



Questionable Male-to-Eunuch Gender Dysphoria with Self-Castration Attempt in a Young Male with Cluster B Personality Organization

Sunita Singh*, Eric MacMaster MD and Luba Leontieva MD

Department of Psychiatry, SUNY Upstate Medical University, Syracuse, NY, USA

***Corresponding Author:** Sunita Singh, Department of Psychiatry, SUNY Upstate Medical University, Syracuse, NY, USA.

Received : July 13, 2020

Published : July 20, 2020

Copyright © All rights are reserved by Sunita Singh., *et al.*

Abstract

Background: Male-to-eunuch gender dysphoria and self-castration are rare phenomena infrequently described in the literature, specifically with self-castration in the context of the desire to be a eunuch as well as a self-harm attempt.

Method: We describe a 19-year-old male without prior psychiatric history who attempted to self-castrate by removing one of his testicles with a pair of shears. We describe his inpatient and outpatient course, psychological assessment results, and defenses he utilized.

Findings: The patient initially presented with rare gender dysphoria – male-to-eunuch – and a drastic impulsive self-castration act. On further interactions and diagnostic investigation, it was revealed that the patient in fact does not have gender dysphoria, but rather personality disorder with narcissistic and borderline features.

Conclusion: This case demonstrates the difficulties in discriminating gender dysphoria and identity confusion in the context of borderline personality organization. Intensive psychotherapy focusing on non-integrated images of self and others, is warranted for such conditions.

Keywords: *Self-castration; male-to-eunuch gender dysphoria; cluster B personality*

Introduction

The term 'eunuch' historically refers to a male whose testicles have been removed. Castration is performed for a variety of reasons including medical therapy for prostate and testicular cancer, surgical removal in sex reassignment surgery, or it can be self-inflicted to satisfy an internal motivation [1]. As a psychological phenomenon, the desire to become eunuch is complex, but most commonly involves a desire to decrease libido or to mitigate a dysmorphic view of one's own genitals [2].

In an online forum for males interested in becoming eunuchs, male respondents with castration ideations responded with what was appealing about the idea of being castrated. The most common answers included a desire to be subservient and to satisfy an erotic fantasy. Among the responses, male-to-female transition was not a common motivation for castration. Instead, males expressed a desire to be non-gendered [3]. Male-to-eunuch transition is separate from a male-to-female transition and should be thought of as a different gender dysphoria.

The majority of patients with gender dysphoria do not perform genital self-mutilation. However, when gender dysphoria exists in an individual with mental illness, the risk of genital self-mutilation increases [4]. In a study examining cases of male genital-self mutilation,

Citation: Sunita Singh., *et al.* "Questionable Male-to-Eunuch Gender Dysphoria with Self-Castration Attempt in a Young Male with Cluster B Personality Organization". *Medical Research and Clinical Case Reports* 4.2 (2020): 28-33.

nearly half of the cases suffered from psychosis. Among the non-psychotic male genital self-mutilation cases, the most common associated conditions were personality disorders, substance-use disorders and gender dysphoria [5]. There is strong evidence for an association between substance-use disorders and self-harm, possibly explained by a common etiology of poor impulse control [6,7].

The most frequent personality disorder seen in patients with gender dysmorphia is borderline personality disorder, a Cluster B personality disorder [5]. The impulsive characteristics and unstable emotions of borderline personality disorder lead to a propensity to self-harm, suggesting an association between male genital self-mutilation and combination of borderline personality disorder and gender dysphoria.

We describe a case report of a male who came to the attention of psychiatry after he self-amputated one of his testicles. In the course of diagnostic investigations and outpatient encounters with his psychiatrist, it became clear that the patient has significant identity diffusion issues, impulsive and labile mood, and defenses of splitting and acting out typical of borderline personality, rather than true gender dysphoria.

Methods

The patient is a 19-year-old male who presented to the Emergency Department following self-inflicted castration of the right testicle with scissors. He aimed to remove both of his testicles, however he hit an artery and started to bleed, which prevented him from completing the act. The patient initially reported that he did not remember the events surrounding his self-mutilation and claiming he “dissociated” during the episode.

