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Psychiatric and Surgical Management of Male Genital Self-Mutilation

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ABSTRACT

Cases of genital self-mutilation are usually seen in the general hospital setting and can be difficult to manage especially in those patients who have psychiatric illness. A joint effort between the psychiatric and the surgical services will be required right from the beginning of hospital ádmission to diagnosis and later, to follow-up. Psychiatric consultation strategies at the different phases of intervention will be needed to cater for the special needs of the surgical team, patient and family. We describe three cases of genital self- mutilators and the general management of these patients.

Keywords: male genital self-mutilation

INTRODUCTION

Male genital mutilation has existed for centuries in various cultural and religious practices. These include circumcision practices among the Muslims, Jews and Roman Catholics, and the insertion of pearls or spherules among the Japanese and Thai men for sexual enhancement. However the actual prevalence of male genital self-mutilation is unknown and the majority of cases may not be reported[1]. Severe traumatic injuries are very rare[2]. The first report was of a 27-year-old young male who believed that his lack of success was attributed to his sexual organ[3], whilst the first successful reunion of a completely severed penis was in 1962.

Greilsheimer and Groves[4] compiled 53 cases of male genital self mutilators reported in the English literature. It was found that 87% of the patients were psychotic; while 25% were alcohol intoxicated at the time of the act. Of the non-psychotic group, most have character disorders or are transsexuals. The peak age occurs among the 20 – 29 years age group but not infrequently among the 30 – 39 years age group as well. Blacker and Wong[5] characterised male genital self-mutilators into 3 diagnostic groups: schizophrenics, transvestites and patients with complex religious or cultural beliefs. Berlin[6] expanded these to include most major psychoses, the neuroses and brain damaged individuals.

These cases can be difficult to manage. This paper reports three cases of genital self-mutilation among psychiatric patients seen at the Hospital Sultanah Aminah, Johor Bahru over the period 1995 – 1997 and discusses the management of these patients.

CASE REPORTS

Case 1

MA is a 70-year-old Malay gentleman who was admitted to the Urology ward in September 1996 with a foul smelling discharge from his genitalia associated with fever. He was noted by the staff to be behaving abnormally (talking to himself and claiming that someone was trying to kill him). He had been unwell for the past 15 years following his hearing loss from long term exposure to loud noises. His condition worsened following the loss of his vision four years ago. He isolated himself in his room, claiming that the spirits of his dead in-laws were threatening to kill him. He also claimed that they have been inserting glass shards into his penis. He attempted to stop them from hurting his penis by tying it up with a wire, soaking it in boiling water and covering it with several layers of cloth.

There was no family history of psychiatric illness. Prior to his illness, he had been overseeing a ten acre oil palm plantation which was taken over by one of his six children. There are no marital problems. Premorbidly, he is described as a responsible and honest person but a hard taskmaster as he tended to be very strict.

On admission, he was found to be febrile. His vital signs were normal. There were no remarkable findings on systemic examination. Examination of the genitalia showed a partially amputated penis with a metal wire tied to the base of the penis. The shaft of the penis was covered with layers of cloth. On removal, the shaft of the penis was swollen, inflamed and covered with foul smelling slough. There were no palpable lymph nodes.

He was immediately started on parenteral antibiotics. A psychiatric referral was made within 12 hours of admission. Mental status examination showed a very preoccupied looking elderly gentleman with irrelevant, irrational speech and looseness of association; with the content of his speech centering around his penis. There were second and third person auditory hallucinations and visual hallucinations. He had persecutory and bizarre delusions of his dead in-laws trying to harm him. His mood was irritable and affect was blunted. There was no cognitive impairment.

A diagnosis of paranoid schizophrenia based on ICD 10 (F 20.0) was made. His immediate psychiatric management was to control his aggressive impulses and reduction of his positive symptoms with the use of antipsychotics. He was started on haloperidol with a gradually increasing dose to a maximum of 30 mg daily. His hostility created anger and reluctance on the part of the nursing staff caring for him. The nurses were given time to express the difficulties they faced with the patient. With the reduction of his symptoms, nursing him became much easier.

His family was dealt with by educating them on his illness and allaying their fears, anxiety and guilt for failing to prevent the incident. They later consented to surgical intervention when a decision for amputation was finally made as parts of his penis turned gangrenous.

He underwent surgery on 3 October 1996. A debridement, penile amputation and creation of a perineal

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urostomy was made. Post-operative recovery was uneventful and he was subsequently discharged on the fourth post-operative day. His behaviour was manageable inspite of persistent delusions and hallucinations. He continued to show improvement in his psycho-social functioning and activities of daily living on subsequent psychiatric follow-up. His perceptual disturbances remained persistent. He showed no distress over the loss of his penis. An outpatient referral was made to assess his vision and hearing loss.

