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Brief Reports

Severe Self-Mutilation Among Kenyan Psychotics

Four case reports are presented of psychotic patients seen in clinical practice in Nairobi over a period of one year, who inflicted serious bodily harm to themselves during that period. Possible psychopathological basis for this self-damage is briefly considered. A review of the literature reveals paucity of similar reports from Africa and the third world. Reasons for this paucity are hard to come by.

Deliberate self-harm, as seen in psychiatric practice, tends to fall into two broad categories — a mild form usually associated with attention-seeking manipulative behaviour, and a severe form usually occurring in psychotic states. The former tends to occur in young individuals with neurotic or personality disorder. In the latter category the patients may be acting under some delusional belief or they may be obeying auditory hallucinations commanding them to do something which may be injurious to them. Rarely are modalities other than auditory involved. The delusions often involve beliefs that certain parts of the body are either deformed or causing the subject some trouble and should therefore be removed (Standage *et al*, 1974). A rather rare cause of self-mutilation is masochistic sexual behaviour. Schott (1973) has described self castration due to sadistic impulsive perversion and Thompson & Abraham (1983) have reported two rare cases of male genital self-mutilation following paternal death.

Severe self-destructive behaviour is rarely reported from the African continent and the third world in general. This raises certain basic questions such as (a) Does self-mutilation occur at all in these countries? (b) If so, is it in any way different from that seen in the Western countries and finally, (c) Are there any cultural beliefs which either protect or aggravate such behaviour?

Below, we report four cases of severe self-mutilation seen by us during the year 1984. The first three were seen at the Government Mental Hospital (Mathari) and the last at our National Teaching Hospital (Kenyatta National Hospital).

Case reports

Case 1

A 35-year-old inpatient former police constable who had been admitted several times to Mathari Hospital with a diagnosis of schizophrenia presented as an emergency with severe bleeding half an hour after he had extracted his four lower incisors. Twenty days later he extracted a further six teeth from his lower jaw and continued to self-mutilate his gums with any hard object he would come across. A week later he attempted to hang himself with a blanket but was rescued by a nurse.

On examination he had extensive lacerations of gums and adjacent soft tissues, leaving ridges of lingual and buccal plates bare. Currettage to remove necrotic tissues, alveolectomy and stitching of buccal/labial and lingual flaps was done.

The patient continued removing stitches and developed osteomyelitis. He voluntarily stopped mutilating himself and made a good recovery but remained thought-disordered and aggressive to other patients. He would give no explanation for his actions.

(NB While this paper was being prepared the patient, by means of a sharp pointed piece of metal, dug a hole into his right flank up to the kidney and bled to death).

Case 2

A 16-year-old housemaid was admitted at midnight with a 2 week history of aggressive behaviour, insomnia and refusal to feed.

One hour after admission the patient was found to have bitten off one-third of her tongue which was found on the floor. The remaining stump was sutured, haemostasis achieved and she was put on antibiotics. The patient removed the stitches from her tongue and left the wound gaping. She denied being depressed or having been mistreated by her employer. She did not give any motive for her actions. There was no history of epilepsy in the patient or her family nor was she ever observed to have fits. After 3 weeks' observation, a diagnosis of schizophrenia was made and she was put on depot phenothiazines. She made a satisfactory recovery and was discharged through the out-patient psychiatric follow-up clinic.

Case 3

A 30-year-old childless housewife was admitted to the maximum security section after allegedly having murdered her mother-in-law. After 2 years as an inpatient, she developed suicidal tendencies although she denied being depressed. She threw herself from the roof of the ward and

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sustained multiple fractures of both lower limbs. Her right foot became gangrenous and had to be amputated. On recovery, she began mutilating her breasts with any sharp object she could get; later, she went on to self-mutilate her genitalia and sustained a third-degree tear. She talked of being worthless since she could not give birth, hence she had no use for the organs she kept mutilating. There was no history of psychiatric illness in the family. A consultant psychiatrist had diagnosed paranoid schizophrenia and put her on appropriate treatment but she has continued to mutilate her external genitalia.