Later, the patient reports a history of gender identity disorder. Specifically, he stated that he “sometimes feels feminine and sometimes feels masculine.” He described himself as heterosexual and reported being interested in females. Within the last two years, he became obsessed with the idea of maintaining a boyish look and avoiding developing more masculine features. He has conducted research on gender reassignment surgery and was pushing his mother to advocate for his surgical castration.

Relevant History

The patient’s family has no history of mental illness, but the patient reported his father exhibits problematic alcohol use. The patient was raised by his mother as his parents divorced when he was a child. He reported depressive symptoms during high school, noting his low self-esteem. His mother facilitated a religious upbringing, demanding the children go to church. The patient denied sexual, emotional or verbal abuse, though he has been exposed to angry outbursts in which his father would display aggression by punching walls. The patient’s older male siblings were masculine and involved in rough play and contact sports. The patient expressed he was different from the siblings as he never felt himself while participating in ‘typical’ masculine activities. Further, the patient revealed that he was disgusted by his father, due to his father’s hyper-masculinity, absent self-care, and being a “slob.” The patient’s aversion to typical “masculine activities” combined with his contempt for his father made the patient aspire to never be like him.

The patient graduated high school, lived with his mother, and was working as a salesclerk at the time of the described events. He had a history of incarceration for stealing a car and driving to another state when he was in 10th grade. He reported remote history of abusing alcohol, heroin, cocaine, MDMA and benzodiazepines without continued dependence on any of these substances.

Hospital Course

After medical stabilization, the patient was transferred to an acute psychiatric unit where he stayed for two days. During his short stay the patient did not display any psychotic symptoms: he absolutely denied that the self-castration was a self-harm or suicide attempt, displayed an even mood, and had no signs of hallucinations or delusions. The patient was polite and cooperative with the unit routine, though refused to participate in group therapy sessions. He stayed to himself and persistently asked to be discharged as he stated he did not belong in the psychiatric unit as he did not acknowledge he had psychological disturbances.

A psychological evaluation with Minnesota Multiphasic Personality Inventory 2nd edition (MMPI-2) was conducted to better

understand his personality organization and rule out possible underlying psychotic processes [8]. The patient generally responded in open and cooperative manner; however, his approach towards the test was somewhat inconsistent as he frequently responded “false” to items regardless of their content. This pattern suggests some carelessness and inattention to the content. His MMPI-2 scales were within the normal limits. The test suggested that he appeared to be an outgoing, friendly and ambitious person with a generally favorable self-image. None of his clinical scales were elevated above the level where psychopathology is considered. The highest scale in his profile was scale 5 - Masculinity-Femininity scale. This suggested some long-term adjustment problems in his gender role, consistent with a diagnosis of gender dysphoria. The patient also showed a pattern of disinhibition that can be reflected in high risk-taking and impulsive behavior, unbound by moral restraint. Based on the test result, the patient did not meet criteria for personality disorder at that time; however, the test revealed distinct personality traits.

The following personality characteristics emerged from the MMP-2 testing:

- Propensity to be impulsive and engage in a high-risk behavior
- Oppositional tendencies
- Propensity to act out without regard for others
- Problems with alcohol and drug use

The patient was discharged from the inpatient unit with the diagnosis of Unspecified Gender Dysphoria (Male-to-Eunuch Gender Dysphoria r/o). Gender dysphoria is described as the “distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender” [9].

Outpatient Treatment Course

Upon discharge, he began seeing a psychiatrist for psychotherapy and possible medication management. He reported some vague symptoms of depression including feelings of anhedonia, loss of interest, and feelings of irritability. He labeled these “existential depression” throughout treatment; this term came to be more clearly defined as a generalized negative viewpoint of people and the world. Often he would relate how his interpersonal experiences (often negative) with others would leave him feeling drained and depressed. In addition to these interactions, he also made generalizations on the state of the world, focusing on negative news or stories as it supported his feelings of hopelessness, depression, and irritability. He requested it to be treated, however he was hesitant to start medication, although they were discussed and offered to him. Approximately two weeks into the outpatient treatment course, he presented to a local emergency department with complaints of depression and was started on fluoxetine by the evaluating psychiatrist. The patient’s switch in response to treatment could be interpreted as splitting defense as the patient could have asked for medication from his existing psychiatrist, yet he chose to go the Emergency Department instead.

