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Klingsor Syndrome: Genital Self-Mutilation in a Psychotic Patient

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ABSTRACT

Self-mutilation attempts are common in psychiatric practice. One form of self-harm, genital self-mutilation (GSM), is less common but may have severe consequences. GSM acts can occur in different diagnoses such as personality disorders, substance abuse disorders, obsessive-compulsive disorders, and psychotic disorders. When GSM is performed due to psychotic symptoms, the clinical picture is called Klingsor Syndrome. GSM is often associated with severe psychosis and often accompanied by religious delusions. In our article, we discussed a case of schizophrenia with penile autoamputation due to religious delusions. A 28-year-old male patient was admitted to our hospital after penile autoamputation. After surgical interventions, the patient's follow-up continued in our clinic. The patient had auditory hallucinations, delusions of persecution, and sinfulness. His symptoms improved after antipsychotic treatment. It is important to identify the risk factors of Klingsor Syndrome, which is a rare but serious condition, and to intervene early in these patients.

Keywords: Self-mutilation, Psychosis, Self-injurious Behavior

INTRODUCTION

Self-harm behavior is an unhealthy emotional expression of one's emotions triggered by acute stressors (Schwerkoske et al. 2012). Genital self-mutilation (GSM) is less common than other self-harm behaviors. It is more common in men than women. The first case of genital self-mutilation was reported in literature in 1901 (Ozan et al. 2010). Psychotic patients account for approximately 54% of cases of GSM. Substance use is the second most common psychiatric condition associated with GSM. Various triggers (perception of rejection, poor social support, problems in accessing health services, acute substance intoxication and/or withdrawal) and experiential factors (delusional thinking, hallucinations, religious preoccupations, intense thoughts of guilt, need for redemption, suicidality) have been reported in publications related to Klingsor Syndrome. These factors have been reported to be more prominent in psychotic patients. Penile autoamputation is the most common type of GSM in psychotic patients. The riskiest period for GSM in patients is the first psychotic episode or early stages of the disease (Veeder and Leo 2017). The term Klingsor is derived from Wagner's opera 'Parsifal'. At first, Klingsor Syndrome was described only for GSM related to religious delusions. Later, this definition was expanded to include other types of GSM associated with other delusional thoughts (Menakuru 2018). A review study showed that patients with religious delusions committed GSM mostly due to misinterpretation of various texts in the Gospel of Matthew (Schwerkoske et al. 2012). However, if GSM is performed due to gender dysphoria, it is called Scoptic Syndrome (Lothstein 1993). We aimed to present a psychotic patient who performed penile autoamputation. Written permission was obtained from the patients and their relatives for the case presentation.

CASE

A 28-year-old single, unemployed male who lives with his family was brought to the nearest hospital by his family due to a total penile auto-amputation. After the first intervention, he was referred to Gazi University Hospital for penile replantation. The patient was followed up in the plastic and reconstructive surgery clinic for 18 days for postoperative wound care and observation. The first psychiatric evaluation of the patient was made by consultation. He did not cooperate during the initial evaluations. His thought process was disorganized. We

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learned afterward that he saw someone who scared him by showing him sharp objects. He was uneasy because he could not do anything about it. After surgical follow-up, the patient was transferred to our psychiatry clinic. He had intermittent psychomotor agitation during his first days in the clinic. His associations were loose. The patient's relatives informed us that he had thoughts that he was controlled by television and tracked by devices, which started about two weeks before the harmful attempt. To remove these devices, he made incisions behind his ears. At the same time, he had excessive preoccupations with cleanliness. He was washing his clothes by hand because he thought the washing machine did not clean them properly. He committed GSM at night while his family was still asleep. However, he got scared after the act and informed the family members. He had been hospitalized with complaints of having strange thoughts and dreams a year before the incident. Even though he was prescribed risperidone he did not use the medication after discharge and did not go to his follow-ups.

According to the DSM-5 criteria, the patient was diagnosed with schizophrenia (American Psychiatric Association 2013). During the initial evaluation, the Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen 1984) score was 57, and the Scale for The Assessment for Negative Symptoms (SANS) (Andreasen 1989) score was 56. Risperidone 8 mg/day and biperiden 4 mg/day were prescribed. His symptoms gradually improved with antipsychotic treatment, and there was a significant reduction in the scores obtained from the scales.

The patient began to cooperate with antipsychotic treatment. A year ago, he had heard a swear word that cursed God while he had been intoxicated. Because of his guilt, he thought that if he cut off his genitals, this guilt would go away. He drank alcohol to lessen the pain before the GSM. However, he was completely sober. He took a knife from the kitchen, went to the bathroom, and committed the act. He told us that even though he knew what he had done was not right, he felt a temporary relief after it. He did not intend to kill himself. It was learned that the last substance use was 10 days before the incident, that he did not use any other substance other than ecstasy, and that he thought that his mind was "cleared" by substances.

