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Trauma and Reconstruction

Genital Self-mutilation Case in High-level Educated Person

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ABSTRACT

Self-mutilation is the deliberate direct injuring of body tissue, often done without suicidal intention. Genital self-mutilation is a very rare event and self-harm of the penis, especially in the genital system is exceedingly rare. Generally, this kind of behavior is related to psychotic disorders but can sometimes be seen in non-psychotic people due to bizarre autoerotic acts, a desire for to change sex or religious beliefs that view sexual intercourse as a sin. Our case was the reported genital self-mutilation as a result of the bizarre sexual arousal of a young man who is employed as an architect.

Introduction

Self-injury known as self-mutilation is common in clinical practice but genital self-mutilation is a severe form of self-injurious behavior and is an extremely rare phenomenon. Self-harm is described as the destruction or alteration of one's own body deliberately without suicidal aim. In self-injury cases, injuries range from simple lacerations, scrotal cutting, testicle removal, penile amputations, self-castration, and a combination of the above, so-called lock, stock and barrel mutilation, presenting a significant challenge to both psychiatrists and urologists in the clinical approach.[1] A review of the literature suggests that it is usually associated with psychotic illness but sometimes is non-psychotic, in people who have a normal mental capacity.

In our case, a well educated young man who has no psychotic disorder, using varied ways for sexual satisfaction is observed.

Case presentation

A 23 year-old young man presented with severe penile pain for six hours in our emergency service. The physician examined the patient and referred him to the urology clinic. The patient alleged that he woke up for prayer early in the morning and observed that pricking a nail on the penis caused bleeding. He placed a bottle before the penis in order to try and prevent this and fell to sleep again. When he woke up somehow the penis was in the bottle. It has been six hours since he arrived at the clinic. Penile examination findings were: penile gland was inserted into a bottle and seemed very ischemic, dropsical and bright.

At first, we thought that irreversible pathologic changes had already occurred to the penis (Fig. 1) but, after cutting the bottle off of the penis, regular color and rigidity returned after five minutes. The penis was wrapped by Coban Bandage and after 2 hours the color of the penis was normal but a little oedema persisted in the glandular area (Fig. 2). At the end of the week, the penis was functioning almost normally and normal color had returned (Fig. 3).

After immediate intervention, the history of the patient was taken and no psychological symptoms such as hallucinations, delusions and obsessions were detected. Weight is 73 kg, Height is 178 cm, physical disability was not observed. He has a brother and two sisters and his parents are together. The patient has no doubts about his gender identity. He was not involved in feminine role play or dress. He does not have homosexual feelings but has no heterosexual experiences. He does not have a female partner. He has never been in a sexual relationship with women and considers masturbation a grave sin.

He has not communicated with women since childhood and relates poorly to women. He does not have comorbidities, smoke cigarette or use any other drugs.

After exploring the patient's whole story in detail, which on occasion is incoherent, he was referred to the psychiatrist. However, the patient refused the treatment and has never visited a psychiatrist.

Abbreviations: GSM, Genital self-mutilation; GSI, Genital self-injury; AMA, American Medical Association.

