Prepuce Restoration Seekers: Psychiatric Aspects

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Abstract

A new subgroup of patients within the homosexual community has been identified who are characterized by preoccupation, with their absent foreskins. They associate their circumcised status with a sense of incompleteness, anger over a lack of choice, and their sense of masculinity. Four patients who sought surgical reconstruction are reported. None were Jewish or psychotic. All tolerated surgery well. Preliminary etiologic hypotheses are advanced, emphasizing psychodynamic and imprinting possibilities.

Introduction

A distinct subgroup within the homosexual community characterized by an erotic attachment to and/or preoccupation with the foreskin has recently come to our attention. This resulted when circumcised members of this subgroup requested surgical reconstruction of their foreskins. The existence of three separate organizations and publications devoted to the concerns of these individuals demonstrates that these individuals represent an authentic, definable group. The organizations are involved in political action such as lobbying against neonatal circumcision, information dispensing, and social and cultural activities. The publications include a quarterly newsletter, a membership directory, and a pornographic magazine. One of the organizations reports 1200 members, 80% homosexual, 10% bisexual, and 10% heterosexual, with 65% uncircumcised, 30% circumcised, and 5% "partially" circumcised. Age range is primarily young adult to early middle age with every state and several foreign countries represented (U.S.A. Newsletter, 1976). Our patients and the newsletter suggest that many of these individuals have been in touch with physicians in an attempt to obtain reconstruction. A few have obtained surgical reconstructions of their foreskins, although most report hostile, amused or anxious responses from physicians (U.S.A. Newsletter, 1974). Despite this evidence of prior contact with physicians, there are no reports in the literature describing these patients. Prior surgical reports have emphasized techniques applied to congenital deformities, traumatic injury, and transsexuals (Goldin, 1975; DeSouza, 1976; Manchanda et al., 1967; Noe et al., 1974). Psychiatric descriptions of patients who have sought "uncircumcision" have emphasized Jews seeking to disguise their identities during times of political and cultural crises (Tushnet, 1965; Schneider, 1976; Levin, 1976). There is one report describing the surgical technique used to reconstruct the foreskin of a patient who sought this for psychological reasons and is reported to have recovered from his emotional discomfort following surgery (Penn, 1963). Another patient, probably psychotic, killed his surgeon following a similar procedure.*

Most of our colleagues assumed that these patients must be psychotic when we initially discussed the subject. None of our patients has been Jewish or psychotic, nor has any had preputial or penile disease or trauma. None bear any resemblance to transsexuals. These patients have a personally motivated obsession to obtain a new foreskin, an obsession sufficiently strong that these patients are willing to undergo an acknowledged experimental procedure of uncertain outcome bearing risk of permanent disfigurement.

* This rumor was confirmed by the Duke University Information Service.

Case Reports

Case #1

Mr. A is a successful 36-year-old schoolteacher from a large southwestern city. When he first presented he was so guarded and hostile he seemed paranoid. He viewed physicians as cruel and sadistic, convincing mothers to have their sons circumcised and then refusing later remedy. He was especially angry that he had had no choice in the matter of his own circumcision. He had contacted 20 physicians with his request prior to being referred to us. The patient had been concerned about his absent foreskin throughout his life and related this to longstanding identity problems. He complained of lifelong excruciating pain at the tip of his penis, which he attributed to his circumcised status. He also held his circumcised status responsible for his sexual difficulties with women, whom he saw as less sensitive than men, and for his decision to avoid physical education during high school. He reported always feeling "yukky" about himself and his body, having been overweight most of his life, frequently depressed, and having obtained rhinoplasty and hair transplants in the past. At one time, he wondered if he was a transsexual, but he reported having satisfactorily come to terms with his homosexuality. He described his father as an uncircumcised authoritarian, domineering, aloof military man and his mother, an "army brat" herself, was more understanding and closer to the patient. However, he viewed them as "the most married people I know" so that there was little room for a child in their lives. He felt they preferred his younger sister to him. Currently, the patient reported a number of satisfying friendships, satisfaction with work and hobbies, but current difficulty with his first long-term intimate homosexual relationship. His prior pattern had been to have several ongoing sexual relationships. Once the patient perceived the open and honest stance of the surgeon, much of his suspiciousness and hostility abated. Since he was able to accept the risks of surgery, appreciate the uncertainties of outcome, and establish a solid collaborative relationship, the surgery was performed. His father was supportive during the operations, frequently bringing Mr. A for his postoperative visits. Mr. A subsequently sought psychotherapy from the evaluating psychologist, which continued for seven months, weekly, and was focused on "here-and-now" issues of trust. Three years after surgery, he reports no further pain, no further depressions, satisfaction with his body, and increasingly gratifying interpersonal relationships, though he has decided not to seek a sustained, intimate sexual relationship at this time. He attributes his greater self-satisfaction to the surgery and his improved interpersonal relationships to the psychotherapy.

