Infantile masturbation in an African female: is this a justification for female genital cutting?

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Case report

Background: **Masturbation is a taboo and not discussed openly in Africa. It is still worse when it occurs in an infant and will thus call for a visit to the traditional healers for 'spiritual intervention' and prompt female genital cutting/mutilation to reduce the child's libido and risk of sexual promiscuity as she gets older. Because of its peculiar presentation in children without manual genital stimulation, it is often misdiagnosed. A Medline search showed sparse information on infantile masturbation and none from Africa.**

Methods: **A 15-month-old female was brought into a clinic in Port Harcourt, Nigeria, with a history of unusual rocking with adduction of the thighs noticed since 3 months of age. At 10 months of age, the child would lean forward and rock continuously on a hard surface such as a chair or an adult's lap. Rocking was accompanied with lip smacking, eye rolling, shaking, "watching of television in the air", spasm and feeling of fatigue and then resumption of the motions unless she was distracted. The child had been spanked occasionally by both parents with no noticeable change in behavior. Older female relatives had suggested female genital cutting or circumcision, but her father resisted vehemently.**

Results: **Infantile masturbation was viewed by the pediatrician and a 10-minute video recording was taken to confirm the diagnosis. The mother was reassured, counseled about behavioral and environmental modification. There was a marked improvement when the baby was seen 6 weeks later.**

Conclusions: **Infantile masturbation rarely diagnosed in our region is probably due to a low index of suspicion and because mothers are afraid of stigma. We suggest that infantile masturbation should always be considered as a differential diagnosis of strange movement mimicking epilepsy in infants, and when a diagnosis is made parents should be counseled against female genital cutting. A video recording is encouraged fora correct diagnosis.**

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Introduction

The term masturbation is derived from the Latin word manus meaning 'hand' and stupratio meaning "defilement".[1] Masturbation or self stimulation of the genitals is a common human behavior said to occur in 90%-94% of males and 50%-60% of females at some time of their lives.[2] Though it is accepted in the developed world as a normal part of human sexual behavior, in Africa masturbation is regarded as sinful, resentful and a taboo and is unlikely to be diagnosed in the doctor's consulting room and especially not in children. Infantile masturbation (IM) is a form of gratification disorder which is seen as a sign of promiscuity as the child grows older and may be one of the reasons for early female circumcision with resultant female genital cutting in Africa.

Masturbatory activity in infants and young children is difficult to recognize because it does not involve manual stimulation of the genitals at all.[3] IM has been mistakenly recognized as epilepsy,[3,4] abdominal pain[5,6] and paroxysmal dystonia or dyskinesia.[7] There have been reports of unnecessary and expensive investigations carried out such as blood gas analysis, metabolic screening, abdominal ultrasound scan, gastrointestinal tract radiography,[4] cerebrospinal fluid analysis, skull X-ray, brain scan,[3] pyelography, cystoscopy, vaginoscopy and colposcopy.[1] Patients have even been mistakenly treated with antiepileptics.[3,4,6]

Case report

A female baby was brought in by her mother with complains of unusual rocking noticed since 3 months of age, which had worsened as the child grew older and become embarrassing to her parents. Her mother recalls that from 3 months of age, the child preferred to adduct her thighs and rock even when held against an adult's shoulders. As soon as she could sit unsupported she would stay in a position rocking herself. This also occurred when she was carried on an adult's lap. There was no genital manipulation with fingers.

During these episodes, which occurred in her cot, on her high chair and when held against any part of the body, there was noisy fast breathing, tongue licking, lip smacking and eye rolling, shakiness and eventual weakness but not sleep. Episodes lasted about 5 minutes but motions would resume spontaneously if she was uninterrupted. There was no loss of consciousness. Her mother claimed movement occurred many times a day and was absent only during sleep or if she could be distracted. She had attempted distracting the child by taking her to play with neighbors' children but withdrew when she was questioned about the child's behavior. The mother had stopped going out to parties and even to church to avoid unnecessary glances and comments. The child had been spanked occasionally by both parents with no noticeable change in behaviour. Grandmother and aunts had suggested female genital cutting, which was opposed by the father vehemently. Her medical history was non-contributory. All other histories were normal.

She was the only child of a happy monogamous Christian family in social class one. Mother is a 30-year-old graduate and father, a 35-year-old graduate. The mother denied any history of sexual abuse of the child. She denied any history of masturbation and circumcision. However, her mother's family members including grandmother and aunts were circumcised.

A video recording lasting over 10 minutes showed the child sitting on a chair and rocking on a spot while wearing a pair of disposable nappy. When the disposable nappy was removed on request, she walked around distracted for about 3 minutes and then returned to the seat. Then she was noticed to lean forward towards the edge of the chair to achieve maximum clitoral friction or stimulation. Between rhythmic movements, she giggled intermittently, with dreamy eyes, grunting, lip smacking, tongue licking, assumed eidetic imagery ("telly in the sky") with sudden spasms, fatigue and sleepiness but would spontaneously resume motions if uninterrupted. When the rhythm was disturbed by moving her from the position, she would go back to the same posture and the cycle would continue. There was no thigh crossing noticed, no abnormal eye movement and no cyanosis. There was no obvious genital stimulation but when disposable nappy were removed she attempted to manually push her clitoris against the seat. Her mother had not noticed this prior to the video. General and systemic examination was normal except for urogenital examination which revealed a slightly hyperaemic clitoris.

