Male genital self-mutilation with special emphasis on the sociocultural meanings

Naseem A. Qureshi, *MD, PhD.*

ABSTRACT

الإيذاء الذاتي للأعضاء التناسلية (GSM)، هو سلوك غير انتحاري نادراً ما يحدث بين مرضى الذهان وغير الذهان. نستعرض في هذا التقرير حالة مريض يعاني من أمراض ذهانية حادة، مع خلفية اجتماعية ثقافية قام بإيذاء عضوه التناسلي الخارجي، خضع على أثر ذلك لعملية جراحية عاجلة وعلاج للذهان أدى إلى تحسين حالته بعد أربعة أسابيع. على ضوء هذه الحالة، تمت دراسة الحالة الذهانية والعوامل الثقافية والاجتماعية للمريض.

Complete genital self-mutilation (GSM), mostly a non-suicidal behavior, is a rare occurrence among patients with psychotic and non-psychotic disorders. This case report is on a patient who, in the shadow of severe psychotic manifestations with overwhelming socio-cultural contents, completely self-mutilated his external genitals. Emergency surgical and psychiatric management improved his condition over 4 weeks. In the light of this case, the psychodynamic and socio-cultural meanings of GSM are discussed.

Neurosciences 2009; Vol. 14 (2): 178-181

From the Administration for Mental Health and Social Services & Medical Research, Ministry of Health, Riyadh, Saudi Arabia. Formerly from the Department of Psychiatry, Rashid Hospital, Dubai, United Arab Emirates.

Received 18th June 2008. Accepted 16th February 2009.

Address correspondence and reprint request to: Dr. Naseem A. Qureshi, Consultant Psychiatrist & Head of Research Unit, Public Health Specialist, Administration for Mental Health and Social Services & Medical Research, Ministry of Health, Riyadh 11176, Saudi Arabia. Tel. +966 (1) 4738269. Fax. +966 (1) 2918017. E-mail: qureshinaseem@live.com

Complete genital self-mutilation (GSM), a major non-suicidal, self-injurious behavior is reported preferentially in males who suffer from a variety of mental disorders. In addition, 3 eponyms in terms of Klingsor syndrome with religious delusions, Caenis syndrome in females with dysorexia, and hysterical personality and the Jerusalem syndrome, which largely involve GSM, are also reported in the literature.[1-3] Furthermore, there are several background factors and predictors of major GSM such as young age, pathological religiosity, sexual guilt, sexual identity confusion, salvation, castration fantasy, sexual obsessions, severe depression, somatic illness, acute alcohol intoxication, schizophrenia, previous attempts of self-injuries, and others.[4-10] However, 87% of patients with male GSM have a modal diagnosis of psychosis.[1] The nonsuicidal GSM differs from suicidal behavior. Around 80% of persons with suicidal intentions give advance warnings of their ideations. Patients with GSM tend not to stop living, because rarely does complete GSM accidentally result in death. Patients with self-injurious behaviors continuingly frequently repeat their acts, but suicide attempts are usually temporary and infrequent. The psychiatric management of patients who present with GSM includes a comprehensive diagnostic evaluation, psychotropic medications, and psychotherapies including psychoeducation and counseling. This paper reports on a rare case of complete GSM with special emphasis on its socio-cultural contents in terms of social values, faith and morality, and also psychodynamic underpinnings.

Case Report. A 37-year-old patient developed 4-day acute psychosis, and as a result he completely auto-mutilated his external genitals with a sharp blade and flushed them away in the toilet. After a few minutes, his colleague found him dazed and pale in a pool of blood and informed the police, and he was taken to the emergency room of Rashid Hospital, Dubai. Following surgical intervention, he was transferred to the Urology Department of Dubai Hospital for follow-up and management. Here, the main focus will be on the psychiatric aspects as surgical issues have been highlighted elsewhere.[11] Four days prior to complete

Disclosure. The production of this work was supported by Janssen-Cilag Pharmaceutical Company, Riyadh, Kingdom of Saudi Arabia.

