CASE REPORT

Addressing Self-Inflicted Urethral Foreign Body Insertion and Masturbation in an Adolescent Girl: A Case Report

Adibah Abdul Jabar[1], Hasmali Mohamad[2], Tengku Mohd Saifuddin Tengku Kamarulbahri[3]

[1] Department of Psychiatry, Kulliyyah of Medicine, International Islamic University Malaysia, Bandar Indera Mahkota, 25200 Kuantan, Pahang Darul Makmur, Malaysia.
[2] Department of Surgery, Faculty of Medicine, Universiti Sultan Zainal Abidin, 20400, Kuala Terengganu, Terengganu, Malaysia.
[3] Department of Psychiatry, Faculty of Medicine, Universiti Sultan Zainal Abidin, 20400, Kuala Terengganu, Terengganu, Malaysia.

ABSTRACT

Self-inflicted foreign body insertion into the urethra represents a rare but concerning behaviour with significant physical and psychological implications. This case report details the presentation and management of an adolescent girl who required surgical intervention following the insertion of a foreign object into her urethra. Her case was compounded by a complex history of depression, trauma from sexual abuse, and maladaptive coping strategies, emphasising the need for a multidisciplinary treatment approach. This case highlights the urgent need for enhanced education on safe sexual practices and increased awareness among healthcare professionals regarding the complex relationship between sexual health and mental health in adolescents. Implementing comprehensive sexual education programs and providing accessible mental health resources can significantly reduce the risks associated with such harmful behaviours. Further research is essential to understand the motivations of foreign body insertions and develop effective preventative strategies aimed at this vulnerable population.
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Corresponding Author:
Tengku Mohd Saifuddin Tengku Kamarulbahri,MMed (Psychiatry)
Email: tgsaifuddin@unisza.edu.my
Tel : +609-627 5546

INTRODUCTION

Self-inflicted foreign bodies in the urethra and bladder are uncommon occurrences (1). A range of objects, including silverware, glass, batteries, rings, tubes, and beads, have been reported to cause injuries and complications (2). These injuries, which involve the insertion of foreign bodies into the genital tract, typically affect both male and female reproductive organs, such as the vagina and urethra, and often necessitate urgent medical intervention (2). While patients provide various explanations for these insertions, the diversity, multiplicity, and large size of these objects strongly suggest that masturbation is a predominant factor (3). Masturbation is defined as the act of manually stimulating one's own genitals, progressing from superficial to deliberate actions, across all genders and ages, with the goal of achieving sexual arousal, often culminating in ejaculation and orgasm (4).

This case report describes the presentation and management of an adolescent girl who required surgery after inserting a sewing needle into her urethra. Upon admission, immediate medical attention was directed toward removing the object and managing related complications. A psychiatric evaluation revealed ongoing depressive symptoms and self-harming behaviours, highlighting the need for continued psychological support. The aim of this report is to emphasise the urgent need for better education on safe sexual practices and to raise awareness among healthcare professionals about the complex relationship between sexual and mental health in adolescents. Safe sexual practices include promoting adaptive coping strategies for managing sexual urges, fostering an understanding of

bodily autonomy, enhancing emotional regulation, and recognising the risks associated with inserting objects into the urethra.

CASE REPORT

An adolescent girl with a history of intrafamilial sexual abuse was admitted to the surgical ward under the urosurgical team for the insertion of a sewing needle into her urethra. She was referred to psychiatry for depressive symptoms and unusual sexual behaviour. She masturbates approximately three times a week and reports increasing difficulty in controlling the behaviour. She uses masturbation as a primary coping strategy to manage psychological distress. Over time, she developed tolerance, leading to experimentation with various objects, including cucumbers, to enhance stimulation. Recently, this escalation resulted in the insertion of a sewing needle into her urethra. She watched pornography with provocative content and communicated with the opposite sex in a sensual manner to gain attention. Her mother was aware of her masturbation behaviour and was emotionally overwhelmed by the situation. She came from a family with strong conservative and religious values, where discussions about sexuality are typically considered taboo.

She has been experiencing a low mood for the past two years, with persistent low mood and no diurnal variation. She also reports mood reactivity. Her symptoms include anhedonia, reduced appetite without significant weight loss, insomnia, persistent lethargy, poor concentration during class, feelings of hopelessness most of the time and passive death wishes, though she has never attempted suicide.

Three years ago, she began engaging in self-harm behaviour, cutting her forearms and thighs with sharp objects to release stress, without the intention of dying. These symptoms have caused significant impairment in her social and personal life. During periods of extreme stress, she has neglected self-care and become socially withdrawn, attending only half of her school periods. Her academic performance has worsened, with a significant drop in exam grades. She has no history of psychotic symptoms, anxiety symptoms, manic or hypomanic episodes, or substance abuse.