His history further revealed that he had abused many illegal substances such as cannabis, heroin, and ecstasy on different occasions since high school. It was learned that he did not have many friends, that there was no one in his family with whom he got along well, and that he had a problematic relationship, especially with his mother. He stated that his mother was tense and tight-fisted, always hoarded stuff at home and their house was not clean, and for these reasons, he thought that she also needed treatment. According to the patient, their house was "rotten" inside. His father was distant and not interested enough in the problems of the house. His father did not come to visit him throughout his hospital stay. He had two brothers; one was in the military and the other was a laborer. He stated that he was not on good terms with any of his family members. We learned that his father named him after a verse in the Qur'an and that he was a shy, quiet boy who could not approach people. He stated that although he was unhappy from time to time, he stated that he had no plans to kill himself until now. The patient avoided answering questions about his sexual background. He stated that his goal in life was to get well and be happy, that he had never had a romantic relationship before, and that if he ever got better, he wished to get married and settle down.

After the clinical improvement shown by the scale scores, the patient was discharged to continue outpatient treatment and follow-up in his hometown. SAPS and SANS scale scores at discharge were 19 and 24, respectively.

DISCUSSION

GSM is a rare but serious symptom of mental illness that can cause permanent disability. Excessive preoccupation with feelings of guilt may cause self-mutilation in psychotic patients (Park et al. 2011). Substance use alone is also a risk factor for GSM. Self-harm is biologically related to the dopamine system. Psychoactive substances (cocaine and cannabis for example) are thought to mediate self-harm behavior by affecting synaptic transmission through dopamine agonism (Vender et al. 2015). In our case, the patient had intermittent psychoactive substance use since adolescence. However, there was no acute psychoactive substance intoxication before GSM. The patient had planned the action, as is the case with most GSM cases in the literature (Ozan et al. 2010). Personality traits, upbringing, and sociocultural environment also have an impact. In the literature, factors such as dominant mother versus passive father figures, sexual conflicts during childhood, masochistic tendencies, and the need to alleviate mental suffering have been mentioned for GSM in men (Blacker and Wong 1963). Some clues in the patient's history may be associated with GSM: 1) Having grown up in a conservative family, 2) Having conflicts with the mother, 3) Having a distant relationship with the father, 4) Lack of social support and unemployment, 5) Pathological guilt about aggressive impulses, 6) Using psychoactive substances to relieve guilt, 7) The emergence of a psychotic illness triggered by substance use. With the emergence of a psychotic episode, self-functions are impaired, there is no obstacle to aggressive impulses and these aggressive impulses are directed towards the patient himself/herself.

In general, patients committing GSM are not suicidal. Our patient also stated he did not intend to kill himself. Therefore, GSM is thought to be not very different in this sense from other acts of self-harm (e.g., self-injurious behavior in patients with borderline personality disorder) (Rosen and Hoffman 1972). Such actions can be interpreted as an unhealthy method of self-protection to avoid threats of destruction and punishment. This fear of punishment is explained by the "Talion Law" (principle of retaliation) in the literature. The Law of Talion, also known as the "eye for an eye" rule, dates back to the Babylonians. This law is also mentioned in various religious texts (Lambert 1972). The tendency to think concretely leads psychotic patients to perceive religious texts in their first meaning. Since the personification of a body part can be attributed to the primary thought process, the person who ascribes sins to the "guilty" organ could be "totally innocent" when that organ is disposed of (Menninger 1989). In our case, the patient committed self-mutilation as a way of relieving his internal conflict. GSM can be interpreted as a "compromise" to appease the critical superego. The patient's strict and religious upbringing could have caused him to feel guilty about his sexual urges. He tried to get rid of his sinful organ so that he could cope with anxiety and avoid complete annihilation. As in our patient, people who have a rigid superego bear intense emotions such as anger, guilt, and fear. The patient sacrificed his organ to avoid the end he feared. The relief he described after seeing blood can be attributed to this. The patient was inclined to use psychoactive substances to ease feelings of guilt, depression, and hopelessness. The psychotic episode after substance use might lead to acts of GSM. This attempt can be counted as a symbolic atonement for his intense anger towards his mother, his sinful nature, his unsuccessful life, and his oedipal fantasies unacceptable to himself (Fisch 1987).

CONCLUSION

When encountered, GSM is an emergency and requires rapid, multidisciplinary intervention. Recognizing individuals at risk and taking precautions are important for prognosis. Our patient had feelings of guilt, obsessive personality traits, and auditory hallucinations shaped by his religious beliefs. All these factors might have caused the patient to engage in self-harm behavior. The fact that the patient did not want to reveal his sexual history may indicate that he still has internal conflict and feelings of guilt about his sexuality. He also chose the word "rotten" to describe their house. While trying to be perfect, an obsessive individual's dreams and choice of words commonly include themes such as filth, contamination, decay, and excretion. In addition, the perception of sexual and aggressive impulses as unacceptable by the self may manifest itself as obsessions. Ironically, religious conservatism and obsessive personality traits can lead to the urge to sin. As in our patient, these individuals may tend to harm themselves at times when they feel insecure about themselves and their environment due to feelings of intense hopelessness and guilt (Miller and Hedges 2008). Psychosis also creates a "suitable environment" for acting without thinking about the consequences. Disposing of organs causing sinful thoughts can be interpreted as an effort to manage one's internal conflict. Such an action can also create anger and helplessness in those around the person. Thus, the person may take "revenge" on those close to him/her and act before the mighty force that can do more harm (Feldman 1988).

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