Case 2

NJY is a 21-year-old single Chinese male who presented to the Urology ward with a wire inserted into his urethral orifice. He has been working in a factory for the past 6 years. He lived with his mother and commuted daily to work. He continued to go to work until the day of admission when he complained of painful micturition. His family doctor discovered a wire protruding from his penis. He was referred to the psychiatric team a day after admission. On further questioning, he admitted that he had been hearing commanding voices for the last one year. There was also a running commentary on all his actions. He claimed that an evil spirit had entered his body and controlled his every action. He had been trying to get rid of the voices by praying and chanting without much success. He also had insomnia in the last one year. In the past one month, he had been ordered by the voices to insert the wire into his penis. He was able to perform his usual activities until recently. There was no family history of mental illness. As a child he was very timid and shy with very few friends in school. He was bullied in school and dropped out of school at the age of 15. He denied any heterosexual or homosexual relationship. Premorbidly, he was described as a quiet, introverted person with few friends. He tend to be very secretive and confided little to anyone.

Mental state examination revealed that he had second person auditory hallucination with a running commentary. There was evidence of passivity phenomena. Physical examination of the genitalia revealed a 5 cm long soft orange coloured wire at the urethral meatus. X-ray showed that the wire had formed a knot inside the bladder.

A diagnosis of schizophrenia (F20.0) was made with an accompanying diagnosis of a foreign body in the urethra. He was immediately started on haloperidol 10 mg daily. His mother was interviewed for further clarification as well as to educate her on his illness. She expressed puzzlement over his action but was not particularly distressed as she felt that the injury was not serious. The nursing staff were receptive towards him and treated the incident as part of his sexual curiosity inspite of his psychotic state.

The wire was removed under a general anaesthetic on the second day of admission. The urethra was enlarged with an otis urethrotomy and a cystoscope inserted to remove the knotted wire.

He was discharged on the second post-operative day with an appointment for psychiatric outpatient follow-up. He continued to show improvement with complete disappearance of the psychotic symptoms. He continued with his medication for a further 6 months after which he decided to stop on his own. Both the patient and his mother refused family counselling with the excuse that they could not find the time because of work commitment. At follow-up a year later, he continued to remain well. He was discharged from psychiatric clinic on his last follow-up with the advice that he and his family could contact us if the need arose.

Case 3

TST is a 48-year-old single Chinese male. He developed mental illness in his late teens. He has had several admissions into a mental hospital since 1968. He has never been completely well even with medication. At his best, he could help with his family business by doing manual work.

He has been living on his own since 1995 as his family members refused to have him in their home. He was sent to the mental hospital when he became disturbed before the present admission to the surgical ward.

He was found to be in a neglected state. He was wearing rings on his 2 fingers which were swollen. Examination of the genitalia revealed another ring on his penis proximal to the corona. The skin distal to the corona was hypertrophied. The ring cut through the ventral surface causing a urethral fistula. Mental state examination revealed a fatuous, unkempt, middle-aged man. His speech was incoherent, irrelevant and irrational. He had auditory hallucinations of male voices laughing and calling him a pretty woman. He was also deluded about being a female. He was started on Chlorpromazine 700 mg daily. The ring on his fingers and penis were removed before transferring him to the Urology ward.

Attempts were made by the general hospital psychiatric team to distract him from his psychotic symptoms but without much success. None of his family members came to visit him inspite of being informed of his admission. Unlike the first patient, the nursing staff kept their contact with him to the minimum. Surgical intervention was done within twenty four hours of admission. The hypertrophic skin was excised but the urethral fistula was left alone as he was able to pass urine. Post-operative recovery was good. He was discharged back to the Mental Institution on the second day of operation.

At present, he remains as irrelevant and irrational in his speech and thoughts. His hallucinations remain but his delusion has undergone a change. Following the circumcision, he now believes that he is a Muslim.

DISCUSSION

The type of damage seen in cases of genital self-mutilation ranges from laceration of the penile or scrotal skin to penile amputation. The most common and serious damage is removal of one or both testes and complete transection of the penis[4]. Common factors in genital self-mutilators include impoverished childhood experiences, long and intense sexual confusion, submissive, masochistic relationships with women, depression which is relieved by genital mutilation, strong feminine identification and repudiation of the penis[5]. Psychotic symptoms in the form of commanding hallucinations and delusions of religious nature were seen in 7% of patients while 14% had delusions of being female[4]. The psychopathological aspect of genital self mutilation will be discussed elsewhere[13].

The management of the male genital mutilators requires the combined effort of surgeons, psychiatrists and experienced medical personnel[8]. Psychiatric consultation should start at the time the patient arrives in the hospital as the patient might be extremely agitated and indirectly provoked, feelings of fear and revulsion in the staff[9]. The team handling psychotic genital self-mutilators have to look into the acute, short-term and the long-term aspects of management.