After one month of outpatient treatment, the patient left a message on the psychiatrist’s office phone reporting hallucinations of seeing people at his workplace. After multiple unsuccessful attempts to reach the patient, his mother was called and she reported hearing nothing about these concerns, but voiced understanding that he should be evaluated at the local Comprehensive Psychiatric Emergency Program (CPEP). The psychiatrist eventually made contact with the patient, and he seemed ambivalent about the prior hallucination concerns and after agreeing to go to CPEP, never actually went. This was interpreted as a hostile move to devalue and bind the psychiatrist, likely with the goal of increasing feelings of parity for the patient and impotence for the psychiatrist.

After this experience, he requested to switch antidepressants because he reported amotivation, lack of energy, and a feeling of emptiness. The patient agreed to start bupropion XL. The patient did very well on this medication and after two weeks the dose was titrated up to 300 mg. In a reenactment of the prior medication trial, the patient left a jarring anonymous message on psychiatrist’s voicemail, whispering “faces, there’s just faces everywhere.” The patient’s treatment interfering behavior was discussed in the next therapy session, however the patient adamantly denied sending the message, instead blaming friends for prank calling, despite it clearly being the patient’s voice on the phone. The patient wished to remain on the bupropion XL but expressed displeasure that the psychiatrist was not making him better. The psychiatrist hypothesized that the patient’s hallmark of reporting psychotic type symptoms

in a detached, nearly anonymous way potentially represented the underlying conflict of the unintegrated parts of himself and his personality. The genesis for this thinking came from dual hypotheses: the first that his lack of adequate trials and generalized “existential depression” may have created some internal ambivalence on whether to treat, increasing internal distress and promoting dissociation. The second relied more on the relationship with the therapist and that by phoning with serious or frightening symptoms he could regain some dominance over the psychiatrist who had just taken the more active role in the relationship by prescribing and confirming there was something wrong with him that needed to be fixed. However, given the borderline personality diagnosis suspiciousness, we must also consider in retrospect that the hallucinatory experiences may in fact have been part of his underlying psychopathology as patients with Borderline Personality Disorder can experience states of micropsychosis with auditory hallucinations, paranoia, and disassociation [10]. It is likely there is a convolution of all three hypotheses as the tone and content of his perceptual disturbances seemingly always showed themes of being stared at, judged, or looked down upon/viewed as weak or deficient.

The patient stated that he wanted to engage more in therapy, however during the ensuing months, he would frequently no-show for appointments or show up over halfway through a scheduled hourlong appointment. Despite being reminded about the no-show/late attendance policy, he continued to externalize his lack of improvement on to the psychiatrist. During one session, he brought his new girlfriend to the appointment; a woman he had met three days prior and subsequently added her as an emergency contact. Shortly after this, the psychiatrist received an email from this woman with screenshots from a text message where the patient had stated “I wish I had impregnated you so I could kill the baby and you.” When the psychiatrist called her, she did not believe that these were legitimate threats and she also stated that she was not pregnant, so she did not have significant concern for safety. Despite this the psychiatrist offered to call police, but she declined. Given that the patient had shared his self-castration with this woman during their relationship, the fantasy of impregnating her and subsequently engaging in homicide and feticide may represent his conflict with his own aversion to masculine aspects of himself; the killings being a way of undoing his maleness.

The psychiatrist considered that overall, his time spent with this patient could be characterized largely by the patient’s attempts to create parity and overfamiliarity with the psychiatrist, rather than engage in treatment. Frequently, this was achieved by binding the doctor either therapeutically or medico-legally. These efforts were seen as displays of control and narcissism and inducing fear within the relationship as a means to erode the relationship, effect relatedness within the dyad, and ultimately push the doctor to reject him as he felt rejected by other men in his life, which constitutes a projective identification defense. This was all conceived with little regard for others (mother and girlfriend) as was indicated to be likely during his MMPI-2 testing. The patient would frequently externalize his lack of improvement on to the psychiatrist abilities and less so to his poor efforts. When the patient described feeling “depressed” it was always “existential” in nature.

