

Case Report

Genital and Nipple Self-Mutilation in a Female Schizophrenic Patient

Adarsh Kumar Vohra

Corresponding author: Consultant Psychiatrist and College Tutor, Parkwood, East Park Drive, Blackpool, FY3 8PW, Lancashire, United Kingdom

Abstract

A case of nipple and genital self-mutilation (GSM) is described in a female patient of first episode of schizophrenia and compared with the only three cases reported so far in the literature. The act of nipple and GSM in the case reported here was in response to a psychotic phenomenon to “protect” her family from some outside harm, in the absence of any sexual connotation, religious delusion, personality disorder, dysmorphophobia of genitalia, eating disorder, substance abuse and sexual abuse. The act of self-mutilation became symptomatic in an interesting clinical setting (German J Psychiatry 2010; 13: 91-93).

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Introduction

Self-mutilation, self-injurious or self-harming behaviour has been defined as deliberate destruction or alteration of body tissue in the absence of conscious suicidal intention (Coons, 1992).

The incidence of self-mutilation is considerably more among women (Greilsheimer & Groves, 1979; French & Nelson, 1972) but genital self-mutilation (GSM) among females seems to be extremely rare (Greilsheimer & Groves, 1979; Young & Feinsilver, 1979). Genital self-mutilation, a rare psychiatric manifestation, may involve injuries resulting into partial or total removal of the external genitalia.

Wise et al. (1989) reported that GSM may be mainly categorized into three types viz. self induced abortion, superficial laceration to the genitalia in women with personality disorder in an attempt to reduce the inner tension and laceration of the external genitalia in patients mainly men in response to delusions or command hallucinations usually accompanied by body image disturbances (Young & Feinsilver, 1986). In certain cultures genital mutilation occurs as a ceremonial ritual. Among Amazon women the self-mutilation of the breasts was well

known; in fact literally the word Amazon means “without breasts”.

In contrast to males where psychosis is associated with 80% of the acts of GSM (Eke, 2000; Grielsheimer & Groves 1979; Marckmann et al, 2005), most of the cases of GSM in females take place in individuals suffering from personality disorders (Goldfield & Glick, 1970; Wise et al; 1989; Marckmann et al. 2005).

To the best of the knowledge of the author, only three cases of female GSM associated with psychosis, one each by Standage et al (1974); Wise et al, (1989) and Krasucki et al, (1995) have been reported. No case of breast/nipple mutilation in female suffering from psychosis has been reported in the literature.

Here in a case of GSM and nipple self-mutilation is discussed in a young woman suffering from 1st episode of schizophrenia.

Case Report

A 29-year-old Caucasian was admitted to Gynecology ward following the discovery by her parents that she had lacerated her nipples and genitalia with a knife. She reported that she mutilated her nipples and genitalia in order to “protect” her family from harm from “external forces”. While on the gynecology ward, she attempted to obtain scissors and a broken glass in order to self-harm her further to complete the process of “protection” of her family. Prior to GSM she was facing the stress of under going divorce after 10 years of her marriage, moving back into her parental home, recent changes in her job and her mother’s critical illness. She was seen by mental health liaison services on the gynecology ward and was transferred to psychiatry inpatient services.

She infrequently harmed herself to a small extent as a teenager but that never attracted the attention of psychiatric services. She has been drinking alcohol socially for few years, but denied abusing any recreational drugs. There was no history of mental illness in the family. The mental state examination on admission revealed her to be anxious and low in her mood. She spoke very little with long pauses in her speech. She expressed ideas of self-harm and delusions of persecution stating that out side forces were threatening to harm her family. She believed that these forces could be neutralised if she mutilated her genitalia. She appeared perplexed, demonstrated intermittent eye contact and lacked insight into her mental health problem. The physical examination including detailed neurological examination, CT scan of head and EEG were normal.

Over the next few days, she continued to appear anxious, perplexed and suspected that the staffs on the ward were in fact police. She needed much reassurance that her parents were safe. She continued to look preoccupied and asked staff members in the ward if she was going to be shot dead or a sniper was coming to get her or if her brain had been removed and her eyelids cut off. She asked if her nose and face were all right but never raised any concern about the appearance of her genitals or of breasts. At times she was noticed to be responding to unseen stimuli suggestive of auditory hallucination. On few occasions she showed evidence suggestive of passivity phenomenon.

