Behavioural Management of Inappropriate Masturbation in an
Eight Year Old Girl

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Abstract

An 8-year-old girl, previously diagnosed with infantile masturbation, was referred and treated for public masturbation. Treatment involved age appropriate sexual education, reinforcement contingencies, the use of distraction and redirection, and when necessary, negative punishment. Public masturbation behaviour was substantially reduced during treatment phase from daily occurrence to occasional occurrence, and at one month post treatment follow up, public masturbation was absent.

Keywords

Infantile masturbation, inappropriate masturbation, treatment, behavioural management, child
Introduction

Sexual behaviour in children is common and considered developmentally normal (Friedrich, Sandfort, Oostveen and Cohen-Kettens, 2000; Hornor, 2004). From early childhood through to adolescence, children engage in a wide range of sexual behaviours including self stimulation, exhibitionism, talking about sexual parts or activities, touching breasts or genitalia of others or self (Friedrich, Fisher, Broughton, Houston & Shafran, 1998; Hornor, 2000; Lindblad, Gustafsson, Larsson & Lundin, 1995). Although there is a wide variation in the type and frequency of child sexual behaviour, some behaviours are rare in children (e.g., inserting objects or digits into the vagina or anus, oral to genital contact, a child asking an adult to touch their genitalia, the use of force or coercion in relation to sexual behaviour and age inappropriate knowledge of sex) and are thought to be indicative of child abuse (Davies Glaser, & Kossoff., 2000; Heiman Leiblum, Esquilin & Pallito., 1998; Hornor, 2004).

Infantile and Childhood Masturbation

Masturbation is one common form of childhood sexual behaviour and is defined as self stimulation of the genitals (Lindblad et al, 1995). It may be accompanied by a number of physiological signs such as flushing, sweating, grunting, irregular breathing, glazed eyes, staring, and may involve unusual body postures or spasms and be climactic (Casteels et al., 2004; Finkelstein, Amichal, Jaworowski & Mukamel, 1996). It has been observed in utero (Meizner, 1983), and in infancy (Casteels, Wouters, Van Geet & Devlieger, 2004; Leung & Robson, 1993; Omran, Ghofrani & Juibary, 2008), with peak periods of masturbation observed around 4 years of age and then again during adolescence (Mink & Neil, 1995; Rutter, 1971; Yang, Fullwood, Goldstein & Wink,
During middle childhood there appears to be a reduction in overt masturbation. For example, research based on parental reports, suggest that on average, 20% of preshoolers and 80% of 13-year-olds masturbated compared to 10% of children in the 7- to 12-year old age range (Rutter, 1971).

Although masturbation is relatively common and normal in children it is not always recognized as such. Because masturbation does not always involve direct manipulation of the genitalia, especially in the case of girls, but may include rubbing, unusual body postures and spasms it may not be recognised as masturbation and clinical intervention in the form of a medical referral is sought because of concerns that there is something wrong with the child (Casteels et al., 2004; Couper & Huynh, 2002). During medical assessment, Paediatricians may also not consider masturbation as an explanation and the child may be misdiagnosed as having epilepsy, recurrent paroxysmal movements, or abdominal pain (Casteels et al., 2004; Couper & Huynh, 2002; Leung & Robson, 1993; Mink & Neil, 1995; Nechay, Ross, Stephenson & O’Regan, 2004; Yang et al, 2005a). Misdiagnosis of masturbation is especially likely in infantile masturbation as it is often poorly recognised by physicians and is less common (Casteels et al., 2004; Couper & Huynh, 2002; Nechay et al., 2004; Omran et al., 2008; Yang et al., 2005).

In medical settings, when differential diagnosis of childhood or infantile masturbation is made, Paediatric treatment largely consists of reassuring the parents that masturbatory behaviour in infants or young children is normal, that the behaviour is reinforced through the pleasurable feelings it elicits or the comfort it provides to the child, and that the child will outgrow overt masturbatory behaviour (Casteels et al, 2004; Finkelstein et al., 1996). Parents are instructed to ignore the behaviour or redirect the child when the
child engages in it. It is emphasised that scolding or forcibly trying to stop the infant or young child from the behaviour may result in the child developing a sense of shame or guilt about engaging in sexual behaviours and may reinforce the behaviour (Casteels et al., 2004; Yang et al., 2005). Recent research, however, suggests that not all children will outgrow overt childhood masturbation and that for some children this will continue to be a problem beyond culturally appropriate age limits (Unal, 2000).

Additionally, although masturbation is considered developmentally ‘normal behaviour’, there are some masturbatory behaviours that are considered to be problematic and for which clinical intervention is sought. In particular, masturbatory behaviours that are excessive, inappropriate (e.g., in public), or cause injury or pain are those that are referred for assessment and treatment (Hornor, 2004; Leung & Robson, 1993; Mallants & Casteels, 2008).