GSM, he developed a constellation of disturbing symptoms including sleep problems, tiredness, giddiness, perplexity, physical aggression, isolation, irrelevant talk, and strange experiences. He fantastically experienced that huge blocks of black sky were falling down on the ground. Soon after he thought that the world would end symbolizing the Day of Doom. In addition, he began to perceive a foul smell emitting either from his genitals or armpits or living room or outside the dormitory. He frequently asked his colleagues about the sickening smell and none of them substantiated his abnormal bizarre experiences. The quality of fetid smell perceived was of 4 types, burning rubber tires, decomposed bodies, rotten eatables, and fecal matter. He also began to hear continuingly complex hissing noises, which were devastatingly disturbing him. Furthermore, he began to think abnormally that he was being watched and followed everywhere by a bad devil who was also commanding him. Then, there developed a psychological struggle between the devil and the patient's self. The devil gave constantly offensive commands to the patient's self to abuse God the All mighty. When the self resisted these orders, the devil commanded him to have sex with prostitutes roaming in Dubai streets, and if the patient's self cannot perform sexual intercourse with these girls, he must self-mutilate his external genitals. On day 4, the continuing fights between the devil and the self cloaked in acute psychosis resulted in complete GSM. Thereafter, the patient's self declared that it can do away with genitals but can never violate the religious values either by having sex with prostitutes or abusing God the All mighty. The patient reported no death wishes prior to complete GSM.

Around 6 years earlier, he was admitted to a psychiatric hospital for the treatment of schizophrenic psychosis. He was prescribed antipsychotic drugs, and a course of modified electroconvulsive treatments was also given. He showed substantial improvement and was advised to take psychiatric medications regularly for the next 6 months. Notably, he reported stopping the abuse of alcohol and marijuana 3 years prior to the psychiatric consultation. There was no positive family history of any psychiatric disorders. He was quite stable and was working in a car garage before he came to Dubai. The patient, the only earner in the family is reported to have 3 children. His relations, including sexual, with his wife were satisfactory. Though he was in touch with his family members through telephone calls, he indeed missed them a lot and often felt frustrated. He was reported to have 3 nocturnal emissions over the past 2-month stay in Dubai. He denied practicing masturbation or having any sexual contact with prostitutes. The patient, a heterosexual, had no history of sexual abuse during early childhood and was moderately religious. However, after stopping alcohol and marijuana abuse, he became religiously more conservative and devoted. On the day of GSM, the psychiatrist examined him, and found him cooperative and fully conscious, but a bit evasive with mostly relevant talk. Neither increased nor decreased psychomotor activity was noticed. He was attentive with good concentration. His affect was shallow. Initially, he denied auditory hallucinations, but later accepted continuing complex hissing noises in both ears. He was deluded and was under the influence of the supernatural powerful devil, who was directing his self to do immoral acts, and if not then to auto-cut his external genitals. There were no suicidal thoughts, or death wishes prior to the GSM. No orientation impairment or memory disturbances were found. Both insight and judgment were impaired. No addictive drug withdrawals were noticed. His IQ was normal on clinical assessment. No cognitive impairment was found on Mini Mental State Examination (score=29). Other investigations including EEG and laboratory tests were not contributory. At index interview he was diagnosed with acute psychotic relapse of schizophrenia. He was prescribed olanzapine 20 mg per day, and lorazepam 4 mg daily. He showed tremendous improvement and all active psychotic features subsided over 4 weeks, except he was preoccupied with certain issues. No features of post-psychotic depression or suicidal ideations were revealed. Three weeks after GSM, he was transferred to the psychiatric ward for follow-up. He was counseled daily, and several emerging issues related to employment, self-esteem, guilt feelings, reconstructive surgery, his wife's reaction, and other future dilemmas were addressed effectively. Finally, he left for Pakistan a week later. Before discharge, he gave written consent to publish the relevant details including a photograph (**Figure 1**). He was given olanzapine and lorazepam for 2 weeks and was advised to regularly use psychiatric medications to prevent future relapses. He