Case #2

Mr. B was a very anxious bisexual man of 42 from the Midwest. He had a Masters Degree in Library Science but spent his time in travel and study,

working off and on as a gardener, model, and at other odd jobs He had been in Jungian therapies for 10 years. He had been concerned about being "cut" as long as he could remember, recalling his childhood fascination with a baby's "natural state." He felt that sex was better with uncut partners and sought out such persons. He described the uncircumcised phallus as more beautiful, more pleasing, and more masculine and felt uncircumcision was related to greater creativity. He viewed circumcision as a barbaric mutilation. He described much concern with his identity and body image, recently having changed his name and feeling that a circumcised phallus made his body inconsistent with his soul. He worked part-time as a nude model. Mr. B was raised in the South in a Victorian atmosphere, the eldest of four children. His father was a photographer whom the patient viewed as hyper-religious, but bigoted and hypocritical. He was constantly critical and emotionally cold. Every time the patient attempted to communicate with him, their relationship seemed to deteriorate. The father considered sex dirty, and the patient recalled discussions about sex in the father's unlit darkroom. He had thought his father had been circumcised, but is now unsure. He viewed his mother as devoting her entire life to preventing her temperamental husband from becoming upset. Mr. B was partly raised by a paternal grandmother in whose bed he slept until early adolescence. He described both female figures as "enveloping" him. He recalls no close peer relations during childhood or adolescence, describing himself as "painfully shy." His first homosexual experience occurred during college with a partner who first checked to ensure that Mr. B had been circumcised. The patient, at age 30, was seduced by a woman whom he subsequently married for five years. During that time, he had rare homosexual contacts. He reported no current intimate relationships, nor did he report any close friends. He did make references to friends in the past but described most relationships in terms of their physical and/or sensual qualities. He reported frequent depressions in the past. He was preoccupied with his own internal experiences and had great difficulty communicating them effectively, frequently blocking. His thought processes were highly intellectual and eccentric, though he displayed no loose associations. His eye contact and rapport with the interviewer were distant. He was extremely anxious during the initial part of the interview, with vague answers alternating with clear direct responses. As the interview continued, he seemed to settle down, and his cognition became more appropriate and controlled. Despite our concerns about this patient's impoverished object relationships, difficulty managing anxiety, and eccentric thought processes, his ability to comprehend and accept the nature of the surgery led us to proceed. Postoperatively, he experienced some significant complications which resolved over time. Using telephone contact with the surgeon, he was able to tolerate the complications well. Now, two years after surgery, he reports that he is doing well, satisfied with the outcome, and psychologically about as before.

Case #3

Mr. C is a 52-year-old homosexual interior designer from a large northeastern city who completed two years of college and three years of night school. He could recall being preoccupied with his circumcised status for as long as he could remember, especially feeling strange and different from his uncircumcised father and childhood peers. As a child, he had thought he was born different from his father and other males. He wondered, as a child, if this made him more effeminate. He expressed anger at having been circumcised without his permission. He described circumcised males as "society oriented, pretentious, and condescending." He felt that he wanted a

