Male Genital Self-mutilation as a Psychotic Solution

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ABSTRACT

Background: Male genital self-mutilation (GSM) is a rare, but serious phenomenon. Some of the risk factors for this act are: presence of religious delusions, command hallucinations, low self-esteem and feelings of guilt associated with sexual offences. Other risk factors include failures in the male role, problems in the early developmental period, such as experiencing difficulties in male identification and persistence of incestuous desires; depression and having a history of GSM. The eponym Klingsor Syndrome, which involves the presence of religious delusions, is proposed for GSM.

Data section: Four male GSM cases are presented: Case 1 and Case 2 were diagnosed with schizophrenia, Case 3 with schizophrenia and depressive disorder, not otherwise specified, and Case 4 with bipolar depression with psychotic features.

Discussion: All definite and probable motives and cultural aspects for their GSM are discussed. Atonement is proposed as a new concept in formulating religiously themed psychotic male GSM.

INTRODUCTION

Behaviors that involve damaging the body tissues without intending suicide are defined as self-mutilation (1, 2). Most common types of self-mutilation are damaging the skin, the eyes or the genitals (1). It is proposed as a fast self-aid action, providing temporary relief from inner tension and confusion (3), depersonalization, feelings of guilt, negative feelings of being rejected, hallucinations and preoccupation with sexual matters (4). Even if the patient attains temporary relief after the self-mutilation behavior, pain is said not to be perceived. Although patients suffering from a psychotic disorder, especially schizophrenia, show more tolerance to pain than healthy people, the sense of pain is known not to have completely disappeared (5).

Bizarre acts aiming to wound oneself, like genital self-mutilation (GSM), are generally related to psychosis (6-8). GSM is usually carried out in a state of clear consciousness, often after a period of planning. It is seen more frequently in males than females (9). Male GSM was recorded in Greek mythology: the God Eshmun castrated himself to evade the erotic advances of the Goddess Astronae; therefore auto castration came to be known as the Eshmun Complex (10). Greilsheimer and Groves (6) identified three groups of men at risk for GSM: 1) patients suffering from a psychotic disorder, 2) transsexuals and patients with personality disorder, 3) those under socio-cultural influence, including patients suffering from schizophrenia with religious delusions and those who consider themselves failures in the male role. Considerable overlap among these three groups complicates the identification of individual potential patients.

The major psychotic motivations for GSM include delusions often religious and command hallucinations that are seen in paranoid schizophrenia and affective psychosis (11-14). Other predisposing factors of GSM include severe deprivation in childhood, pathological feelings of guilt associated with aberrant sexual conduct and conflicts, suicide attempts or other self-destructive behaviors in the history, social withdrawal and being depressed (5, 9, 15, 16). However, the motives for GSM are usually mixed (7, 8). It is estimated that <10% of self-mutilators intend to kill themselves (17). A general belief is that amputation of the penis is fatal (7), and GSM among the Chinese is suggested to be considered a suicidal attempt (18).

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Blacker and Wong (19) identified six risk factors for male GSM: 1) absence of a competent male figure for identification during the early developmental period, 2) over-controlling mothers who encouraged their sons' masochistic behaviors, 3) pathological feminine behaviors of the male child, 4) repudiation of body image (especially the penis), 5) unresolved sexual conflicts, 6) anxiety and feelings of guilt often relieved by GSM. Psychoanalytically, self-mutilating behaviors are explained as persistence of infantile sexuality patterns and castration anxiety as a result of unresolved Oedipal conflicts (20), or as self-punishment, focal suicide and aggression directed to oneself (21). The clinical application of these factors to a potential or actual patient is cumbersome due to the fact that the same factors can exist in those who do not resort to GSM. These predictors help only to identify the patients at risk retrospectively (12).

The term Klingsor Syndrome has been suggested for GSM associated with religious delusions (22). The name Klingsor was based on a fictitious character in Wagner's opera, Parsifal: Klingsor was a magician who wanted to be accepted as a Knight of the Grail, a religious brotherhood. He castrated himself because of his inability to remain chaste in order to be accepted into this brotherhood (5). Schweitzer (9) has suggested expanding the definition of this syndrome to include GSM resulting from all delusional syndromes.