Case 4

A 24-year-old man presented as a surgical emergency with a deep cut into the shaft of the penis which he could not explain. He was a lonely and withdrawn single and unemployed young man with minimal education. He had no girl friend and lived with his elderly parents in the slums of Nairobi. At interview, he revealed that he had attempted to amputate the penis because some voices kept telling him to do so. He believed that the penis was useless to him. Surgical repair of the penis was done and he made satisfactory recovery on oral phenothiazines.

Discussion

Self-mutilation in psychotic patients is not rare in the West (Greilsheimer & Groves, 1979), though we could not find any case report from the African continent. Reports of oral self-mutilation are predominantly male (Mendez *et al*, 1972; MacLean & Robertson, 1976; Greilsheimer & Groves, 1979; Pattison & Kahan, 1983; Rada & James, 1982). This is surprising in view of the reported excess of self-damaging behaviour in women. Our cases show no specific pattern either by age, sex, or site, except that two mutilated their mouths and two their genitalia. In either category, one was male and other female. Genital self-mutilation has been associated with unresolved sexual conflicts (MacLean & Robertson, 1976). Symbolically, oral self-mutilation might, in theory, be considered to represent a desire to avoid saying something which is stress-provoking. This would be particularly so in case number 2. In case number 3 there may be severe social pressures. The social and cultural stigma associated with infertility in Africa in general and Kenya in particular does sometimes lead to suicidal attempts but not to self-mutilation, in our experience.

Most of the published reports stress the surgical management and there is very little said about the psychiatric management (Mendez *et al*, 1972; Engelman *et al*, 1974; Standage *et al*, 1974). This is a pattern which should be corrected. Once the emergency surgical management has been carried out, urgent psychiatric referral is essential (Standage *et al*, 1974). The majority of such cases will probably turn out to be psychotic, and should therefore benefit from neuroleptics. There will, however, be a small minority of personality and neurotic disorders (Thomson & Abraham, 1983) who will benefit from psychotherapy, as do the majority of psychotics once insight has been restored.

With regard to the questions raised earlier in the second paragraph of this paper, although we have not found published reports on this subject, the occurrence of four cases within a period of 1 year in Nairobi alone (population approx. 1 million) suggests that severe self-mutilation may be occurring as commonly in our setting as in the more developed Western countries. From our series the pattern, mode and severity of such self-destructive behaviour does not differ much from reported cases in the West. We were unable to find any cultural beliefs which have an effect on such behaviour, and overall one is impressed more by the similarities across the cultures than any differences.

It is the belief of the present authors that 'detribalisation' has less influence on manifestations of psychotic illness but in neurotic disorders the situation may be quite different. Earlier psychiatrists in Kenya (Gordon, 1936; Carothers, 1947) had forecast increased psychiatric morbidity with the erosion of traditional coping mechanisms, such as the extended family, resulting from urbanisation and western style of living. All our cases, however, had lived a substantial part of their lives in rural Kenya where traditions are still closely adhered to. In this regard it would have been interesting to find out about any visits to traditional healers as recent work in Kenya (Dhadphale, 1984, unpublished thesis) has shown that a significant number of psychiatric patients visit traditional healers as compared with those with physical disorders.

References

CAROTHER, J. C. (1947) A study of mental derangement in Africans and an attempt to explain its peculiarities more especially in relation to the African attitude to life. *Journal of Mental Science*, **93**, 548–597.

ENGELMAN, E. R., POLITO, G., PERLEY, J. & MARTIN, D. C. (1974) Traumatic amputation of the penis. *Journal of Urology*, **112**, 774–748.

GORDON, H. L. (1936) An enquiry into the correlation of civilization and mental disorders in Kenyan Native. *Kenya and East African Medical Journal*, **12**, 327–335.

GREILSHEIMER, H. & GROVES, J. E. (1979) Male genital self-mutilation. *Archives of General Psychiatry*, **36**, 441–446.