During extended evaluation it became clearer that he had never met the criteria for major depressive disorder and instead was showing significant borderline and narcissistic personality traits. Behaviors noted that suggests borderline personality defenses included poor boundaries and enmeshment attempts: referring to the psychiatrist by his first name despite repeated corrections, beginning to attend the same gym, and commenting about seeing the psychiatrist in public as well. Another predominant theme that became clear was a perceived narcissistic level disgust with humanity. He would often spend time during the sessions lamenting how people in the world were hideous and aspiring to go to medical school to become a plastic surgeon to correct them and “make them a better product.” He would sometimes extrapolate this to his own experience and would frequently talk about how he preferred to have streamlined and more boyish features. Despite these musings, he did not ever meet criteria for typical gender dysphoria disorder-desiring to be another gender entirely, but a less common sub-type where the desire expressed was more so to be a eunuch (less masculine). He also adamantly denied wanting to be a woman, but then requested the psychiatrist to write a letter of support to start gender affirming hormone therapy. When the psychiatrist declined to write such letter as the patient did not meet criteria for gender dysphoria, the patient began acting out and sabotaging treatment further, demonstrating splitting and acting out defenses.

The patient would often push his no-show rate to the point of discharge, only to return for a session long enough to maintain care. He would not pay his bills, nor would he do any of the assigned therapy. He also discontinued his bupropion XL as he felt that it was

no longer helpful and requested to engage only in therapy. It was recommended that he engage in Dialectical Behavior Therapy (DBT), however he no showed his intake appointment with the DBT therapist. At his next appointment with the psychiatrist the patient arrived extremely late, so the psychiatrist could not to see him. Soon after leaving the office, he called and left a message firing the psychiatrist and informing him that he would be moving out of state.

Discussion

The intricacies of the case reflect the multifactorial nature of gender dysphoria. Individuals with gender dysphoria presenting to trans-gender health services exhibit higher levels of psychiatric disorders than the cis population [11]. Although the patient did not meet the criteria for personality disorder on his initial MMPI-2, his behavior in outpatient therapy showed narcissistic and borderline features, aligning with Cluster B personality disorders. These personality traits make treatment challenging, as the patient demonstrated by frequently being late to appointments, refusing and then proceeding to seek medication (splitting defense), and externalizing his lack of improvement toward the psychiatrist.

Dialectical Behavior Therapy (DBT) is the most often used treatment for borderline personality disorder, and might have been beneficial to the patient, as it would have helped to treat his impulsivity, therapy-interfering behaviors and emphasize the importance of therapeutic relationships [12]. DBT also teaches patients to accept their identity, which nicely complements the identity struggles in borderline patients also experiencing gender dysphoria. Our patient was recommended to engage in DBT but did not follow through with attending his intake appointment.

However, the patient's unstable self-image and inability to establish substantial relationships with others provokes the consideration of psychotherapy focusing on non-integrated images of self and others. In his outpatient treatment, the patient frequently exhibited behaviors to sabotage the relationship between himself and the psychiatrist. Even in his personal life, the patient did not demonstrate any significant relationships. He displayed little regard for others, as seen in his relationships with his mother and girlfriend.

In addition to his inability to create relationships, the patient also expressed conflicting statements about himself, especially relating to his gender identity. The patient initially stated that his self-castration was performed in a dissociative state, then disclosed that he wished to have more "boyish" features, and later requested gender affirming hormone therapy while denying that he wanted to be a woman. These conflicting statements illustrate the patient's struggle with self-identity. Furthermore, although the patient did not meet the criteria for major depressive disorder, he consistently stated that he has "existential depression", which he attributed to entirely external factors, again showing a lack of self-awareness.

Because of his unstable relationships and self-image, Dynamic Deconstructive Psychotherapy (DDP) could be potentially beneficial to the patient. DDP is used for patients with borderline personality disorder who are resistant to treatment, and often have a co-occurring psychiatric condition [13]. It is suggested that patients with borderline personality disorder display decreased activity in the regions of brain responsible for verbalizing emotion and establishing a sense of self. Instead, borderline patients paradoxically show increased activity in the regions of the brain responsible for hyperarousal and impulsivity. DDP addresses this theory by focusing on labeling and reflecting on emotions from patients' experiences. Patients also learn to develop stable relationships with others while maintaining a sense of self (Gregory, n.d.) DDP has been shown to decrease non-suicidal self-injury among patients with borderline personality disorder [14]. Our patient's history of attempted self-castration provides further support that DDP could be beneficial.

