Caso clinico

Cannabis use and genital self-mutilation: an update of case reports

Consumo di cannabis e auto-mutilazione genitale: un aggiornamento di casi clinici

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SUMMARY. We reported and compared two case reports of genital self-mutilation with concurrent increasing psychotic symptoms resulting from substance abuse such as cannabis and alcohol.

KEY WORDS: cannabis, genital self-mutilation, psychotic symptoms, substance abuse.

RIASSUNTO. Vengono riportati e confrontati due casi clinici di automutilazione genitale. La mutilazione è avvenuta durante la comparsa di sintomi psicotici con abuso di cannabis e alcol.

PAROLE CHIAVE: cannabis, sintomi psicotici, automutilazione genitale, abuso di sostanze.

INTRODUCTION

Cannabis is one of the most widely used drug of abuse. Many authors claim that the correlation between substance abuse and the onset or exacerbation of psychotic symptoms is very high1-3. There is no evidence of increased use of cannabis with the occurrence of psychotic experiences as you would expect from self healing phenomenon4. It is known instead the close temporal relationship between THC abuse and psychotic onset1,5. Cannabis and alcohol abuse are not only responsible in triggering psychotic symptoms but their use in vulnerable individuals may precipitate these events1,6-8.

Genital self-mutilation (GSM) is also an event present in the early stages of acute psychosis, more evident in schizophrenia but also in other psychiatric disorders such as affective psychosis, exogenous psychosis, dementia and borderline personality disorder4-9. The reasons underlying this event are supported by feelings of guilt and self-punishment10. The action also happens in consequence to delusional intuition of mystical-religious content11 or to experiences of bodily transformation and is intended as an attempt to rapid and violent relief from feelings of depersonalization and denial of their sexual identity10.

CASE REPORT I

In 2008, the first case11 of a 26-year-old man with no psychiatric disorders and lacking schooling was described. G.S. worked as a builder’s labourer for different companies, before entering the family firm as his brother’s partner. The man began to use cannabis in adolescence. In the period leading up to his admission to hospital he had developed adaptation and relational difficulties at work, which had prompted his family to encourage him to take time off work at his girlfriend’s home. Here G.S. had increased consumption of cannabis. After a period of increasing consumption he started to manifest symptoms like hyperactivity, insomnia, restlessness, up to the clear manifestation of a psychotic episode with mystical-persecutory traits. The intention to punish himself through an expiatory sacrifice was fomented by auditory and mystical perceptions. GSM occurred under the cannabis effect.

CASE REPORT II

F.R. is 36-year-old man in care of psychiatric services since the last 10 years. His parents have been separated, and he has a younger sister. He used living together with his mother. He terminated the high school but then he failed to pursue the studies at the University and to find an employment. A prodromal phase of the duration of some years characterised by the onset of the basic symptoms12 and persecutorial traits can be tracked. Moreover, his history included substances abuse (opiates and LSD in the past, cannabis in the last years), alcohol and HCV positivity.

At the first psychiatric visit the psychopathological picture of the patient was characterised by serious paranoid and grandeur/religious delusions. There were also acoustic hallucinations and alterations of the behaviour with suspiciousness towards the relatives, the police and the medical staff. In addition there was also hetero aggressiveness and self-harm. The mood was characterised by mixed symptoms and anxiety symptoms. In the course of the years the social anxiety and deficit of social cognition induced F.R. to live isolated, aside from the relationships (negative symptoms), in a situation with a poor insight and lack of...
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Table 1. Similarities and differences between case I and case II

<table>
<thead>
<tr>
<th>Substance abuse onset</th>
<th>Case report I</th>
<th>Case report II</th>
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<tbody>
<tr>
<td>Adolescence</td>
<td>G.S.</td>
<td>Early adulthood</td>
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<tr>
<th>Substances</th>
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<th>Case report II</th>
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<tbody>
<tr>
<td>Cannabis</td>
<td>LSD, cannabis, alcohol</td>
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<table>
<thead>
<tr>
<th>Psychiatric history</th>
<th>Case report I</th>
<th>Case report II</th>
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</thead>
<tbody>
<tr>
<td>Absent</td>
<td></td>
<td>Psychotic onset 4 years before substance abuse</td>
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<tr>
<th>Diagnosis</th>
<th>Case report I</th>
<th>Case report II</th>
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<tbody>
<tr>
<td>Schizophrenic symptoms caused by cannabinoid abuse and genital self-mutilation</td>
<td>Paranoid schizophrenia and genital self-mutilation in cannabinoid abuse</td>
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<tr>
<th>Explanation provided</th>
<th>Case report I</th>
<th>Case report II</th>
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<tbody>
<tr>
<td>Mystical-religious delusions</td>
<td>Sexual identity refusal and physical transformation</td>
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COMPARISONS

Table 1 shows the two cases (G.S. and F.R.) with similarities and differences.

DISCUSSION

Self-mutilation (that can be genital mutilation and eye enucleation) is an episode associated with psychosis and drug abuse. It is well known the linkage between dopamine and self-castration: high dosage consumption of dopamine-agonist substances (such as cocaine and cannabis) can generate self-injurious behaviours like self-mutilation.

Regarding GSM about 110 cases in men have been described in the literature and the majority of these patients were either psychotic or intoxicated during auto-mutilation. However the assumption that genital self-injuries are more often seen in non-psychotic conditions than in productive psychotic states is substantiated.

This linkage between abuse of cannabis and GSM is confirmed also in our case report II, with reference to an episode of self-castration in a patient with schizophrenic disorder. While the case I showed “schizophrenic symptoms” in a period of increased cannabis consumption, F.R. had a mental chronic disorder, with severe social dysfunction.

CONCLUSIONS

In Table 1 we reported the similarities and differences of the two cases: absence of mental illness in the first and paranoid schizophrenia in the second, positive evolution in the first and chronic evolution in the second. In addition to cannabis consumption that caused psychotic symptoms, they had in common the religious delusion, generated by mixed mood (elation and guilt) and at the same time the analgesic state caused by cannabis and drug abuse.

REFERENCES

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