foreskin for myself, seeing it as more aesthetic and pleasing. He also looked forward to using it in sexual foreplay. He reported past associations of uncircumcision with sexual prowess and masculinity but felt he had resolved those issues. Mr. C was born and raised in a large Midwestern city. His earliest memory is from around age 3, when he was at a vacation cottage surrounded by several male adult family members staring at his penis saying "he's too young to have one" (presumably an erection). At age 5, he was caught "playing doctor" by his father, who directly threatened castration as punishment. His father was a general contractor who was uncircumcised. The patient reported a "terrible relationship" with him and saw him as rigid and distant. He saw his mother as warmer but very anxious, using the patient to calm herself. He is on good terms with his 5years-older sister but has never been able to discuss his feelings with any family member. At age 10, he had his first homosexual experience with a neighborhood boy who was "verrry uncircumcised." During high school he dated girls, and during an army stint he engaged in group heterosexual activities with Pacific Island natives. He consulted a psychiatrist for two months in his late 20s due to emotional turmoil associated with an unhappy love affair. He has had four prior cosmetic plastic surgical procedures (including acne removal, hair transplant, face lift, and blepharoplasty). He had sought foreskin reconstruction unsuccessfully from several plastic surgeons. The patient reported having several gratifying sexual partners, one nonsexual lover, and several close friends. He finds his work gratifying, although he had wanted to be an architect. When initially evaluated, the patient was extremely anxious and ambivalent about the surgery. He was preoccupied with a foreskin making him more "macho" and increasing his sexual pleasure, feelings he knew fo be unrealistic. He elected not to have the procedure. Six months later he returned, less anxious, less ambivalent, and more realistic in his expectations. He established excellent rapport, was very open during both psychiatric interviews, and clearly had above-average intelligence. He tolerated the surgery well, including some anxiety-provoking and very painful testicular swelling due to epididymitis, which responded to treatment. He has continued in his well-established, gratifying lifestyle and is pleased with the result of surgery one year postoperatively.

Case #4

Mr. D is a 45-year-old bisexual, self-employed architect who lives alone in a rural area of the Pacific Northwest. He had undergone 18 prior procedures to restore his foreskin by another plastic surgeon who became reluctant to perform additional surgeries. The patient consulted us due to continued dissatisfaction with the results. He seemed to be seeking a perfect phallus. He recalled being preoccupied with his absent foreskin since age 5 or 6, when his parents slapped him for asking any questions about his body. He feels that had they explained circumcision to him at that time he would not have focused all his feelings of insecurity and inadequacy on his absent foreskin. He sees the phallus as the outward sign of his masculinity, which is, in turn, the most important part of his self. He expressed anger at the absence of choice in his circumcision and a feeling of incompleteness without a foreskin. Mr. D was born in the Southeast, the only child of a rigid Victorian woman and an alcoholic man. He was to have been the "cement" of their troubled marriage but became, instead, the "burden." The patient's father was circumcised, though the patient was unaware of this until he was 36 and insisted on viewing his father's naked body for the first time prior to burial. The father was preoccupied with his own masculinity, collected guns, enjoyed scaring people, turned hugs into painful experiences, and verbally abused the

patient. The mother imposed rigid rules and tried to obtain her emotional needs from the patient, leaving him feeling inadequate. The patient's first homosexual experience occurred when he was 5, and he continued with these contacts through latency. In high school and college, the patient dated women and almost married twice under pressure from his mother. In his mid-20s, he acknowledged his primary homosexual orientation. He was by then a successful architect and sculptor. He saw a psychoanalyst for two years in his early 30s due to recurrent feelings of depression and inadequacy. This therapy was very helpful to him, although he was disappointed in its failure to affect his foreskin preoccupation. He felt that his analyst was unable to listen objectively when he discussed his foreskin obsession. Subsequently, he was able to establish a 4-year-long intimate relationship, the abrupt ending of which precipitated his move to the West Coast. At that time he "rediscovered women." His current relationships consist of homosexual "one night stands," an episodic heterosexual relationship, and several close friends who live in a city two hours away by car. He finds a committed relationship best for him but has been unable to establish one, thus far. The patient describes himself as vain about his body, enjoying exhibiting it at nude beaches, baths, and gymnasiums. He has had a blepharoplasty in addition to the 18 foreskin procedures. He related in an open, intellectual manner, yet there was a sense of guarded rage and tension. He acknowledged difficulty with his hostility. Due to the patient's perfectionist hopes and his unwillingness to allow contact with his prior surgeon, an impasse was reached, and we refused to contemplate any further procedures.

