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Genital Self - Mutilation in Schizophrenia - A Case Series

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Abstract

Background: Major self-mutilation of various parts of the body with or without suicidal intent is seen in mental illness. It needs attention due to risk of significant disability. Available literature finds majority of cases to be psychotic. These are associated with motives and various risk factors.

Case Series: In our study we describe lacerations over penis inflicted by two elderly gentlemen, both diagnoses with schizophrenia, with different motives.

Discussion and Conclusions: Various psychodynamic factors have been ascribed to genital self-mutilation. The ability to carry out GSM without anaesthetics also points to deficiencies in pain expression in attempters. A multidisciplinary approach with antipsychotics, surgery and addressing non-compliance needs to be adopted in treatment of genital self-mutilation. Further studies are required to find out social and risk factors pertaining to genital self-mutilation.

Keywords: Genital self-mutilation; Major self-mutilation; Auto-castration; Genital lacerations; Schizophrenia

Background

Self-mutilation is defined as the direct and deliberate self-destruction of one's own body part without suicidal intent [1]. Minor self-mutilation as a part of ritual is known in many societies. In contrast, major self-mutilation is rare and usually associated with severe mental illnesses. It can result in death or severe disability [2]. Self-mutilation has been observed in psychosis, affective and personality disorders and in Lesch-Nyhan Syndrome [3,4]. Rare causes may be under influence of psychoactive substances [4,5]. Research has shown non-fatal self-harm to have highest prevalence among patients with schizophrenia [6,7]. Motives for self-mutilation vary. Patients may perform such acts to relieve inner tension, depersonalization, feelings of guilt and rejection or due to command hallucinations and preoccupation with sexual matters. Several review articles and case studies have described auto-castration, glossectomy, self-enucleation and amputation of the hand in schizophrenia [8]. The literature so far is largely anecdotal, and it is difficult to predict the risk of self-harm. Some risk factors though exist. In this case report, we describe two cases of Genital Self-mutilation (GSM) in patients with schizophrenia and attempt to review risk factors for such attempts.

Case Series

Case 1

A 68 year old male Mr X was admitted with history of sustaining multiple lacerations over the body. He had been suffering from paranoid schizophrenia of continuous course with delusions of reference and persecution for 20 years. He had experienced history of sad mood with death wishes in the past. Behavioural disturbances like uprooting plants in the garden and drinking petrol for unknown reasons was elicited. There was no family history of mental illness or self-harm. Substance use and intellectual disability were ruled out. Records of past treatment were unavailable.

Physical examination revealed a lacerated wound of size 7x1x0.5cm over neck and 2 lacerations over scrotum, the larger being 2.5x1x0.5 cm and a single laceration over penile shaft measuring 2x1x0.5cm. Though patient claimed to have sustained the injuries by accident, family members felt it to be intentional. Photograph of the injury could not be taken as the patient or the informants did not provide consent.

The patient later reported having missed his usual dose of antipsychotics after receiving news

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Figure: Genital self-mutilation by Mr Y showing extent of injury requiring suturing and bandaging of whole shaft of penis with catheter *in situ* (photographed and reproduced after permission of patient and family members).

that his spouse was ill and had undergone cardiac bypass surgery. He had felt helpless that he had not been informed of her condition previously so that he could plan her treatment. These factors had driven him to harm himself.

General investigations including complete blood count, random blood glucose, renal function test, liver function test, thyroid profile and serum electrolytes were normal. Criteria for mild depression (score: 11) on Hamilton Depression Rating Scale was met. He improved with a course of Escitalopram 10 mg and Risperidone 4 mg over 2 weeks and was discharged. At the time of discharge, he was asymptomatic.

Follow up mental status at 1 month revealed multiple delusional beliefs and Risperidone was increased to 8 mg. The patient then dropped out and could not be contacted.

Case 2

A 60 year old male Mr Y was admitted in Surgery and seen for referral. He had been suffering from a psychotic illness for the past 10 years with history of delusions of reference, persecution, anger, auditory hallucinations and disturbed sleep. There was no significant past or family history. Substance use and intellectual disability were ruled out. He had never been on psychotropics.

