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Klingsor Syndrome (Self-Emasculation): About a Case and Literature Review

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Abstract **Case Report**

Self-mutilation is a behavior in which an individual deliberately inflicts more or less severe injuries on their own body. This behavior is often, but not exclusively, a way for individuals to manage intense emotions, relieve emotional or psychological pain, or punish themselves. Self-mutilation can be observed in various psychiatric contexts, including personality disorders, mood disorders, and psychotic disorders. This psychiatric manifestation, which transcends diagnostic categories, can involve various types of self-harm to different parts of the body, including the genitals, known as Klingsor Syndrome. Inspired by a fictional character from Wagner's opera, Klingsor Syndrome is a term used to describe extreme cases of self-destructive behavior where an individual, often in a psychotic state, inflicts severe injuries on their genital organs. This syndrome is often associated with psychosensory or intrapsychic hallucinations and delusional ideas occurring within the context of acute or chronic psychotic disorders. Treatment is multidisciplinary, involving surgical repair and rigorous psychiatric follow-up. In this paper, we report the case of genital self-mutilation occurring in a psychotic patient.

Keywords: Self-mutilation, Klingsor Syndrome, Genital self-harm, Psychotic disorders, Multidisciplinary treatment.

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INTRODUCTION

Self-mutilation is an intentional injury that a subject inflicts on a part of their body without any apparent intent to commit suicide; it is a complex and often difficult-to-understand phenomenon, characterized by intentional self-inflicted damage [1]. Among the most severe forms of this manifestation are genital self-mutilations, particularly in men, referred to as Klingsor syndrome, which poses a particular challenge for mental health professionals and clinicians [2]. This behavior, although rare and most often occurring in a psychotic context, remains transnosographic and may be part of an infinite number of psychiatric or non-psychiatric conditions (cultural or religious, such as the autocastration of the Skoptsy [3]), with complications, without neglecting the serious consequences it may have on the physical, sexual, mental, and relational health of both the individual concerned and their entourage [4].

METHOD

In this article, which focuses on self-mutilation, we will define this behavior in its entirety, outline its etiopathogenesis and nosological frameworks, before concentrating on a specific and rare form of self-mutilation, emasculation. This will be explored through the clinical case of a patient admitted to the psychiatry department of the Mohamed V Military Instruction Hospital for genital self-mutilation, where we will conduct a semiological analysis and detail the steps of care management.

CLINICAL CASE

Mr. X. X., a 43-year-old male, with a history of an undocumented psychiatric hospitalization for a few days in 2014, followed by non-compliance with follow-up, and a satisfactory return to his pre-morbid state as evidenced by his good social integration and professional progress since his hospitalization.

Mr. X. X. was brought to the emergency department by his colleagues around noon for self-inflicted wounds to the genital area: a deep 5 cm wound on the penis and 5 superficial wounds on the scrotum with significant bleeding.

After being managed in the urology department with hemostatic suturing and debridement, the hemorrhage was controlled. The patient received tetanus prophylaxis and preventive antibiotic therapy before being placed on anti-erectile treatment to better secure the sutures and facilitate healing. His stay in the urology department was assisted by our liaison psychiatry team with effective anxiolysis, and given the favorable evolution of the lesions, he was transferred to the psychiatry department for evaluation and psychiatric care.

The initial history reported by the patient dates back to the morning of his evacuation around 7 a.m., while he was showering at his workplace; he claimed to have accidentally cut himself while shaving his pubic hair. Frightened and bleeding, he dressed and rushed to his colleagues for help and was immediately taken to the emergency department. However, due to the inconsistency of his statements with the observed lesions (number and location of the wounds), he was kept under observation for a more thorough psychiatric evaluation.

Upon admission to our department, the physical examination did not reveal any old scars of similar lesions on his genital organs or elsewhere on his body. Subsequent interviews were marked by denial and trivialization of his act with strong reluctance, but also by a marked anxious component. He was initially placed on anxiolytics.

During the first week of his hospitalization, we were able to establish contact with the psychiatric service where our patient stayed in 2014; we learned that he was admitted for an agitation crisis with incoherent speech, and after a few days of observation, a diagnosis of brief psychotic disorder was made, and he was placed on antipsychotic treatment which he only adhered to for a short period.

