Early Childhood Masturbation

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ABSTRACT

Early childhood masturbation is confused with seizures, abdominal pain, colic, or other neurologic or medical problems. The diagnosis is based on detailed medical history and video recordings. This paper report cases to enable physicians better recognize this disorder, prevent costly and invasive evaluations, and provide appropriate guidance to parents. It is a shameful event for parents, and health care professionals should encourage parents share all related events about their children.

Key words: Childhood, masturbation, shame

INTRODUCTION

Childhood masturbation was recognized in 1909 (1). Masturbation involves the stimulation of the genitals and typically begins at 2 months of age, although *in utero* masturbatory behavior has also been reported (2,3). The incidence peaks at 4 years and again in adolescents. In adolescence, 90%–94% of males and 50%–60% of females get involved in masturbation at some point in their lives (2). Because of frequent absence of genital manipulation, it is often unrecognized by families and caregivers (2,4,5). It is confused with seizures, abdominal pain, colic, or other neurologic or medical problems (6,7,8,9). In infancy, common clinical features include stereotyped posturing with tightening of the thighs, mechanical pressure applied to the suprapubic area, or both accompanied by intermittent quiet grunting, irregular breathing, facial flushing, and diaphoresis (10).

The etiology of childhood masturbation and its predisposing factors are still controversial and poorly understood. Childhood masturbation has been linked to emotional deprivation, which may, in turn, lead to more self-stimulation.

Perineal discomfort such as that caused by vulvovaginitis, urinary tract infections, or dermatitis may exacerbate the behavior but may also be the result of the behavior (11). In these patients, a thorough genital examination should be performed, and in the case of need medical therapy should be performed.

In the literature, an extensive work-up was performed such as magnetic resonance imaging, electroencephalography, intravenous pyelography, small bowel biopsy, and gastrointestinal barium swallow (8,9,11–15). And also in some cases, treatment with antiepileptic agents was initiated before establishing a diagnosis of masturbatory behaviors (8,11,15).

CASE REPORTS

This paper reported 11 cases of masturbatory behavior to enable physicians better recognize this disorder, prevent costly and invasive evaluations, and provide appropriate guidance to parents.

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Case 1

A 19-month-old boy was admitted to the health care center because of couching. At the end of the examination, his mother sent him to outdoor with his father and told us about his behavior with a feeling of shame. She first noticed this behavior when he was 11 months old; he lay on the floor in the prone position, rubbed on the floor, posturing was stereotyped with tightening of the thighs, and his hands were on his pubic area for approximately 2–3 min. He grunted and sweat, and also he had an erection. He cried when he was stopped in the middle. He had this behavior sometimes every day and sometimes twice a week.

Case 2

4-year-old girl was admitted to the health care center because of fever. At the end of examination, her mother told us with a feeling of shame and in a low voice about the child's behavior. First, 1 year ago when she was jumping on a jumping balloon, she was sweating with the tightening of the thighs. When her mother noticed this behavior, she threw the balloon. But she continued exhibiting the same behavior when she sat on a chair. She would cross her legs and tighten the thighs for 3–4 min when she would sit on a chair, and would sweat after that. She had this behavior every day. Her physical examination showed that she had perineal irritation.

Cases 3 and 4

Twin sisters of the age of 3.5 year were admitted to the health care center because of couching and fever. Their mother told us about their behavior. First, one child began this behavior and then the other child. Both of them had the same behavior, mostly in the same time or sometimes consecutively. They lay on the couch in the prone position and tightened the thighs, with their hands on the pubic area making pressure. They grunted and sweat, and became angry when blocked. They had this behavior for 3 months almost every day for 10 min.

Case 5

A 2-year-old girl was admitted to our center for routine control. She had this behavior for 6 months nearly once a week, but then she had every day for 10 min. She would apply pressure on her suprapubic area with her hands and sweat, and would cry when disturbed. After this, she had a smell in her urine.

Case 6

A 22-month-old boy was admitted to the health care center with his aunt and mother. He was the guest for a week in his aunt house. He masturbated for 2 months, for 10 min, but in the last 1 week he masturbated frequently and for a very long time (nearly 1.5 hours). He lay on the floor and tightened the thighs, and cried when blocked.

Case 7

A 23–month-old girl was admitted to the health care center for masturbation as the sole complaint. She had this behavior for 8–9 months and repeated four times in a month and lasted in 3-4 min. She lay and with thighs tightened and applied pressures on her suprapubic area with her hands without sweating. She used antifungal cream, trimethoprim-sulfamethoxazol, for vaginitis. In the perineal examination she had mild perineal irritation. Having a sister is stressful event and should exacerbate this behaviour.

Case 8

A 27-month-old. girl was admitted to our center for epistaxis. Like other patients at the end of the examination, her mother told us about her behavior. Her mother had noticed her behavior for a year, but once a week. In the last month, she had this behavior nearly every day. She rubbed on pillow, floor, and seat, and sweat.