During GSM, varying amounts of tissues get amputated. The most severe is the total amputation of the penis, scrotum and testes (23, 24), which occurs in <10% of the GSM cases (17). 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. The GSM acts of these cases were also related to psychotic religious experiences that were often the direct motives. Self-mutilators with sexual conflicts and guilt feelings were more likely to injure themselves more severely than those without (16). Erdur et al. (25) reported on a male patient suffering from schizophrenia, who mutilated his tongue two years after the GSM. In both acts, the patient had used local anesthesia.

While most patients show no interest in their amputated parts and dispose of them immediately, some patients who have sought help are reported to have preserved the amputated organs (6). A few of the patients, who did not want the amputated parts retrieved or reattached flushed them away or ritually burned them (10). Complications from GSM vary with the extent of the injury inflicted. A common complication is hemorrhage, which may be fatal (13).

Psychotic and non-psychotic GSM is well recognized in males but not in females, even though the incidence of self-mutilating behavior has been estimated to be higher in females. A possible explanation is that castration is more dramatic than cutting and therefore tends to be more frequently reported. Although most reported cases of female GSM involve self-induced abortions or insertion of a foreign object into the body, one report describes a female who masturbated with a pair of scissors. It has also been suggested that female habitual self-mutilators may have a higher incidence of GSM. Female GSM may present as unexplained vaginal bleeding. Although self-mutilation is reported to be common in personality disorders, the use of sharp objects inserted into the vagina may suggest a more severe psychopathology (26).

CASE 1

A 26-year-old male patient, who amputated his penis after self-administered local anesthesia, is presented. The patient was taken unconscious to hospital due to hemorrhage. After receiving a blood transfusion and uretro-cutaneous anastomosis, he was transferred to the psychiatry clinic. Positive symptoms remitted with clozapine 250 mg/day treatment. After remission, the patient began insisting on a penile prosthesis.

The patient's parents were reported to have divorced when he was 10 months old. He complained about his father's apathy and unloving behavior and his mother's extreme protective and watchful behavior during his childhood and adolescence. His adult circle consisted of very religious people. When the patient was 20 persecutory, referential, bizarre and grandiose delusions appeared. The delusions consisted of a religious theme where the patient thought that he was Jesus Christ and his mental energy covered the cosmos. The patient indicated that other people's energies got inside his body and caused distress. The patient also had visual hallucinations which he described as colorful light rings around women and he interpreted these light rings as his own sperm. He believed his sperms died when the light rings disappeared by exploding. He explained his distress as "*I was fighting to keep my sperm alive.*" He saw light rays coming down from the sky to the earth and believed that girls would come via these rays and

would have sex with him, and they would together float into space. His symptoms subsided with prescribed drugs, but he was apparently noncompliant with his medication. The patient reported that a few years later his anxiety gradually intensified, and guilt and sinful delusions reappeared. He believed that he was the Antichrist this time and had auditory hallucinations such as *"the Antichrist entered the mosque*." He believed that the devil deceived him, he attributed a partner to God, and so committed a great sin, and due to this sin, God punished him with intense anxiety. He started to recite the "*azan*" (the Islamic call to prayer) aloud in the house. Fearing that he had lost his faith, he entered a mosque by breaking a window and performed the ritual prayers in his bloody clothes. He was taken to a psychiatric hospital by the police, but after being discharged he was again non-compliant with his medication. He concluded that if he shed his "*dirty blood*," his sins would be forgiven. He reported going to the Red Crescent (equivalent to the Red Cross) to donate his blood, but he was refused because of aspirin use. He then tried to cut his abdominal skin to shed his blood, but was not able to bear the pain. After several attempts to shed his blood, the patient then reported buying prilocaine 20 mg/ml flacon and an injector. Under the influence of intense guilt and delusions of sin and command hallucinations like *"Shed blood, get rid of the dirt and the sins*," he reported injecting Prilocaine under the skin of his penis and cutting his penis off using a razor blade. He said he wrapped the amputated tissue in a handkerchief. The patient described his final act in his own words as *"after that, I buried it somewhere by wrapping a shroud around it*."

CASE 2

A 29-year-old male patient, who had amputated one of his testicles with a knife and had thrown it into the toilet, is presented. He was taken to an emergency room immediately and then referred to an inpatient urology clinic. After completion of treatment in urology, he was referred to the psychiatry clinic, where he was diagnosed with schizophrenia and treated with haloperidol.

