

CASE REPORT**A ROCKING CHILD: INFANTILE MASTURBATION IN A FIVE-YEAR-OLD GIRL**Shiferaw Negash, MD^{1*}, Yonas Bahiretibeb, MD²**ABSTRACT**

Summary: Gratification behavior considered taboo and highly stigmatizing as it is rarely discussed openly in Ethiopia, a highly conservative society. This response is especially encountered when it occurs in a very young girl and may thus call for a visit to the religious healers for 'spiritual intervention' and prompt female genital cutting/mutilation to reduce the child's libido and the presumed risk of sexual promiscuity as she gets older. Because of its rarity and peculiar presentation in children without manual genital stimulation, it is often misdiagnosed. A Medline search showed sparse information on gratification disorder and none from Ethiopia.

Key words: Rocking child, Infantile masturbation.

INTRODUCTION

Gratification disorder or "infantile masturbation" is also sometimes known as "benign idiopathic infantile dyskinesia" and is a form of masturbatory behavior that is often mistaken for epilepsy, abdominal pain, paroxysmal dystonia, or dyskinesia (1, 2). Though often called a 'disorder', masturbation is a normal behavioral variant seen in early childhood (2). There is a great variation at the age of onset of symptoms, age at first clinical diagnosis, and the frequency of occurrence of the behavior.

The age of onset ranges from 2 months to 5 years with a second peak incidence at about the adolescent age, the age at first diagnosis ranges from 5 months to 8 years, with the frequency of the event once per week to 12/ day (1). Its exact mechanism is poorly understood, but has been associated with the relief of self-tension, sexual pleasure, boredom, excitement, genital infection, and lack of stimulation, especially in adolescents' boredom has been strongly associated with masturbation (2).

Gratification behavior or self-stimulation of the genitalia in children is quite common, and reported in 90-94% of males and 50-55% of females (3). Whereas, gratification behavior not involving the self-stimulation of the genitalia has variable clinical presentations in early childhood and failure to recognize these behaviors may result in unnecessary investigations and treatment and moreover stigmatization (2,4,5, 6,7).

Despite ample evidences of self-genital stimulation in children in the western literature, there is paucity of literature depicting its exact physical characteristics in the Ethiopian context. This may in part be due to few or no parental complaints of these problems, partly because, genital stimulation considered religiously and culturally as a sin and taboo and rarely discussed openly in the Ethiopian society.

We therefore present a case of gratification disorder in a 5 years old girl diagnosed initially to have epilepsy.

CASE SUMMARY

This 5 year old female child was referred from pediatric neurology clinic to psychiatry clinic in Tikur Anbassa Specialized Hospital after 2 years of close observation and follow up, because the mother reported the child has been exhibiting inappropriate sexual behaviors. From her birth, the mother described her as an irritable infant for which the mother used to sooth her by holding her over her back. The mother noticed the child rubbing herself against her mother's back at about the age of 6months.

As the child grew, the mother witnessed additional behavior, like crossing and rubbing her thighs/legs together by supporting herself against the wall. She used to do this irregularly and every time she did it her mother used to scold her, after which she would become irritable and cry for a long time.

¹Addis Abeba university, CHS, SOM, Department of Obstetrics and Gynecology.

²Addis Abeba university, CHS, SOM, Department of Psychiatry.

*Corresponding author E-mail: shiferaw_negash@yahoo.com

As time passed, the behavior escalated and began to be seen while the child was on her mother's lap, sitting on chair, or in bed and when quiet, with more frequency, 5-6 times per day. The family thought their daughter was posed by evil spirit for which they took her to different spiritual healers and holy water but with no improvement. When she was 2 years old, the mother decided to visit a nearby health center where the doctor suspected abnormal body movement, described as seizure disorder, and started her on two antiepileptic medications.

Despite the treatment for more than a year, as described by her mother, episodically the child would lean forward and rock continuously on a hard surface such as a chair or an adult's lap. The child exhibited rocking accompanied with lip smacking, eye rolling, shaking, watching of television in the air, "eidetic imagery", spasm, and feeling of fatigue, and resumption of the motions unless she was distracted. Typically, the movements stopped by gentle restraints, are not present during sleep, and not associated with loss of consciousness. The family after consulting church clergy decided to stop the medication and took the child to different holy waters but to no avail.

The parents used to punish her sometimes with no noticeable improvement in behavior. Older female relatives and traditional birth attendants suggested female genital cutting or circumcision, but her father resisted strongly. For reasons unknown to the mother, her daughter is lonely at school and in the village. Village kids do not want to play with her and associate themselves with her, they use nickname "Tewezawazua Lije" means the "Rocking Child" to tease the child. For four months, the mother decided not to send her daughter to school and allow her to play with other kids.