Infantile masturbation was diagnosed and the mother was reassured and counseled to stop the use of disposable nappy, which apparently provided direct clitoral stimulation, and to stop wearing her trousers or thigh fitting underwear. She was also counseled to wear child loose cotton pants, distract her more often with toys, and avoid carrying her astride on the body. She was advised never to hit her again. The mother was counseled on the harms associated with female genital cutting. The patient was seen 6 weeks later with her happy mother who said that the episodes had reduced and only when she was carried on the body. She is being followed up to know when it will stop completely.

Discussion

Infantile self-stimulation is said to be rare in children. Misdiagnosis seems to occur because there is an absence of direct stimulation of the genitalia with hands and it may present with only repeated adduction of the thighs.

The age of the presentation is variable within the period of infancy. A review of the literature showed two series[2,3] of 15 patients and 12 patients respectively who presented with symptoms at less than one year of age. Though the first symptom of the present patient was noticed at 3 months of age, the age of first symptom has been reported at 2 months,[7] 3.5 months,[8] and 4 and 5 months.[9]

The age at the diagnosis in the present patient of 15 months was due to the mother's reluctance to discuss it with doctors earlier for fear of being blamed and to avoid stigmatization. However, in a prior study the mean age of diagnosis was 35 months.[7]

Though the mother could not be specific about the frequency of events, a mean of 16 times per week has been reported.[1] In this patient each episode lasted about 5 minutes at a time, but ranges of 30 seconds to 2 hours have been reported.[4]

The patient came from a stable home with parents in social class one, although class had no bias in a prior study done.[7]

There was no significant medical history in this patient, though histories of reflex anoxic seizures, neonatal seizures and megalencephaly in other patients

have been reported.[1] Episodes in this patient were found to occur on an adult's lap or seat but never when sleeping, but there are reports of IM when sleeping, in car seats, when bored or tired, when watching television, in a baby walker, when lying on the floor, during nappy change and when the child was upset.[1]

Behaviors noted in this patient such as grunting, rocking, lip smacking, giggling, eidetic starring, fatigue and sleepiness were recorded previously. Others include dystonia, cyanosis, pallor and feeling frightened.[1] The occasional genital manipulation the mother noted for the first time in this patient was an attempt by the child to place her clitoris against the seat. The mother had unfortunately always dressed her in disposable nappy not realizing that it was the probable cause of clitoral stimulation. Whereas the diagnosis was made without investigations in this patient, reports of EEG, brain CT scan, electrolytes and blood count have been done. Barium meals and others have also been reported.[1]

That the older female relatives of the patient requested for female genital cutting (FGC) is not unexpected in this setting in Africa where FGC has been practiced for years. FGC is the partial or complete removal of the external female genitalia for cultural rather than medical reasons.[10] One of the reasons given to justify FGC is to reduce female sexual response which will reduce sexual promiscuity and help maintain a girl's virginity until marriage.[11] The grandmother and aunts of this patient were circumcised, though her mother was not, because she was born and bred in the city. FGC is usually carried out by older females in the village community and is still practiced today in the rural areas of the country.

There is no law barring the practice of FGC in Nigeria. The prevalence of FGC in Edo State, Southern Nigeria has been recorded to be as high as 45.9%,[12] which has a common boundary and similar cultural and religious inclinations as Delta State where the patient's parents come from. A study of women attending an ante-natal clinic in Edo State revealed that FGC does not attenuate sexual feeling and thus cannot be justified by suggesting that it reduces sexual activity in women.[13] The refusal of FGC by the father and the high social class of the family may contribute to the avoidance of FGC in this child. However, if IM had been noticed in the village, the mother and child would have been subjected to FGC because her mother had also not been circumcised.

Careful interrogation appears to be one of the keys to diagnosis. One of the most important symptoms is that the child may be stopped during gratification if distracted as noticed in this patient, and may also show anger and annoyance when interrupted.[7]

The correct diagnosis of IM as done in the present patient is best made by recording and watching a video of the episodes to understand the nature of the attack.[6,7,14-16] Once the diagnosis is made and there are no suspicions of child sexual abuse requiring further investigation and management, reassurance seems to be the most effective management.[8] Treatment of this patient involved reassuring parents, environmental manipulation and behavioral modification with a resultant positive effect.

IM has been reported to be associated with behavioral problems but few data are available on the clinical outcome of childhood masturbation but most children tend to develop normally.[7]

In conclusion, IM is rarely diagnosed in our region probably due to a low index of suspicion and because mothers are afraid of stigma. We suggest that IM should always be considered as a differential diagnosis of strange movement mimicking epilepsy in infants, and FGC should be discussed and discouraged. IM is not a justification for female genital cutting. A video recording is encouraged for a correct diagnosis.

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Dragonfly By Qi Bai-shi (1864-1957)