Exploring the patient's incongruent self-image and unstable relationships through psychoanalysis would help the patient be successful with his gender dysphoria and personality disorder. The present case illustrating the intertwining of Cluster B personality, male-to-eunuch gender dysphoria, and self-castration prove to be a difficult case, requiring a careful approach to treatment. Future similar cases should consider employing psychotherapy techniques focusing on non-integrated images of self and others, such as DDP or other dynamic psychotherapy approaches. This is important to consider before any gender re-assigning surgery/procedures is considered.

Citation: Sunita Singh., *et al.* "Questionable Male-to-Eunuch Gender Dysphoria with Self-Castration Attempt in a Young Male with Cluster B Personality Organization". *Medical Research and Clinical Case Reports* 4.2 (2020): 28-33.

Conflict of Interest: The authors declare that they have no conflict of interest.

Ethical Approval: For this type of study, formal consent is not required.

References

1. Wassersug RJ, et al. "Eunuch as a gender identity after castration". *Journal of Gender Studies* 21.3 (2012): 253-270.
2. Wassersug RJ and Johnson TW. "Modern-day eunuchs: motivations for and consequences of contemporary castration". *Perspectives in Biology and Medicine* 50.4 (2007): 544-556.
3. Roberts L F, et al. "A passion for castration: characterizing men who are fascinated with castration, but have not been castrated". *The Journal of Sexual Medicine* 5.7 (2008): 1669-1680.
4. Donnelly-Boylan, K. "Gender dysphoria, serious mental illness, and genital self-mutilation: A case report". *Journal of Gay & Lesbian Mental Health* 20.4 (2016): 376-381.
5. Moller C, et al. "Deliberate self-harm, substance use, and negative affect in nonclinical samples: a systematic review". *Substance Abuse* 34.2 (2013): 188-207.
6. Veeder TA and Leo RJ. "Male genital self-mutilation: a systematic review of psychiatric disorders and psychosocial factors". *General Hospital Psychiatry* 44 (2017): 43-50.
7. Haw, C., et al. "Psychiatric and personality disorders in deliberate self-harm patients". *British Journal of Psychiatry* 178.1 (2001): 48-54.
8. Graham, J. R. "MMPI-2: Assessing personality and psychopathology". New York: Oxford University Press (1993).
9. American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders: Diagnostic and Statistical Manual of Mental Disorders". Fifth Edition. Arlington VA (2013).
10. Grosjean, Bernadette. "Differentiating Borderline Personality Disorder from Bipolar Disorder." *The Carlat Psychiatry Report* 10.3 (2013).
11. Dhejne C, et al. "Mental health and gender dysphoria: A review of the literature". *International Review of Psychiatry* 28.1 (2016): 44-57.
12. Linehan, M. M. "Cognitive Behavioral Treatment of Borderline Personality Disorder". New York: Guilford Press (1993).
13. Goldman GA and Gregory RJ. "Relationships between techniques and outcomes for borderline personality disorder". *American Journal of Psychotherapy* 64.4 (2010): 359-371.
14. Turner BJ, et al. "Treating nonsuicidal self-injury: a systematic review of psychological and pharmacological interventions". *Canadian journal of psychiatry* 59.11 (2014): 576-585.
15. Gregory R, et al. Dynamic Deconstructive Psychotherapy: Psychiatry: SUNY Upstate Medical University. Retrieved from https://www.upstate.edu/psych/education/psychotherapy/dynamic_decon.php

Submit your next manuscript to Scientia Ricerca and benefit from:

- Quality Editorial service
- Swift Peer Review
- Timely updates about your manuscript status
- Rapid publication on acceptance
- Issue of Publication Certificate
- Global attainment for your research

Submit your manuscript at:

<https://scientiaricerca.com/submit-manuscript.php>



This work is licensed under Creative Commons Attribution 4.0 License