

Direct genital manipulation is rare a manifestation of childhood gratification behaviour below 5 years of age: A case series



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ABSTRACT

Childhood masturbation/self-gratification behaviour means self-stimulation of the genitals by an immature child. Literature on this topic is scarce and scattered. Though most of the paediatricians seem to know about this entity, precise knowledge on spectrum of different behavioural patterns these children may show is lacking. Masturbatory activity in infants and young children is difficult to recognise because it often does not involve manual stimulation of the genitalia at all. We hereby report a series of 3 cases of childhood masturbation where direct genital manipulation, a very rare manifestation, was evident during gratification spells.

Key words: Childhood masturbation; self-gratification behaviour; children

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INTRODUCTION

Masturbation (gratification behaviour) is a common and normal behaviour. It occurs in 90-94% of males and 50-60% of females at some point in their lives.¹⁻³ This behaviour is also not very uncommon in pediatric population of our present-day society.²⁻⁶ However, unlike adolescents, most episodes in children lack direct hand stimulation of the genitalia making their identification difficult and often leading to misdiagnosis.^{4,6}

CASE REPORTS

Case 1

A 1 year 8 months old healthy male child was brought to pediatric outpatient clinic to seek consultation for a

common cold. During conversation, mother hesitantly expressed concern over the fact that her son rubs his genitalia too often to be noticed for last 2 months. She told that initially her child exhibited the behaviour mostly at toilet times; now this is happening whenever the child is left alone. Average frequency was 10-15 times/week and on an average, the episodes lasted for 8-10 minutes or more if not interrupted in the middle. Episodes were associated with penile erection and profuse sweating. The child was in general a happy and playful one. This was the only child born out of a non-consanguineous marriage. Birth and perinatal events were unremarkable. Developmental milestones were achieved at appropriate times. There was no major health event in the past history. Father was self-employed and mother was a

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home-maker and the family belonged to upper-middle social class. As there was no confusion about the diagnosis, further work up was avoided. Parents were advised to use distraction method during the spells and to spend more time with the child. On follow up, this behaviour persisted at the same frequency for next 2-3 months; then started decreasing and stopped from around 3 years of age (Table 1).

Case 2

3 years 8 months old girl, a regular patient of a private clinic was brought for routine check-up. At the end of examination, parents wanted to discuss about some peculiar behaviour of the child privately. Mother told that 10-12 months back, she noticed her child rubbing the perineum against her trunk while climbing on to her in a way that appeared socially unacceptable. This was noticed by other family members also. Anti-fungal cream was applied around child's genitalia without medical consultation but the problem did not subside. Over past 6 months child was doing more mysterious things. She lies down on the bed or floor prone with thighs adducted tightly; putting one hand over the pubis she rubs vigorously and makes grunting noises. She becomes very angry if someone comes near her during these episodes. Mother noticed that the child sweats excessively and respiration goes high at those times. Video clips were available and were examined in presence of parents. Episodes lasted for 10-15 minutes and happened 2-3 times/week. Birth/perinatal/developmental history were normal. General physical and neurological examination was unremarkable. Genital examination, however, showed features of irritation. Anaesthetic gel was prescribed for topical use. Parents were disclosed about the diagnosis and were assured about the self-limiting nature of the

problem. They were educated about how to break those spells and avoid them happening. Condition started improving from 1 month thereafter (Table 1).

Case 3

A 3 years 5 months old male child was brought by his mother to the private clinic with masturbation as the sole complaint. Mother was a high school teacher; father died in a road traffic accident 2 years back. They lived with 69 years old grandmother. Mother was nervous telling that she noticed her child to play with his genitalia in a very unusual manner for last 7-8 months. The boy manipulates the genitalia very much the way adults do and seems to enjoy the episodes. Sometimes, he used to lie down on bed/floor prone and rub his perineum on the surface. To begin with, the boy used to practise those while alone but recently he is exhibiting these behaviours in public also compelling the mother to seek medical advice. In last 2-3 months, episodes are happening 2-3 times/day with an average duration of 8-10 minutes each time. The child had a history of simple febrile convulsion. General and neurological examination yielded normal findings. Child's intelligence and social communication was good and appropriate. There was no sign of sexual precocity and endocrine evaluation came normal. Mother was reassured and counselled and a psychiatry consultation was advised. After one year of behavioural therapy child seemed to have improved a lot (Table 1).

