Autocastration as a Presenting Sign of Incipient Schizophrenia

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Previous case reports on autocastration have identified individuals who engaged in genital self-mutilation as being overtly psychotic, as having previously received a diagnosis of schizophrenia, or as having significant dysfunction of ego integrity, manifesting as guilt and low self-esteem. This paper describes a patient who had had no previous psychiatric symptoms or mental health treatment and for whom the act of autocastration was the first sign of incipient schizophrenia. (*Psychiatric Services* 52:685–686, 2001)

Self-mutilation is described as the "deliberate destruction or alteration of body tissue without conscious suicidal intent" (1). It has been performed by individuals throughout history. Genital self-mutilation has been a religious practice since ancient Roman times (2). Roman priests regarded this custom as "a supreme sacrifice of sexual life in favor of the emotion to the highest known good" (3).

Cases of genital self-mutilation are rare. In the early 1960s Blacker and Wong (4) uncovered 40 cases worldwide since the turn of the century, and the number had increased to only 53 cases by 1979 (5). Earlier investigators had assumed that these individuals were psychotic, given the nature of their acts. Later research showed that many of these individuals were not psychotic at the time they performed the self-mutilation.

Romilly and Isaac (6) concluded that in one-third of the 44 cases they reviewed, psychosis was not present. In looking at cases of autocastration, Greilsheimer and Groves (7) identified three general patient groupings: psychotic individuals, nonpsychotic individuals with significant character pathology, and individuals influenced by sociocultural factors and religious beliefs. Schweitzer (8) elaborated further, identifying four common premorbid characteristics: delusions, particularly religious delusions; themes of guilt and sexual conflict; a history of depression, often with past suicide attempts; and "severe deprivation in childhood [with] major personality deviation in adult life."

A handful of case reports detail autocastration among persons with schizophrenia who had biblical delusions. Waugh (9) described a 31-year-old man who severed his testicles in response to Matthew 19:12: "There are eunuchs born that way from their mother's womb, there are eunuchs made so by men, and there are eunuchs who have made themselves that way for the sake of the Kingdom of Heaven." In this case, the genital mutilation was seen as atonement for masturbation (9). Kushner (10) described a 37-year-old man with religious preoccupations who eventually performed a bilateral orchiectomy "as a freewill offering to God . . . [so] that [he could] walk unimpaired, work at peace, and re-live the new life." In each of these cases, the diagnosis of schizophrenia was made before the self-mutilation.

Here we describe a case of an individual whose autocastration was the presenting sign of incipient schizophrenia.

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Case report

Mr. M was a 29-year-old single white man who came to the inpatient psychiatric unit in 1997 after having cut off his scrotum and testes with a razor several days earlier. Originally he claimed that his testicles had been "bitten off by a large black dog," but eventually he disclosed the truth.

Mr. M had anesthetized the region with a topical nonprescription gel containing benzocaine and phenol, encircled it with a rubber band to act as a tourniquet, laid his testicles on a table, cut through the base of his scrotum with a razor, and flushed the testicles down the toilet. To halt the bleeding, Mr. M heated a butcher's knife over an open range and cauterized the vessels. He threaded three fishhooks through the remaining edges of the scrotum to close the wound. To minimize the likelihood of infection, he washed his wound with water and periodically trimmed away areas of necrotic tissue with scissors.

When he was in a store buying bandages and medicine several days later, Mr. M collapsed from sepsis and dehydration and was brought to the emergency department. He required several debridements and skin grafting by the urology department. Once stabilized, he was transferred to the psychiatric unit.

On the psychiatric unit, Mr. M was guarded and stated that he was concerned about being manipulated through hypnotism. He did not appear to be overtly psychotic, and his trust of the staff gradually increased. The treatment team interpreted his previous statement about hypnosis as being a result of naivete about the

mental health system rather than a sign of delusional thinking.

