

CASE REPORT

A Case of Genital Self-Mutilation in a Patient With Psychosis

Rehan Ahmed Siddiquee¹ and Sandip Deshpande²

¹Shelton Hospital, Shrewsbury, UK

²Leeds Mental Health Trust, Leeds, UK

Corresponding author: Dr. Rehan Ahmed Siddiquee MBBS, MRCPsych, Specialist Registrar, Shelton Hospital, Shrewsbury, UK. E-mail: dr.rehan.007@gmail.com

Abstract

The following case report highlights an act of Genital Self Mutilation. This case had multiple interacting risk factors which were- being a single unemployed male suffering from schizophrenia with religious delusions. After a review of the clinical information available the case best fits the description for Klingsor Syndrome (German J Psychiatry 2007;10: 25-28).

Keywords: Genital self mutilation, Klingsor Syndrome, Schizophrenia, Male

Received: 26.5.2006

Revised version: 5.11.2006

Published: 23.1.2007

Introduction

Self mutilation has been defined as the deliberate destruction or alteration of body tissue without conscious suicidal intent (Coons, 1992). It is rare for people who self mutilate to deliberately destroy their genitalia. This could involve injuring, partial or total removal of the external genitalia. Genital Self Mutilation (GSM) is a very rare manifestation of psychiatric illness. The first report in English literature of GSM was in 1901 by Strock (Eke, 2000). The number of cases of GSM reported in published literature has varied between 51 and 114 since the first report in 1901 (Eke, 2000). Although our case report is based on a male patient, GSM has also been reported in female patients in published literature (Eke, 2000; Krasucki et al., 1995; Standage et al., 1974; Wise et al., 1989). However, the associated psychiatric illnesses differ in males and females. Various symptoms and psychiatric illnesses have been associated with GSM in published case reports (Mishra and Kar, 2001). In females, most of the cases of GSM are associated with personality disorders (Goldflick and Glick,

1970; Wise et al., 1989; Marckmann et al., 2005). In males, psychosis has been associated with 80% of acts of GSM (Eke, 2000; Greilsheimer and Groves, 1977; Nakaya, 1996; Marckmann et al., 2005). Here, we present a case report of a male patient suffering from schizophrenia who attempted to amputate his testicles.

Case Report

Index event

A forty year old divorced, unemployed male patient presented to casualty with severe self-inflicted injuries to his scrotal sac in addition to superficial injuries to the right side of his neck and left wrist.

At the time, the patient was on weekend leave from an adult in-patient psychiatric ward.

The scrotal injury involved a deep incised wound to two-thirds of the circumference of the scrotal sac and a testicular haematoma. The scrotal injury required admission to the surgical unit and surgical repair in the operation theatre.

Psychiatric History

The patient first came in contact with psychiatric services via the Genito-Urinary Medicine (GUM) clinic when he was 26 years old. He presented with a belief that he was suffering from multiple sexually transmitted diseases (STD) including Acquired Immune Deficiency Syndrome (AIDS). He based this belief on a single episode of dysuria he had experienced. On full and repeated examinations and investigation the patient was found to be normal but persisted to believe that he was suffering from a STD. The patient was referred to his General Practitioner (GP) by the GUM clinic. On assessment by his GP he was found to have paranoid ideas, and delusions of being unclean. The patient had told his GP that bacteria were oozing out of his skin. This led to him being referred to psychiatric services for an assessment.

The patient's condition soon worsened, and he was admitted to a psychiatric hospital following an assault on his wife. In addition to his previous symptoms he now presented with made volitional acts (claimed that God had made him assault his wife), delusions of grandeur (said that he had cured all the patients on the ward and that he had the power to destroy the world), delusions of religious nature (claimed he was the God's representative on Earth and that he could prophesize the future). It was during this admission that the patient was diagnosed with Schizophrenia (F20.0) as per the ICD-10 criteria based on the assessments of two independent, experienced, consultant psychiatrists. Other possible diagnoses such as hypo-mania, mania and depression were ruled out. He was commenced on an anti-psychotic medication to which he responded well and was subsequently discharged. He had two further relapses four years and 10 years later and presented with the same symptoms described above. Both the relapses were due to non-concordance with his medication. During the second relapse, the patient was sent home for weekend leave. On his psychiatric review prior to his discharge he did not present with any psychotic or depressive symptoms. During the leave period, he collected a knife from his kitchen, went to a Church to attend Sunday service and then proceeded to an isolated field where he self-mutilated his genitals.

