

Case Report

GENITAL SELF MUTILATION

Tabowei¹ BI, Kombo BB²

¹Niger Delta University Teaching Hospital, Okolobiri..

²University of Port Harcourt Teaching Hospital, Port Harcourt.

ABSTRACT

We report a case of a 27 year old married man, a Nigerian, of the Ijaw tribe, who castrated himself. There was an absence of any detectable psychosis at the time of the incident. A possible psychological and socio-cultural pressure which were responsible for this abnormal and bizarre behavior are discussed. With family pressure, he was discharged against medical advice and was lost to follow up despite advice.

Key Words: Genital, Self-Mutilation, Psychosis.

Corresponding Author

Tabowei BI

Department of Surgery

Niger Delta University Teaching Hospital, Okolobiri

Bayelsa State Nigeria

Email Ifytabs@yahoo.com

INTRODUCTION.

Genital self-mutilation(GSM) is a rare phenomenon in African society^{1,2} The earliest recorded genital self-mutilation appeared in the Greek mythology; the beautiful god Eshmun castrated himself to evade the erotic advances, of the goddess Astronae, and auto-castration came to be known as the Eshmun complex.^{2,3}

Though there are several background factors and predictors to major genital self mutilation,^{4,5} however, complete genital self-mutilation is linked mostly with Psychotic disorders such as schizophrenic psychosis, drug induced or organic psychosis, and affective disorders.¹⁻²⁰

A multitude of other social and psychological factors such as financial debt, stress of migration and acculturation, low paid job, lack of social support, separation from family, frustration and others can precipitate acute psychosis that may lead to genital mutilation.⁷. Also seeking for attention and sympathy from members of the family may be a contributory factor to this self destructive phenomenon.

We present a case of genital self-mutilation who had no previous psychotic illness, but pressure from society, shame and guilt.

CASE PRESENTATION.

We present a case of a 27 year old male who was rushed to the accident and emergency unit of our hospital Niger Delta University Teaching Hospital Okolobiri Bayelsa State Nigeria (NDUTH) with a history of self inflicted genital mutilation. He was said to have amputated his genitals about two hours before presentation. The patient was the first child in a family of six whose father worked as a manager in an oil prospecting company in the Niger Delta region.

The father had died a few years earlier, and the patient was paid a huge sum of money as gratuity of his father, being the next of kin. He was alleged to have run away, and went into a spending spree with friends and his peer group.

The money got exhausted and he became indebted to many persons. His action was precipitated by the demands of a lady he owed over a hundred thousand naira. He was alleged to have entered his room, brought out

a kitchen knife and cut off both his penis and the scrotum.

He admitted to being unhappy, and lacked energy and sleep. His appetite had been poor and he has been feeling guilty for his action against his kindred. He denied ever conceiving an idea to cut off his genitalia or kill himself and denied history of impotence. He had been keeping away from members of his family. He is married to a 18 year old woman who was 30 weeks pregnant and had a 3 years old baby girl. He takes alcohol but smokes about three packets of cigarette daily. He denied history of medical or psychiatric disorders among close family members. He had no suicidal behavior, ideation or desire for self-injury.

Examination revealed a young man in painful distress, looked depressed, in shock, and staring into space. His clothing was soaked in blood, very pale, anicteric, and had cold and clammy extremities.

His pulse was 120/min, small volume and thready. The blood pressure was not recordable.

Uro-genital system-blood stain all over the perianal region.

The entire genitalia – penis, scrotal sac with testicles was absent.

There was arterial bleeding in both the superior and lateral aspect of the perianal wound.

The urethral meatus was patent, but there was no dribbling of urine.

All other systems were normal

A diagnosis of self castration/amputation of the penis was made.

He was resuscitated with crystalloid infusion, the bleeding vessels were clamped and ligated. A size 16 Foleys catheter was passed which yielded clear urine. The wound was

sutured. Analgesic, Tetanus toxoid and antibiotics were administered. An urgent packed cell volume done was 27% and he had 2 unit of whole blood transfused. The psychiatrist was invited. His condition remained stable.

24 hours later, family members came and signed against medical advice despite adequate counselling and took him to a spiritual home.

DISCUSSION.

