show some similarities: both patients had a delusional distortion of their body image, leading to the belief that their genitals were abnormal so that they finally tried to remove them. The history of our patient shows similarities with the woman reported be Standage et al: both patients were young, were described as quiet personalities and developed erotomania in an psychotic episode. The patient reported by Standage et al injured herself in an attempt to stop an expected sexual assault, our patient injured herself because she wanted to stop dysaesthesias which she connected with the feeling of being influenced externally.

Although GSM in our patient occurred during a psychotic episode, her history shows similarities to group 1. During adolescence she had a severe compulsive disorder with focus on self-punishment and repeated automutilation as well as

anorexia. These symptoms may have been associated with borderline personality disorder, but the course of the illness makes a psychotic condition more likely. Most of the patients reported from group 1 have a history of sexual abuse during childhood. This was also the case in two of the three previously reported psychotic patients. In our patient a previous sexual abuse could not be confirmed. Her father has been reported to have a paranoid personality disorder, sometimes becoming violent, her mother showed an overprotective and indirectly aggressive behaviour.

An interesting factor is the combination of erotomania with self-mutilation. Erotomania has been described by Kraepelin (1909), who mentioned the importance of biographic factors in the development of this syndrome. Clérambault (1999) introduced 1921 diagnostic criteria, differentiating a "monomania" and a secondary form which is connected with a mental disorder, mostly schizophrenia, affective or organic disorder. The DSM-IV diagnostic criteria include a delusional conviction about mutual love and delusional misinterpretation of gestures or actions of the object of the erotomania. The object is usually a socially higher ranked person. The risk of aggressive behaviour of erotomanic patients has especially been addressed by Mullen and Pathé (1994) in a series of 14 patients who became aggressive against the persons they fell in love with or their partners. They employed more extensive criteria in order to diagnose a pathological extension of love. In addition to the criteria mentioned above they demanded that the object of the patient's affection did nothing to encourage or reject the affections, that the love preoccupies the patient to the exclusion of other interests and repeated attempts to follow or approach the object of affections (stalking). In our patient this aggressive component seems to have been directed against herself, which can mainly be explained by her low self-esteem and insecure personality structure.

Erotomania was in one case report interpreted as a conflict of autonomy and dependence (Brüggemann et al, 2002) especially in relation to the parents. Even if information about the family of our patient is rare, the intrafamliar interaction is complicated. The first episode of her illness had led to conflicts with her mother, the symptoms improved when the patient finally moved into another town and started to work. The present episode has led to an increasing contact with and dependency on her parents and a renewal of old modes of interaction. Although the symptoms of our patient occur in relation with her present psychotic disorder, her history suggests that intrapsychic factors might play a role in the formation of the psychotic symptomatology.

Conclusion

We report a patient with GSM in connection with a paranoid psychosis and secondary erotomania. Concluding from our experience in this case we believe that GSM in women might be underreported. As has been proposed in relation to men, reports might be biased towards patients needing acute medical attention (Becker & Hartmann, 1997). Patients who chronically injure themselves might be able to hide their injuries and might not volunteer information about it. Therefore these injuries can be overlooked when attention is not drawn to this fact in the physical examination. They might come to the attention of a gynaecologist in patients who avoid psychiatric treatment and allude psychiatric evaluation. In fact, some of the recent case-reports have been puplished in gynaecological journals (Ajibona & Hartwell, 2002; Habek et al, 2002)

To sum up, several hints which should rise suspicion of GSM in psychotic women can be concluded: 1. A history similar to the patients of group 1 with sexual abuse, dysorexia and/or previous automutilation, 2. a delusional dystortion of the body image, especially when related to the genitals, dysmorphobia or genital coenaesthesia, and 3. erotomania. Higher numbers of reported cases are necessary in order to determine whether these really are risk factors for female GSM.

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