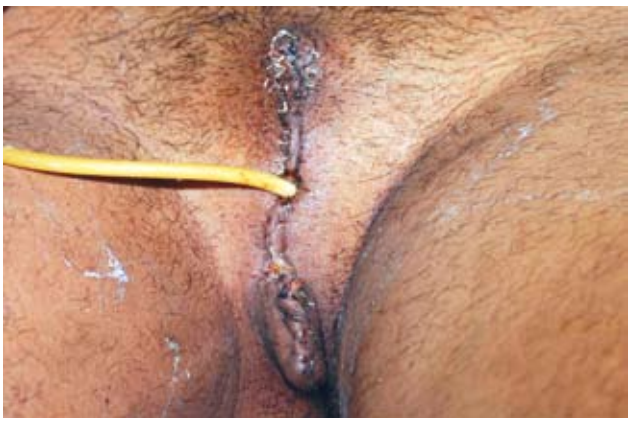

Figure 1 - The post-operative scar and the site of the anterior urethrostomy.

was further advised to invite his wife for joint counseling. Notably, the permanent loss of genital parts often evokes both a cascade of conflicts and causes a variety of adverse consequences, especially depression in both partners that should be addressed during couples therapy. He was informed that the joint counseling might act as a preventive measure against redeveloping a psychotic relapse.

Discussion. Complete GSM is reported less commonly in the eastern world as compared to the huge literature from western nations. This case report is one among few patients with penile and combined GSM from Indian sub-continents.[12] Penile mutilation is more commonly reported than complete GSM, but testicular mutilation alone is a rarer phenomenon. Waugh[13] described a 31-year-old man who severed his testicles in response to Matthew 19:12: "There are eunuchs born that way from their mother's womb, there are eunuchs made so by men, and there are eunuchs who have made themselves that way for the sake of the Kingdom of Heaven." The genital mutilation was seen as atonement for masturbation. Similarly, Kushner[14] described a 37-year-old man with religious preoccupations, who eventually performed a bilateral orchiectomy "as a free will offering to God . . . so that, he could walk unimpaired, work at peace, and relive the new life." Complete GSM is linked mostly with psychotic disorders such as schizophrenic psychosis, drug-induced or organic psychosis, and affective psychosis.[6-9,13] Conversely, superficial to moderate self-injurious behaviors are commonly associated with non-psychotic disorders including borderline personality disorder, erectile dysfunctions, eating disorders, drug abuse, and others.[4,7,8]

Knowledge of characteristics of patients who mutilate their external genitals is of paramount preventive importance.[1,6-8,10] These factors that are common denominators across all cultures were also revealed in this patient; male gender, psychotic disorder, strange delusional experiences, perplexity and confusion, ruminative thinking, obsessionality and rigidity, complex religious beliefs and the transgression of religious code, commanding hallucinations, and lack of insight and impaired judgment. A multitude of other social factors and psychodynamic mechanisms in terms of financial debt, stress of migration and acculturation, low paid job and expensive living, lack of social supports, separation from the family and fear of sexual impulses and contingent frustrations not only precipitated the acute psychotic relapse, but also contributed to the GSM behavior. For instance, the absence of his wife coupled with a strong desire for sex created a conflict, namely, to have or not to have sex with girls. Ultimately, the severe sexual frustrations were directed to self and, possibly as a result of failure of psychological defenses, he mutilated his genitals. Furthermore, psychotic patients tend to completely repudiate symbolic castration as if it had never existed and this leads to the return of castration in the real, namely, self-mutilation of the real genitals. To put the concept of self-mutilation in perspective, Favazza[4] reported that all forms of self-mutilations are practiced collectively in religious, political, and healing rituals. Psychiatric patients tend to engage privately and idiosyncratically, and self-mutilations tend to sub serve some sociocultural functions including sharing a common goal of warding off some perceived threat or to promote a sense of wholeness, belonging, or social worth. He further argued that culturally sanctioned, and deviant self-mutilations are significantly similar in their shared purposefulness.

Patients with schizophrenic psychosis uncommonly manifest delusions of bromosis,[15] and their cultural relationship with and contribution to GSM is yet to be reported in the psychiatric literature, and in this context this case appears to be unique. It is felt that obsessive ruminations with religious connotations and convolutions and auditory hallucinations commanding the patient to transgress religious code are the most powerful predictors of GSM.

