

GENITAL SELF-MUTILATION IN DEPRESSION: A CASE REPORT

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ABSTRACT

Genital self-mutilation is a rare severe form of self-injurious behaviour usually described in psychotic disorders with delusions & hallucinations. It has been ascribed to sexual conflicts, body image distortion, internalized aggression and suicidal intent. This phenomenon has been described in schizophrenia, affective psychosis, alcohol intoxication and personality disorders. In the present case genital self-mutilation in a case of Major-Depressive Disorder in an 82 yrs old male is being reported and psychosocial factors are discussed. This case has some unusual features.

Key words: Genital self-mutilation, Depression

Genital self-mutilation is a rare severe form of Self-injurious behaviour. It is usually described in Psychotic disorders mostly in Schizophrenia as a result of delusions & hallucinations (Becker & Hartmann,1997; Martin & Gattaz, 1991; Schweitzer,1990). In most cases penile mutilation is common. Combined amputation of penis & scrotum has also been reported (Becker & Hartmann,1997; Mishra & Kar,2001). Risk factors of genital self-mutilation include commanding hallucinations, religious delusions (Klingsor syndrome; Schweitzer, 1990; Bhargava et al.,2001), substance abuse and social isolation (Tobias et al., 1988). Genital mutilation has been ascribed to sexual conflicts and offences (Martin & Gattaz, 1991), body image preoccupation and distortion (Krasucki et al., 1995), expression of internalized aggression and suicidal intent (Becker & Hartmann, 1997) and a means to get relieved of urinary symptoms (Mishra & Kar,2001). This phenomenon has been described in schizophrenia (Martin & Gattaz, 1991), affective

psychosis, alcohol intoxication (Krasucki et al., 1995), and personality disorders.

In the present case self-mutilation of both testes & scrotum sparing penis in a case of Major-Depressive Disorder in an 82 yrs old male is being reported and psychosocial factors are discussed.

CASE REPORT

An 82 years old Hindu married, male priest was admitted in the emergency surgical ward with history of amputating his both testicles with the scrotum using a razor blade. He was referred to psychiatry the next day after the wound was sutured.

History revealed that he was sad and sleepless since nine months. He had wished to shift to his son's new place of job. Son assured it. His sadness gradually worsened. He felt he was a burden and unfortunate that he could not be with his son during his last days. His son

again reassured him. Five days prior to the incident he was informed that it was unwise to shift as his son might return to his previous job in the same place. Patient was helpless to nullify the argument. A day earlier to hospitalization he had requested his neighbours to buy poison for (?him) bed bugs, which was refused. Except for occasional difficulty in retrieving his things like walking stick, wristwatch, spectacles etc, there was no impairment of memory or intelligence.

He had attempted suicide in 1991 by consuming tablets of Alprazolam as his son had refused to marry due to his vitiligo. He was dull and depressed in his 71st year for few weeks. As an astrologer had predicted his death in that age. His brother had committed suicide. His nephew has mental retardation. He was educated up to 8th standard and was a priest. He was married. His relation with his wife was superficial but there was no overt disharmony. There was no sexual relation between them since 12 years. There was no apparent sexual discontent or conflict. There was no history of alcohol, tobacco or drug abuse. He had a son and two daughters, all married.

Premorbidly he was reserved, had few friends, sincere, neat and orderly in his work. He was irritable, stubborn, dominating and cold towards his family members. He was not over religious. He was a short sleeper and was taking Alprazolam infrequently since 15 years.

On admission he was conscious, had subjective & objective sadness, expressed suicidal ideas and said that he had cut his testicles with intention to die. His attention was easily aroused but ill sustained. His orientation and memory were normal. He was diagnosed to have Major Depressive Disorder. He was started on Fluoxetine 20mg. Patient continued to be dull and was refusing to eat and drink. In about two days he became very weak and mute. He had throat secretions needing frequent suction. His chest X-ray showed bilateral pulmonary tuberculosis. He was started on antibiotics and antitubercular drugs. He continued to be weak. His level of sensorium gradually declined. Despite

medical care his condition deteriorated and he expired 18 days later.

DISCUSSION

There are some unusual features in the present case: 1) Most cases of genital self mutilation reported are in the young. This case occurred in an old man of 82 years. 2) Commonly amputation of penis and sometimes combined amputation of penis and scrotum have been reported. In the present case penis was spared. 3) Severe self-injuries have been reported mostly in schizophrenia and other psychotic conditions. Present case occurred in major depressive disorder without psychotic features and as an act of suicidal attempt. 4) This case had no apparent sexual or religious connotation. Lack of sexual connotation in this case is in tune with Indian culture in that sexual abstinence in old age is the prevailing social norm. 5) This case might have lapsed into depressive stupor, this along with tuberculosis, general infection, old age and lack of will to survive might have led to rapid deterioration and death.

Khandelwal et al. (1981) have also reported a case of auto castration in an eighty years old Depressive male with a serious suicidal intention. The authors were surprised about an old man selecting this unusual and gruesome method for suicide.

Discussion with the patient's son about this unusual method of suicidal attempt instead of common methods led to some interesting explanations. He reasoned that his father might have not resorted to poisoning due to hesitancy to buy poison himself fearing refusal, doubts, and sympathy. He stated that he might have lacked faith in sleeping pills due to failed previous attempt. He opined that his physical weakness might have prevented him from resorting to methods like jumping into well, falling under train or hanging. Unfortunately these points could not be confirmed from the patient due to his serious condition.

Various psychopathological models have

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been proposed for genital self-mutilation. Those includes psychodynamic, biochemical and moral delusion models.

Psychoanalytically self injurious behaviour has been linked to castration and explained as a process of failure to resolve oedipal complex, repressed impulses, self punishment (Maclean and Robertson, 1976), focal suicide and aggression turned inwards especially in cases of depression (Yager, 1989). Liebowitz and Klein (1979) have postulated interpersonal loss preceding self-injurious behaviour and linked it to rejection sensitivity. In the present case patient's frustration and resultant aggression turned inwards could be postulated which is supported by psychosocial context of the patient in which his wish to live with his only son during his presumed last days was not fulfilled. He was not in a position to insist on such an arrangement vowing to helplessness due to old age, covert unwillingness of his wife and son to fulfil his wish.

Biologically serotonergic depletion preceding genital self mutilation has been linked to aggression (Ciaranello et al., 1976, Dolan et al., 2001) and depression which could be at work in the present case of depression.

Some authors have claimed strong moral, religious and delusional component (Schweitzer, 1990; Bhargava et al., 2001), in the present case there was no evidence of moral, religious or delusional component.

As has been communicated earlier by the first author (Rao & Begum, 1996) we are in agreement that genital self mutilation like any other serious self injury is not a single clinical entity and it occurs in any psychiatric condition with corresponding psychopathology.

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