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# Case Reports

# Two Cases of Male Genital Self-Mutilation: An Examination of Liaison Dynamics

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Genital self-mutilation (GSM) presents to hospital surgical services in a dramatic fashion, requiring immediate surgical evaluation, often evoking strong countertransferential feelings, and eluding an easy categorical psychiatric diagnosis. It is defined as the direct destruction of genital tissue without suicidal intent.[1] Psychiatric involvement is called for in many cases because of the obvious issue of self-harm, and to assist in discerning motivations for the injuries.

We present two cases of GSM recently evaluated by our Consultation-Liaison (C-L) psychiatry service**.** They highlight not only the complexity and clinical heterogeneity of patients who present after GSM but also the importance of investigating whether both medical and non-psychiatric diagnoses could explain the cause for self-injury. We discuss the countertransference that may develop between the patient and the primary treating team, and liaison issues that C-L psychiatrists should be mindful of to improve patient care.

*Case Report*

## Case 1

Mr. S, a 59-year-old with type 2 diabetes mellitus, hypertension, chronic renal insufficiency (baseline Cr 2.1), erectile dysfunction (with a penile implant), and no psychiatric history, presented to the emergency department (ED) with 5 days of lethargy, weakness, darkening of the skin at the base of his penis, scrotal pain, and purulent and bloody urethral discharge. He also described recent voiding difficulties, including straining to void and hesitancy. Laboratory studies showed a significant leukocytosis (24.1 cells/mm$^3$) and elevated creatinine (4.1 mg/dl). On mental status exam, Mr. S was listless but able to describe how he had been unable to inflate his penile implant, placed multiple rubber bands around the base of his penis instead to achieve an erection, and "forgot about them." Physical exam was remarkable for diffuse, necrotic changes in his penis, suggestive of gangrene. CT scan of the abdomen and pelvis identified subcutaneous emphysema throughout Mr. S's entire penile shaft, findings consistent with gangrene. After stabilization in the ICU, Mr. S had debridement of necrotic tissue on hospital day 2. The subsequent surgical pathology report identified necrotizing fasciitis. The urology team predicted that he would likely require total penectomy with perineal urethrostomy but they elected to first try hyperbaric oxygen therapy to preserve as much penile tissue as possible to avoid surgery. During this time, they noted Mr. S's flat affect, memory problems, and a relative apathy to the potentially devastating consequences of a possible penectomy. These findings made the team question not only his cognitive capacities but also his ability to consent to further surgery, if warranted. On hospital day 4, psychiatry was consulted to "evaluate for cognitive impairment." Mr. S's wife reported that he had experienced a steady decline in his memory for the past 2–3 years and he often wandered confused and with gait instability throughout the house. For the past 4–5 months, he had become irritable and developed urinary and fecal incontinence. Mr. S had no history of substance abuse. He never told his wife about the rubber bands. On examination, he appeared emotionally detached as he described how he remembered the rubber bands only after develop-

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ing urinary symptoms later in the week. He had mild cognitive impairment scoring a 25/30 on the MMSE, but he was judged to have the capacity to consent for penectomy. He consistently stated his desire to proceed with surgery if hyperbaric treatment failed and he was able to discuss the risks and benefits of the procedure during numerous visits with the psychiatric team.

The diagnosis was early dementia, most likely secondary to an undiagnosed normal pressure hydrocephalus. This diagnosis was made in light of his personality and mild-moderate cognitive changes, enough to cause a notable decline in his usual function. Mr. S's CT imaging showed abnormally prominent ventricles without evidence of acute infarct or hemorrhage: a diagnosis of normal pressure hydrocephalus was given based on the radiological findings. Mr. S ultimately underwent penectomy and was discharged to home on hospital day 12**.** Follow-up was scheduled with the Neurology Service, and a ventriculo-peritoneal shunt was planned.

## Case 2

Mr. D, a 43-year-old in-transition (with estradiol 2 mg b.i.d., and spironolactone 300 mg/day) transgendered male with a psychiatric history significant for major depression, social anxiety disorder, gender identity disorder, and complex post-traumatic stress disorder, presented to the ED after attempting to perform an auto-orchiectomy. After researching the procedure on the internet, Mr. D took 3 mg of lorazepam and an unknown dose of ramelteon, which was prescribed by his primary care physician, and he proceeded to apply ligation bands around each testicle. He then severed each spermatic cord with pruning shears and waited 7 hours for the blood flow to diminish, spending that time lying in a warm bath to relax. One of the ligation bands slipped and "about a pint of blood spurted out." He flushed both excised testicles down the toilet and then went to the ED due to profuse bleeding. He was evaluated by the Urology Service and he emergently underwent bilateral inguinal exploration, ligation of the spermatic cords, scrotal debridement, and a scrotal washout.

Mr. D denied suicidal intent, depressive symptoms, or symptoms of psychosis. He described a life-long desire to become a female and reported how "bigots" in his neighborhood teased him for wearing his sister's dress on the first day of kindergarten. The C-L team concurred with the diagnosis of gender identity disorder (GID), which had been given to him by his outpatient psychiatrist**,** based on a lifelong history, dating back to his prepubescent years, feeling that he was assigned the wrong gender. Mr. D reported being physically and sexually abused by both his mother (whom he described as "borderline psychotic") and his father ("antisocial") as a child. He also reported an incestuous relationship with a sister**.** He has been repeatedly hospitalized for depression with suicidal attempts, including an overdose on tricyclic antidepressants (TCAs) and tetracyclic antidepressants and gassing himself. This historical data also made a diagnosis of borderline personality disorder likely.

Mr. D described a sense of relief while discussing his GSM, noting that "I could not be happier. I am resourceful and was trying to make the best with what I could. I've wanted this since the age of 13." He planned to travel to Thailand for the rest of gender reassignment surgery once he could afford it, and he was discharged on hospital day 4.

