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Self-Inflicted Eye-Injuries

Three cases of self-inflicted eye injuries are described and discussed. A review of the literature shows that several psychiatric diagnoses have been assigned to those who mutilate their eyes, and various unconscious mechanisms proposed to explain this unusual phenomenon.

Self-inflicted eye injuries are uncommon. Despite this they are widely mentioned in ancient literature and assume a prominent place in mythology. The Norse god Odin is said to have given one of his eyes for the right to drink a single draught from the Spring of Mimir, whose waters contained wisdom and understanding. Oedipus, the legendary King of Thebes, gouged out his eyes when he discovered the truth of his ancestry.

The notion of self-blinding for sinful thoughts comes from a variety of sources. St Matthew's gospel contains the exhortation: "And if thy right eye offend thee, pluck it out and cast it from thee; for it is profitable for thee that one of thy members should perish, and not that thy whole body should be cast into hell" (St Matthew ch. 5, v. 29). Self-blinding as a punishment for misdirected thoughts has endowed ophthalmology with three patron saints – Lucia of Syracuse, Triduana, and Medana (Stannard *et al*, 1984).

A comprehensive review of some of the older and less accessible literature showed that self-inflicted eye injuries may occur in a wide variety of situations (Tapper *et al*, 1979). Severe self-inflicted injury, including complete removal of the eye (self-enucleation) is usually associated with psychosis, or organic disorders such as epilepsy, encephalitis, and diabetes. LSD-induced psychosis has been particularly associated with self-injurious behaviour (Rosen & Hoffman, 1972).

Minor injuries may occur in the absence of any demonstrable psychiatric illness, when the motive is usually financial or to escape unpleasant duty. Self-mutilation occurring as a compulsive act is rare, but self-inflicted traumatic cataracts and retinal detachments have been described. A 30-year-old male with obsessive–compulsive neurosis virtually blinded himself by repeatedly hitting his eyes with his hands (Tapper *et al*, 1979).

Self-inflicted orbitocranial injury has been described in attempted suicide. A 44-year-old shopkeeper was admitted to a psychiatric ward following an overdose of barbiturates. Five days after admission he was found collapsed, with right-sided spasticity and a right periorbital haematoma. A diagnosis of cerebrovascular accident was made, but was revised when a straight skull X-ray revealed a ballpoint pen within the cranial cavity. The pen had been thrust through the right orbit, across the midline of the head, into the left tempero-occipital region. It was retrieved by a neurosurgeon, and two years later the patient had a right hemiparesis with some loss of visual fields in both eyes but otherwise normal vision. He described his action as a suicide attempt (Bowen, 1971, cited by Tapper *et al*, 1979).

In a wide-ranging review of the eye in psychiatry, Trevor-Roper (1980) reported a young Frenchman who proffered one of his eyes saying "It just fell out while I was playing cards". A tell-tale drop of blood was discovered on his fingernails. Trevor-Roper describes the eye as a "sounding-board for the travails of the whole persona" and emphasises the rôle of the eye in sexuality. To him the eye is "a sort of sexual surrogate, since it is such a convenient organ of displacement whenever fear, guilt, impotence or despair debar a more physiological outlet". Thus self-enucleation becomes "the final solution".

Case Report 1

A 67-year-old widow attended a casualty department with a history of having "poked" herself in the eye with a pair of scissors. Initially she said that it had been "a silly accident", but later volunteered that she had injured her eye deliberately. She was admitted to the ophthalmology ward where her minor injury was repaired.

Until the time of the incident the patient had been living with her son and daughter-in-law, despite having a house of her own nearby. Her son had tried to persuade her to return to her house, but she felt that she was too old to live on her own. Following her eye injury her son and daughter-in-law refused to allow her to return to their home. They described her behaviour as "manipulative".

The patient was examined by a psychiatric Senior Registrar, who found no evidence of psychiatric illness. In particular there were no depressive features and no cognitive impairment. She would not say why she had injured her eye.

A few days before she was due to be discharged the patient committed suicide by jumping from the fourth floor of the hospital.

Case Report 2

A 21-year-old unmarried NCO was invalided out of the services following the onset of a schizophrenic illness for

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which he received major tranquillisers. He suffered from auditory and somatic hallucinations and thought-broadcasting. He was convinced that one eye was of immense size and that his pituitary gland travelled out of his eye, damaging other people. In response to these delusions he fired an air pistol at his eye, the resulting damage requiring enucleation.

He continues intermittently to be deluded about his remaining eye, and is at risk of blinding himself during a future relapse.

Case Report 3

A 42-year-old single man with a history of paranoid schizophrenia was admitted to hospital in an agitated state. He had been acting strangely for several days, quoting from the Bible and singing hymns at work. He had absented himself from work for four days, and had returned wearing an eye-patch over his right eye. He refused to discuss the eye-patch, saying "It's a private matter between me and God."

Examination of his mental state revealed paranoid delusions and religiosity. He refused to allow his eye-patch to be removed or his eye to be examined. He made a good response to phenothiazines and later admitted that he had ruptured his eye by pressing with his fingers because "certain forces were tricking me. If thy eye offend thee, pluck it out. It's not as painful as you think."

One year later the remains of his eye were removed surgically. Five years later, during a relapse in his illness, he castrated himself using a razor blade.