Discussion

All four of these patients (and four others we have evaluated) were seen not in psychoanalytic psychotherapy but in pre-surgical diagnostic consultation. Thus, we did not obtain the kind of anamnesis and fantasy material which would lend itself to confident psychodynamic exegesis. Further, the material we do have must be addressed in terms of the individual dynamics and as potentially descriptive of a large group of patients and potential patients. Finally, the issue of our use of surgical intervention must be considered. Certain themes emerge from the four case histories. First, all of our patients were currently or had in the past been exclusively homosexual. All had family constellations frequently reported with homosexuality: a Victorian attitude toward sexuality, a distant father, and an emotionally intrusive mother. Second, all four of our patients reported a lifelong concern about circumcision, starting with early childhood recollections. Concern with the status of their father's penis was also prominent. Lifelong concern with identity and body image was another consistent finding. Body image was associated with both narcissistic and exhibitionistic issues. Third, depressions were a common experience for all four patients, some apparently lifelong, others more episodic. Psychotherapy had been helpful to three of the four patients, though the preoccupation with the foreskin remained unaffected. Fourth, three issues were regularly associated with the foreskin: a sense of incompleteness when it was absent, an association of masculinity with the foreskin, and anger related to the absence of choice and control in the decision. Fifth, previous approaches to physicians had been consistently painful, this exacerbating the anger. On the other hand, these patients showed a diversity in their patterns of interpersonal relationships, preferred coping mechanisms, and personality patterns. Mr. A was diagnosed as a narcissistic personality with paranoid trends prior to treatment and obsessive compulsive with narcissistic traits following psychotherapy. Mr. B appeared

to be a well-treated schizotypal personality. Mr. C was diagnosed as mildly obsessive compulsive, and Mr. D was thought to be severely obsessive compulsive, with narcissistic traits. In spite of the degree of psychopathology noted, they all tolerated the procedures well. The three we ,have operated on report satisfaction with their treatment. In attempting to understand these phenomena, several hypotheses come to mind. In these patients, for some reason, conflicts at every developmental level have been condensed or displaced onto the absent foreskin. The sense of incompleteness, difficulties in interpersonal relationships, and identity concerns suggest primitive object relationship issues; the rage over the absence of choice suggests anal conflicts; and the masculinity concerns suggest phallic issues.

Two reported cases may be of help here. Khan (1965) described a patient with a foreskin fetish. This fetish was found to be a defense against severe latent ego pathology. The state of excitement in which the patient sought another's foreskin was seen as a panicky state in which symbiotic fusion with the breast/mother was symbolized by the penis/foreskin. This patient also experienced feelings of humiliation and rage following completion of his fetishistic acts. This was understood as a sadomasochistic mechanism. Another relevant case was reported by Nunberg (1947). In this case, a man developed symptoms in response to the circumcision of his infant son. This was eventually related to the patient's identification of his penis with his primitive infant self, and his foreskin with his enveloping mother/vagina. Circumcision was seen as a symbolic separation from mother. Our patients are somewhat different from these two cases, being preoccupied with their own foreskins. The patient who preferred uncircumcised partners did not seem to be fetishistic in his preoccupation. None of our patients reported sadomasochistic activities or fantasies, although we suspected some in Mr. D's case. Mr. A and Mr. B expressed strong feelings about the role of physicians and/or society in neonatal circumcision. These feelings were expressed in terms of the barbarity and cruel mutilation involved in circumcising a helpless infant. Similar feelings were echoed by many writers in the pages of the USA Newsletter. Support for the foreskin as fetishistic object comes also from the pages of the USA Newsletter, where many writers describe a variety of practices in which the foreskin appears to be central object of sexual activity. Practices for manipulating, stimulating, and decorating the prepuce are glowingly described. Most of our patients, however, described these practices as bizarre and dissociated themselves from those they saw as excessive or extreme in their prepuce preoccupation. Our patients do, however, report some material which lends support to the foreskin as primitive mother and/or self-symbol hypothesis. They all spoke of the foreskin with a sensual warmth and reverence. All spontaneously described themselves as feeling "incomplete" without one. Mr. A and Mr. B spoke of feeling empty. All patients described feelings of loneliness, depression, and inadequacy at some points in their lives. All reported lifelong identity concerns. Mr. B and Mr. D overtly articulated the connection between their identity concerns and foreskin preoccupations. The feelings of incompleteness and deep warmth toward the foreskin are also reported frequently in the USA Newsletter. To summarize these psychodynamic observations, these patients all experienced major defects in early mothering, leading to self and object relations pathology. Two report clear early memories of events which focused their attention on the absent foreskin. The other two recall a lifelong concern but appear to have repressed similar early experiences. Thus, there is strong likelihood that this symptom is connected to and, perhaps, defends against severe ego pathology. Of concern, however, is the resistance of the symptom to psychotherapeutic intervention, even