There were 2 suicidal attempts in the past month by attempt to drown. He had to be admitted after he had hit himself on the head with a brick followed by GSM. Examination revealed a lacerated wound of 10x3x1 cm over the dorsum of penis extending to root of scrotum bilaterally. Breach of corpora cavernosum with bleeding was noted.

The patient was guarded and had hallucinatory behaviour. There were no depressive features. Computerised tomography of head was done and was normal. Other investigations included complete blood count, blood glucose, thyroid profile, renal function, electrocardiogram and serum electrolytes which were normal.

Diagnosis of schizophrenia was made and treated with risperidone 4 mg at night, trihexyphenidyl 2 mg in morning and clonazepam 0.5 mg at night. He was discharged against medical advice after 2 days and thereafter lost to follow up.

Discussion

GSM has a rare occurrence. Greilshheimer and Groves found

87% of genital self-mutilators to have psychosis [9]. Among the cases studied so far, most cases have been diagnosed as paranoid schizophrenia. Most cases are noted in young males. Blacker and Wong [10] identified six risk factors for male GSM:

- 1) Absence of a competent male figure for identification in early developmental life,
 - 2) Over-controlling mothers encouraging their sons' masochistic behaviours,
 - 3) Pathological feminine behaviours of the male child,
 - 4) Repudiation of body image (especially the penis),
 - 5) Unresolved sexual conflicts,
 - 6) Anxiety and feelings of guilt relieved by GSM.
- Psychoanalytically, self-mutilation is explained as persistence of infantile sexuality patterns and castration anxiety due to unresolved oedipal conflicts, or as self-punishment, focal suicide and aggression directed to oneself [11].

It may also be secondary to religious delusions and are often accompanied by command hallucinations where it is known as Klingsor Syndrome [12].

Both our cases are elderly males in their sixties suffering from psychotic illnesses who were off treatment at the time of GSM. They were both lost to follow up early after intervention. These suggest increased risk of GSM in untreated or non-compliant patients who are actively psychotic. In Case 1, the patient also met a diagnosis of mild depression which is likely to post-schizophrenic which had assumed serious proportions due to stressors and non-compliance. In Case 2, the individual had poor support system and GSM was likely from hallucinatory experiences associated with religious delusions as in Klingsor Syndrome.

A remarkable finding in GSM in schizophrenia is the high threshold to pain as patients commit self-mutilation without using anaesthetics. Result postulates that it may be related to beta-endorphin, Substance P and calcitonin Gene Related Peptide (cGRP) levels in patients rather than blunting of the nociceptive pathways [13]. Cognitive and negative symptoms in schizophrenia are also known to influence the expression of pain [11,13]. There are also reports of derealization and depersonalization experiences prior to GSM which may contribute to diminished awareness during the act and to the pain.

The motives for GSM are variable; with around 10% of the attempters intending suicide [14]. Yearning for sympathy has been noted in grief-stricken patients as in Case 1 [15].

Patients with self-mutilation should be hospitalized immediately and medical, surgical and psychiatric consultation should be sought. Outcome depends on the integrated collaborative work. Patients with GSM warrant a detailed assessment for the presence of psychosis and even patients who are not initially forthcoming about the reason for self-mutilation should be regarded as suffering from a psychosis until proved otherwise [16]. The cultural background of the patient should be explored.

Psychotropic medication must be the first line intervention in both treating the active psychotic episode and in preventing recurrences. An important contributing and motivating factor for male GSM appears to be sexual dysfunction, so medications causing fewer

sexual side effects should be chosen. During the remission period, cognitive and behavioural techniques may be helpful for replacing thoughts of sacrifice with harmless alternatives for atonement. Issues of compliance should also be addressed in these patients.

Conclusions

The literature regarding GSM is sparse. More studies are required to know about the social characteristics of attempters and find out risk factors. They should be treated for psychosis unless definite indication for non-psychotic illness is present. Treatment should be multidisciplinary to reduce disability.

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