Case 9

An 8 month-old girl was admitted to our center because of atypical movements before sleeping. It initiated after the application of estrogen cream in the genital region for labial synechiae when she was 6 months old. She would tighten the thighs, breathe frequently, and close her eyes, and would cry when disturbed. After 10 min of masturbation, she would go to sleep. She was evaluated by a pediatric neurologist for seizure and pediatric surgery. Her videotape was viewed, and no extensive work-up was performed. Nowadays, she is 17 months old, and would compress pillow or baby doll in her intercrural region for 1 or 2 min once a day. Child psychiatrist consultation was held.

Case 10

A 26-month-old boy was admitted to our center because of fever. At the end of the examination, his mother talked about his behavior. Especially when he wanted attention, he tightened the

Table 1: Characteristics of cases.

Number of case	Age (mo)	Sex	Age of onset	Median frequency of event (wk)	Mean duration of the event (min)	Increase in frequency	Sweating	Vocalization	Posture	Hands on the pubic area
1	19	M	11	2-7	2-3	NO	YES	YES	PRONE	YES
2	48	F	36	7	3-4	NO	YES	NO	SUPINE	NO
3	42	F	38	7	10	NO	YES	YES	PRONE	YES
4	42	F	39	7	10	NO	YES	YES	PRONE	YES
5	24	F	18	1	10	YES	YES	NO	SUPINE	YES
6	22	M	20	1	10	YES	NO	NO	PRONE	YES
7	23	F	14	3	5-6	NO	NO	NO	PRONE	YES
8	27	F	15	1	4-5	YES	YES	NO	PRONE	YES
9	8	F	6	14	10	NO	NO	NO	SUPINE	NO
10	26	M	24	21	1-2	NO	NO	NO	PRONE	NO
11	12	F	9	21	15	YES	NO	YES	SUPINE	NO

thighs for 1 or 2 min three times a day. When her mother distracted his attention and spent quality time together, he did not go on any more. Now he is 30 months old, goes to a daycare center. He would lie on the desk and tighten the thighs with sweating at the daycare center. Child psychiatrist consultation was held.

Case 11

A 12-month-old girl was admitted to our center for a routine follow-up. She tightened the thighs putting her hands on her legs and grunting without sweating for 3 months. In the last 2 months, this masturbatory behavior became frequent. When her mother did not disturb her, she could go on for a long time. Also when disturbed, she did not cry. Her physical and genital examination was normal.

There were no diaper dermatitis, urinary system infection, and vulvovaginitis or parasite infestation in all patients. Only in two patients, there was perineal irritation (cases 2 and 7). No advanced evaluations were required, when there were already video tapes and full anamnesis available.

In Table 1, the characteristics of the cases are reported.

DISCUSSION

The diagnosis of masturbation is mainly clinical (7–9,11,16). Video recordings facilitate the diagnosis. In these cases, video recordings taken by parents were viewed along with the parents, to avoid additional investigations, unnecessary treatments, and worsening parental concern.

If the physical and neurologic examinations are normal, no additional diagnostic testing needs to be performed. Sources of perineal discomfort such as local irritation, pinworms, diaper rash, and poor perineal hygiene should be ruled out (17). Only in two children (case 2 and 7), perineal irritation was observed and treated.

The true prevalence of masturbation in childhood changes by countries and cultures. In Turkey, there is no evidence about the prevalence. As seen in our series, except two (cases 6 and 7), masturbatory behaviors were not the main complaint for attendance. Mostly, at the end of the examination, children's mothers told about this behavior with a feeling of shame. Although our hospital is a private hospital in the capital city of Turkey, Ankara, and also most of patients are in high socioeconomic status, masturbatory behaviors cause feeling of shame in parents. This behavior should cause feeling of shame especially in Eastern countries (18).

In a study from Turkey, Unal has noticed that the onset of masturbation was often associated with a genito-urinary disorder or a stressful life event like weaning, the birth of a sibling, or separation from the parents (19). But in our series, parents take an eager interest in their children. In two children, we noticed stressful events (case 6, having a visit to his aunt; case 7, having a baby sister) that did not initiate the behavior but increased the frequency. We advised all the parents to spend more time with their children and take adequate care of their children. We also advised parents having psychiatric consultation.

In an 8-month-old. child (case 9) admitted to our center because of atypical movements, pediatric neurology consultation was held. Without more investigations, her masturbatory behavior was identified. In the literature, an extensive work-up was performed (8,9,11–15). Of course, these investigations inputted cost, and parents were under stress until the results were obtained.

CONCLUSION

As a practitioner we should encourage parents to open up every complaint of their children, and we should view the video recording of masturbatory behavior along with parents. And we should also advise parents to take a close interest in their children, especially in stressful events, and to have a child psychiatric consultation.

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