Case Report

Genital self-mutilation in an attempt of suicide by a patient with a borderline personality

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ABSTRACT

Self-mutilation acts are known to characterize the borderline personality disorders. However, voluntary cutting of the male genital organ remains extremely rare. The present paper reports a case of a 25-years-old young male with a borderline personality. The patient committed a genital self-mutilation (GSM) targeting suicide during incarceration stage in jail. In addition, a discussion of the epidemiological and psychopathological aspects of the self-mutilation of borderline patients was been conducted. A particular interest is attributed to the genital self-mutilation and a review of the literature is presented.

Key words: Borderline, genital self-mutilation, personality disorders

Introduction

Many clinical cases of genital self-mutilation (GSM) were reported in the literature. They are mostly associated to psychotic disorders compared to severe personality disorders.[1,2] Indeed, the self-mutilation act is characterizing the borderline personality disorder. It is also included in the diagnostic criteria of DSM IV_R. However, the voluntary cutting of the genital organ remains extremely rare. In this paper, we report a case of genital self-mutilation committed in a jail while associating a depression episode. The patient was characterized by a borderline personality disorder. In addition, we will discuss the epidemiological and psychopathological aspects of the self-mutilation of the borderline patients with a focus on the genital self-mutilation. A review of the literature will be also presented.

Case Report

Our male patient was 25-years-old, he was hospitalized in March 2003 in the department of psychiatry of the university hospital of Fez (Morocco) for genital self-mutilation while attempting to suicide. The patient achieved the complete cutting of his genital organ using a razor cutter. This act was carried out during the incarceration stage in the civil prison of Fez. The patient was been jailed for a sentence following a premeditated murder.

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The patient belongs to large family composed of 11 brothers and sisters; the family belongs to a low-income class of the rural area of Fez (Morocco). The patient received a severe family education from his father demonstrating a full use of authority, power and violence. The patient has spent seven years to learn the holly book of "Koran". Then he practiced several jobs such agriculture and shoemaker at early age without achieving any professional stability.

The patient interpersonal relationships demonstrated instability and frequent ruptures. He believed that people do not try to understand him; they do not identify his concerns, issues and needs; and he believed that he might be rejected any time. The relationship of the patient with women was restricted and limited since he feared to be abandoned. Concerning the sexuality, the patient declared that he has had three successful sexual interactions before. However, the patient expressed that his not confident about his sexual identity and virility. Nonetheless, no physical or sexual abuse was revealed during his childhood. In addition, neither familial

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psychiatric history disorders or mood disorders nor suicidal behaviors or addiction behavior were recorded.

Through his 15 years old, a succession of various psychiatric symptoms occurred in the patient with collection of clinical aspects. Evermore, the patient reported episodically fluctuating anxiety in abandoned or accompanied contexts and sometimes-associating periods of depersonalization and derealization. The patient revealed also episodes of a permanent feeling of emptiness and lack of goals in life, with a frequent feeling of uselessness and underestimation. An excessive and abusive consumption of cannabis and alcohol was reported during episodes of anxiety and distress.

During his 19-years old, the patient attempted to commit suicide using organo-phosphorics chemicals, this required hospitalization in the intensive care department along ten days. This suicidal behavior was considered secondary to a major depressive disorder. A year later, the patient demonstrated a brief psychotic disorder associating persecuting delusions, hypochondria and a diabolic possession. These disorders regressed after a three weeks of antipsychotic treatment.

At 21-years old, our patient committed a murder in an impulsive context. Thus, while he was walking with his girlfriend, two young men from his village tried to humiliate him and captivate the girl away with them. The patient could not control his aggressive behavior and he wounded one of his aggressors that died in the emergency department of the hospital. He was condemned guilty and sentenced for ten years of jail.

Since his incarceration, the anxiety disorder, emptiness and abandon feelings were worsening. The patient was self-isolating in the prison cell and established very few relationships with the prison colleagues. The feeling of abandon has increased by the incarceration circumstances and the rare family visits.

The patient started the self-mutilation in the prison iteratively commencing with the left arm and the thorax [Figures 1 and 2]; these occurred in a context of infringement of impulsion, abandon and anxiety. He reported that these self-destructive acts allowed him to discard fear and tension feelings without being determined to suicide. Two weeks earlier the GSM, the patient has acquired a massive anxiety, a feeling of emptiness and uselessness. Accordingly, a strong desire to die was subsequent. Subsequently, he began to think ending his life. The patient decided to cut his genital organ since he always believes that this organ is the center of his existence. He started to organize the means to accomplish his act with a complete dissimulation of his suicidal intention. By the day of the GSM act, our patient borrowed a razor cutter from another detainee in the prison pretending that he wanted to shave. The patient took the opportunity of the absence of other detainees and prison guards who were in their morning break, he has hided himself in a corner of the prison cell and proceeded to completely cut his genital organ using the razor cutter around 10 AM [Figure 3].

