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Self-Amputation in Two Non-Psychotic Patients

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Self-amputation, the extreme form of self-mutilation, is uncommon. The vast majority of cases are associated with psychosis, with a small number being assigned the controversial diagnosis of body identity integrity disorder. In this article, we report two cases of non-psychotic self-amputation and their similarities with a view to highlighting the risk factors and formulating an appropriate management plan.

Keywords: Non-Psychotic; Self-Amputation; Self-Mutilation

1. Introduction

Self-amputation, the extreme form of self-mutilation, is uncommon. The vast majority of cases are associated with psychosis, with a small number being assigned the controversial diagnosis of body identity integrity disorder (BIID). Favazza and Rosenthal (1) define self-mutilation as the deliberate alteration or destruction of body tissue without conscious suicidal intent, proposing three categories of self-mutilating behavior: (a) superficial-moderate self-mutilation e.g. superficial cuts, burns and scratches, associated with various mental disorders such as personality disorders; (b) stereotypic-fixed self-mutilation, associated with mental retardation but not psychosis; and (c) major-infrequent self-mutilation e.g., self-amputation of limbs and genitals, associated mainly with psychoses and acute intoxication (2).

In this article, we report two cases of non-psychotic self-amputation examining the similarities, with a view to highlighting the risk factors and develop appropriate management plan.

2. Case Presentation

2.1. Case A

This was a 47-year-old gentleman with an existing diagnosis of exhibitionism. He had repeatedly felt compelled to expose himself in public places, in front of women, and continued to do so even though he considered his behavior offensive and harmful to others. His conduct led to repeated arrests and three incarcerations.

At the age of 5, he had been taken away from his alcoholic parents by the Social Services. He subsequently experienced extensive physical, emotional, and sexual abuse at a children's home. He left school without qualifications when he was 15. Seven years later he started exposing himself for the first time, at a train station. He suffered from alcohol-dependency until his third incarceration, when he received.

In prison, he received treatment in the form of counseling and antidepressants, which he discontinued afterwards. In 2005, he was admitted to the hospital following an overdose, but had no further contact with the psychiatric services since discharge. The patient had no delusions or hallucinations and was reported to be feeling desperate as he was unable to stop his exposing behavior.

Three months after being released from prison, he amputated his hand with an electric saw in an attempt to prevent himself from re-offending. He denied any intention of killing himself by committing this act. Following amputation, he was assessed and found to have the capacity; this allowed him to refuse re-plantation of his finger. Despite this drastic action, his mood did not improve, and 15 days later he committed suicide by hanging himself.

2.2. Case B

This was a 46-year-old man with a history of severe depression in the context of a mixed personality disorder. He had a history of repeatedly attempting suicide by overdose and was once hospitalized after stabbing himself in the abdomen. He was also verbally and physically aggressive towards others.

The patient reported being physically and verbally abused by parents in his childhood. He left school without any qualifications and began misusing alcohol at the age of 13. He has a history of successfully completing detoxification from alcohol in 2008.

The patient had been admitted to a psychiatric unit

twice following his suicide attempts; the first admission was a compulsory detention. He had also received counseling and had been treated with antidepressants. His personality was of impulsive nature, but there was no evidence of formal thought disorder and he was not having hallucinations. The patient had regretted his violent behavior and was keen to accept help in any form as he felt that he could not cope any longer.

In February 2010, the patient accidentally injured his left little finger with a kitchen knife while preparing his dinner. He was distressed by the deformed finger, and it was causing him severe pain that radiated up to his arm. He had asked the doctors to remove the remainder of his finger, but they refused. In June 2011, and after much deliberation according to him, he amputated the finger himself in a safe manner. He subsequently admitted that it was an "extreme" action to take for getting rid of discomfort. Following the amputation, his mood seemed to have improved as he stated he was feeling "happy now."

3. Discussion

In the above, two non-psychotic and non-BIID cases have been reported. The first patient removed his hand out of guilt and desperation to stop his exhibitionism and completed suicide. The second patient reacted to the pain and deformity, which seems to have improved his psychological well-being. Both patients are in their mid-forties, share a history of childhood abuse, alcohol dependency and self-harming behavior, and both were careful and well-prepared when executing their planned self-mutilation. Neither intended to commit suicide by the act. There was no formal thought disorder, no hallucinations and no delusions of sin or distorted body image.

Minor or superficial self-mutilation is common, and not necessarily associated with psychosis. In contrast, major self-mutilating behavior is rare and almost exclusively occurs in the presence of serious mental illness, e.g., schizophrenia-spectrum psychosis. Major self-mutilation can be classified into ocular, genital or limb mutilation (2). Patients, who have removed an eye or have amputated a limb, are almost always psychotic, and so are 75% of patients with genital mutilation (3). Our knowledge of major self-mutilation is drawn almost entirely from case reports (3, 4). Due to a lack of epidemiological studies on the subject, the risk factors for major self-mutilating behavior are not yet clear but it is generally agreed that it is the direct effect of psychosis. Large et al. (5) reviewed the cases that had removed an eye or amputated their genitals or portion of a limb. The researchers concluded that the etiology behind major self-mutilation was acute psychosis, especially first-episode schizophrenia. They proposed that an earlier treatment of psychosis could help reduce the frequency of these incidents.

A small number of self-amputees have been controversially diagnosed as BIID, a condition that characterizes individuals, who are convinced that they were meant to have a physical defect, for example, an amputated leg, and who feel trapped in their able bodies. BIID's principles are similar to gender identity disorder in that the patient, instead of having gender dysphoria, has a body integrity dysphoria, which disappears once the "corrective" amputation has been performed (6).

As established earlier, the infrequent reporting of non-psychotic self-amputation cases has meant that no universal risk factors have been identified to predict this behavior, with the exception of genital self-mutilation (GSM). Several risk factors that Greilsheimer and Groves (4) listed for GSM, seem to apply to one or both cases we reported, including paraphilia-stemming guilt, childhood deprivation, depression, deliberate self-harm and suicide attempts (5). We propose that a positive answer to routine psychiatric screening questions about self-harming ideation should serve as a springboard for the mental health professional to explore self-amputation ideation. Special attention should be given to the patients who report feelings of guilt, those who are distressed by their behavior, and those who deliberately self-harm.

Due to the "case report" nature of this phenomenon, there is no set management protocol in non-psychotic/non-BIID patients that have self-amputated or are considered to be at risk. Careful monitoring is required, and these patients may benefit from individual cognitive behavioral therapy to modify their negative thinking and thoughts of guilt, or psychotherapy to understand the source of and attempt to learn to control their guilt and self-destructive behavior.

Authors' Contributions

Hamid Rahmanian conceived and designed the evaluation, collected the clinical data and interpreted them, drafted the manuscript and revised it according to reviewers' comments. Nikoletta A. Petrou helped in interpretation of clinical data and drafting the manuscript. M. Aamer Sarfraz contributed to conception and designing the case report, and interpretation of data. He also revised the manuscript. All authors read and approve the final manuscript.

Declaration of Interest

None declared.

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