

**BRIEF COMMUNICATION****Major Self-Mutilation: Profile of Seven Cases**

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**Abstract**

**Background:** Behaviours that involve damaging the body tissues without intending suicide are defined as self-mutilation. Self-mutilation is not a separate disorder but it is a symptom of other psychiatric conditions. Major self-mutilations such as self-amputations are rare in psychiatric practice and most patients are psychotic during such acts. Common types of major self-mutilation are damaging the digits, the eyes or the genitals. **Case Data:** We report four cases of penile self-amputation and three cases of digital self-amputation. Four cases were diagnosed as schizophrenia and three cases were diagnosed as cannabis induced psychosis. **Results:** Out of the seven self-mutilated cases, four were reported due to command hallucinations and in three cases delusions were responsible for self-mutilation. **Conclusion:** The motives and provoking situations behind the self-mutilating acts should be identified to prevent or at least lessen the risk of episodes.

**Keywords:** Self-mutilation, Self-amputation, Command Hallucinations, Schizophrenia, Cannabis induced Psychosis

**Introduction**

Self-mutilation has been defined as “the deliberate alteration or destruction of body tissue without conscious suicidal intent”, which distinguishes it from self-injury incurred during a cultural ritual (e.g. body piercing) or socially accepted body modification (e.g. tattooing).<sup>1</sup> Favazza and Simeon<sup>2</sup> had classified self-mutilation into two categories on the basis of severity and frequency: a) moderate or superficial type: low intensity, high frequency form seen in personality disorders and mental retardation; and b) severe or major type: low frequency, highly destructive form which occurs in the

context of psychosis or acute intoxications. The low intensity high frequency forms were further classified into compulsive, impulsive and stereotypic types.

Self-injurious behaviour (SIB) in form of self-mutilation is reported with a variety of psychiatric conditions, like psychotic disorders, affective disorders, personality disorders (mainly borderline), substance abuse, anxiety disorders, and medical conditions such as Lesch-Nyhan Syndrome.<sup>3</sup> At times person with no obvious psychiatric disorders injure themselves and some types of self-injuries (e.g. tattooing) are culturally sanctioned.<sup>4</sup> Feldman distinguishes self-

mutilation from self injurious behaviour; according to him, self mutilation is intentionally damaging a part of own body apparently without a conscious intent to die, and SIB is an array of behaviours ranging from self-biting and hitting to pica occurring in psychiatric conditions.<sup>5</sup>

Minor or mild form of 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 (MSM) is rare, usually occurs in association with serious mental illness and often results in permanent loss of an organ or its function.<sup>1</sup> The major form of self mutilation is usually sporadic and non-repetitive, involving highly destructive forms which are not suicidal.<sup>6</sup> The 3 main forms of MSM are ocular, genital, and limb mutilation.<sup>7</sup> Among these patients the exotic examples of self-mutilation such as amputation of body part, self-enucleation, stabbing, auto-castration, and even auto-cannibalism and auto-surgery have been reported.<sup>8</sup> 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.<sup>7</sup> Major self mutilations are seen in psychotic conditions like schizophrenia, intoxicated states and severe depression.<sup>2,9</sup> Self-injurious behaviour among psychotic patients often occurs in response to command hallucinations or delusions, which are frequently religious in nature.<sup>8</sup> Common themes include punishment for guilt and sexual transgression.<sup>8</sup>

## Case Histories

### Case 1

A-34-year-old Hindu, single unemployed male presented at surgical emergency with self amputation of penis at its base. After surgical closure of wound, he was referred to psychiatry department. History revealed presence of irrelevant talk, odd behaviours, hearing of unusual voices and fearfulness for 17 years. He was addicted to cannabis, smoking daily for 20 years. He was abusing 10-20 Spasmo-Proxyvon capsules per day for 10 years. He used to take nitrazepam tablets occasionally. Occasional use of alcohol and tobacco (Khaini) was also present. Mental status examination (MSE) showed circumstantiality, tangentiality, second and third person auditory hallucinations. Patient was born as one of the triplets, where other two expired within couple of days after delivery. Patient failed four times in tenth class before leaving school. Maternal uncle of patient was suffering from psychiatric illness suggestive of psychosis.

