**CASE REPORT**

# ‘The Voices Told Me to Cut My Hand’ – A Case Report of Recurrent Psychotic Self-Amputation

**Choy Seng Kit and Rathan Kumar A/L Nachemutu**

**Department of Psychiatry and Mental Health, Hospital Taiping, Perak, Malaysia**

**Abstract**

**One of the common referrals to psychiatry services is pathological self-mutilating behaviour. In general, there are three types of pathological self-mutilation. Among them, major self-mutilation (MSM) probably receives the most attention because of its rarity and bizarreness. MSM is an uncommon act but often result in serious injury to the patient. It is almost always caused by psychotic illness. Some exotic examples of MSM include eye-enucleation, self-castration and self-amputation of limb. In this case report, we will discuss on a patient having schizophrenia with comorbid of polysubstance abuse performed self-amputation of his distal limb not once, but twice in a short space of few months due to command auditory hallucination. In the best of author’s knowledge, this is the first case report in Malaysia that focuses on recurrent psychotic self-amputation.**

**Keywords: Major Self-Mutilation, Self-Amputation of Limb, Command Hallucination**

## Introduction

Pathological self-mutilation, defined as deliberate alternation or destruction of body tissue without obvious suicide intent, is often encountered in psychiatric practices [1]. It is associated with wide range of psychiatric illnesses, such as psychosis, substance intoxication, mood disorders, intellectual disability and personality disorders [2]. A well-known case of self-mutilation is Vincent Van Gogh, a famous painter in 19th century. He suffered from bipolar disorder and severed his left ear during a psychotic episode [3].

Pathological self-mutilation can be categorized into three types – major, stereotypic and superficial/moderate as each type is closely related to certain mental disorder [4]. Commonly seen in psychosis and substance intoxication, major self-mutilation (MSM) is an isolated and infrequent act which results in significant tissue damage [4]. Examples of these acts include eye-enucleation and amputation of penis or part of the limb.

Here, we will describe a case of MSM where the patient, following the command hallucination, displayed recurrent violent behaviour by amputating his left two fingers

and few months later, his entire left hand. Patient's informed consent was obtained for publication of this case report.

**Case Report**

Mr H is a 41-year-old Chinese man from Taiping. He is married with one son. He worked as a helper in a temple in Taiping and had been living there as well.

His first admission to Taiping Hospital psychiatry ward was on 25th November 2018 after he amputated his distal phalanges of left middle and rings fingers with a knife due to command hallucination. He was just released from the prison two days prior to the incident. After the release, he took back *syabu* (stimulant) and started to experience auditory hallucination. He heard the voices of his wife and son crying for help. He had auditory hallucination of men and women's voices telling him that someone wanted to take revenge on his family. The voices also instruct him to cut his fingers to prove his willingness to compensate his old sins. Thus, after influenced by the command hallucination, he used a knife to chop off his distal phalanges of left middle and ring fingers.

He is a known case of stimulant and heroin user since early twenties. He abused ketamine and heroin initially for about 10 years but was able to achieve abstinence in the subsequent five years. However, he began to abuse *syabu* (stimulant) on and off five years ago and almost daily for the past three years. His occupational and social functions deteriorated significantly in this recent three years. He lost his job and his wife requested for divorce. He was sentenced to prison four times for substance related offences whereby three of them occurred in these short three years period. He had auditory hallucination, persecutory delusion and irritability after the stimulant intake. The psychosis resolved when he was abstinent from the substances (e.g. during the period of imprisonment). There were no significant mood symptoms.

He was diagnosed with stimulant induced psychotic disorder with underlying stimulant use disorder. During the ward stay, the fingers injuries were secured with debridement and refashioning by the orthopaedic team. Antipsychotic (risperidone) was initiated. He showed good response to the medication and the auditory hallucination reduced. He was in the contemplation stage of stopping substance abuse. He was discharged well after one month stay in ward.

However, five months later, he was readmitted to psychiatry ward (on 21st May 2019) after he amputated his whole left hand with a cleaver. He defaulted the medications and follow-up since the last discharge. He started to experience the similar auditory hallucination almost daily which commanded him to cut off his hand. The voices became more severe over time. On the day of admission, while he was having dinner in the temple, he heard the distressing voices again. Consequently, as instructed by the voices, he went to the kitchen, took a cleaver and cut off his left hand in single attempt. The people there was shocked and immediately rushed him to the hospital. He claimed taking stimulant only once in early 2019 after the last discharge from hospital. He denied taking other illicit substances.

Upon arrival to the hospital, the patient generally looked calm. Urine for drugs was negative. Wound debridement and refashioning were done by the orthopaedic team. He was admitted to psychiatric ward for further observation and stabilization. The diagnosis was revised to schizophrenia with

comorbid of stimulant abuse. Antipsychotic was restarted and good response was seen. Throughout the ward stay, he appeared emotionally indifferent to the incident. He once told the nurse - ‘I cut my hand only, not my arm.’ He was in ward for a month and discharged well to a nursing home with arrangement by his family.