As in this case, the management of complete GSM involves surgical procedures, comprehensive diagnostic evaluation, and long-term antipsychotic drug treatment of the underlying psychotic disorder, together with psychotherapy including counseling. Spouse and family support are needed for monitoring and encouraging treatment compliance. The biopsychosocial consequences of GSM, which include an imbalance of sex hormones, low self-esteem, guilt feelings, depression, repeat self-injury, and suicide needs to be addressed appropriately.

In summary, this is a rare case of complete GSM with acute psychotic relapse coupled with morally disparaging social and cultural contents that adds new data to the existing literature, and such cases need an integrated effective treatment approach shared by the urologist and mental health professionals.

Acknowledgment. *The author expresses sincere thanks to the staff of the Department of Medicine, Rashid Hospital, Dubai, UAE for inviting him to discuss this case in their morning meeting.*

References

1. Siddiquee RA, Deshpande S. A case of genital self-mutilation in a patient with psychosis. ***German Journal of Psychiatry*** 2007; 10: 25-28.
2. Goldney RD, Simpson IG. Female genital self-mutilation, dysorexia and the hysterical personality: the Caenis syndrome. ***Can Psychiatr Assoc*** 1975; 20: 435-441.

3. Zislin J, Katz G, Raskin S, Strauss Z, Teitelbaum A, Durst R. Male genital self-mutilation in the context of religious belief: The Jerusalem syndrome. ***Transcultural Psychiatry*** 2002; 39: 257-264.
4. Favazza AR. Bodies under siege: Self-mutilation and body modifications in culture and psychiatry. Baltimore (MD): John Hopkins University Press; 1996.
5. Stunell H, Power RE, Floyd M Jr, Quinlan DM. Genital self-mutilation. ***Int J Urol*** 2006; 13: 1358-1360.
6. Moufid K, Joual A, Debbagh A, Bennani S, El-Mrini M. Genital self-mutilation. Report of 3 cases. ***Prog Urol*** 2004; 14: 540-543.
7. Israel JA, Lee K. Amphetamine usage and genital self-mutilation. ***Addiction*** 2002; 97: 1215-1218.
8. Premand NE, Eytan A. A case of non-psychotic autocastration: the importance of cultural factors. ***Psychiatry*** 2005; 68: 174-178.
9. Green CA, Knysz W 3 rd, Tsuang MT. A homeless person with bipolar disorder and a history of serious self-mutilation. ***Am J Psychiatry*** 2000; 157: 1392-1397.
10. 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.
11. Shirodkar SS, Hammad FT, Qureshi NA. Male genital self-amputation in the Middle East: A simple repair by anterior urethrotomy. ***Saudi Med J*** 2007; 28: 791-793.
12. Sudarshan CY, Rao KN, Santosh SV. Genital self-mutilation in erectile disorder. ***Indian J Psychiatry*** 2006; 48: 64-65.
13. Waugh AC. Autocastration and biblical delusions in schizophrenia. ***Br J Psychiatry*** 1986; 149: 656-658.
14. Kushner AW. Two cases of auto-castration due to religious delusions. ***Br J Med Psychol*** 1967; 40: 293-298.
15. Qureshi NA. Monosymptomatic hypochondriacal psychosis manifesting as delusion of bromosis: successful treatment with trifluoperazine. ***The Arab Journal of Psychiatry*** 1993; 4: 43-54.

ILLUSTRATIONS, FIGURES, PHOTOGRAPHS

Four copies of all figures or photographs should be included with the submitted manuscript. Figures submitted electronically should be in JPEG or TIFF format with a 300 dpi minimum resolution and in grayscale or CMYK (not RGB). Printed submissions should be on high-contrast glossy paper, and must be unmounted and untrimmed, with a preferred size between 4 x 5 inches and 5 x 7 inches (10 x 13 cm and 13 x 18 cm). The figure number, name of first author and an arrow indicating "top" should be typed on a gummed label and affixed to the back of each illustration. If arrows are used these should appear in a different color to the background color. Titles and detailed explanations belong in the legends, which should be submitted on a separate sheet, and not on the illustrations themselves. Written informed consent for publication must accompany any photograph in which the subject can be identified. Written copyright permission, from the publishers, must accompany any illustration that has been previously published. Photographs will be accepted at the discretion of the Editorial Board.