when the self and object relations pathology seemed to improve. All our patients continue to view their concern as normal, natural, and non-symptomatic. We are hoping to identify one of these patients who has undergone, or would like to undergo, a thorough psychoanalysis. Money et al. (1957) emphasized the issue of imprinting in sexual identity. This hypothesis, closely related to primitive object relationship issues, suggests that there is a failure to form an adequate mother-infant bond, which may lead to failure in establishing any clear definition of one's body and self. Then, depending on later experience, this deficit may be focused in a variety of ways (transsexualism, paraphilias, etc.). The imprinting hypothesis suggests a biological fixedness to these disorders which the psychodynamic hypotheses do not. One rationale for treating these patients with surgery rather than psychotherapy is the imprinting paradigm. The resistance of our patients to psychotherapy tends to support this, although further clinical research is necessary.

Although we obviously favor consideration of surgical restoration, we do not advocate it for all such cases. We have now seen a total of eight patients but have operated on only four. We have refused surgery to those who had unrealistic expectations or who displayed overt, untreated psychiatric symptoms. We recommended extensive psychiatric treatment to three before reconsideration of surgical intervention. We emphasize to these patients, as we emphasize to all candidates for reconstructive surgery, that the surgery will not affect their conflicts, anxieties, or interpersonal relationships, that it will only make their bodies more as they wish. The ethical issues are no different than for any other cosmetic procedure. There is high risk of psychological sequellae in any patient with unrealistic, conscious or unconscious wishes or hopes with respect to the surgery, and it would be inappropriate to offer this procedure to such a patient or to one lacking the ego strength or support system necessary to cope with the frustrations and anxieties of a multistage procedure. It would also be inappropriate to withhold reconstruction from a patient who met the above criteria but had other psychological problems. Many physicians have great difficulty dealing with these patients, generally reacting with anger, amusement, rejection, or assumptions that the patients are psychotic. The source of these countertransference reactions is not clear. Intellectually, the request is similar to a request for augmentation mammoplasty. Both are requests for change to bring the body into compliance with a self body image. The operation is more difficult than mammoplasty but is not mutilating like transsexual surgery, which is far more accepted. We are not the first professionals to encounter such patients; however, prior clinicians have been reluctant to report these cases even when they were willing to proceed with the surgery! We were not immune to countertransference feelings, but our curiosity overcame our initial feelings of shock and horror. Our curiosity led to empathy for the discomfort felt by these patients, discomfort largely relieved by the foreskin restoration in the four we accepted for surgery. Whether these patients represent a new diagnostic entity or an unusual symptom that may be related to a variety of personality or neurotic psychopathology is unanswered at the present time. They tolerate and respond to surgical restoration of their foreskins despite the presence of other psychopathology and postoperative complications. Their body image preoccupations have been unresponsive to conventional psychotherapy despite benefit in other areas. Further research will be necessary to confirm these preliminary observations.

Mohl PC, Adams R, Greer DM, Sheley KA. Prepuce restoration seekers: psychiatric aspects. *Arch Sex Behav*. 1982; 10: 383-93