Clinical features of all 3 cases are summarised in Table 1. Common features in all 3 cases were: direct genital manipulation, expression of anger when confronted with anybody during the episodes, termination of the spells when distracted, no loss of consciousness and normal physical and neurological examination. All of them showed improvement in 2 years follow up time.

Table 1: Summary of the clinical features (n=3)

Case no	Age at presentation (year/month)	Age at first symptom (year/month)	Average frequency of spells	Average duration of spells (minutes)	Usual manifestation	Behaviours during gratification	Common situation when events occurred	Treatment and follow up
1 Boy	1 year 8 months	1 year 6 months	10-15 times/week	8-10 minutes or more	Rubbing of the penis with use of hands, erection of penis	Excessive sweating	-At toilet times -When bored	Stopped around 3 years of age with distraction
2 Girl	3 years 8 months	2 years 8 months	2-3 times/week	10-15 minutes	-Rubbing of pubis against mother's trunk -Prone, tightly adducted thighs and genital manipulation	-Grunting noise -Excessive sweating -Irregular respiration	-In any situation	Started improving 1 months after diagnosis with distraction
3 Boy	3 years 5 months	2 years 9 months	2-3 times/day	8-10 minutes	-Direct manipulation of penis like adolescents -Rubbing of pubis against any surface in prone position	-Sweating -Various sound in amusement	-Any situation -In front of others	Child required psychiatry consultation and behavior therapy

DISCUSSION

Childhood masturbation or self-gratification was first described by Still in 1909 and it is characterized by stimulation of the genitalia by an immature child knowing nothing about the sexuality attached to it.^{2,5,6} They just know that this act makes them amused somehow. Gratification episodes are manifested in a number of diverse and mysterious ways; and most of the parents find it difficult to understand the problem underlying these patterns of behaviours. The most commonly reported manifestations of childhood gratification include dystonic posture (supine/prone), friction of thighs, rocking pelvic movements in prone position, grunting, facial flushing and sweating, and pressure on the perineum.²⁻⁶

Making a diagnosis becomes a difficult task when direct stimulation of genitalia with use of the hands is absent. Most of the published literatures do not mention direct genital manipulation as a mode of presentation.^{4,5,6} Othman SA⁶, however, reported that 3 children in his series of 11 children with gratification habits had direct genital manipulation as an obvious finding. The diagnosis is more difficult when these children manifest signs of unpleasantness during these spells.⁴ For all these reasons, gratification often leads to over-investigation and inappropriate use of medication.

Gratification behaviours are commonly misdiagnosed as epilepsy, paroxysmal movement disorder/dystonia and even gastrointestinal disorders like gastro-oesophageal reflux or abdominal pain.⁷⁻¹⁰ Nechay A, Ross LM, Stephenson JBP *et al*⁴ in their review of 31 cases of masturbatory behaviour in children found that majority of the patients were initially misdiagnosed with seizure disorder. Yang ML, Fullwood E, Goldstein J *et al*⁷ reported that childhood gratification was misdiagnosed as movement disorders. Couper and Huynh⁸ have described dramatic examples of masturbation mimicking abdominal pain in girls. Smart phones being available to almost every family nowadays, most of these events can easily be recorded and misdiagnosis can be avoided. The most consistent findings which could help in diagnosis and in differentiating these behaviours from other paroxysmal pediatric disorders and epilepsy are: 1) typical stereotypy with variable duration, 2) no loss of consciousness 3) child can be distracted 4) anger and annoyance when distracted, and 5) normal physical and neurological examination before and after the spells.^{4,6,9,10}

Gratification behaviour can be diagnosed clinically by careful history taking and meticulous evaluation of the videoclips in presence of both the parents.^{4,6,9,11} Unnecessary investigations have to be avoided.

Parents should be reassured that that spontaneous resolution is the expected outcome and that most of them will grow out of this habit with passage of time.^{2,3,11} Child should be distracted with a toy or another playful activity to break the spell. Parents should spend more time with their children to improve bonding. There is no role for physical punishment or shouting at these children.^{2,3,11} Some children, however, might require psychiatry consultation and behaviour therapy.

Further studies are required in this field to understand the possible aetiologies of these events and to know the long-term impacts of these early childhood behaviours on their adult pattern sexual instinct.

CONCLUSION

Although gratification behaviours involved direct genital manipulation in all 3 cases in our series, we would like to emphasize that this is a very rare manifestation of the event. Paediatricians should know about the diversity of its presentation and should always encourage parents to open up. Video-clipping should be asked for in all suspected cases in order to diagnose the condition correctly and to avoid unnecessary costly investigation and harmful therapy.

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