Genital-self mutilation is uncommon in this region.^{1,2}, and also an uncommon psychiatric presentation in the accident and emergency room. Although the act was considered unknown in Africa, a few cases have been reported in Kenya and Nigeria.^{8,9} From other reports, serious underlying psychological pathology is responsible for 87%^{2,1} of the cases and sometimes, drug abuse are other important background factor. The incidence of GSM seems to be on the increase², however, whether this is due to an increase of GSM or due to an increase in the frequency of it being reported is not clear. However, it is a phenomenon which is present in all races, culture and religion.²

The motives behind, causes, and association for GSM are varied. These ranges from ritual and religious practices^{2,11}. Many theories consider self-mutilation to be a strategy to reduce distress or tension, or expression of anger or shame, or manipulative behavior. Some authors link this behavior to borderline personality disorder¹⁸, while others think it is a means for the patient of controlling traumatic childhood experience¹⁹. Our patient however, had no such history of childhood behavioral disorder or trauma. His behavior may have been triggered by pathologic feeling of guilt and shame.

It is estimated that approximately 10% of self-mutilators intended suicide and the incidence of this motive is increasing.^{11,12}. This also could not be established in our

patient who stated that he had no intension of killing himself.

Drug and alcohol-induced psychosis have been reported to play a significant role in GSM^{1,10,12,13},. Although in the index case, the patient denied taken cannabis or other addictive drug as at the time of incidence, the stigma, social attitude and condemnation attached to those who take this drug may have made him deny the use of such drug. Lesser psychiatric illness that is associated with GSM included pathologic guilt feelings, aberrant sexual conduct and conflict, and aberrant body image in transsexuals trying to resign their gender on their own in clear consciousness and issues of religious disturbances specific to males^{14,15}.,

Though the patient presented in a state of shock and exhibited no obvious pre-morbid symptoms and signs of psychosis, this behavior is rather peculiar. Substance abuse, the severe feeling of guilt and total helplessness due to the degree of indebtedness he found himself, pressure from peer group and family alike may have been responsible for this abnormal behavior.

The severe guilt feelings might have led to an anxiety neurosis and acute depressive psychosis that was responsible for his behavior and damage to his manhood. However, a change in his attitude could not be noticed by his wife and members of his family because he had distanced himself from them.

This bizarre self destructive behavior cannot also be traceable to Freudian theory of Oedipus complex¹⁷, for this usually occurs in younger age group. According to the theory, a young boy of less than 5 years falls in love with his mother. He subsequently develops fear of castration by his father as a punishment for his incestuous sexual desire for his mother. He may have regressed to his childhood days due to the increasing pressure he was undergoing.

He had felt unhappy, lost appetite, had insomnia and loss of energy.^{1,2,16,17} These are all documented evidence of neurosis and constitute part of depressive anxiety that was missed by members of family.

Though he presented to the hospital in a state of shock, blood loss alone cannot explain this. Severe pain arising from the autonomic effect of cutting off the testicles and fear of the unknown could all be contributory.

The treatment of a patient who inflicted such a destructive trauma to himself is multi-disciplinary.^{1,2,3,4} It poses a great challenge to physicians.^{1,20} The surgeon, the Psychiatrist and the social and rehabilitation department should all be involved. Our patient was still bleeding as at the time of presentation and was in state of shock .He was resuscitated with fluid and had blood transfused but was lost for follow up even before the Psychiatrist could intervene.

No mental state examination by the psychiatrist was conducted on our patient before he was discharge against medical advice despite adequate counselling, but it is known that men who intentionally remove their genitals are likely to be psychotic at the time of the act.¹⁻²⁰.

That he was discharged against medical advice is not surprising. In this part of the world, people attribute abnormal behavioral changes to spiritual attacks. Poverty, ignorance and the quest for miraculous healing prompt the people to seek spiritual advice from a self acclaimed spiritualist who had advertised instant healing in such cases.

This trend is bound to continue in the third world until the people are educated on the need to seek medical attention when the need arises. Painstaking counseling on the part of the doctor and other health workers by explaining the disease, its likely etiology and complication will go a long way in enlightening our people. In our opinion, this is lacking in most health centers.

CONCLUSION

A careful stepwise approach is essential, as the prognosis, follow up and eventual rehabilitation can be problematic as was demonstrated in this case.

By and large, the clinical characteristic of self-mutilation is manifold and there is lack of agreement about its etiology.



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