MACLEAN, G. & ROBERTSON, B. M. (1976) Self-enucleation and psychosis. *Archives of General Psychiatry*, **33**(2), 242–249.

MENDEZ, R., KIELY, W. F. & MORROW, J. W. (1972) Self-emasculation. *Journal of Urology*, **107**, 981–985.

https://doi.org/10.1192/bjp.149.6.778 Published online by Cambridge University Press

PATTISON, E. M. & KAHAN, J. (1983) The deliberate self-harm syndrome. *American Journal of Psychiatry*, **140**, (7), 867–872.
RADA, R. & JAMES, W. (1982) Urethral insertion of foreign bodies. A report of contagious self-mutilation in a maximum security hospital. *Archives of General Psychiatry*, **39**, 423–429.
SCHOTT, G. (1973) Self castration due to sadistic impulsive perversion. *Psychiatrie, Neurologie and Medizinische Psychologie (Leipzig)*, **25**, 435–442. (Eng. Abstr.)
STANDAGE, K. F., MOORE, J. A. & COLE, M. G. (1974) Self-mutilation of the genitalia by a female schizophrenic. *Canadian Psychiatric Journal*, **19**, 17–20.
THOMSON, J. N. & ABRAHAM, T. K. (1983) Male genital self-mutilation after paternal death. *British Medical Journal*, **287**, 727–728.

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Anorexia Nervosa and Dysmorphobia

A Case Study

Anorexia nervosa is frequently associated with neurotic traits and symptoms. The symptomatology and history of a housebound 20-year-old woman with anorexia nervosa and dysmorphophobia are described. The role of the family in maintaining the problems, use of external cues to control behaviour, overvalued somatic ideas and the definition of dysmorphophobia are discussed.

Anorexia nervosa frequently occurs alongside a variety of neurotic symptoms and traits. These include neuroticism, introversion (Smart *et al*, 1976; Hsu & Crisp, 1980), depression (Morgan & Russell, 1975; Eckert *et al*, 1982) and obsessionality (Morgan & Russell, 1975; Smart *et al*, 1976; Gomez & Daly, 1980). Following recovery of weight and menstruation these neurotic symptoms and social difficulties frequently remain. (Stonehill & Crisp, 1977; Hsu & Crisp, 1980). On average, anorexics also overestimate their bodysize compared to both normal and neurotic controls (Slade, 1985). Preoccupation with body image and food may become an overvalued idea (Thomas, 1984) and has been considered delusional by some (Bruch, 1974).

This paper gives details of the symptomatology and history an unusual case of anorexia nervosa and dysmorphophobia.

Case study

A 21-year-old woman was re-referred to a university-based clinical psychology department following an overdose of 50 paracetamol tablets at 2 a.m., 1 week previously. Assessment was carried out during three domiciliary visits. The patient's pattern of eating, as assessed by 1 week of self-recording was highly abnormal. She claimed to eat an average of 122 calories (range 79–148) per day. Food was restricted to grapes, melon, apple, tea with skimmed milk and unsweetened orange juice. Most eating occurred between midday and 7 pm. She reported that she did not induce vomiting. She did not use laxatives as they were not available to her, although in the past she had used them. Her height was 5'7" and she weighed approximately 8 stone (51.3 kg).

She reported being highly pre-occupied with her physical appearance. Her aim was not to reach any particular target weight, but rather to attain a slim appearance. She considered herself to be generally too "broad". Using a Body Satisfaction Scale (Slade, 1985b) she rated 16 body parts as follows: *Very Satisified*—none; *Moderately Satisified*—eyes, ears; *Slightly Satisfied*—none; *Undecided*—head, nose, mouth, chest, hands; *Slightly Unsatisfied*—face, jaw, shoulder arms; *Moderately Unsatisfied*—teeth, legs, feet; *Very Satisfied*—tummy. In order to gain a better body shape, she said that she carried

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