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CASE REPORT

Genital Self-Mutilation and Regret in Gender Dysphoria: A Case Report

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Abstract

Genital self-mutilation is a rare but serious urological surgical emergency; it is most often associated with psychosis, but it may also occur in the context of gender dysphoria in the absence of psychosis. A 23-year-old male, at age 20, amputated his penis and testes following online encouragement to pursue a female identity. Postoperatively, he experienced regret, distress, and requested reconstructive surgery to restore his male identity. His history included childhood bullying, obsessive–compulsive traits, and late-onset gender dysphoria, but no psychotic illness. This case highlights the interplay between gender dysphoria, psychosocial vulnerability, irreversible self-harm, and urgent urological management. It underscores detransition risk in rapid-onset gender dysphoria and the necessity of psychiatric evaluation, extended follow-up, and ethical consideration before irreversible genital surgery.

Keywords: gender dysphoria, detransition, genital self-mutilation, regret, urgent urology

INTRODUCTION

Genital self-mutilation (GSM) is a rare but serious medical emergency that usually causes irreversible anatomical loss. Because of the rich vascular supply and microbial flora, injuries may lead to life-threatening complications and long-term functional and psychosexual impairment (1). Thus, GSM requires urgent urological surgery and mandates multidisciplinary evaluation for optimal management.

Most reported cases are linked to schizophrenia or mood disorders (2,3). However, GSM without psychosis has been described in relation to gender dysphoria (GD), obsessive-compulsive symptoms, dissociation, or intense psychosocial stress such as bullying (4,5). Rapid-onset GD is associated with higher detransition rates and regret after gender-affirming interventions or self-inflicted changes (6,7). Ethical and legal implications must therefore be considered when evaluating surgical requests.

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We present a case of GSM in a 23-year-old male who amputated his genitalia at 20 to become female, later regretted the act, and sought penile reconstruction and testicular transplantation. The case is discussed in relation to rapid-onset GD, detransition, and ethical concerns.

CASE REPORT

A 23-year-old male presented requesting penile and testicular transplantation. In November 2022, at the age of 20, he amputated his penis and testes with a kitchen knife due to distress related to his genitalia. He was found unconscious and bleeding by his sister and underwent emergency surgery. The patient was brought to the emergency department within one hour of the amputation, resulting in a near-total penile amputation, with approximately 1–1.5 cm of proximal stump remaining. Since the amputated penis had been discarded in the toilet, reanastomosis or revascularization could not be performed. Necrotic tissue was debrided, and the scrotum was closed. He was hospitalized for three months. Urethral stricture had not developed, and urinary continence was preserved. There were no complaints regarding voiding function; urinary flow was adequate, and ultrasonographic follow-up demonstrated complete bladder emptying.

His psychiatric history revealed obsessive-compulsive disorder at age 10, for which he was followed for two years due to excessive handwashing and prolonged bathroom use. Since elementary school, he had been subjected to persistent bullying with phrases such as "you act like a girl" and "don't you have a penis?", and had been physically assaulted, including repeated kicks to the genital area. Bullying continued into high school and later in public settings. At age 17, he was physically assaulted on a bus following humiliating remarks. During adolescence, he told his mother that he felt "more suited to be a girl" and verbalized a desire to become female. He was evaluated at Hacettepe University Faculty of Medicine Psychiatry Clinic, where gender transition was recommended; however, the process had not yet been initiated. Due to lack of access to detailed medical records and discharge summaries, the duration of follow-up and the specific psychiatric assessments and recommendations from that period remain unknown.

Developmental history revealed playing with toy cars and trains, predominantly with male peers, and engagement in football and volleyball. During puberty, he reported satisfaction with male secondary sexual characteristics, enjoyment of masturbation, and sexual attraction to women. Approximately 5–6 months before the incident, he began expressing intentions to amputate his penis, with increasing frequency in the two months preceding the act. The night before the event, he again verbalized this intention. He communicated online with individuals abroad who encouraged the act and provided instructions.