The patient was transferred to the surgical unit of the emergency department, where he immediately followed a re-implantation of the genital organ with a realignment of the urethra. However, necrosis was been noticed and treated during the control of the implant. Unfortunately, the necrosis caused tissues shrinking, and the urological surgery team removed the necrotized graft and proceeded to a plastic surgery

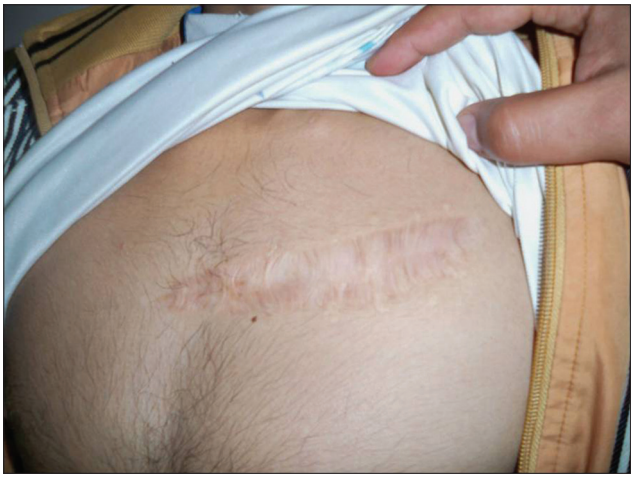

Figure 1: The image clearly demonstrates the self-mutilation at the thoracic level

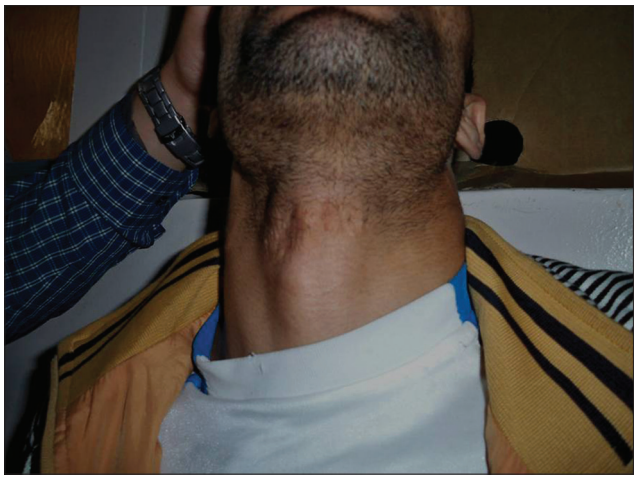

Figure 2: The image clearly demonstrates the self-mutilation at the neck level

of the remaining base of the genital organ [Figure 4]. However, the patient completely refused any surgery and therapeutical approach despite all explanations provided about the consequences including the vital prognosis.

Afterward, the patient was hospitalized in the psychiatric department where he showed a clear depressive syndrome, a self-culpability regarding the execution and declared that he has lost his virility. Our case adopted a desperate vision of his future but he did not reveal any intention to recommit suicide. In addition, none of symptoms such disorganized speech, delusional, or perceptive disorders were noticed. The somatic examination was without particularity besides a routine biological assessment that was conducted and was negative.

The psychometric test DIB_R (diagnostic interview for borderline-revised) revealed a borderline personality. During the admission in the psychiatry department, the patient demonstrated a progressive improvement of the symptomatology while using anxiolytic and antidepressant treatments including Clomipramine at 150 mg/day and Diazepam 20 mg/day. The patient showed an attenuation of the psychomotor reduction within 4 weeks of treatment. Additionally the desperate, hopeless and self-culpability feelings have decreased within 6 weeks. During the hospitalization stage, the patient developed washing compulsions, which regressed after one month of treatment. The patient left the hospital after the stabilization of his clinical state lasting 64 days of hospitalization.

Six months later, the psychiatric test revealed a significant recovery of depressive disorder. In addition, the patient refused to talk about his self-destructive act and declared that he does not want to remember it again. One year later, the patient was examined in the jail and neither self-mutilation nor suicidal behavioral signs were recorded. Since he left hospital, he declared that his act was committed without his determination and God would forgive him. He superficially mentioned the self-mutilation with avoiding to talk about the circumstances again.

Indeed, the GSM of a borderline personality diagnosis was evoked first considering the omnipresent fear of being abandoned, the permanent dysphoria, the instability characterizing the interpersonal relationship, the life sentimental, the recurrent suicidal behaviors, the psychiatric disorders alternation of varied categories and the significant values recorded in psychometric tests.