Subsequent interviews revealed a delusional syndrome consisting of a poorly systematized persecutory delusion with an interpretative mechanism reported with a strong emotional charge, without regret or criticism of his self-mutilating act, while remaining reluctant about the intentionality of self-mutilation, with depressive features including: mood sadness, slowed speech in a whispered tone, and low self-esteem, strong anxiety, and manifest judgment disorder. He was then placed on atypical antipsychotic (olanzapine) and a selective serotonin reuptake inhibitor (sertraline).

The evolution after a few days of treatment was marked by an improvement in the emotional charge related to his delusional ideas. Meanwhile, we were able to establish contact with his wife, who reported that they did not live together due to the nature of the patient's work, that they only saw each other on weekends, that the patient had erectile dysfunction during their last intimate encounter (which was a week before the self-mutilation), and that they were supposed to meet the same day he self-mutilated.

After 2 weeks of antipsychotic treatment, the patient became less reluctant and acknowledged the intentionality of his self-mutilation, explaining it as follows: "I was supposed to see my wife that day. I wanted to avoid experiencing impotence again at all costs and wanted to punish and stimulate my genital organ to ensure it would perform this time, because otherwise, my wife would seek sexual satisfaction with another man."

These statements indicate a manifest judgment disorder with morbid rationalization. He also reported that the week following his erectile dysfunction, which he spent away from his wife, was marked by anxious ruminations about his virility, poorly systematized jealousy ideas as he was convinced his wife would quickly cheat on him, leading to incessant phone calls and insomnia. This symptomatology confirms the psychotic nature of his self-mutilation act.

After 4 weeks, Mr. X. X. began to criticize his delusional ideas and his self-mutilation act, with a marked improvement in his depressive and anxious symptoms. The psychiatric evaluation after stabilization of the initial symptomatology did not reveal any previous traits of impulsivity, risk behaviors, or other signs suggesting a pathological personality.

Discussion

Self-Mutilation: Types and Explanations

The International Network for the Study of Self-injury defines self-mutilation as: "The deliberate self-destruction of body tissue causing immediate injury, without suicidal intent and for socially unacceptable reasons" [5]. There are several types of self-mutilation:

Major Self-Mutilation: This involves significant damage to body tissues, such as castration, as seen in our patient. This form is generally associated with psychosis [6].

Stereotypic Self-Mutilation: Often linked to neurodevelopmental disorders.

Superficial Self-Mutilation: Involves tissue destruction without lethal intent, often episodic, and associated with anxiety disorders or personality disorders [7]. Several theories attempt to explain this phenomenon:

- Drive Model: Conceptualizes self-mutilation as an expression or repression of life, death, and sexual drives, giving it an anti-suicidal function [8]. It is an active coping strategy that channels destructive impulses towards self-mutilation to avoid suicide [9].
- Affect Regulation: The primary purpose of self-mutilation is to express intense emotions and the

relief it provides [10]. It is the expression of an unpleasant feeling turned against oneself, preferring to experience physical pain, perceived as easier to control and less overwhelming, to replace emotional pain [11].

- Interpersonal Model: Self-mutilation is motivated by its effects on relationships between the person who practices it and others.
- Communication Model: Views self-mutilation as a form of communication; a way to express distress and a desire to communicate their suffering to others [12].
- Biological factors can partly explain self-mutilation. A failure of the serotonergic system associated with difficulties in mood regulation and impulsivity favors self-mutilation. Additionally, self-mutilation increases endorphin levels, causing a state of well-being, thus engaging the endogenous opioid system, which could partly explain the maintenance of self-mutilating behaviors [13].

In summary, although some biological factors seem to predispose the use and maintenance of such behaviors, self-mutilation appears as a cry for help, a temporary solution to manage psychological suffering [13].

Genital Self-Mutilation: Specificities and Meanings

As demonstrated by our patient's case, genital self-mutilation, like all forms of self-mutilation, serves a psychological function by alleviating disturbing emotions caused by stress. It can satisfy a deficiency related to neurotransmitters such as endorphins and dopamine, and serves to shift moral pain to the body. It can also be a form of communicating psychological suffering to others, reinforcing the sense of existence in states of depersonalization, and responding to feelings of guilt.