The self-mutilation behavior was interpreted as primarily identity-related, occurring in the context of persistent gender dysphoria. The patient reported that the act was motivated by the belief that genital removal would align his body with a female identity, rather than being an impulsive, psychotic, or purely self-punitive act. No evidence of acute psychosis or dissociative state was identified at the time of evaluation.

Following self-injury, upon regaining consciousness, he reported profound regret, re-affirmed his male identity, and expressed a strong desire to regain his sexual organs to resume life in his male identity.

On mental status examination at presentation to our clinic, he appeared his stated age, was cooperative and well-groomed, with a masculine appearance and facial hair. No abnormalities in thought content, perception, or reality testing were identified. No acute psychiatric intervention was required at that time.

During follow-up after orchiectomy, he was started on intramuscular testosterone therapy due to suspected muscle and bone mass loss, administered every three weeks. Imaging studies showed no abnormalities, and biochemical parameters were within normal limits.

DISCUSSION

This case illustrates GSM in a young man without psychosis, highlighting rapid-onset GD and detransition risks. GSM should be considered not only surgically and psychiatrically but also ethically.

In a review of 173 GSM cases, Veeder and Leo (8) reported schizophrenia (49%), substance use (18.5%), personality disorders (15.9%), and GD (15.3%) as major associations.

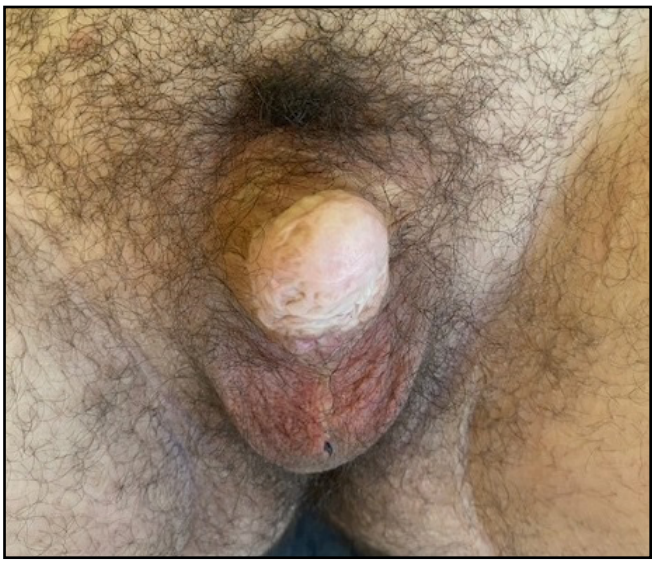

Figure 1. Appearance of penile stump 4 years after GSM: scarred, epithelialized glans, meatus at stump tip.

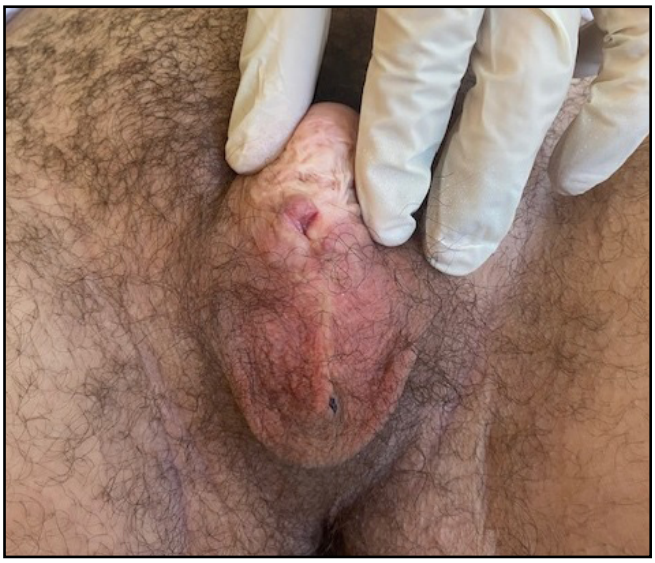

Figure 2. Ventral view showing penoscrotal region and absent testes.