She was raped by her older brother, starting four years ago, involving vaginal penetration a total of five times, with the last episode occurring last year. Her brother admitted his wrongdoing but denied vaginal penetration, claiming the acts were consensual. Initially, they continued to reside in the same household, making it difficult for her to avoid the perpetrator. The case was reported to the social welfare department, and a child protection officer was promptly assigned. In collaboration with child protection services, the perpetrator was temporarily removed from the household to ensure her safety. A multidisciplinary team, including mental health professionals, social workers, and child protection personnel, was involved in developing an individualised safety plan. Following the disclosure of the abuse, her parents were initially shocked and struggled to accept the incident. However, over time, the family became more receptive to professional support and demonstrated a greater willingness to cooperate with the primary team.

She was born full-term with no perinatal complications, and her developmental milestones were age-appropriate. There was no known history of learning disabilities or symptoms suggestive of attention-deficit and hyperactivity disorder or autism spectrum disorder. She attained menarche at age 12 and has been menstruating regularly with monthly cycles. No family history of neurodevelopmental or psychiatric disorders was reported. Although her academic performance declined following the onset of depressive symptoms, her cognitive functioning appears to be within the average range based on her exam results.

On mental status examination, she was a medium-built adolescent with fair hygiene, appearing calm and cooperative. Her tone of speech was low, and her affect was low but appropriate. She denied suicidal ideation but expressed hopelessness. There were no perceptual disturbances. The Columbia Suicide Severity Rating Scale (C-SSRS) indicated a low risk of suicide.

The insertion of a sewing needle into her urethra caused discomfort and haematuria, necessitating cystoscopic removal, which was completed without complications. She was prescribed a short course of antibiotics to prevent infection and referred for urological follow-up to monitor for potential complications such as urethral stricture.

The patient displayed significant psychological distress following prolonged intrafamilial sexual abuse. She was diagnosed with persistent depressive disorder with intermittent major depressive episodes. The initial management plan included trauma-informed care and a safety plan, while pharmacological treatment was deferred at the family's request. Other plans involve counselling, with an emphasis on developing adaptive coping skills when dealing with sexual urges and psychological distress. She also received comprehensive sexual education, which covered understanding sexual boundaries and bodily autonomy, and avoiding harmful behaviours such as foreign body insertion.

DISCUSSION

Since ancient times, foreign bodies have been extracted from the urethra and bladder of young females (3). Studies have documented the presence of various objects in the

urinary bladder, such as gauze, worms, electrical wires, chicken bones, thermometers, Foley catheter fragments, batteries, and even snakes (1). A review of 141 cases of genital injuries resulting from foreign body insertion during sexual activities reported 128 cases in males, 12 in females, and one in a transgender female (2). The most frequent motivation for the self-insertion of foreign bodies into the male urethra is sexual gratification or erotic stimulation (1). Retrospective studies confirm that urethral masturbation using foreign objects occurs among healthy adult males (3).

These injuries are often linked to autoerotic behaviour, psychiatric conditions, curiosity, self-harm, or a lack of understanding of safe sexual practices (2). However, another study found that none of the patients had any diagnosed psychiatric illness (3). While some researchers argue that psychiatric evaluation is necessary for these patients due to the potential for self-punitive and impulsive behaviour, this remains controversial as many patients are psychologically stable (1).

Timely diagnosis and intervention in the emergency department are essential to prevent irreversible damage and life-threatening complications (2). The definitive treatment involves the complete removal of the foreign body, either through an endoscopic or open surgical approach. The choice of technique depends on the patient's clinical status, the extent of urinary tract injury, and the size, shape, and material of the foreign object (1). Further research is needed to determine whether foreign body insertion could be a potential cause of urethral stricture in patients with an insufficient clinical history (3). Preventative measures, such as sexual education programs in schools, are critical to promoting safe sexual practices and reducing the incidence of such injuries (5).

In this case report, regular psychotherapy is vital to support her emotions. This may be attributed to the impact of intrafamilial sexual abuse and an emotionally invalidating environment, both of which can significantly impair emotional development, often resulting in emotional dysregulation and self-injurious behaviour, which may predispose individuals to the later development of borderline personality disorder.

Moreover, the insertion of sharp or rigid objects into the urethra carries the risk of long-term genitourinary sequelae, such as urethral scarring, strictures, chronic pain, and an increased susceptibility to urinary tract infections, even though the patient's cystoscopic removal of the foreign body was successful and there were no immediate complications. These issues may contribute to dyspareunia, genitourinary discomfort, or psychological distress associated with sexual activity, which may have an effect on future sexual functioning. Urological surveillance and long-term follow-up are consequently crucial in these situations.
identity conflict is intensified by doctrinal teachings.

CONCLUSION

This case highlights the clinical complexities of self-inflicted foreign body insertion into the urethra in an adolescent with psychological distress and a history of trauma. It underlines the need for a thorough assessment to understand motivations such as sexual gratification, coping with distress, or self-harm. The case also emphasises the importance of educating young people on safe sexual practices and raising awareness among healthcare professionals about the link between sexual abuse and psychiatric disorders. In Southeast Asian societies, masturbation and female sexual behaviour are taboo topics, shaped by religious and cultural norms. This stigma contributes to underreporting and a lack of guidance, delaying intervention. Regionally tailored sex education and mental health awareness programs are needed to overcome these barriers.

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