## *Discussion*

A review of the literature suggests that there is an increasing incidence of GSM, from the first published medical article on the subject in 1846 to the present. Between 1900 and 1977, Evins et al. identified 51 reports of GSM,[2] and in 1996 it was estimated that almost 100 cases of male GSM had been documented in the English literature.[3] Nakaya identified 110 reported cases.[4] There is a strong gender bias in the number of GSM cases (M > F).[5] Individuals in their third and fourth decades are predominantly represented.[3] Risk factors include command auditory hallucinations, feelings of guilt associated with sexual offenses, presence of religious delusions, low self-esteem, and perceived failures in the male role.[6] Other risk factors include deprivation in childhood, suicide attempts and/or other self-destructive behaviors, social withdrawal, and major depression.[7]

Within the context of these aforementioned risk factors for GSM, our two cases represent profoundly different individuals with complex medical and psychiatric needs. Each assessment shared a need to cast a broad set of differential diagnoses to attempt to explain both patients' injuries, as neither Mr. S nor Mr. D was overtly psychotic, depressed, or impulsive in his actions. This fact highlights two important issues in consulting to other teams when managing patients with GSM. Not all GSM patients are acutely mentally ill; however a comprehensive medical work-up should be pursued alongside psychiatric assessment. Second, it is critical to adopt a neutral stance when assessing a patient with GSM. Mr. S's team of clinicians was not derailed by the dramatic element of his presentation and

consequently was able to intuit a mental issue, that may have led to his injury. His neurological disorder, normal pressure hydrocephalus with dementia, likely became the material factor in his accidental injury. Mr. S's GSM served as a sentinel event that pointed to a specific pathology and treatment. A meaningful medical intervention was borne out of this neutrality, including the patient's evaluation for a possible V-P shunt, which has success rates of up to 60% in NPH.[8]

In the case of Mr. D, his GSM was rooted in his desire for a sex change, a decision which for him crystallized at the age of 13. In contrast to our first case, his GSM served not as a sentinel event leading to diagnosis, but rather as a phenomenon that may be underreported in the literature: gender dysphoric individuals performing self-castration due to the expenses of gender reassignment surgery. Mr. D complained about being disrespected and claimed that nursing staff was abrupt with him and minimized his need for pain medications because he was transgendered. Such feelings of exclusion, alienation, and mistrust towards the medical field are not uncommon in transgendered patients; this represents an important target of liaison work. The psychiatric team can serve as the mediator in the evaluation of identity, distress, and likelihood of repeat self-mutilation. All evaluations of transgendered individuals should include questions about ideation to perform GSM and, if present, further screening for an underlying serious psychiatric disorder, such as schizophrenia and borderline personality disorder, should be undertaken.

Whether the complaints of mistreatment as illustrated above are valid, such distrust affects the therapeutic alliance between the patient and treatment team. In this context, it is important to screen for negative psychological responses in the patient's treatment team. Greilsheimer and Groves eloquently described how psychiatrists must prepare to encounter "stunning negative effects" in the caregivers elicited by the act of genital self-mutilation, affects so strong as to prevent their effective action. The medical or surgical house staff may at times experience dysfunctional behavior, inaccurate cognition, and ungovernable affects because of one difficult patient on a ward.[9] While we did not see evidence for poor care based on Mr. D's being transgendered, it is reasonable to speculate that his distrust may have been an element in his decision to perform auto-orchiectomy—he may not have seen any possibility for help within medical institutions to help him afford surgical orchiectomy. This form of alienation deserves further scrutiny and systematic research.

A lack of standardized guidelines for the different medical specialties is also an unfortunate reality in liaison work with these patients. This is exemplified by transgendered individuals being referred to as "he" and "she" interchangeably; there is a lack of consensus as to whether gender should be assigned based on anatomical sex or the gender GSM patients attempt to become. At our institution, we refer to such individuals based on the gender they wish to become, as we believe that this practice lends greater dignity to their care, but debate is likely to continue.

These two cases afford us an opportunity to detect potentially remediable or reversible medical and surgical conditions and also to demonstrate the importance of collaboration and liaison relationships across specialties to help patients and detect problematic issues in systems of care. Future efforts should be made to show that GSM injuries, while seemingly senseless, could be better understood as forms of self-help and, in rare cases, the result of occult medical illness.

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**References**

1. Favazza A: The coming of age of self-mutilation. J Nerv Mental Dis 1998; 186(5):259–268
2. Evins SC, Whittle T, Rous SN: Self-emasculation: review of the literature, report of a case and outline of the objectives of management. J Urol 1977; 118(5):775–776
3. Romily CS, Isaac MT: Male genital self-mutilation. Br J Hosp Med 1996; 55(7):427–431
4. Nakaya M: On background factors of male genital self-mutilation. Psychopathology 1996; 29(4):242–248
5. Schweitzer I: Genital self-amputation and the Klingsor syndrome. Aust NZ J Psychiatry 1990; 24:566–569
6. Ozan E, Deveci E, Meltem O, Yazici E, Kirpinar I: Male genital self-mutilation as a psychotic solution. Isr J Psychiatry Relat Sci 2010; 47(4):297–303
7. Siddiquee RA, Deshpande S: A case of genital self-mutilation in a patient with psychosis. German J Psychiatry 2007; 10: 25–28
8. Shprecher D, Schwalb J, Kurlan R: Normal pressure hydrocephalus: diagnosis and treatment. Curr Neurol Neurosci Rep 2008; 8(5):371–376
9. Greilsheimer H, Groves J: Male genital self-mutilation. Arch Gen Psychiatry 1979; 36(4):441–446