Thus, GD, though less common, is a significant risk factor. Our patient experienced childhood bullying, expressed female identity wishes in adolescence, amputated his genitalia, then regretted it and sought male identity restoration.

Rapid-onset gender dysphoria (ROGD) is not a diagnostic entity in DSM classification and remains a controversial and hypothesized construct. It has been proposed to describe cases in which gender dysphoria emerges or intensifies during adolescence in association with psychosocial and environmental influences. However, in the present case, the patient reported gender-related concerns extending back to adolescence, which limits the applicability of a strict ROGD framework. Therefore, this case is more appropriately interpreted within the broader spectrum of persistent gender dysphoria with fluctuating intensity rather than a discrete rapid-onset subtype.

Detransition and regret following gender-related interventions or self-directed body modification have been reported in the literature, although reported rates vary significantly across studies and populations. In the present case, the patient re-affirmed his male identity following self-mutilation and expressed a desire for reconstructive procedures, illustrating the potential reversibility of identity-related decisions under extreme distress conditions. This highlights the importance of long-term psychiatric evaluation and stability of decision-making capacity prior to irreversible bodily interventions.

Some reports suggest GD may occur within psychotic episodes, making diagnosis difficult and supporting recommendations to defer irreversible surgery until comprehensive psychiatric evaluation and long observation are complete (9). Our case similarly shows how regret may alter identity goals, emphasizing the importance of delaying irreversible interventions.

A cohort study conducted in Sweden found that some individuals who had completed surgical transition later experienced regret (6). Detransition is particularly more common in rapid-onset GD. In a survey of 100 detransitioners, Littman (7) reported 55% felt inadequately evaluated before transition, many linking their decision to psychological distress. Kettula et al. (10) similarly found high psychiatric comorbidity and childhood trauma among detransitioners. In their study, nine adult individuals who detransitioned all exhibited psychiatric comorbidities, including mood disorders, anxiety, borderline personality disorder, and dissociative disorders. Childhood traumas—such as sexual abuse, bullying, attachment problems, and eating disorders—were reported in 78% of cases. Most participants described their transition process not as a permanent expression of identity but as a consequence of psychological distress. After an average of seven years of hormone therapy and surgical interventions, the majority reported significant regret. Our

patient aligns with these findings, as his irreversible self-surgery was followed by regret and re-identification with his male sex.

Complications of GSM often lead to permanent loss (1). Although penile transplantation has been attempted, testicular transplantation is not performed due to technical and ethical issues. Genital transplants remain experimental with donor, surgical, immunologic, and ethical challenges.

Accurate psychiatric assessment is essential. Many GSM patients attempt suicide, and self-mutilation often represents an attempt to relieve distress or externalize overwhelming emotions (1). Early detection of psychiatric illness, thorough evaluation, and long-term follow-up in GD are crucial before irreversible surgery. In GSM with GD, reconstructive or gender-affirming surgery should be delayed, with psychiatric care prioritized (9).

CONCLUSIONS

GSM is an urgent urological condition; however, urologists should not rush penile reconstruction or other reconstructive procedures. This case demonstrates GSM without psychosis, leading to regret and detransition in rapid-onset GD. In such patients, surgical transition decisions should not be immediate; reconstructive procedures must be postponed. Comprehensive psychiatric evaluation, long-term monitoring, and ethical reflection are vital before irreversible interventions. A multidisciplinary approach is essential to safeguard patients and minimize regret and complications.

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Author Contributions:

Conception and design: Zeki Bayraktar

Data acquisition: Zeki Bayraktar

Data analysis and interpretation: Zeki Bayraktar, Şenol Turan

Darfting the manuscript: Zeki Bayraktar, Şenol Turan

Critical revision of the manuscript for scientific and fatual content: Zeki Bayraktar

Supervision: Şenol Turan

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