At the age of 3 years, the mother brought the child to Tikur Anbessa Specialized Hospital, pediatric neurology clinic, and with the suspicion of seizure disorder, investigated with CBC, serum electrolytes, ultrasound, electroencephalogram, all investigations were normal. Since no definite diagnosis was made, no specific treatment was obtainable at the neurology clinic except close observation and follow up. As no noticeable changes seen at the neurology clinic after two years of follow up, and the mother continued to report abnormal sexual behavior, she was referred for psychiatric and gynecologic evaluation. Otherwise, the child did not exhibit abnormal vaginal discharge, urinary or gastrointestinal symptoms or symptoms of itching and the mother denied history of sexual abuse, nor similar illness history in the family.

The evaluation at the gynecology clinic revealed normal female breast and external genitalia development appropriate for her age. Trans-abdominal ultrasound shows normal female internal pelvic organs. Six months after being transferred to the psychiatry clinic, a detailed history was taken from the mother regarding the behaviors the child exhibited at home. A cellphone recording by her mother, that showed typical features of gratification behavior, was instrumental in making the diagnosis. Childhood gratification disorder was diagnosed and all medications stopped. The mother was given psycho-education with a special focus on avoiding corporal punishment, reassured that the behavior is self-limiting and go away slowly, and advised to distract the child with interactive play during the episodes. She has a follow up currently at the psychiatry clinic and has shown slight improvement.

DISCUSSION

Gratification disorder observed in our patient, who is 5 years, is similar to the report by other authors. It is commonly seen between 2 months and 8 years (1, 3). It has never been reported in infants less than 2 months, though the existence of the disorder even in the fetus in utero has been reported (9). Infants and young girls with the gratification disorder, as has been revealed in our index case, first misdiagnosed to have epilepsy or movement disorders, underwent many investigations and took antiepileptic for 2 years (3, 5). This is because, unlike in adolescents, it does not usually involve self-genital manipulation and the clinical presentations are variable. Therefore, infants and children with this disorder wrongly labeled to have epilepsy, non-epileptic paroxysmal movement disorder, or even gastrointestinal disorder like gastro-esophageal reflux disease (1).

Nechay et al in their review of 31 cases of masturbatory behavior in children found that majority of the patients were initially misdiagnosed with seizure disorder (1), while other authors in their case series, reported abdominal pain and movement disorder as the commonest initially diagnosis (2,10). The unhappy expression observed in our patient during the event is similar to earlier reports, where, diagnosis of infantile masturbation is more difficult when the infant or young child seems unhappy during the rhythmic movements. When there are repeated jerky spasms, there may be confusion with epileptic infantile spasms (10). It is for these reasons that gratification behavior often leads to over-investigation, and unnecessary treatments, including antiepileptic drugs (2, 5-7).

A detailed interview of the mother was a key to considering gratification behavior in our index case. This is consistent with the previous reports, where, careful interview of parents, caregivers, and the child, appears to be one of the hubs to accurate diagnosis (9). One of the most important features of the behaviors is that the child may be stopped during gratification if distracted but responds with anger and annoyance, which was demonstrated in our case (6). The diagnosis made possible only after the video clip obtained by the mother's cellphone was seen in our patient. This finding is consistent with the case reports and series by the earlier authors, where, video recording of events has been documented to be of significant help in understanding the nature of the episodes (2, 6, 11).

Because of illiteracy, culture, sexual taboo, and tradition parents may use descriptive terminology and language that is difficult to understand for some of these movement and postural features, moving the working diagnosis to a culture bound syndrome, like possession, or to a medical disorder such as seizure disorder, movement disorder, or gastrointestinal disorder. Moreover, female relatives, elders and traditional birth attendants recommended female genital cutting, though resisted by the father is in accordance with African reports of female genital cutting considered as means of reducing the future risk of sexual promiscuity (12). In this case report, patterns of help seeking vary according to a range of factors, including the evaluation of symptoms, patient and family explanatory model of the illness and prior experiences of illness and treatment. Helman suggested that the decision to seek medical aid is influenced by social, cultural, and emotional factors, rather than the severity of the illness (13).

In our case report, the child, because of her masturbation behaviors, was isolated, bullied and not able to attend school. This shows that stigma often leads to discrimination, in our case, the child was unable to attend school and play with other children – vital resources in the healthily development of a child.

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In our context, using cellphone videotaping of these episodic events is invaluable in the diagnosis of gratification behavior.

As this is the first case reported in an Ethiopian child, health professionals who are engaged in the treatment of children with abnormal body movement need to consider gratification disorder in the differential diagnosis. Though it is a benign condition and self-limiting, failing to appreciate the condition may impose unnecessary resource utilization for diagnosis and treatment, unnecessary punishment and stigmatization of the child and inflict undue anxiety and stress on the parents/guardians.

Conclusion

Infantile masturbation rarely diagnosed in Ethiopia, probably due to a low index of suspicion and mothers are afraid of stigma and alienation. We suggest health professionals to consider gratification behavior in the differential diagnosis of strange movement mimicking epilepsy in infants and young children. Once diagnosed, parents should be reassured, advised against female genital cutting, physical punishment and segregation. Video recording of the events by parents using cellphone is strongly encouraged for better understanding of the episodes and make the correct diagnosis.

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Competing Interest

The authors declare that this manuscript was approved by all authors in its current form and that no competing interest exists.

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