Various facts allowed suggesting recurrent major depressive disorders including the re-occurrence of episodic suicidal attempt during depressive state and the suicidal goal behind the genital self-mutilation. However, a combination of depressive episodes with fear of abandon and the occurrence of psychiatric disorders such psychotic, obsession, substance abuse and substance dependence disorders were not supporting this hypothesis. The atypical GSM of the borderline personality might suggest a schizophrenia diagnosis, which was discarded considering the absence of any element of disorganization and the preservation of a good lucidity toward reality. An antisocial personality diagnosis was also envisaged considering the relational and professional instability, the impulsivity of repetitive self-mutilations. However, the biographical data, the interaction of the patient with events and the prevalence of fear of separation allowed withdrawing this diagnosis.

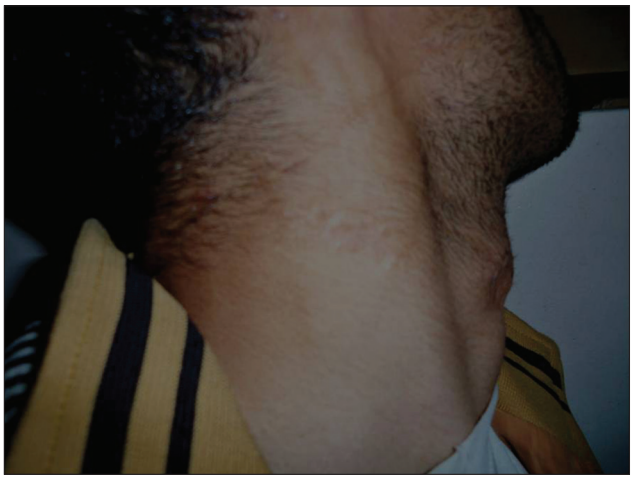

Figure 3: The image clearly demonstrates the self-mutilation at the neck level

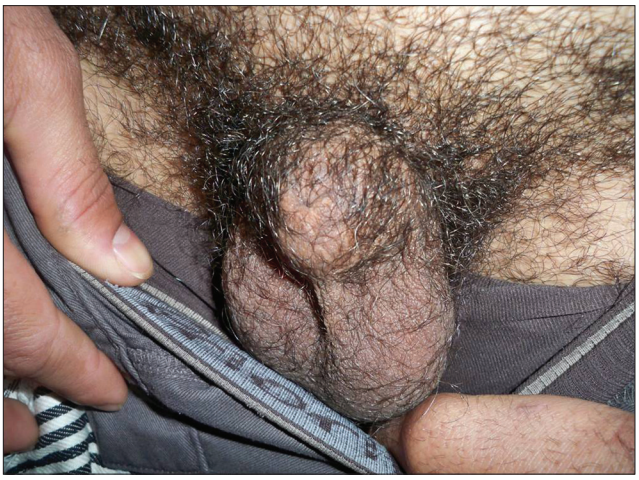

Figure 4: The image clearly demonstrates the complete cut of the genital organ

Discussion

The self-mutilation is an intentional injury committed by a patient on his/her body without an apparent intention to pass away.[3,4] This definition opposes the DurKeim definition that considers these acts such a slight figure of suicide. Several denominations were used to describe the self-mutilation acts. The first scientific description of the self-mutilation act was given by Ströch in 1901, and reported a case of a 27-year-old male that self-mutilated in because of success lack with women.[5]

According to Joyce *et al*.,[6] the rate of self-mutilation in the general population is comprised between 0.75% and 4%, while it varies between 5.5% and 77% in hospitalized psychiatric population[7] and between 50% to 80% in borderline personality patients.[2] Patients used various means for self-mutilation and might select any part of their bodies.[8] Zanarini *et al*., studied 290 borderline patients during 10 years;[7] they reported high prevalence of self-destructive acts in this category of patients as well as large varieties of methods and means used for this purpose. Hence, more than 70% of patients revealed a history of multiple sequences of self-mutilation and 60% have previously undergone a suicide attempt. In the same longitudinal study,[7] a prospective periodical follow-up of two years revealed a significant decrease of self-destructive behavior in 75% of patients; the improvement was mainly due to medical and psychotherapeutical treatments and to the maturation cumulated by the age increase of patients during treatment stage.

In contrast, the genital self-mutilation incidence is poorly known. The GSM achievement circumstances correlated with long surgical treatment mostly combined to coordination lack between the surgical and psychiatric care departments. The most reported GSM cases in the literature are not associated to another mutilation form of the body.[2-5]

Generally, the masculine GSM concerns bourses including contents and the penis. Lesions vary in intensity from the simple superficial cutaneous laceration to almost complete ablation of testicles and cutting of the penis.[5] Compared to males, the GSM of females is exceptional and the most frequent lesions are cuts or scarifications.

