Genital self mutilation: is a solution for bipolar depression? – A case report

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Abstract

The act of genital self mutilation in males is said to be one of the rarest behaviour in the world. Behaviours that involve damaging the body tissues without intending suicide are defined as self-mutilation. Most common types of self-mutilation are damaging the skin, the eyes or the genitals. 55 years old married male patient, known case of BPAD on irregular medications, with family history of mental illness in first degree relatives and past history of 2 episodes of mania and 3 episodes of depression and suicidal attempt 5 months back by self stabbing on abdomen multiple times, presented with complaints of self inflicted wound on penis and right scrotum with knife. As per the history given by the family members, patient was seen to be withdrawn, decrease interaction with family members, impaired biological functions, not going for work for the past one month. Patient eloped a day before the incident and was found in a distant place lying in a pool of blood the next morning and was brought to hospital immediately with alleged history of suicidal attempt which was high in intentionality, high lethality and high inimicality. On further clarification, wife reported family was complete, quality of marital and sexual life - satisfactory. Initial consultation was done and the impression made was bipolar affective disorder, current episode severe depression without psychotic symptoms. The psychiatric consultant's role in the management of such an individual in the general hospital setting includes not only care of a patient with a psychotic or impulse disorder but also involves support of the family members, who are distressed by the fear, guilt, hopelessness, anger, and revulsion that are caused by the patient's act of GSM and also multidisciplinary approach is needed for management of such cases.

Keywords: Self mutilation; genitalia; depression; bipolar disorder

Introduction

The act of genital self mutilation in males is said to be one of the rarest behaviour in the world. Behaviours that involve damaging the body tissues without intending suicide are defined as self-mutilation. Most common types of self-mutilation are damaging the skin, the eyes or the genitals[1]. It is seen more frequently in males than females[2]. It is proposed as a fast self-aid action, providing temporary relief from inner tension and confusion, depersonalization, feelings of guilt, negative feelings of being rejected, hallucinations and preoccupations with sexual matters[3,4]. The first recorded case is thought to be a letter in the Journal of the American Medical Association by Stroch in 1901.

Self-mutilation is common in psychiatric disorder and occurs due to various reasons. The various causes of self-mutilation are psychotic, non-psychotic illness and various organic and functional syndromes. Psychotic illness includes command hallucinations in schizophrenic patients, bipolar affective disorder with psychotic features and borderline personality disorder[5]. It is commonly estimated that 25% to 50% of patients with bipolar disorder, attempt suicide atleast once and 30% to 40% have suicidal ideation[6]. However, GSM as a method of suicide in BPAD depression is a rare finding. Here we report a case of GSM in a patient with BPAD with depression.

Case report

55 years old married male patient, known case of BPAD on irregular medications, with family history of mental illness in first degree relatives and past history of 2 episodes of mania and 3 episodes of depression and suicidal attempt 5 months back by self stabbing on abdomen multiple times (Figure 1), presented with complaints of self inflicted wound on penis and right scrotum with knife. As per the history given by the family members, patient was seen to be withdrawn, decrease interaction with family members, impaired biological functions, not going for work for the past

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one month. Patient eloped a day before the incident and was found in a distant place lying in a pool of blood the next morning and was brought to hospital immediately with alleged history of suicidal attempt which was high in intentionality, high lethality and high inimicality. On further clarification, wife reported family was complete, quality of marital and sexual life - satisfactory. Initial consultation was done and the impression made was Bipolar affective disorder, current episode severe depression without psychotic symptoms.

Mental status examination: Patient was moderately built and poorly nourished, ill dressed and unkempt, appears depressed, sits with down casting eyes. Rapport was difficult to establish and psychomotor activity was decreased. Patient was conscious and oriented to time, place and person. Attention and concentration being aroused and ill sustained with decreased tone, tempo, volume of speech and increased reaction time. The content of thought revealed ideas of guilt, that he was responsible for his son's mental illness which was associated with active suicidal ideation with some intent to act without specific plans. Depressive cognitions present. He reported subjective sadness and looked depressed. Personal judgement being impaired and grade 4 insight.

Assessments: HAM D(Hamilton depression rating scale) score was 40, indicating very severe depression according to following interpretation of HAM D[7],

A total score of 0-7 indicate no depressive symptoms, 8-13 mild depression, 14-18 moderate depression, 19-22 severe depression, and more than 23 is very severe depression.

BPRS(Brief psychiatric rating scale) score was 24. A total score of 31 and above indicate mildly ill, 41 and above moderately ill and 53 and above markedly ill[8].

Relevant investigation revealed no organicity for his psychiatry symptomatology. Later patient was referred to surgery for further management in view of injury and patient underwent debridement with secondary suturing and right orchidectomy (Figure 2). He was then shifted to psychiatry ward, for further management. Patient was started on antipsychotics olanzapine and lamotrigine, started with low dose and titrated to effective dose.

