

CASE REPORT

Challenges in the Management of Male Genital Self-Mutilation in a Patient with Schizophrenia and Gender Dysphoria

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ABSTRACT

Male genital self-mutilation (GSM) is a rare but serious clinical challenge, frequently associated with severe psychiatric conditions such as schizophrenia and, in some cases, gender dysphoria. This case report highlights a 27-year-old male patient with schizophrenia and gender dysphoria who presented with self-inflicted genital injuries following command hallucinations. The patient underwent surgical intervention for his injuries and antipsychotic therapy; however, challenges emerged in providing appropriate ward placement and gender-affirming support due to sociocultural constraints. The patient's psychotic symptoms improved with antipsychotic treatment and psychosocial support, and he was discharged with outpatient follow-up, including linkage to a support group. This case highlights the critical need for tailored, culturally sensitive psychiatric and medical care, as well as accessible gender-affirming resources. Improved multidisciplinary collaboration and family education are essential to prevent recurrence and enhance outcomes for individuals with coexisting severe mental illness and gender dysphoria.

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individualized care to support the patient's mental health and identity.

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INTRODUCTION

Male genital self-mutilation refers to self-inflicted injuries to the external genitalia, often occurring without suicidal intent. While it is frequently observed in psychotic contexts, it may also arise due to other conditions, such as erectile dysfunction or among individuals seeking gender reassignment [1]. Despite its presumed rarity, epidemiological data on GSM are limited, making comprehensive understanding of this behavior challenging [2].

This case illustrates the challenges faced by healthcare teams managing patients with both schizophrenia and gender dysphoria, particularly in settings with limited gender-affirming resources. This highlights the need for thoughtful coordination across medical and psychiatric disciplines, sensitive handling of sociocultural factors, and the importance of providing compassionate,

A 27-year-old male patient was brought to the emergency department following a severe self-inflicted genital injury involving lacerations to his scrotum and partial amputation of his penis. The patient has a known history of schizophrenia, which has been inconsistently managed due to poor medication adherence. Recently, he began to experience significant gender dysphoria, identifying as female and expressing a desire to transition. This gender identity distress intensified his isolation, as his family and community did not support his transition, and he faced limited access to gender-affirming care due to socio-legal constraints.

The patient reported that, leading up to the incident, he had been experiencing worsening psychotic symptoms, including auditory hallucinations commanding him to "remove his male parts." These hallucinations coincided with heightened distress over his gender identity, ultimately culminating in his self-mutilation. Upon

presentation at the emergency department, the patient was agitated, disoriented, and actively hallucinating, which necessitated urgent intervention. The medical team addressed his physical injuries first, providing wound care and infection prevention. Following immediate stabilization, surgical intervention was performed to prevent further complications from the injury.

A psychiatric consultation was initiated, and antipsychotic medications were administered to manage his acute psychotic symptoms. The patient was initially started on intramuscular haloperidol (5 mg) to control agitation. Once stabilized, he was transitioned to oral risperidone (4 mg/day) for long-term management of schizophrenia. However, determining an appropriate hospital ward placement proved challenging. Given local cultural norms and the binary ward system, the healthcare team had limited options for accommodating his female gender identity in a respectful, supportive manner. Ultimately, he was placed in a male psychiatric ward near the staff counter, where he could be closely monitored. Special accommodations were made to ensure his privacy and comfort, such as providing access to a private bathroom within an isolation area to minimize interactions with other male patients that might heighten his distress.

As the patient's psychotic symptoms began to stabilise, he continued to express strong feelings of gender dysphoria and a desire for gender-affirming care. The multidisciplinary team developed a comprehensive treatment plan that included continued psychiatric stabilisation for schizophrenia, targeted support to help him manage his gender dysphoria, and a long-term care strategy that engaged his family and involved social services. The targeted support included psychotherapy sessions focusing on psychological distress, emotional regulation, and coping strategies. Psychoeducation for his family was prioritised, to foster a more supportive environment that could facilitate better adherence to treatment and improve his quality of life upon discharge.