The patient had been reportedly socially withdrawn, introverted and shy during his childhood and adolescent years. He had become increasingly interested in religion and magic in early adulthood. He reported having pre-psychotic experiences like déjà vu and jamais vu. His success in medical school decreased gradually and he started failing his classes. He reported falling in love with a girl when he was 28. He proposed to the girl but was rejected. Meanwhile, he was thrown out of medical school and returned to his family. He became socially withdrawn and was constantly dreaming about the girl he had fallen in love with. After a long prodromal period, religious delusions and hallucinations appeared. The patient believed that the Devil caused him to have sexual dreams about the girl he loved, and he heard voices such as "you are the devil." He mentioned feeling guilty and sinful, and thought that God would punish him. He concluded that his sexual organs and desires were the only reason for being thrown out of medical school and rejected by the girl he loved. He believed if he could rid himself of his genitals, he would rid himself of his sins too. Six months after the beginning of his delusions and hallucinations, he took a knife and went to the bathroom where he skinned his scrotum, separated and cut off one of his testicles, despite the pain it caused, and threw it into the toilet.

CASE 3

A 55-year-old married male patient, who had surgery in a urology clinic after cutting his penis off with a knife, is presented. He was then referred to inpatient psychiatry where he was diagnosed with paranoid schizophrenia and depressive disorder not otherwise specified. The patient was treated with haloperidol and an SSRI.

Apparently, when the patient was 37, he had started experiencing delusions of jealousy and thought insertion. The patient reported that a very powerful creature inserted a thought into his mind that his wife and his closest friend were having an affair. He then began to follow his wife even at night. Because of his jealous delusions, he moved to another city with his family. He received no treatment while his jealous delusions, talking to self and angry behavior continued. Over the last six years, the patient started having depressed feelings with guilt and delusions of sin. He reported feeling intense grief, unwillingness, incapability, and had insomnia and loss of appetite as well. He complained that no one loved him; everyone appeared to be an enemy and that he felt worthless and God would send him to hell because of his sins. He reported that he had sold a few of his cars and had given all the money to the poor for the purpose of atonement. The patient said that the same powerful creature ordered him to donate his eyes, and for this purpose he went to the hospital. But

he was told that this was not possible. The patient also indicated that he ran away from his home five times, sometimes returned on his own and sometimes was brought back by the police. In the last two years, the patient reported having erectile dysfunction as well. He said he started sleeping apart from his wife. He was taken to a psychiatrist but was non-compliant with the antidepressant and antipsychotic medication prescribed. The patient indicated that 20 days prior to his GSM he was preoccupied with the thought of cutting his penis off. He said that this thought was put into his mind by the same powerful creature. Two weeks before the GSM, the patient said he had left home without informing anyone, aiming at performing a pilgrimage. He said he traveled through many other distant cities on foot. He then decided to use the bathroom of a hospital to cut his penis off. He said he preferred a hospital bathroom to perform this act where help would be more available if bleeding would not stop. Despite the pain, he said he cut off his penis and threw it into the toilet and flushed it away. During the first psychiatric interview with him, he said that the same powerful creature was now ordering him to cut his arm off.

CASE 4

A 38-year-old male patient, who was treated in the emergency room and referred to a urology clinic after GSM, is presented. The consultant psychiatrist ordered lithium 900 mg/day, sertraline 50 mg/day and risperidone 3 mg/day. He was fully remitted at the first month; he was still in remission four months later.

The patient was a devout person during the premorbid period. When he was 31 years old, he had his first psychotic depressive episode. He was treated in an inpatient psychiatry clinic and within one month he was fully remitted. After discharge, he was apparently non-compliant with his medications. At the end of six months of full remission, the patient had his first manic episode. During the manic episode, he started using obscene words to women and touching them inappropriately. After being treated as an inpatient for one month, manic symptoms fully remitted. Full remission continued for almost 2.5 years despite the patient's non-compliance with medication. The second manic episode occurred when the patient was 34 years old. He was treated with haloperidol and biperiden, and again was fully remitted within one month. However, the patient was non-compliant with his medications again. After almost two years of full remission, his third manic episode occurred at age 36. Full remission was achieved again within one month, with haloperidol and biperidene treatment. The patient said he used no medication and was symptom-free for 2.5 years. Nevertheless, after the 2.5 year period, the patient started having depressive feelings along with mood congruent psychotic symptoms which then led to the GSM.