Events following genital mutilation

The patient was reviewed by his psychiatrist following the GSM and the possibility of suicide was ruled out. The patient's illness continued in a similar vein of relapse and remission depending on his concordance to anti-psychotic medication, in both oral and depot form. Each relapse was characterised by psychotic symptoms of a religious nature.

Following the GSM the patient's mental state was stabilised and he was discharged from hospital. He however suffered

with another relapse, again due to non-concordance with his medication. He was arrested in London where he was attempting to meet the Queen and transferred to hospital following an assessment by a psychiatrist in London who found the patient to be suffering from delusions.

He was once again assessed on admission by the duty doctor and at the time was exhibiting delusions of a religious nature. The day after he was admitted, the patient managed to abscond from the hospital and committed suicide. There were no symptoms of depression on either of the two assessments prior to his suicide.

Medication History

The patient during the entire period of his illness was very reluctant to take his medication. He was given a trial of flupenthixol in depot form but refused to continue it because of the extra-pyramidal side-effects he was experiencing. He was given a trial of sulphiride but again had to be switched to amisulpride following the GSM. This change had to be made because the patient said that he felt over-sedated on the sulphiride. He was given both these anti-psychotics for a sufficient period of time and in sufficient dose prior to discharge. However, after discharge the patient always took a much lower dose of the medication than that prescribed to him, he also consistently refused to take anti-psychotics in the depot form. On all his admissions, the patient did not show any symptoms of depression and therefore not put on any anti-depressants. He was able to mask his psychosis for long periods of time and would continue not taking his medication as prescribed to him until he would have a full relapse and end up being admitted to hospital.

Discussion

Not much information could be gained from the patient regarding the motives behind his act of GSM immediately after the act or at a later time. He remained very guarded about his GSM and refused to discuss the event with anyone even during subsequent admissions to the hospital. It is very difficult to gain further insight into this matter as the subject unexpectedly committed suicide. Therefore we had to rely on retrospective information obtained from his case notes and guided by published relevant literature on the subject of GSM.

Unlike previous published reports, this case report presents a combination of associated factors which could have led to the GSM. Although this makes the case more interesting, it makes the formulation of a hypothesis with a single driving force as an explanation for the GSM very difficult.

One of the reported symptoms with GSM is the presence of religious psychotic experiences (Nakaya, 1996; Schweitzer, 1990). Some of the religious psychotic phenomena in our patient are mentioned above. He could have tried to attain a higher, pure form of existence by amputating his genitals.

The patient often referred to himself as the representative of God on Earth and that when he wrote, it was the hand of God writing through his hand.

Schizophrenia has been reported as an associated factor in GSM (Martin and Gattaz, 1991; Feldman 1988). Men who self-mutilated their genitals are most likely to be psychotic at the time of the act (Greilshheimer and Groves, 1979). The patient in our case report was diagnosed with schizophrenia when he was around 27 years old. Though his illness started with somatic hallucinations and a persistent pre-occupation with genitals and sexual health, it took a little more than a year for him to develop other symptoms of schizophrenia. He always responded very well to anti-psychotic medication but the problem with concordance was always the key issue.

Guilt feelings associated with sexual offences and conflicts (Nakaya, 1996; Martin and Gattaz, 1991). The patient had got divorced from his wife shortly after he had physically abused her. It has also been documented in his case notes that the patient repeatedly behaved in a sexually inappropriate manner with the female staff on the ward. It cannot be ruled out that the GSM could have been due to guilt for the above actions.

Preoccupation with sexually transmitted disease and GSM to relieve for urinary symptoms has also been reported (Mishra and Kar, 2001). The first presentation of our case was for dysuria which resulted in the patient forming a belief that he was suffering from sexually transmitted diseases. The possibility of an Obsessive Compulsive Disorder was ruled out by a full mental state exam conducted by two experienced consultant psychiatrists independently. The possibility of urinary symptoms being the cause of GSM in our case is remote as he did not present with urinary symptoms at the time of the act.

After a review of all the above literature, our case best fits the criteria for Klingsor Syndrome. The name Klingsor was suggested for this eponymous syndrome which involved self inflicted castration because of religious delusions by Ames in 1987 (Catalano et al., 2002). It was Schweitzer who proposed that the syndrome should also include cases which involve genital self mutilation associated with all delusional syndromes (Schweitzer, 1990). The name 'Klingsor' was based on a fictitious character in Wagner's music-drama. In this drama, Klingsor was a magician who tried to get accepted as a Knight of the Grail, a religious brotherhood. He castrated himself because of his inability to remain chaste in order to be accepted into this brotherhood. The other associations our case had with published literature on GSM were being single, male, and the possibility of feeling guilt for sexual offences committed.