On interview, Mr. M denied having auditory or visual hallucinations. He was not overtly paranoid and did not demonstrate gross disorganization of thought. His speech was articulate, his thoughts were well formed, and his cognition was intact. He denied the autocastration as being atonement for past sins or an attempt to change his gender identity. Mr. M explained that he had performed the autocastration on the basis of Matthew 19:12, hoping that he would be "assured of a higher place in heaven and a greater closeness with God."

An interview with his parents revealed that Mr. M had been a somewhat isolative child with mediocre grades and few friends. His parents did not perceive him as being odd or overly preoccupied with religion. Mr. M stated that he had "rediscovered religion" eight months earlier. Before that, he was a self-described promiscuous heterosexual with multiple hospitalizations for liver problems related to former chronic alcohol abuse.

During his hospitalization, Mr. M underwent psychological testing. The Weschler Adult Intelligence Scale revealed a full-scale intelligence quotient of 102, comprising a performance score of 98 and a verbal score of 107. His responses to the Minnesota Multiphasic Personality Inventory rendered his scores invalid and reflected a deliberate and unsophisticated attempt to present himself in a favorable light.

Projective testing did not reveal overt psychosis or disorganization of thought but did indicate difficulty in making or implementing decisions. Rorschach testing indicated low self-esteem and a tendency to ruminate on undesirable personal features. Mr. M was discharged with a diagnosis of schizotypal personality disorder, although some members of the treatment team doubted that he met the criteria for that condition.

Mr. M reappeared in the emergency department three years later, after his family discovered that he had not been eating and had become more isolative. In the emergency room, he was fearful that the water, food, and air conditioner had been poisoned. Also, he had become religiously preoccupied and spent much of his time reading the Bible. Again, he denied any auditory or visual hallucinations, but he appeared paranoid. He was given a prescription for olanzapine 5 mg daily and was diagnosed as having paranoid type schizophrenia. Three weeks after his discharge, Mr. M returned to the university hospital with similar symptoms after having stopped taking his medication. Because of concerns about medication noncompliance, haloperidol decanoate in twice-monthly 100 mg injections was prescribed.

Four months after that hospitalization, Mr. M was interviewed. He presented as paranoid, with psychomotor retardation and mild thought blocking. He continued to deny any history of auditory or visual hallucinations. Although he declined to talk about the specific details of the autocastration, he did reiterate that he was not paranoid at the time of the act and that the paranoia came a few years later. He also denied having been influenced by religious delusions. He continued to read the Bible extensively, although he claimed not to understand much of it and described himself as "not religious."

Mr. M expressed no regret about having castrated himself. Although his sex drive is greatly diminished, he continues to have occasional sexual urges. He lives alone, has never married, and keeps to himself at his job, where he works as a printer.

Discussion

Mr. M required psychiatric hospitalization on three separate occasions. His first encounter with psychiatry was precipitated by his act of autocastration. Extensive clinical interviews and psychological testing indicated no clear psychotic processes. Given the patient's lack of close friends, his initial guardedness and social anxiety, and his seemingly odd thinking, the patient was initially diagnosed as having schizotypal personality disorder. His history of alcoholism raised the possibility of a substance-induced psychotic disorder contributing to his bizarre act. However, the treatment team eventually rejected this possibility on the basis of the patient's clinical presentation and his report of having had no alcohol for eight months.

Three years later, Mr. M presented with frank paranoia and disorganization of thought, which are clear signs of a psychotic disorder. His presentation had become consistent with paranoid type schizophrenia. By his own recollection, the autocastration predated, by years, his feelings of paranoia.

This case is unique in that autocastration may have been the first presenting sign of schizophrenia. The patient did not clearly fit into the categories previously outlined by Greilsheimer and Groves (7)—his character pathology did not appear to be commensurate with his act. However, schizotypal personality disorder may itself be a prodrome to schizophrenia in certain cases. Although the patient did not have overt psychosis by the standard definition, this case raises the question of whether the act of autocastration, in the absence of clear psychotic symptoms, justifies labeling an individual as psychotic. Perhaps future reports will help elucidate the complex relationship between autocastration and associated psychopathology. ♦

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