Because of the patient's conduct during his manic episode, such as inappropriate sexual advances towards women, his feelings of guilt and sin rose to a delusional level. The patient also had command hallucinations, like "you burned the Holy Qur'an; you are sinful, you will go to hell; butcher your children, amputate your penis." He left home secretly early one morning, taking a razor blade and went to the countryside. Despite the intense pain, he said he amputated 2/3 of the distal part of his penis. He then reported throwing away the amputated tissue. Immediately after the GSM, he cut an edge of his tongue. When he was asked why he cut his tongue, the patient indicated that he was criticized several times by other people but he couldn't talk or defend himself and he thought his tongue was useless, and so he cut it. He was found by his wife and taken to hospital. After the first intervention, he was hospitalized in the urology clinic. During the first psychiatric interview, he said he was afraid that he might butcher his children if he went back home.

DISCUSSION

In all of the cases, intense guilt and delusions of sin were definite motives (9, 16) which match well with Klingsor Syndrome (9, 22). Cases 1 and 4 also had command hallucinations (1, 14). All cases were preoccupied with sexual matters (3, 4). Case 1 had visual hallucinations and bizarre delusions with a sexual theme. Case 2 considered his sexual desires sinful and aimed at getting rid of them (9). In Case 3, because of his erectile dysfunction and failure in the male role (6, 21), he felt guilty and also had delusions of sin. Case 4 had guilt and delusions of sin associated with his aberrant sexual conduct (15). We may say that GSM transiently saved these patients from the negative feelings that were brought about by preoccupation with sexual matters (4).

In all of the cases, it is obvious that none of the patients intended suicide (1, 2). Case 1 had repeated self harming behaviors (8) aiming only at shedding his "dirty blood." The patient wanted to donate his blood and then tried shedding his "dirty blood" by cutting

his skin. Finally, for the same purpose, he sacrificed his penis. Furthermore, he administered local anesthesia before his act (25). This supports the information that the sense of pain does not disappear completely in patients suffering from schizophrenia (5). The GSM act might have rapidly but temporarily saved him from the feelings of guilt and delusions of sin, and being preoccupied with sexual matters (3, 4). Likewise, Case 2 considered his sexual organs and desires to be the only reason for the loss of his educational rights and the girl he loved. He sacrificed only one of his testicles meticulously which shows that he had no intent to commit suicide. The GSM act might have rapidly but temporarily allowed him to get rid of the negative feelings of being rejected by the girl he loved and constantly dealing with sexual matters (4). Case 3 had preferred the hospital for his GSM, planning to receive urgent intervention in case of excessive bleeding. He also was a patient at risk for repeated self-harm (8). He had delusions of thought insertion, ordering him to cut off his arm. Case 4 had auditory hallucinations commanding him to butcher his children and to amputate his penis. Just after the GSM act, the patient also cut his tongue.

The motives for GSM are multi-factorial (7, 8). Aside from the major motives, we can offer some probable motives that might have contributed to the GSM act. Early developmental problems and a premorbid lifestyle, like being a devout person, may be mentioned. Case 1 had a close relationship with his mother and had no competent male figure for identification during his childhood (14, 19, 21). He might have failed in repressing incestuous desires. Thus, guilt feelings and belief that he deserved punishment might have intensified in this patient. Also, an over-controlling mother might have prompted him to engage in masochistic behavior (19). In addition, identification with a devout adult circle during his childhood might have strengthened the guilt and sinful beliefs in the patient and therefore caused him to seek punishment (9, 14, 21). The guilt and sinful beliefs might have turned into delusions and hallucinations during the psychotic attack which might have directed the patient to perform GSM (21). Case 2 was socially withdrawn during GSM (5). In Case 3, the major motive for GSM was the patient's thought that he had failed in his male role (6) which caused shame and guilt feelings (27). Delusions of thought insertion also seemed to have contributed to the GSM act.

Patients' attitudes concerning their amputated parts show that none of them could return to reality, even after the action. Cases 2, 3 and 4 showed no interest in the amputated organs and flushed them away. Case 1 stated that he enshrouded and buried his amputated organ; instead of saving the amputated tissue, he buried it according to his religious rituals (10).