She denied experiencing of any physical pain or discomfort to her breast and genitals due to self-harm. She in fact felt that these self- inflicted injuries were helpful to deal with numerous stresses that were building up over few months. She experienced the thoughts that people were going to harm her family couple of weeks prior to actually harming herself.

She was commenced on olanzapine 10 mg daily to which she responded favourably. She became pleasant and sociable and started engaging well with others on the ward and returned to her work fairly soon following her discharge.

Discussion

Cases of GSM are fairly rare in men and far rarer in women, although surprisingly enough self-harm behaviour is far commonly seen in women as compared to men (Alao et al. 1999; French & Nelson, 1972; Ziolk & Hoffmann, 1977). The self mutilation of breast/nipple in men occurs with greater rarity (Rao & Penneys, 1984) while in women the breast/nipple self mutilation is not heard of except as a ceremonial events in Amazonian culture to make these women less feminine and less sexually attractive (Cawte et al., 1966). GSM in the form of clitoral removal and labial excision are carried out to maintain the virginity of girls in African and Australian tribes (Favazza, 1987).

Case reports of female GSM are strikingly rare in the literature and mostly anecdotal.

A computerised search of Psychiatric literature has shown that only three comparable cases of female GSM in psychosis have been described but none with breast/ nipple self mutilation in females.

The first case of female GSM was of 20-year old single woman who mutilated her cervix and vaginal vault by inserting sharp objects in response to command hallucination. These sharp objects in her vagina gave her the sense of security to prevent any unwanted sexual advances towards her. An elderly neighbour sexually abused her as a child. Five years prior act of GSM she had periods of abdominal pain, dysuria, and frequency of micturation and was treated several times for urinary tract infections. She was depressed and expressed fears that some men were planning to sexually assault her. Once she took a large overdose of aspirin impulsively (Standage et al., 1974).

The other patient was a 33 year old, single women who amputated one labia majora as she believed that her labia was “gross and ugly” and that her employer was out to get her for having genital warts on her labia. She experienced severe pain during the act of mutilation. She struggled with alcohol abuse and financial difficulties and hence had to move to her parents’ home. She had no previous psychiatric history. She had delusions that were restricted to her belief about labia and her colleagues. (Wise et al. 1989).

The third case was of a 29-year old single Afro- Caribbean woman who had schizophrenic illness at the age of 20. She lacerated her right labia majora, as she believed that her genitalia were enlarged due to masturbation and were more masculine. She experienced delusion of control, referential thinking about her sexuality, heard voices commenting on her actions and size of her genitals. Her brother, uncle and aunt also suffered from schizophrenia. Around the age of 15 she was rejected by boy friend for another girl. She started masturbating at the age of 17. She also believed that she was overweight and was involved with dieting and exercise (Krasucki et al, 1995).

The patient described here by the author shows some similarities and differences to the comparable patients described in the literature. The major theme of the case reported by the author is persecutory delusion and acting on a magical belief that self-mutilation of genital and nipple

would protect her family from any harm from “outside forces”. Unlike the above three cases, the case reported by the author did not show evidence of eating disorder, unusual sexual behaviour/preoccupation, dysmorphobia of genitals, sexual abuse, genito-urinary complications, experiencing of pain during the act of self mutilation and history of past psychiatric disorder. However like all the three patients reported earlier and the patient reported here in by the author expressed delusion of persecution. Two of the three cases reported earlier the age of onset of mental disorder was about 9 years younger than the case reported by the author. Similar to other patients, the case reported here also had previous history of self-harm, financial difficulties, stress of moving back into the parents’ home and delusion of control. Both in the case reported by Standage et al. (1974) and the case reported by the author the acts of GSM were attempts to protect them from sexual assault and protect the family from other forces. However, the two cases reported earlier (Wise et al, 1989 & Krasucki et al, 1995), were mainly driven from dysmorphophobia of the genitals in the setting of schizophrenia.

Further this case is presented because of interesting psychopathology of female GSM occurring in interesting clinical settings. This case may also suggest that GSM in psychotic females may not be as rare as reported and the low reporting could be attributed to the embarrassment attached with the sexual nature of the symptom.

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