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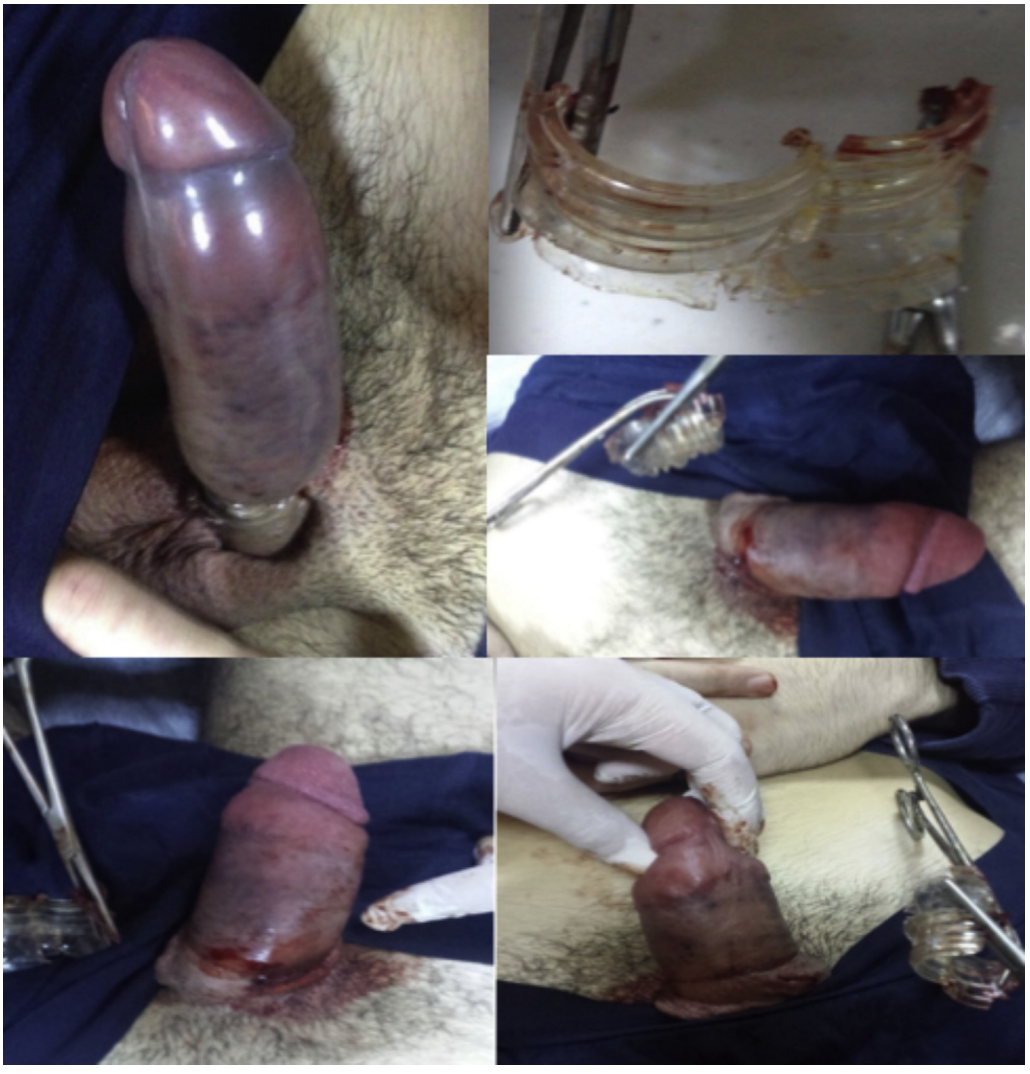

Figure 1. Irreversible pathologic changes already occurred at the penis after the event, squeezing part of the bootle, and shortly after the procedure photos of penis.

Discussion

Patients do present at our clinic with self-harm and this is not an unusual occurence in hospitals. The term self-mutilation was first discovered in a study by L.E.emerson in 1931. Following this, Karl Menninger also used the same term in his book which differentiates self-destructiveness and self-mutilation. It is reported that self-mutilation is a partial suicide – in these cases, self-abusive people do not aim to kill themselves.[2] 40 years on from this study, Sigmund Freud describes the self-mutilation from different aspects – the psycho-sexual drives of the patients.

GSM is not more common than other types of self-mutilations, it only can be found the over the 100 cases in the literature review.

The reason behind of this kind of behavior varies widely: personal crisis related to mental problems (such as gender identity, mental illness, self-mutilation, body dysmorphia) or non-psychotic problems (social reasons, the desire to change sex, bizarre sexual arousal and religious beliefs). The proportion of psychotic causes of sexual harm is higher than non-psychotic causes.

Psychotic patients have a history of suicidal and self-destructive attempts, attacks of depression and, in morbidly obese people, committing to change body formation. Non-psychotic reasons such as transsexualism and different sexual arousals are common in the population. The range of severity is mild to severe; severe pathologic conditions can be the result of self-mutilation. Religious beliefs can also be the cause with the point of view of religions and religious believers varying widely, giving sex and sexuality a rather negative meaning. Beliefs by themselves or combined with a psychotic disorder can be a reason for self-injury, as well as social reasons and friendship. The first GSI cases were reported in the Journal of the AMA by Dr D.Stroch in 1901. The incidence of genital self-mutilation has increased over the last few decades, however, the cause of this may be an increase in the number of cases reported. Genital self-harm usually occurs in Caucasians in their 20s and 30s.[3] Aboseif et al reported that among repeated mutilators, over a half (55%) have a drug addiction background and around one-third (31%) have a history of alcohol abuse. The degree of injury does not differ between the psychotic and non-psychotic self-mutilators.[4]