Inferences

The incidence of GSM seems to be on the increase (Eke, 2000), however, whether this is due to an increase in the incidence of GSM or due to an increase in the frequency of it being reported is not clear. It is a phenomenon which is present in all races, cultures and religions, has been

mentioned in Greek mythology, and practised by priests in early Rome. The motives behind, causes, and associations for GSM are varied. These range from ritual and religious practices (Eke, 2000), transsexuals trying to reassign their gender on their own in clear consciousness (Baltieri and Andrade, 2005), patients suffering from personality disorders (Eke, 2000), secondary to drug or alcohol abuse (Israel and Lee, 2002; Moufid et al., 2004), suffering with a psychotic illness (Schweitzer, 1990), and in attempts to commit suicide (Eke, 2000). Although it has been argued that there is no comprehensible pattern to GSM, 65% of patients had been suffering from a psychotic illness, and 31% of the patients made repeated attempts at GSM mainly in the psychotic group of patients (Aboseif et al., 1993)

Cases of GSM are urological and surgical emergencies, therefore it is more likely that patients will have a surgical assessment first rather than a psychiatric assessment. The high rate of repeated mutilation could probably be attributed to the fact that patients do not come under the scrutiny of psychiatric services.

Therefore it is important that surgical and psychiatric teams liaise closely while managing cases of GSM (Romilly and Isaac, 1996). It is also important that there is more awareness amongst medical practitioners of the underreported phenomena of GSM (Catalano et al., 1996) and repetitive GSM (Catalano et al., 2002) so that it can be treated effectively and its recurrence prevented.

References

- Aboseif S, Gomez R, McAninch JW. Genital self-mutilation. *J Urol* 1993;150:1143-1146
- Baltieri Da, de Andrade AG. Transsexual genital self-mutilation. *Am J Forensic Med, Pathol* 2005;26:268-270
- Catalano G, Catalano MC, Carroll KM. Repetitive male genital self-mutilation: a case Report and discussion of possible risk factors. *J Sex Marital Ther* 2002;28:27-37
- Catalano G, Morejon M, Alberts VA, Catalano MC. Report of a case of male genital self-mutilation and review of the literature with special emphasis on the effects of the media. *J Sex Marital Ther* 1996; 22:35-46
- Coons PM. Self amputation of the breasts by a male with schizotypal personality disorder. *Hospital and Community Psychiatry* 1992; 43:175-176
- Eke N. Genital self-mutilation: there is no method in this madness. *Br J Urol Int* 2000; 85:295-298
- Feldman MD. More on female genital self-mutilation. *Psychosomatics* 1998; 29:141
- Goldfield MD, Glick ID. Self-mutilation of the female genitalia (A case report). *Dis Nerv System* 1970; 31:843-845
- Greilshheimer H, Groves JE. Male genital self-mutilation. *Arch Gen Psychiatry* 1979; 36:441-446
- Israel JA, Lee K. Amphetamine usage and genital self-mutilation. *Addiction* 2002; 97 1215-1218

- Krasucki C, Kemp R, David A. A case study of female genital self-mutilation in schizophrenia. *Br J Med Psychol* 1995;68:179-186
- MacLean C, Robertson BM. Self enucleation and psychosis. *Arch Gen Psychiatry* 1976; 33:242-249
- Marckmann S, Garlipp P, Krampfl K, Haltenhof H. Genital self-mutilation and Erotomania: A case report. *German J Psychiatry* 2005; 8:38-41
- Martin T, Gattaz WF. Psychiatric aspects of male genital self-mutilation. *Psychopathology* 1991; 24:170-178
- Mishra B, Kar N. Genital self amputation for urinary symptom relief or suicide? *Indian J Psychiatry* 2001; 43:342-344
- Nakaya M. On background factors of male genital self-mutilation. *Psychopathology* 1996; 29:242-248
- Moufid K, Joual A, Debbagh A, Bennani S, El Mrini M. Genital self-mutilation. Report of 3 cases. *Prog Urol* 2004; 14:540-543
- Romilly CS, Isaac MT. Male genital self-mutilation. *Br J Hosp Med* 1996;55:427-431
- Schweitzer I. Genital self amputation and the Klingsor syndrome. *Aust N Z J Psychiatry* 1990; 24:566-569
- Standage KF, Moore JA, Cole MG. Self-mutilation of the genitalia by a female Schizophrenic. *Can Psychiatr Ass J* 1974; 19:17-20
- Wise TN, Dietrich AM, Segall E. Female genital self-mutilation: Case reports and literature review. *J Sex Mar Ther* 1989; 15:269-274