Discussion

There have been several attempts over the years to fit self-mutilation of the eye into a single conceptual framework. A moral or religious model is often used by patients themselves, who feel they are carrying out the instructions of the Bible. In the earliest clinical case report the patient quotes from St Matthew's gospel, and a diagnosis of '*délire mystique*' is made (Bergmann, 1846, cited by Rosen & Hoffman, 1972). The case is similar to case report 3 above. The vast majority of Christians interpret the gospel in a symbolic and metaphorical way, but some psychotic individuals demonstrate 'concrete thinking' in their inability to make abstract generalizations.

Some psychoanalysts interpret Oedipus' self-blinding as the equivalent of self-castration, believing in an unconscious equating of the eyes with the genitals. One recent paper stated that "castration fears, failure to resolve Oedipal conflicts, repressed homosexual impulses and self-punishment are ubiquitous in self-enucleation" (MacLean & Robertson, 1976). A review of the literature shows this to be an unwarranted oversimplification (Tapper *et al*, 1979). An alternative psychodynamic paradigm is that the eye represents the symbolic condensation of the self, so that self-enucleation "is a substitute of a part of the body for the whole. It allows one to kill the devilish responsible self and yet live" (Rosen & Hoffman, 1972). This is the concept of "focal suicide". There are similarities between this psychodynamic interpretation and the exhortation in St Matthew's gospel.

Kell Yang *et al* (1981) emphasised neurochemical factors in self-inflicted injury. They noted that self-mutilation has been successfully treated with L-tryptophan and suggested that "biochemical assays of red blood cell purine metabolism should be done in patients with histories of self-inflicted mutilation of the eyes". This approach has received little support, although it may have a limited rôle in Lesch-Nyhan syndrome and Gilles de la Tourette syndrome, both characterised by self-mutilation.

The three cases reported here demonstrate that self-mutilation of the eye is not a single clinical entity. Two patients suffered from severe psychoses, while the third was a lonely woman with no demonstrable psychiatric illness. Ultimately, this form of behaviour may remain incomprehensible and impossible to anticipate. What can be said is that patients who damage their own eyes are likely to be suffering from a high level of distress, and should not be dismissed lightly.

The authors would be interested to hear of similar case reports from other clinicians.

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Paranoid Psychosis as the First Presentation of a Fulminating Lethal Case of AIDS

A 34-year-old heterosexual intravenous drug abuser presented with a paranoid psychosis and was subsequently found to have the Acquired Immune Deficiency Syndrome (AIDS). The patient died 14 days later of generalised septicaemia. The case is reported and the aetiology and pathogenesis of the organic psychosis are discussed. It is anticipated that similar psychiatric manifestations will occur as the AIDS epidemic increases.

The Human Immunodeficiency Virus (HIV) is the retrovirus thought to be the causal agent in Acquired Immune Deficiency Syndrome (AIDS). It infects and destroys T-helper/inducer (T4) lymphocytes, causing profound deficits in cell-mediated immunity. Consequently, the central nervous system is often affected by opportunistic infections and lymphomas (Snider *et al*, 1983). HIV is also neurotropic and may be the direct cause of dementia (Shaw *et al*, 1985; Navia *et al*, 1986), myelopathy (Petito *et al*, 1985) or neuropathy (Ho *et al*, 1985).

HIV was first isolated in France (Barre-Sinoussi *et al*, 1983) and in the USA (Gallo *et al*, 1984) from blood. It was known as Lymphadenopathy Associated Virus (LAV) and Human T-Cell Lymphotropic Virus (HTLV III) respectively.

The number of subjects exposed to HIV is increasing exponentially. The first case of AIDS reported in the United Kingdom was in 1981. By 1 August 1986, 465 cases of AIDS and 234 deaths from AIDS had been reported, and 3162 subjects had antibodies to HTLV III (figures compiled by Public Health Laboratory Service, Communicable Diseases Centre, London). As the epidemic increases, psychiatrists will be consulted more frequently to treat AIDS-related organic brain syndromes, reactions to the diagnosis or its psychosocial consequences.

The following case history is an example of a man who presented with a paranoid psychosis as the first feature of AIDS.

Case report

A 34-year-old married heterosexual plumber was referred to the out-patient department for treatment of heroin-dependency. He first started smoking heroin at the age of 29 years at the time of the break-up of his first marriage. Within two months he was injecting the heroin intravenously, up to 0.5 g/day. Over the next five years (except for a 12-month period of self-enforced abstinence), he continued to abuse heroin. At the same time he started to abuse benzodiazepines, mainly diazepam and chloridazepoxide (40–50 mg/day), which he obtained both from his GP and the black market.

During the eight months prior to his referral to our department he had developed a persistent sore throat and had lost 20 kg in weight. For three weeks he had abstained from heroin following the prescription of a reducing course of methadone. At interview he was an unshaven cachectic man who looked ill. His behaviour was inappropriate, he sucked a bright red lollipop throughout the interview and later pulled out a bottle of methadone and started to drink it.

He was orientated in time, place, and person but was not fully aware of the purpose of our meeting. He talked in a slow monotone and said that he felt anxious and physically ill. He looked perplexed. He believed that his parents' house was infested with bugs and that some of these were inside his stomach eating his methadone. He incorrectly believed that his father was watering down his methadone and selling the remainder. He admitted to seeing fleas on his bedspread a few days earlier and to hearing second-person auditory hallucinations. Cognitive testing revealed slightly reduced attention and concentration. He correctly registered a name

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