Patient was diagnosed as cannabis induced psychosis with substance abuse and insight was grade I.

Command hallucinations were telling him to cut his penis was responsible for self mutilation. He amputated his penis to get rid of derogatory remarks made by the hallucinatory voices. (See Figure 1)



**Figure 1:**

**Self amputation of Penis at its base following command Hallucinations telling him to cut his penis.**

### **Case 2**

A 26 years Christian, single unemployed male reported to psychiatric OPD with complaints of wandering tendency, odd behaviour, self laughing, aggressive and violent behaviour off and on for 5 years. Patient was educated up to BA. He was smoking cannabis daily for ten years. He was also addicted to alcohol and tobacco which he takes daily for about seven years. It was also brought to notice that he had tried to amputate his own penis few months back. On local examination, partially healed scar at shaft of penis was seen.

Circumstantiality and disorganised thoughts was present. Hallucinations were absent.

Patient was diagnosed as cannabis induced psychosis with substance abuse and insight was grade II.

When asked about self amputation, he told that he did so as he wanted to be a female. He told that he did not want to become female anymore but didn't regret the act. Sudden delusional idea was responsible for self amputation. (See Figure 2)



**Figure 2: Self amputation (partial) of Penis at its shaft.**

**Case 3**

A-40-year-old Hindu, single unemployed male with irrelevant talks, odd behaviour, self muttering, hearing of unusual voices and decreased self care for 15 years was brought to psychiatry OPD and subsequently admitted in psychiatry ward. On examination, it was seen that left index finger was amputated at first Interphalangeal joint and stump was healed. Patient had amputated his own finger. MSE revealed delusions, disorganised thoughts; second and third person hallucinations. He was arts graduate. During adolescence



period, patient had consumed cannabis. Patient's father was under psychiatric medications.

Diagnosis was schizophrenia and insight was grade II.

Patient was hearing voice of "God" in the form of commands asking him to cut the finger. He was deluded because of voices and cut his own finger believing that good things will prevail in the society after his sacrifice. (See Figure 3)

**Figure 3:**

**Self amputation of left index finger at first Interphalangeal joint**

**Case 4**

A-34-year-old Hindu married, illiterate, rickshaw puller was brought to emergency room with profuse bleeding from amputated stump of penis, irrelevant talks and psychomotor agitation. After sedation and closure of the wound he was admitted in plastic surgery ward. There was history of suspiciousness, fearfulness, disturbed sleep and decreased self care for 8 years. Patient was abusing alcohol and cannabis infrequently for 15 years. Family history was positive for psychosis in his brother. MSE was positive for delusion of

persecution, second and third person auditory hallucinations.

Patient was diagnosed as paranoid schizophrenia with co-morbid substance abuse and insight was grade I.

Command Hallucinations from male voice was telling him to cut his penis. He was very frustrated and tired of the commands, so he succumbed to the wishes of the hallucinations and cut the penis. He had thrown away the cut penis into bushes so as no one could find it and try to rejoin it.

**Case 5**

A-59-year-old Hindu unmarried female presented to private hospital with self amputation of right middle finger when she was not able to remove iron pipe put around her finger. Finger could not be saved as local area was gangrenous due to repeated trauma. Patient was subsequently referred to psychiatric department. Relatives gave history of irrelevant talks, odd behavior, self muttering, hallucinatory behavior, poor hygiene for 35 years. She was studied till 4<sup>th</sup> class but detailed pre-morbid history was not available. She was chewing tobacco (Khaini) for more than 20 yrs. Delusions, disorganized thoughts and hallucinations were present.

She was diagnosed as schizophrenia with insight grade I.

Patient believed “Iron Pipe” as “Ring” and used to insert Iron Pipe into her right middle finger repeatedly. Local tissue was traumatized, and one day, she chopped that middle finger when she could not remove her “Ring”.

**Case 6**

A-31-year-old Hindu, married male presented to surgical emergency with self amputation of left little finger at second interphalangeal joint. There was history of suspiciousness, fearfulness and hearing unusual voices for previous five years. Patient was alcohol dependant and used to drink two/three times in a week. Cannabis was abused occasionally. He was matriculate and a shop owner. He was married with one son but separated for last one year. He had jumped from the third floor of the building in previous year. Mother was suffering from depression and was on antidepressant medications. MSE was positive for auditory hallucinations and delusion of persecution.