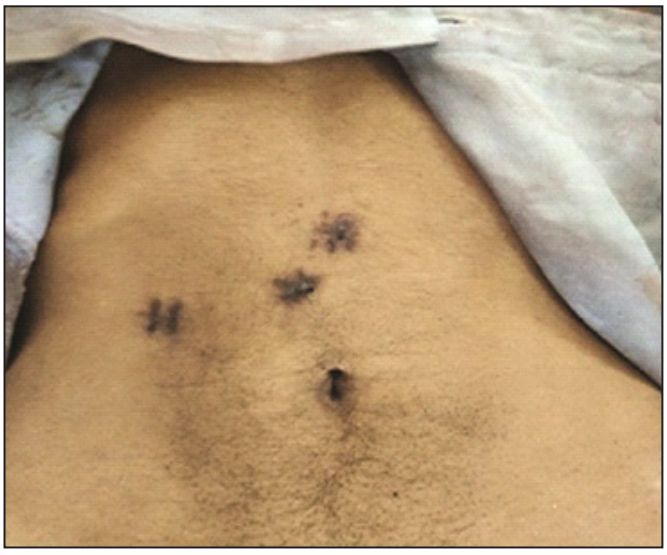

Figure 1. Self stabbing on abdomen multiple times 5 months back

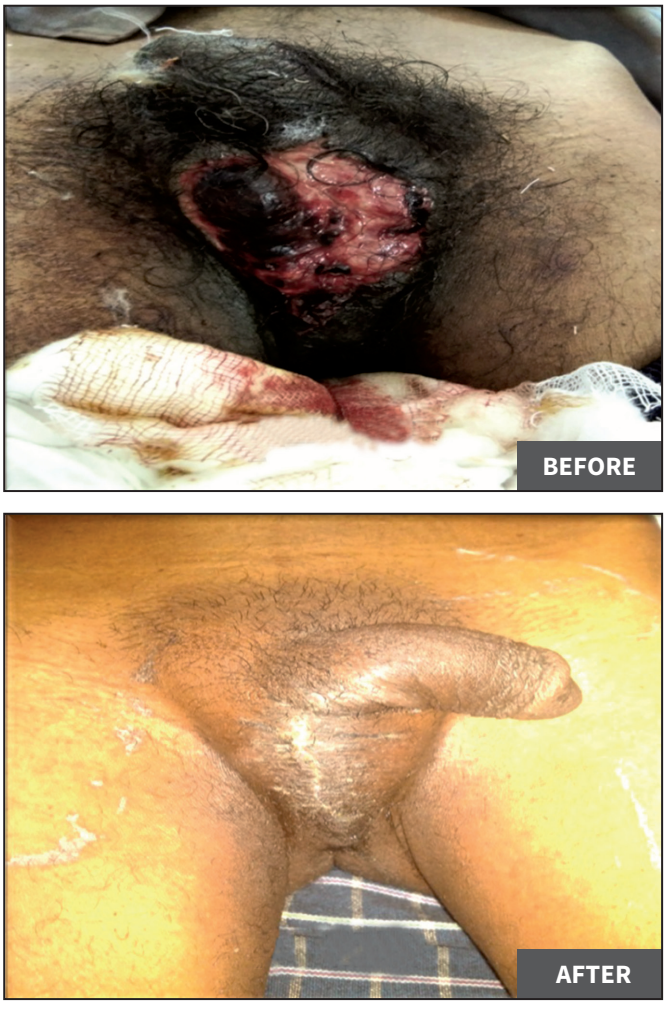

Figure 2. Genital Self Mutilation injury before and after surgery

Discussion

Genital self-mutilators tend to fall into one of four types – schizophrenics, transsexuals (i.e., those with a gender identity crisis), those with complex cultural and religious beliefs, and a small number of severely depressed people who engage in GSM as part of a suicide attempt (around one-tenth of cases)[9]. A review of 110 male GSM cases revealed that guilt feelings associated with sexual conflicts were the most significant factor leading to self-mutilation in a state of psychosis. In a 2007 issue of the Jefferson Journal of Psychiatry, Franke and Rush provided some risk factors that help in the identification of people at risk for GSM. These included: (i) Psychotic patients with delusions of sexual guilt, (ii) psychotic patients with sexual conflict issues, (iii) prior self-destructive behavior, (iv) depression, (v) severe childhood deprivation, and (vi) premorbid personality disorders[10]. However, the condition is complex, and as Sudarshan *et al*. highlighted in the Indian Journal of Psychiatry, "GSM like any other serious self-injury is not a single clinical entity and it occurs in any psychiatric condition with corresponding psychopathology.[11]

Herein we report a case of 55 yr old male patient suffering from BPAD depression for last 6 months and made an attempt of suicide by GSM. Our case however had no association with any religious or sexual theme[12]. In this case, there was no evidence of hallucinations, delusions, body image disturbance or sexual conflicts. In the present case there was also no history suggestive of gender dysphoria, male identification, guilt for sexual offences, sexual conflicts and offences, erotic purposes and body image preoccupation. Here patient presented with self mutilation of genitalia as an attempt of suicide.

It is suggested that the examining psychiatrist needs to be aware of the cultural background of the patient. 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; hence, clinicians may prefer medications causing fewer sexual side effects. Furthermore, during the remission period, cognitive and behavioral techniques may be helpful for replacing thoughts of sacrifice with harmless alternatives for atonement.

Conclusion: The psychiatric consultant's role in the management of such an individual in the general hospital setting includes not only care of a patient with a psychotic or impulse disorder but also involves support of the family members, who are distressed by the fear, guilt, hopelessness, anger, and revulsion that are caused by the patient's act of GSM and also multidisciplinary approach is needed for management of such cases.

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