It appears that the phenomenon of genital self-mutilation endorsed by religious beliefs is not specific to Islam. Zislin et al. (28) also discusses GSM in the context of religious belief: the Jerusalem Syndrome. This syndrome is a well-defined example, named for a group of mental phenomena involving the presence of religiously themed obsessive ideas, delusions or other psychosis-like experiences triggered by, or leading to, a visit to the city of Jerusalem. It is not endemic to one single religion or denomination, but has affected Jews and Christians of many different backgrounds. The best known, although not the most prevalent manifestation of the Jerusalem Syndrome, is the phenomenon whereby a person who seems previously balanced and devoid of any signs of psychopathology becomes psychotic after arriving in Jerusalem. The psychosis is characterized by an intense religious theme and typically resolves to full recovery after a few weeks, or after being removed from the area (29).

We propose that GSM in the cases mentioned above were performed for "atonement" for perceived sins. In the Encyclopaedia Britannica (30), atonement is defined as "the process by which a person removes obstacles to his reconciliation with God. It is a recurring theme in the history of religion and theology. Rituals of expiation and satisfaction appear in most religions, whether primitive or developed, as the means by which the religious person reestablishes or strengthens his relation to the holy or divine. Atonement is often attached to sacrifice, both of which often connect ritual cleanliness with moral purity and religious acceptability."

In Christianity, the Scriptures emphasize the shedding of blood and shaming and mutilation of the body in order to avoid or atone for sin (31).

"According to the law almost everything is purified by the blood, and without the shedding of blood there is no forgiveness." (Hebrews 9:22)

"If your hand or foot is your undoing, cut it off and throw it from you! Better to enter life maimed or crippled than be thrown with two hands or two feet into the endless fire. If your eye is your downfall, gouge it out and cast it from you! Better to enter life with one eye than be thrown with both into Gehenna." (Matthew 18:7-9)

However, in Islam and Judaism, physical suffering and mutilation does not appear to be the primary means of

atonement. In Islam, depending on the sin, atonement can range from repentance and compensation of the sin if possible, feeding the poor, freeing slaves to even stoning to death or cutting off hands. Acknowledging one's wrongdoing, apologizing, and repenting in front of the wronged person and in front of God can make possible forgiveness from the wronged person and also from God. Muslims are encouraged to forgive because God is the most forgiving. Similar to Islam, Judaism also teaches atonement between individual persons. If a person harms another but personally apologizes and tries to rectify the wrong done, then the wronged person is religiously required to grant forgiveness for atonement (32). We can suggest that in Anatolia, the concept of atonement might have been influenced more by the ancient Christian and Roman cultures that existed in the area than by the Islamic culture. This may be why the behaviors of the cases mentioned above, such as shedding blood and self-mutilation, are more similar to the Christian concept of atonement than the Islamic concept.

The concept of atonement is not specific only to religion. In most societies, punishment such as beating, amputation of limbs and tongues, castration, etc., can also be a means to achieve atonement. The discipline of children still involves physical punishment in many societies. There is also the notion that through punishment atonement can be achieved. A person who is physically punished in childhood learns that one must physically suffer in order to atone for wrongdoings. The idea that wrongdoing deserves and can be atoned through physical punishment is highly significant for the understanding of self-injury among individuals in emotional distress (31).

Although physical suffering and mutilation does not seem to be the primary means of atonement in Islam, in a state of active psychosis, the perception of atonement seems to exceed cultural boundaries. In Case 1, hallucinations and delusions ordered the patient to shed his "dirty blood" in order to be forgiven. The patient sacrificed his penis to shed his blood. In Case 2, the patient's sexual desires led to guilt and delusions of sin. In Case 3, the patient sold his property and donated the proceeds to the poor and the inserted thoughts directed him to donate his eye for transplantation. In Case 4, auditory hallucinations commanding the patient to butcher his children resemble the historical roots of ritual sacrifice. All of these acts appear with the aim of strengthening the patient's relation to the holy. With failure in the male role being the major motive, atonement might be another important motive for this patient's GSM act. We can assume that, as a psychotic solution, the patients sacrificed their genitals or donated their belongings in order to atone for their sins and to feel purified.

Auto castration may be a psychotic solution. Patients having problems with the early developmental period as mentioned above and with a self-mutilation history as well as experiencing religious delusions, command hallucinations to self-mutilate and who are non-compliant with treatment are at greater risk for GSM. Therefore, they need special attention and may need to be hospitalized. It is suggested that the examining psychiatrist needs to be aware of the cultural background of the patient (33). Investigating probable plans for sacrifice related to atonement might be helpful in predicting and preventing self-mutilation acts, especially GSM. 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 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.

Note

All four patients gave a written informed consent for the publication of the manuscript under hidden identities.

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