

Case Report

Penile Self-amputation by a Non-psychotic Young Male

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Abstract : *Genital self-mutilation in men is relatively rare and usually manifests in either psychotic disorders or gender-identity disorder (GID). We report a case of penile self-amputation in a nonpsychotic, non-GID young male, who presented in emergency trauma ward, and following acute management of this catastrophic event, subsequently referred for psychiatric evaluation. The case was evaluated and possible differential diagnoses were discussed. We also reviewed the possible etiologies of this phenomenon and assessed the pathoplastic effects of culture and up-bringing.*

Keywords: Self amputation, Self mutilation

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INTRODUCTION

Self-mutilation has been defined as the direct and deliberate self-destruction of a part of a person's own body without the intention of suicide. Minor self-mutilation is quite common, does not usually cause significant disability, and may even be part of recognized cultural practices. In contrast, major self-mutilation is rare, usually only occurs in association with serious mental illness and often results in permanent loss of an organ or its function. The three main forms of major self-mutilation are Ocular, genital, and limb mutilation. Patients who have removed an eye or cut off a limb are almost always psychotic, as are three quarters of patients who severely injure their genitals.¹ Psychotic patients with delusions (often religious), sexual conflict associated with guilt, past suicide attempts or other self-destructive behaviour and depression, severe childhood deprivation, and major premorbid personality disorder, are the group at risk for genital self-amputation². Genital self-mutilation in men is relatively rare and usually manifests in either psychotic disorders or gender-identity disorder (GID).³

Here, we report a case of penile self-amputation in a nonpsychotic young male. Patient's informed consent was taken.

CASE

Mr. A, 30 yrs. old, male presented to emergency trauma ward after he had amputated his penis from its base using a razor blade. After acute management and subsequent stabilization, patient was referred for psychiatric evaluation. During evaluation, patient was found to be unmarried hindu male, was accompanied by his mother. His mother narrated that as per his routine, patient went to toilet to a place nearby his house in the morning of that event. After sometime, she was informed by a neighbourer that patient was lying on ground some distance away from his house, where he was about to faint with heavy bleed from his body. Patient's mother and other relatives rushed to that place, where patient was found crying with pain and appeared in severe discomfort, he merely told them that he had cut his penis using a razor blade which he had brought with him from home. They hurriedly carried the fainting patient to the emergency trauma deptt. of hospital.

During evaluation patient stated that he intentionally cut his penis, with thought that having cut his penis, he will no longer have distractions from sexual feelings or pleasures, from which he was disturbed since long. He believed that without having penis, he would be able to devote himself

more completely in worship of God. Though he was feeling distractions since long, the idea to commit this act came on the very morning of the incidence.

There was no history of previous self-injury or any suicide or homicide attempt nor any past or family history of psychiatric illness. There was no history of substance abuse. Patient used to indulge in masturbation occasionally, however he expressed it as bad and there was guilt associated with it. He believed that normal sexual relations are integral part of marital life, but he was follower of 'Brahma-charya' and considered normal sexual feelings as 'disturbing' so he was unwilling to marry despite repeated pursuance by his mother. Patient was educated upto standard⁶. Patient's father died in early childhood. He was reared by his mother. The patient was involved in religious activities excessively since childhood, such as sitting in temple for several hours every day, performing various religious rituals routinely and rightly. Though, he was not attached to any specific religious sect. Apart from his religious involvement, he used to do his routine house hold chores regularly as reported by her mother. During his childhood, patient was an average student academically, spending little time in his studies. Also, he was less inclined towards play activities with similar aged kids; instead he was always keen to help needy or ill persons or wounded animals in his village. His these interests were persisting till now. In village, he was considered as person who will help those who are in need.

On mental status evaluation, he was calm, quiet, comfortable, oriented to time, place and person. He did not exhibit any abnormal mannerisms or gestures. He spoke coherently and relevantly and answered adequately and appropriately. He expressed normal range of emotions. He credibly denied any thought disturbances or suicidal or homicidal ideations. No perceptual abnormalities were elicited. His cognitive capabilities appeared clinically intact. He did not express any regret or guilt regarding his act of cutting off his penis. Physical examination and laboratory investigations including

hemogram, various counts, biochemistry, EEG as well as imaging studies including CT scan head revealed nothing abnormal.

On Psychological assessment, patient revealed 50 p.p. on Raven's progressive matrices test (which is a culture-free, non-verbal, standardized I. Q. assessment test) suggestive of normal intellectual functioning. Patient's responses on Roscharch ink-blot test indicated emotional instability with introvert personality and difficulty in adjustment. Any other intelligence tests or personality inventories were not used due to patient's surgical problem. Hamilton Rating Scale for Depression score of 6 suggests there is no depression. No positive or negative symptoms found on PANSS scale.

DISCUSSION

The published accounts of Genital self-mutilation are almost all either single-case histories or small case series, from which it is difficult to make valid causal inferences. Even quite recent publications sometimes explain Genital self-mutilation in terms of the patient's reaction to passages in religious texts or unconscious sexual conflicts. The few authors who have reviewed more than a small number of cases have attributed Genital self-mutilation to the direct effects of psychotic illness.² This case highlights the need to recognize cultural and religious beliefs with regard to self amputation, specially in Indian context where 'brahma-charya' is advocated as a symbol of purity of body as well as soul and a way to devote oneself towards God.

In this case patient's belief can not be an obsession as it is not without purpose and it does not cause the patient anxiety and guilt. Patient's belief can be considered to be an 'overvalued idea' as it is defined as a thought that, because of the associated feeling tone, takes precedence over all other ideas and maintains this precedence permanently or for a long period of time. Even though overvalued ideas tend to be less fixed than delusions and tend to have some degree of basis in reality, it may at times be difficult to distinguish between overvalued ideas and delusions.⁴ But still, it can not be put into a diagnostic category. Other

diagnostic category 'sexual masochism (code 302.83, DSM-IV)' describes persons who have a recurrent preoccupation with sexual urges and fantasies involving the act of being humiliated, beaten, bound, or otherwise made to suffer.⁵ As there is no such preoccupation in our patient, this diagnosis can not be considered. Acts of self harm also characterize borderline personality disorder (code 60.31; ICD-10) but other features of this disorder, which include unclear identity, intense and unstable interpersonal relationships, unpredictable affect, repetitive threats or acts of self harm and impulsivity,⁶ are not present in our patient.

ICD-10, in its chapter XX: 'External causes of morbidity and mortality', describes "Intentional self injury using sharp object" under code X 78.⁷ The present case can be put in this diagnostic category. Though it does not completely explain the underlying psychological aspects yet it seems to be the nearest possible diagnosis applicable for this case.

Major concern is the treatment or management part. Though patient had cut off penis, phantom penis experiences may still persist, as it has been reported that after total penectomy persons have sensations of erection and feeling of sexual desires.

Considering this case with no definite diagnostic conclusion, only psychotherapeutic interventions which may include cognitive behaviour therapy, family education or counselling could be considered as management strategy. Seeing the psychopathology of this case which reveal that such problem may occur

because of various mis-beliefs, faulty assumptions and myths regarding sexuality and religion, prevalent in culture and society, it is recommended that sex education should form integral part of formal as well as informal teaching and should be considered in each sphere of life. Sex education should also be incorporated as an important component in various national health programs.

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