The patient's symptoms improved after stabilisation with antipsychotic treatment. Following stabilisation of psychotic symptoms, the multidisciplinary team, including psychiatry and psychology, conducted a reassessment using clinical interviews aligned with DSM-5-TR criteria for gender dysphoria. Persisting, consistent expressions of gender dysphoria in the absence of overt psychotic content suggested that the gender identity distress was not merely secondary to schizophrenia. He was referred to a psychiatric outpatient clinic for continued care and was linked with a support group to help navigate his psychological distress. In this case, LAI risperidone or paliperidone was considered to improve adherence and prevent relapses. However, due to patient and family resistance, oral risperidone

was initiated instead. Close outpatient follow-up was arranged to reassess the feasibility of transitioning to an LAI, highlighting the need for ongoing monitoring and patient engagement in treatment decisions.

DISCUSSION

GSM is often considered a subset of apotemnophilia, a condition characterized by an obsessive desire to amputate a healthy limb or organ (derived from Greek, where "apo" means "away from," "temno" means "to cut," and "philia" means "love") [3]. In males, GSM manifestations range from minor self-inflicted cuts to severe injuries requiring urgent medical intervention, such as testicular or penile amputation [4].

Numerous factors have been associated with GSM, with psychiatric conditions and substance use disorders frequently implicated [2]. In a systematic review, nearly half of GSM cases were found to involve schizophrenia spectrum disorders [5]. While psychotic disorders are a common backdrop for GSM, non-psychotic factors (including drug use, sexual practices, cultural beliefs, and religious motivations) also contribute [4]. Interestingly, only 15.3% of GSM cases were associated with gender dysphoria, with many of these individuals also presenting with additional psychiatric conditions [5]. This complicates the delineation of cases driven primarily by psychosis from those with non-psychotic motivations, particularly as mental health factors are often interwoven [4].

Effective treatment of GSM requires a holistic and multidisciplinary approach, as 90% of cases have a psychiatric basis, necessitating intervention from psychiatrists [1]. Coordinated care involving urologists, psychiatrists, and emergency medical professionals is essential for managing GSM and mitigating the risk of recurrence through the targeted identification and treatment of underlying causes [2]. Recent advances in reconstructive microsurgical techniques have shown promise in treating GSM-related amputations [4]. However, outcomes remain mixed, with high rates of necrosis in cases where penile reimplantation has been attempted [1].

When GSM presents alongside gender dysphoria and psychosis, treatment becomes especially challenging, particularly in contexts requiring gender-affirming care. Gender-affirming care encompasses providing support and medical care that respects the individual's gender identity, a significant consideration for transgender and gender-diverse individuals [5]. In Malaysia, for instance, socio-legal and cultural challenges can complicate decisions about patient ward placement, as the binary ward system may not effectively accommodate non-binary or transgender individuals. In this case, the patient was housed in a male ward near the staff

area, granted access to a private toilet in an isolation room, and monitored closely to prevent disturbances from other patients. This approach underscores the complexity and cultural sensitivity required to provide safe and respectful care for gender-diverse individuals experiencing severe psychiatric distress.

A comparison with a previously reported case highlights critical differences in clinical presentation and management. In their case, recurrent GSM was primarily driven by chronic gender dysphoria, whereas our patient had no prior history of self-harm, with acute psychosis serving as the main trigger. Management strategies also varied significantly; our approach prioritized crisis stabilization with antipsychotic treatment within existing sociocultural limitations, while the referenced case involved prolonged psychiatric hospitalization and structured psychotherapy [5]. These differences emphasize the importance of individualized care that addresses both psychiatric symptoms and sociocultural constraints.

CONCLUSION

Male genital self-mutilation (GSM) in patients with schizophrenia and gender dysphoria requires a complex, multidisciplinary approach. The co-occurrence of psychotic symptoms and gender dysphoria intensifies the risk of self-harm, emphasising the need for integrated psychiatric, surgical, and gender-affirming care. Effective management depends on close collaboration across specialties, culturally sensitive treatment environments, and family education. Providing patient-centered, supportive care and expanding access to gender-affirming resources can significantly improve outcomes and reduce the recurrence of self-harm in these patients.

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