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CASE REPORT

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Childhood masturbation simulating epileptic seizures: A report of two cases and review of the literature

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Abstract *Background:* Childhood masturbation (self-gratification) may mimic epileptic seizures, and is regarded as one of paroxysmal non-epileptic disorders in children, which incorporate several potential diagnoses. It is characterized by self-stimulation of the genitalia, associated with unusual postures and movements which could be mistaken for seizures. If not recognized, childhood masturbation could pose diagnostic difficulties, unnecessary investigative spending and considerable parental anxiety.
Aim: To highlight two cases of childhood female masturbation simulating epileptic seizures
Design: Descriptive report of clinical presentation of two cases of child masturbation mimicking seizures
Conclusion: There is need for high index of suspicion in order to diagnose cases of childhood masturbation which may be confused with epileptic seizures. Home video recording of the events is very helpful in making timely diagnosis; so that unnecessary investigations and treatment is avoided.

Key words: childhood masturbation, non-epileptic disorder, seizure mimics

Introduction

Developmental studies have shown that masturbation (self-gratification) is common in infancy and childhood,[1,2] and was first reported by Still in 1909. It is characterized by self-stimulation of the genitalia, associated with unusual postures and movements which could be mistaken for seizures. Childhood masturbation is regarded as one of the paroxysmal, non-epileptic disorders in children, which incorporate several potential diagnoses. Therefore, if not recognized, it could pose diagnostic difficulties, unnecessary investigative spending and considerable parental anxiety.[3]
There is paucity of information on childhood masturbation simulating epileptic seizures in our environment, and to the best of our knowledge; this report is the first from this area. Two cases of childhood female masturbation that were referred to our clinic as 'seizure disorders' are highlighted.

Case 1

ZMG, a 6year old nursery 2 female pupil was referred from a private clinic as a case of seizure disorder with poor response to anticonvulsant treatment. Her abnormal body movement (thought to be convulsions) started at age of 7months. The "convulsion" was described as abnormal movement of the limbs and trunk, occurring mainly while lying down, associated with repeated flexion and extension of the lower limbs. No history of sudden fall to the ground during any of the episodes, no facial twitching or staring gaze and no impairment of consciousness. Child would leave the family to find a separate place to lie whenever the episode is about to occur. Of recent, child would look for a towel/piece of cloth that she rubs over the genital region during the episodes. She was having 2-3 episodes per week initially, but the frequency progressively increased to 2-3 episodes per day at the time of presentation.
Mother is uncertain if episodes occur in school, but there was no report of such from the teachers. She has been on traditional interventions including exorcisms without significant change. She was subsequently taken to the referring private clinic where she was placed on carbamazepine anticonvulsant for some weeks with no clinical benefit.
On presentation at our Paediatric Neurology clinic, further evaluation revealed normal neurodevelopmental history and normal clinical examination including anthropometry. Investigations done included electroencephalograph (EEG), serum electrolytes including sodium, potassium, chloride, calcium, magnesium and phosphate were all within normal limit.

Due to poor response to the increasing doses of the anticonvulsant (carbamazepine) for up to 9-weeks, the

sexual development in females, would rather be expected to be high. Therefore, the low levels found by Ajlouni *et al.* do not seem to explain masturbatory behavior in these children. Hence, in line with the authors conclusion,[3] further studies are needed to substantiate this finding.

Masturbation may occasionally be a manifestation of sexual abuse in a child.[1] Some indicators to the possibility of sexual exposure may be suggested if the child is suspected to be taught to masturbate by someone, or the child tries to stimulate other children or continues to masturbate in public. When children report being sexually abused, there is a high likelihood that it is true, because young children rarely make false accusations. Therefore, a search for evidence of sexual abuse or other abnormalities in the genital area; by external genital examination should be carried out. This is particularly important in view of the rising ugly trend of child sexual assault/abuse in different communities. Due to frequent initial misdiagnosis of masturbation in young children, a lot of investigative spending, extensive diagnostic work-up and unnecessary drug prescriptions may occur (as in the first case report), before the final diagnosis is often made. Therefore, particular emphasis should be paid to detailed history taking, high index of suspicion and observation of the abnormal events (which may be in form of video-recording) whenever possible. Important clues to the diagnosis of childhood masturbation includes normal EEG between or during the attacks, lack of response to antiepileptic medication and careful reviewing of videotape recording of the events.[10,12]

As these behaviors are a normal occurrence in child development, interpretation, reassurance and behavioral modification are the keys in management of the child and the family.[10,12] The events usually disappear with time, without any drug treatment.[9] Distraction/ redirection can be helpful while the child is attempting to masturbate, by engaging the child's interest in other objects or activities away from the behavior. The spectrum of distraction strategies includes playing with the child, carrying the child or offering different toys of interest, in various combinations. Since boredom and parental inattention are some of the risk factors considered for masturbation in younger children, parents should spend enough time with the child, hugging and cuddling the child as necessary. Most children will stop the behavior over time if they are appropriately supervised, mildly restricted/redirected and are praised for appropriate behavior. There is also the need for more understanding of infant and child sexuality issues, so that child sexuality would be viewed as a normal developmental process.

Conclusion

There is need for high index of suspicion in order to diagnose cases of childhood masturbation which are commonly misdiagnosed as 'seizures' or movement disorders. Home video-recording of the events is very helpful in making timely diagnosis, so that unnecessary investigations and treatment is avoided.

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