Among the types of self-mutilation most frequently mentioned in the literature are enucleation of the eyeball, amputation of a limb, and mutilation of the genital organs. However, the incidence of these acts remains poorly known, as most cases are not reported by patients or their families. The most frequent cases involve young adult men (Dékou *et al*., 2009), which corresponds to the case described in the given example [14].

Genital self-mutilation occurs in a psychotic context in 87% of cases (Greilsheimer and Groves, 1979) [15]. Similarly to our patient, the act is precipitated by a deep sense of frustration related to erectile dysfunction (Kamoun-Siala *et al*., 2005) [16], but can also follow drug use (Israel and Lee, 2002) or occur in a mystical-religious delusional context. Psychosis is involved in 80% of self-mutilation cases in the male population [17].

In women, genital self-mutilation is mostly seen in patients with mood disorders, pathological personalities, and eating disorders with a history of sexual assault (Carney and Brozovic, 1978) [18].

The most common form of male genital self-mutilation is testicle removal (unilateral or bilateral), followed by laceration of the scrotal or penile skin, and finally, penile amputation (Aboseif *et al*., 1993). Only 10% of genital self-mutilations are radical (Romilly and Isaac, 1996), which is not the case for our patient [19].

In the case of our patient, who describes his self-mutilation—within a framework of judgment disorder/morbid rationalism—as a "punitive" and "therapeutic" act, there was no intention of complete organ amputation, thus not a "gender suicide" or "sexual suicide" by "resignation from the community" (Ghorbel, 1981). Through this act, our patient expressed his desire to punish his genital organ and stimulate it through pain to "cure" his erectile dysfunction and avoid the frustration he experienced a few days earlier.

A study conducted at the Ar-Razi University Hospital in Morocco reported three cases of genital self-mutilation, all characterized by a precarious socio-economic situation, a low level of education similar to our patient, and the absence of a paternal and male model leading to a lack of security, belonging, and recognition in their family upbringing [20].

Reimplantation should be considered if it is possible and/or deemed acceptable. The best reimplantation results have been achieved with microsurgical techniques. In the absence of a microscope, the technique recommended by Moufid et al. can be attempted. This involves repairing only the corpora cavernosa and the urethra after stripping the penis and burying it in the scrotum to avoid skin necrosis [21].

Regarding our patient, after a thorough urological examination and radiological exploration, the injuries were superficial without anatomical damage (tunica albuginea of the corpora cavernosa), vascular damage (dorsal and deep cavernous arteries and veins), or nerve damage. Therefore, there was no need for vascular microsurgery, and there was no functional damage. The patient only required debridement of the wound edges, excision of non-viable tissues, and skin suturing with tetanus prophylaxis, prophylactic antibiotic therapy, and anti-erectile treatment. He was kept under observation for 3 days with a urethral catheter [22]. However, the psychiatric aspect of his act necessitated hospitalization in the psychiatric department under antipsychotic treatment until he was stabilized, with a complete critique of his delusional ideas and self-mutilation act, psychoeducation for the patient and his family, and close follow-up appointments to monitor for any signs or events that might indicate or announce a potential relapse.

Cases of self-mutilation in general, and particularly genital self-mutilation in a psychotic context, highlight the complex and urgent challenges faced by mental health professionals. Several theories have attempted to explain this phenomenon with various models, but they all converge on the externalization of moral suffering. Close collaboration between psychiatrists, psychologists, emergency physicians, and surgeons is essential to provide comprehensive and appropriate care.

CONCLUSION

Although difficult to predict, this case underscores the importance of prevention and early detection of psychotic disorders. Special attention should be paid to psychiatric history and warning signs. Treatment strategies should include a combination of pharmacotherapy, psychological therapy, and social support to help patients manage their symptoms and reduce the risk of recurrence.

In conclusion, managing self-destructive behaviors in a psychotic context requires a holistic and integrated approach. Awareness, continuous training of healthcare professionals, and support for patients and their families are essential to improve clinical outcomes and prevent future crises.

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