Case Report

Genital Self-mutilation in a Case of First Episode Psychosis

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ABSTRACT

Genital self-mutilation (GSM) is a much rare finding and more commonly associated with psychosis when it comes to comparison with self-mutilation as a whole. There have been anecdotal case reports of GSM in psychotic disorders with most of them being in long standing psychoses. We describe herein a case of GSM during the first episode of psychosis where multiple phenomenological variables were seen responsible for the act.

Key words: *First episode psychosis, genital self-mutilation, self-mutilation*

INTRODUCTION

Self-mutilation is defined as the deliberate and direct destruction or alteration of part of the person's body without conscious suicidal intent.[1] Genital self-mutilation (GSM) is usually seen in individuals suffering from psychotic illness and more so in response to a delusional process.[2] Studies on GSM behavior have revealed that around 70-80% of cases have underlying psychiatric disorder.[3-5] It is important to note that significant dysfunction of ego-integrity manifesting as low self-esteem and guilt is another cause for GSM.[5,6] Case reports on GSM are found in various forms spanning the literature on schizophrenia. A syndrome named "van Gogh syndrome" has been the name given to patients attempting self-mutilation under the influence of imperative hallucinations.[7] Few case reports mention GSM in patients with schizophrenia having religious/biblical delusions referred to as "Klingsor Syndrome."[8-10] Case reports on GSM in schizophrenia are not limited to males alone but have been noted in female patients as well.[11] Although GSM is an extremely rare and castrophic event, there is a huge gap between the published case reports and the actual incidence. Literature does not report on the prevalence of GSM in schizophrenia though, such acts are infrequent when we look at the case reports of the same over the years.[2] Managing such patients requires a close liaison between surgical specialties and psychiatry. Immediate surgical attention to the genital injury with a combined psychiatric evaluation and management is prudent in all cases.[12-14] We present herein a case report of a patient with schizophrenia who attempted suicide, amputated his testicles, and

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inflicted a degloving injury to the penis in the first episode of psychosis.

CASE REPORT

A 22-year-old Hindu unmarried, male was brought by the police and admitted to the emergency surgical ward of our hospital with a history of jumping from the over bridge of a railway station, sustaining injury to his lower limbs. He was referred to psychiatry on the day of admission due to a suicidal attempt, irritability, and disorganized behavior shown in the ward. On the first day of admission, he was restrained in the ward due to marked irritability and increased psychomotor activity with confusion. His speech was spontaneous, coherent but irrelevant at times with increased rate and volume. His affect was labile with inappropriate smiling during the mental status examination. His thoughts revealed pathological guilt with sexual content and excessive preoccupation with pseudo-philosophical content and spirituality but denied suicidal thoughts. He reported second person auditory hallucinations of a commanding type due to which he jumped off the over bridge. His social judgment was impaired and insight was absent. No relative was available and history of past illness could not be corroborated. The patient was started on injectable antipsychotic medication (haloperidol 5 mg intramuscular twice a day and promethazine 50 mg twice a day) to control aggression and psychotic symptoms. Next day patient was referred again after he managed to gain access to a knife in the ward and self-mutilated himself with a degloving injury of the penis and bilateral orchidectomy in the ward. This time, the patient's family was present and a detailed history was available. History of the current episode revealed that the patient had behavioral disturbances 6 days prior to presentation in the form reading religious mythology books when actually he should have been studying for his The Graduate Aptitude Test in Engineering Examinations. This had never happened before. The patient would keenly look at the surrounding as though trying to search something. He then suddenly decided to travel from Hyderabad to Pune for motivational lectures and to meet his guru (unknown). The patient reached Pune but was unable to meet his guru. He started having intense thoughts (? hearing voices), which were commanding him to eat feces and roll over in garbage. The patient acted on his thoughts and ate his feces, but was also confused, fearful and was finding it difficult to understand what was going on. He reached the railway station where he jumped off the over bridge after commands for the same by the voices. He reported that he had thoughts of achieving self-actualization by giving up his life. The patient was rescued by the railway police and was brought to hospital with injuries of the lower limbs. After admission the patient had intense thoughts of achieving self-actualization by pulling off his penis along with his testicles. He tried pulling off his penis along with testicles with a sharp object during the ward stay and suffered a degloving injury to penis and complete removal of both the testicles with a urethral gap of 1 cm. He reported that by doing so, he was expecting to attain self-actualization (as per the voices) but again failed as he could not remove the whole penis. He also reported guilt of having sexual contact with his cousin sister during his adolescence for which he was getting punished now.

During the ward stay, he was fearful and confused. He had delusions of reference and persecution and perceived that people were against him. He even tried to abscond from the ward twice but was stopped by the family members. There was no history suggestive of substance use and family history suggestive of psychiatric illness. Premorbid personality was reserved though he was sincere in his work. He was dominating, stubborn and cold toward his family members from a young age. He was diagnosed as brief psychotic disorder and was started on oral atypical antipsychotics (olanzapine 5 mg twice a day) with low dose benzodiazepine (clonazepam 0.25 mg twice a day) for anxiety and he showed significant improvement. He was also operated for the genital injuries by the surgeon and reconstructive surgery was carried out. He recovered fully in 1 month, but did develop depressive symptoms after what happened and once insight came in, for which an additional antidepressant therapy (escitalopram 5 mg twice a day) was added along with supportive counseling of the patient and psychoeducation for the family members. The patient is currently following up and doing well.

DISCUSSION

Self-mutilation may be seen in patients with major depression, obsessive-compulsive disorder, borderline personality disorder and schizophrenia.[2] GSM is an extreme and severe form of self-mutilation. Published literature has described various motives for GSM. These range from nonpsychotic patients inflicting GSM secondary to rituals and religious beliefs,[15] transsexuals attempting to reassign their gender on their own,[16] in patients with personality disorders[17] and substance abuse.[18] The most common association has been GSM associated with psychotic disorders as seen in our case.[15] The unique feature of our case was that GSM was noted in the first episode of psychosis while cases are normally reported in chronic schizophrenia, long-standing psychotic illnesses and delusional disorder.[15] Here, the GSM occurred within a week of psychotic illness due to command hallucinations. Our patient presented with a combination of factors like pseudo-philosophical beliefs

(religious beliefs) of attaining self-actualization, guilt about his sexual contact with sister and commanding auditory hallucinations. Such combinations of factors are uncommon and we came across just one instance reported in literature earlier.[19] Another important factor in patients with GSM as seen in our case and being single is the effect that GSM would have on future sexual performance and fertility. A consultation-liaison team approach between the surgical specialties and psychiatry works best as seen in our case.

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Conflicts of interest
There are no conflicts of interest.

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