**Discussion**

MSM is almost always caused by psychotic illness, in where schizophrenia spectrum disorders account for the majority of the cases [5]. Affective psychosis, psychosis due to substances or medical conditions are other causes of psychotic MSM. The exact reason of why MSM tends to occur in psychotic illness is unknown. Nevertheless, the aetiology of psychotic self- mutilation could be seen as interaction of multiple factors, including severe psychotic symptoms (especially religious delusion or command hallucination) [6,7], lack of insight [8], increased pain threshold [9] and threat/control override [10]. Threat/control override is a phenomenon where the patient, under perceived threat of psychotic experiences (e.g. delusion, hallucination), lost internal self-control and engaged in violent act [11].

In the best knowledge of the author, this case report is the first one on recurrent psychotic self-amputation of limb in Malaysia. There is one case report in Malaysia on penile self-amputation due to command hallucination [12]. The patient is a Rohingya refugee from Myanmar with chronic schizophrenia. Compared with self-enucleation or castration, studies on MSM of limb are relatively less due to several reasons [5]. First, it is more difficult to amputate own limb than self-enucleation or castration. Second, cases of self-enucleation or castration may receive more attention because of their psychological significance. These cases are considered more ‘interesting’ and thus, resulting in publication bias.

Delusion (particularly those of religion and sex) and command hallucination are common mediators of psychotic MSM [5]. Delusion accounts for two third of the cases while command hallucination is found in one third [5]. As seen in this patient, presence of command hallucination is the main contributing factor of MSM. However, the dangerousness of the command hallucination alone is not a strong predictor of the compliance. Other factors which increase patient’s compliance to command hallucination in this case are past history of self-amputation, presence of chronic familiar voices and comorbid of substance abuse. Studies have showed that all these factors are associated with increased compliance [8,13,14].

Despite the traumatizing event, the patient generally appeared calm and unconcerned with the loss of his left hand. Self-amputation can be viewed as a method to resolve unconscious conflict, which explained the emotional indifference to the injury [15].

This patient has high risk of reinjuring himself. The long-term management of MSM is basically to treat the underlying psychotic disorder. Treatment should be delivered via multimodal approach, comprising pharmacological intervention (antipsychotic with consideration of long acting injection), non-pharmacological intervention (individual psychoeducation, family intervention, management of substance abuse) and reduce access to lethal means.

**References**

[1] Favazza A. Bodies under siege. Baltimore: John Hopkins University Press; 1987.

[2] Favazza A and Rosenthau RJ. Varieties of pathological self-mutilation. Behavioural Neurology. 1990;3:77-85.

[3] Fern AM. John Rewald: Post-impressionism from van Gogh to Gauguin. College Art Journal. 1958;17(4):447-448.

[4] Favazza A, Rosenthal RJ. Diagnostic issues of self-mutilation. Hosp Community Psychiatry. 1993;44:134-40.

[5] Large M, Babidge N, Andrews D, Storey P, and Nielssen O. Major Self-mutilation in the first episode of psychosis. Schizophrenia Bulletin. 2009; 35(5):1012–1021.

[6] Favazza A. Why patients mutilate themselves. Hospital and Community Psychiatry. 1989;40:137-145.

[7] Blacker KH and Wong N. Four cases of autocastration. Archives of General Psychiatry. 1963;8:169-176.

[8] Gojendra Singh S, Bhushan BM, Heramani Singh N, Lenin Singh RK. Major self-mutilation: Profile of seven cases. Malaysia Journal of Psychiatry. 2013;22(2):84-90.

[9] Dworkin RH. Pain insensitivity in schizophrenia: a neglected phenomenon and some implications. Schizophrenia Bulletin. 1994;20(2):235–248.

[10] Swanson J, Borum R, Swartz M, Monahan J: Psychotic symptoms and disorders and the risk of violent behaviour in the community. Crim Behav Ment Health. 1996;6:317-38.

[11] Link BG, Stueve A, Phelan J. Psychotic symptoms and violent behaviors: Probing the components of ‘threat/control-override’ symptoms. Social Psychiatry and Psychiatric Epidemiology. 1998;33:S55–SS60. [PubMed: 9857780].

[12] Maszaidi Z, Hatta S, Muhammad Hizri H. Penile amputation as to secondary to the psychopathology of schizophrenia. Med & Health. 2016;11(2):294-297.

[13] Lee TM, Chong SA, Chan YH, Sathyadevan G. Command hallucinations among Asian patients with schizophrenia. Can J Psychiatry. 2004;49:838-42.

[14] Junginger J: Command hallucinations and the prediction of dangerousness. Psychiatr Serv. 1995;46:911-914.

[15] Menninger K: Man against himself. New York: Harcourt Brace World; 1938.

**Corresponding Author**
Dr Choy Seng Kit
Department of Psychiatry and Mental Health,
Hospital Taiping,
Jalan Taming Sari,
34000 Taiping,
Perak, Malaysia
**Tel:** 05-8204094
**Fax:** 05-8073894 / 05-8053976

**Email:** choysk1228@hotmail.com