Diagnosis was paranoid schizophrenia with co-morbid Substance abuse and insight was grade II.

Amputation of Left little finger, distal phalanx was because of command hallucination to chop the finger from patient’s expired uncle “Budhichandra”. Patient had jumped from the third floor after hearing the command from same voice before.

**Case 7**

A-37-year-old Christian, unmarried male presented to psychiatry outpatient department with self withdrawal, abnormal behavior, self muttering, wandering tendencies, and hearing unusual voices. His history revealed that patient had amputated his penis five months earlier to the visit. On local examination healed scar was noticed above the scrotum. Patient was undergone operation at private hospital, where urethra was reconstructed and meatus was created. He was not availed of psychiatric consultation. There was history of psychosis for previous eight years. Patient was alcohol dependant. Cannabis was abused almost daily at the beginning of the illness for four to five years. He was matriculate and unemployed. MSE was positive for auditory hallucinations and formal thought disorder. Diagnosis was cannabis induced psychosis and insight was grade II.

Accordant to mother of the patient, who is significant caregiver, patient was deluded with religious beliefs and amputated the penis as part of religious ritual.

**Discussion and Conclusion**

All seven patients were chronically psychotic at the time of self mutilation acts. Duration of illness was ranging from five years to thirty-five years. Insight into illness

was poor (grade I or grade II) in all cases. Family history of psychiatric illness was present in four cases. All of them belong to the low socioeconomic class and are residing in North- Eastern Indian state of Manipur which has ethno-cultural diversity from other parts of India. Such major self mutilations are also reported in other parts of India and world and are seen in different ethno-cultural populations.<sup>4,5,7,9</sup>

Cannabis abuse (lifetime) was present in six out of seven cases, and all cases abused tobacco (in various forms). Four self-mutilations were reported due to command hallucinations and other three were due to delusions. None of the penile amputation was associated with mutilation of scrotum/testes. Past history of self harm was present in only one patient who had jumped from the building.

It is not known when in the course of psychotic illness, severe self mutilation is most likely to occur.<sup>10</sup> History of self harm is present in mild/moderate self mutilation but severe self mutilation occur as an isolated event.<sup>4</sup> Third quarter of patients severely self-mutilate and injure their genitals, followed by eyes and fingers.<sup>10</sup>

Majority of reported cases of self mutilation are psychotic with command hallucinations and delusions as leading underlying psychopathologies.<sup>11</sup> A recent study has found that command hallucinations are common (53%) amongst Asian patients with schizophrenia and that there is a high rate (62%) of acting upon them. The same study also found that a history of self harm predicts compliance with command hallucinations.<sup>12</sup> A study suggested that self-mutilation may be explained by interpersonal circumstances and specific delusions which develop over a period of a few weeks and may occur as the last event

in a sequence, indicating that self-mutilation may not be an impulsive act but an end result of treatable psychotic thinking.<sup>13</sup>

One of our patients was repeatedly putting her finger in Iron pipe without feeling much pain. Diminished pain sensation in schizophrenia has been described previously; it can be so extreme that the lack of pain delays the diagnosis and management of acute, serious conditions such as peritonitis and perforated bowels.<sup>14</sup>

Non-suicidal self-injury as deliberate direct destruction of body tissue without conscious suicidal intent is a relatively common occurrence in forensic referrals. Distinguishing between them is very important and forensic practitioners must be trained for this purpose.<sup>15</sup>

Though extremely rare, the patients with body integrity identity disorder (BIID) mutilate themselves; or ask surgeons for an amputation or for the transection of their spinal cord. Patients who desire the amputation of one or more healthy limbs or who desire a paralysis need to be addressed carefully.<sup>16</sup>

Patients who are not initially forthcoming with the reason should be regarded as a psychosis until proved otherwise. Self mutilation is common in chronic psychotic patients, thus, early diagnosis and treatment of psychosis may reduce such acts. Motives and provoking situations should be identified to prevent or lessen the risk of episodes. We emphasize the importance of a trans-disciplinary approach in treating self-mutilation in psychiatric patients. The interaction between the treatment teams affords improvement of the patient's condition.

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