In the acute short-term surgical care of the patient, the management is based on the availability of the organ and the duration of amputation[4]. The psychiatric management includes attention to the caregivers, nursing staff and the patient. A 3-model phase involving an early (admission), a middle (post-surgical) and a late (discharge) phase has been suggested[8,10]. These include symptom reduction, support for the family and liaising with healthcare givers. The decision for surgical intervention is purely a surgical issue and psychiatric diagnosis is not a contraindication. Surgical staff need to be informed of psychiatric

management and allowed to ventilate their feelings and reassured to allay their fears.

Post-surgically, patients need continuing emotional support and reassurance. Further assessments are needed to review the dosages of medication. Staff have to be encouraged and reassured on handling these patients so that care of the wound is carried out effectively.

In the late or discharge phase; preparations can be made to transfer the patient to a psychiatric unit if the patient is still unstable at this time. In a more stable patient, individual supportive psychotherapy can be initiated. A joint session between the therapist, the patient and the family will be very useful to facilitate discussions about the patient's problem and arrangement for future care. There should be facilitation of contact between the family and the psychiatric services.

The long-term management of the patient will include control of the psychotic illness as well as containment of aggressive impulses. This may be done with the help of pharmacotherapy, supportive therapy and other behavioural techniques such as positive reinforcement, extinction, shaping and modelling and task simplification.

Penile reimplantation has been described in cases of complete and near complete amputation[11]. Success can be defined as preservation of urination, erection, intromission, ejaculation and partial sensation. It is related to the duration of ischaemia of less than 6 hours. Repeated mutilation is uncommon in the majority of the cases when properly monitored[12]. However, an earlier report found that repeat genital self-mutilation was documented in 10 of 53 cases (19%)[4]. When it happened in the psychotic patient, it is usually due to the persistence and incomplete resolution of psychiatric illness.

The three patients reported here came with presentations unlike those reported in the literature. The first patient presented with a partially amputated penis but the process of amputation was gradual and secondary to a necrotic process, rather than an acute cut of the penis. This self-castration occurred as a direct consequence of his delusions and hallucinations. The antipsychotic was not entirely effective in controlling his psychotic symptoms but was able to contain his aggression adequately for the team and later the family to engage him. The nurses were supported at an early stage thus reducing their hostility towards him. Adequate time was given to control his symptoms before surgery was done so as not to jeopardise his recovery. Supportive intervention with the family was also started early and carried out in the interval before discharge. The family was taught to use distraction techniques and positive feedback for the control of his psychotic symptoms. By involving him with simple activities such as taking out his dirty laundry, they were able draw him out of his isolation.

The second case involved minimal injury to the penile skin and occurred secondary to directive and commanding hallucinations. His psychotic symptoms were easily brought under control by antipsychotics. Surgical management was simple and straightforward. The nurses were more empathetic towards him. Attention should be more focused on helping him handle his sexual needs and impulses, improving his social skills and further exploration of family dynamics. However the team failed to develop a good therapeutic relationship with him and his mother. Time factor, severity of the injury, distance between the patient's home and the hospital and work commitment were contributing factors.

The third patient had been in and out of the Mental Institution since young and was unable to cope with life outside the institution. It is not uncommon for a patient to be sexually abused in such a setting, which might be the basis for his delusions of being a female. His use of the ring on the penis was probably for cosmetic reasons, as a response to his delusion. The penile injury was minimal and surgical management was simple. The tourniquet caused by the ring had not done enough damage to the organ. The patient was transferred back to the Mental Institution less than 24 hours after surgery. Not enough time was given to the team to work with either the staff or the family. A visit to see him at the Institution was arranged six months after the operation. He was placed in an isolated ward in the company of patients very similar to him. His delusions remain, albeit in a different context. A possible explanation could be that the majority of the patients at the Mental Institution are Malays and would have been circumcised. Communal bathing is still very common in such a setting and it is highly possible that this contributed to the change in his delusions. Medication alone is unable to control his symptoms entirely. The staff are taught to use behavioural techniques of positive reinforcement, extinction and task simplification for the control of his psychotic symptoms.

All three patients require long-term management for their mental illness. The occurrence of repeated mutilation is unlikely in the first patient as the combination of medication and family work appear to be effective in controlling his symptoms. In the second patient, a repeat act will be more likely inspite of the resolution of his psychotic symptoms for the reasons stated above. Repeated mutilation is most likely to happen again in the third patient as he remains very psychotic. It is doubtful that the behavioural methods taught would be carried out in an overcrowded, understaffed and unstimulating environment at the Mental Institution.

CONCLUSION

In conclusion, psychiatric patients who come in with self-inflicted injuries to their genitalia need to be referred to a major center as they require the joint involvement of both the psychiatric and surgical team from an early stage. The psychiatric team will not only have to deal with the patient but special attention has to be given to the surgical staff involved in the care of the patient as well as the patient's family.

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