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Letters to the Editor

LETTERS TO THE EDITOR

We welcome all letters and encourage authors to reply. In this forum we hope to encourage the kind of communication that is so vital to our continued growth as professionals. Please send any letters to: John Matt Dorn, Chief Editor, *Jefferson Journal of Psychiatry,* 1015 Chestnut Street, Second Floor, Philadelphia, PA 19107.

Sir:

The article by Dr. Stabinsky, et al., on genital self-mutilation prompts me to share my experience with a similar patient. Mr. L was a middle-aged man of strict Catholic upbringing, the oldest son in a sibship of three. After high school, instead of entering the priesthood, he joined the armed services. During this time he developed alcoholism, prompting admissions for rehabilitation. Upon leaving the service, he entered college but was unable to complete his course of study due to his drinking. A few years ago, while intoxicated, he completely severed his penis at its base. He suffered severe blood loss and the severed member was not recovered (an attempt at phalloplasty was only partially successful). He suffers severe recurrent episodes of depression and loss of self esteem associated with the idea that he cannot urinate "like a man." Two years after he severed his penis, Mr. L continued to lacerate his scrotum on several occasions while intoxicated in an attempt to rid himself of sexual urges. He was started on Depo-Provera®, 400 mg., IM weekly, with abatement of his self-destructive sexual urges. Since that time he has maintained abstinence and participated in a day hospital program. His psychiatric history is most consistent with a diagnosis of manic-depressive disorder. In addition to the Depo-Provera, Mr. L is treated with a combination of Mellaril®, lithium carbonate, and alprazolam. He episodically requires hospitalization for depressive episodes characterized by severe loss of self esteem, hopelessness about the completion of his reconstructive surgery, and suicidal ideation.

In a review of eighty-three cases, Greilsheimer and Groves associated male genital self-mutilation with alcohol abuse, men with character disorders, acutely psychotic young men with sexual fears, older men with psychotic depressions and serious somatic illness, men prone to violence during pathological intoxication, and homosexual men (1). Observation of the patient described highlights the necessity for teasing out and treating the various components of these patients' illness, including alcoholism, affective psychosis, and self-destructiveness associated with impulse disorders.

Ron Serota, M.D.
Director, Inpatient
Drug and Alcohol Service

REFERENCE

1. Greilsheimer H, Groves JE: Male genital self-mutilation. *Arch Gen Psych* 36: 441–446, 1979

Sir:

I enjoyed reading Dr. Greenspan's article in the July 1984 issue of the *Journal* on "The Evaluation and Treatment of a Patient with Anorexia Nervosa." As the attending psychiatrist in this case, I wanted to underscore several of the points made by Dr. Greenspan. This case was particularly interesting from a liaison standpoint in that we were challenged to work with every facet of the medical care team before the behavioral program could be effectively instituted. Our role as teacher was vital to the medical team who were not familiar with this type of patient.

Although anorexia is an entity which tends to foster a lot of polemics among the various disciplines of our field, successful work, particularly with the more ingrained cases, definitely requires that the clinicians be comfortable with a combination of behavioral, family, and psychodynamic approaches. With this particlar patient, the strength of the family dynamics ultimately undermined follow-up treatment, in spite of the success of the behavioral program and individual psychotherapy during the medical hospitalization.

In her discussion of countertransference issues, Dr. Greenspan illustrates well how an examination of the therapist's own counter-transference can illuminate the functioning of the larger system, in this case the medical ward. Even though the ultimate progress of this particular patient is not assured, the article demonstrates the type of approach required with a seriously ill patient in a medical setting.

Jean W. Helz, M.D.
Assistant Director, Consultation and Liaison Psychiatry

Sir:

Thank you for sending me the July 1984 issue of the *Jefferson Journal of Psychiatry*. My eye was caught by the article by Dr. Charneco. I have never heard of the term Autoimmune Deficiency Syndrome, although certainly many of the so-called autoimmune or collagen-vascular diseases are associated with many immunological abnormalities which result in increased susceptibility to infection.

It is apparent from the text that Dr. Charneco is referring to Acquired Immune Deficiency Syndrome, also called AIDS. In view of the enormous number of publications on this very important, severe, and increasingly common illness, it is important to refer to it by its correct name.

Dr. Charneco's statement that the chief criterion for the diagnosis of Acquired Immune Deficiency Syndrome is "an inverted helper to suppressor T-cell ratio" is quite incorrect. Abnormalities in the T-lymphocyte OKT_4/OKT_8 ratios are seen in a number of illnesses. The diagnosis of AIDS is presently a clinical diagnosis and is likely to remain so for some time yet.

The CDC case definition for AIDS requires that a patient have either Kaposi's sarcoma with onset before the age of sixty years or an infection suggestive of an underlying defect in cell-mediated immunity (such as *Pneumocystis carinii* pneumonia) in a patient who has no known underlying illness or history of steroid or immunosuppressive therapy which could produce a defect in cell-mediated immunity.

It is because I agree with Dr. Charneco's concluding statement, that I am submitting these comments. Unfortunately, we will all have the opportunity to see more cases of Acquired Immune Deficiency Syndrome before this epidemic is over.

Sheila A. Murphey, M.D.
Director, Division of Infectious Diseases

Sir:

Thank you very much for sending me Volume Two, Number Two of your splendid publication. The residency training program is to be highly commended for their outstanding work. You have set a high mark and by your example have potentially advanced residency training at all institutions.

If past issues of the Journal are available I would appreciate receiving them.

I am passing my copy of the Journal on to our Chief Residents in the hope that they will encourage some of our resident group to contribute to your splendid publication.

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