The literature review of Greisheiner and Groves[8] achieved on 52 GSM cases, demonstrated that 87% of GSM patients are caused by psychotic context including 28.5% schizophrenic. The same paper reported the recurrence of 19% of genital self-mutilation cases. Nakaya *et al*. literature review of 110 cases showed that most of patients have suffered of psychoses associating sexual conflicts and delirious disorder about mystic-religious topics; while non-psychotic cases have presented sexual identity disorders.[9] The psychiatric disorders consisted of psychosis, erotomania,[10] dysmorphophobia disorder,[11] histrionic personality,[2,10] Munchausen's syndrome,[12] alcoholic dementia,[13] temporal lobe epilepsy,[14] and sexual identity disorders. Lennon *et al*., reported a case of mood disorder during a manic episode.[8] The literature reported many isolated cases of psychotic patients that are rarely associated to 'axis II diagnostic criteria' of borderline personality. However, Tharoor *et al*.,[15] reported a 72 years old patient that committed GSM secondary to familial conflicts without any remarkable psychiatric disorder history.

To our knowledge, a unique case was reported in the literature associating GSM and borderline personality.[16] Fayed *et al*., reported a 17-year-old girl who was admitted in the gynecological emergency department for an acute hemorrhage resulting from a GSM using an electric knife. The self-destructive act was accomplished during an episode of dissociation of a borderline personality. Three years earlier, this young girl was a victim of sexual abuse without penetration by three people; and she kept the incident secrete.[16] The investigation of the risk factors of the self-mutilation behavior in borderline patients found factors counting loss of physical integrity, confusion, the feeling of guiltiness, self-underestimation, the dependence or the abusive consumption of a substance.[3,17-22] The presence of maltreatment during childhood including physical or effective negligence, sexual abuse is mostly mentioned as a predictive factor of the self-mutilation in borderline personality patients.[1]

In-contrast, functions were attributed to these acts such coping with dissociative states, stress communication to others, symbolic expression of emotions especially guiltiness, regulation of dysphoric element such an anti-suicide role.[3,20,22] Authors insisted on the addictive nature through deliverance of endorphin and dopamine in blood, and on the distractive function consisting of shifting patient attention from moral pain to physical pain. Subsequently, 60% of borderline patients did not report any pain feeling during the self-mutilation acts.[2,18] Bohus[1,2] has achieved two perception tests of cold and pain in 12 borderline patients and 19 witness women (the cold pressure test, the tourniquet pain test). Results showed a significant decrease of pain perception in borderline patients compared to the witness group regardless of their stress state. Similar results were found by Schmahl *et al*.[18] They noted that there was neither a modification of sensory discriminative component of the pain nor a deficit of attention.[18] This approach would involve either a serotoninergic dysfunction yielding impulsive and aggressive aspects or a low limit

of excitability in the secondary limbic structure with repeated emotional trauma during a fast evolution.[8] Conacher[4,8,16] considered that GSM is a model of suicidal act. Indeed our clinical case illustrates the issue that is often raised in the literature such: what is the suicidal component in the self -mutilation behaviors?

Key elements of differentiation were studied. These included the patient suicidal intention, the physical damage resulting of the self-destructive act, the frequency or the chronicity of the act supporting the self-mutilation and used methods.[19-22] They found that these varied for the self mutilation acts and are identical for the suicide attempts.[8] Fulwiter *et al*.,studied 31 self-mutilated prisoner patients and noticed that 15 cases reported their act targeting an attempt to commit suicide, while 16 patients simply targeted hurting themselves.[2,3,12] The suicide attempt was associated to affective disorders, while the mutilation injuries were related to a history of hyperactivity and dysthymia or to an anxiety disorder during childhood.[8,20] In addition, Greilsheimer and Groves[8] reported a series of 53 patients of GSM including five cases with suicidal profile. Jason *et al*.,[8] presented three Chinese patients followed for psychotic disorder while they committed GSM for suicidal purposes. Recently, Tharoor *et al*.,[15] reported a 72 years old married patient without major medical or psychiatric history who tried to suicide using GSM. The cultural aspect motivating the GSM for suicidal purposes was underlined.[19-22] In fact, it is believed in Chinese and Indian cultures that the penis is the source of the life. Hence destroying this organ might lead to death. Indeed, our case report meet the same believes. In addition, it is to highlight that our patient does not have any associated delirious religious believes.

Conclusion

The self-mutilation of borderline patients is very common. However, the GSM is extremely rare. Hence, our case might have significant clinical interest for the psychiatric literature.

Indeed the original aspects of the genital self-mutilation in a borderline personality of the psychiatric profile discussed have demonstrated almost unique case. The suicidal aspect of this self-destructive act constituted another originality of our case study. Therefore, our paper might contribute to better understanding and clarification of unknown aspects of the profile of the borderline personality behaviors.

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