*Treatment for excessive or public masturbatory problems*

The research surrounding the treatment of public or excessive masturbation is limited and consists of a number of case studies. Many of the early case studies reported the use of aversion techniques that were punishment based (e.g., McGuire & Vallence, 1964) including the use of aversive verbal contingencies, oral lemon juice, (Cook, Altman, Shaw & Blaylock, 1978; Wagner, 1968) electric shock (McGuire & Vallence, 1964) and negative punishment (e.g., taking away valued items from the child) when problematic masturbation occurred (Armstrong & Drabman, 1998). Although many of these treatments were effective in reducing masturbatory behaviours they were also criticised for being punitive, harsh, sending the message that masturbation is wrong, and teaching the child what not to do without encouraging other positive replacement
behaviours (Dufrene et al., 2005 Tarnai, 2006). Medical or surgical interventions have also been applied, especially in the case of unsuccessful treatment of problematic masturbation, and include castration, and hormonal drug therapies to reduce sexual drive (Carlson, Taylor & Wilson, 2000; Gilbert, 1916; Realmuto & Ruble, 1999). These treatments have been criticised in that they limit a person’s ability to engage in what is considered normal sexual or masturbatory private behaviours, and have also been questioned in terms of ethical or human rights concerns (Tarnai, 2006).

More recently, Reinforcement-based treatments have been used to treat excessive or inappropriate masturbatory behaviours. For example, Ferguson and Rekers (1979) used positive reinforcement for competing behaviours in a 4 year old girl with excessive masturbation. That is, when the child began to masturbate she was prompted to engage in alternate behaviours (e.g., playing appropriately) and was rewarded with M & M chocolates for doing so. The treatment was effective in that it reduced the behaviour from frequent (i.e., 4 times in one hour) to infrequent (i.e., occasional behaviour that was not considered problematic) over a 24 month follow up period. Other studies have also showed the effectiveness of using positive reinforcement procedures such as praise, or access to preferred activities, for not engaging in masturbatory behaviours as an effective means for eliminating problematic masturbation in children ranging from 8 years to 11 years (Janzen & Peacock, 1978, Wagner, 1968).

Not all studies have found reinforcement schedules, alone, effective in eliminating masturbation. For example, Luiselli, Helfen, Pemberton and Reisman (1977) used differential reinforcement to treat a mentally retarded 8 year old boy for excessive and public masturbation. The child earned tokens for working on task (i.e., not engaging in
mastubatory behaviour). The reinforcement procedure was ineffective and they therefore implemented a mildly adverse punishment regime in the form of overcorrective functional movements (e.g., raising arms over head, wrapping arms around his chest). This was highly effective in reducing masturbatory behaviours to zero within 4 days and treatment gain was maintained over a 12 month follow up period. Similarly, Dufrene, Watson and Weaver (2005) found that a reinforcement schedule alone (e.g., praise for on-task non masturbatory behaviour) did not reduce public masturbation in a 7 year old girl who also had a traumatic brain injury. In addition, they used a response blocking guided compliance (RBGC) procedure which entailed the child being told “no” when she engaged in public masturbatory behaviour, her hand was taken from the genital region and she was then guided through a writing assignment. The RBGC procedure reduced masturbation substantially, however, when the RBGC procedure was paired with the reinforcement schedule it eliminated masturbation and had the added benefit of increasing on task behaviour. These authors concluded that multi component treatments which include response blocking, guided compliance and reinforcement of on task behaviours may be effective in eliminating difficult masturbatory behaviours as well as helping to increase adaptive behaviours.

Recent literature on the treatment of problematic masturbation also highlight the need of education of the parent and/or teacher in the management of the problem and that age appropriate sexual knowledge about masturbation is given to the child, to ensure that the child’s sexuality and sexual activities are valued positively, but that there are clear boundaries and rules around these behaviours (i.e., they are private not public behaviours, Mallants & Casteel, 2008; Tarnai, 2006).
In summary, there are a number of approaches to problematic masturbatory behaviour in children. More recently, the emphasis is on treatment that uses positive reinforcement, but may include non aversive punishment contingencies if reinforcement does not work, and also includes education and normalisation of child sexual behaviour, as well as boundary setting. Children with developmental or intellectual difficulties may require additional help in understanding cultural norms and boundaries about sexual behaviours. Although not discussed in this review, screening for child sexual abuse is crucial.

The present study is a case study describing a multi component individualised treatment programme for reduction of public masturbatory behaviour in an eight year old girl.

**Method**

**Participant**

Jane (a pseudonym to protect anonymity) is an 8-year old European girl, previously diagnosed with infantile masturbation, who was referred by her Pediatrician for management of inappropriate masturbation (i.e., masturbation that occurred in the presence of others at home or at school).

Parental and teacher interviews were conducted and it was reported that Jane’s masturbation occurred in the context of sitting on a hard chair. At home, the masturbation involved Jane sitting upright on the chair, crossing her ankles, closing her legs together and making a rocking movement. It was frequently accompanied by panting sounds, and if left uninterrupted, would continue in this manner until orgasmic relief was reached as indicated by a sigh, relaxation of her body and cessation of the rocking movement. Masturbation
typically lasted from two to several minutes and occurred approximately twice a day either after school, or in the early evening when Jane was doing her homework or other activity seated at the table. Jane’s mother did not think that the behaviour increased or decreased according to stress in the home environment but remained fairly constant. Jane’s teacher reported Jane engaging in masturbatory behaviour in the classroom when she is sitting on her chair but described the behaviour as not overt. She reported a small rocking movement that was non climactic, and she didn’t think other children would notice it. She reported that the behaviour did not happen everyday, but most days it would occur on one occasion. She did not report any other behavioural issues with Jane.

Jane’s mother reported responding to Jane’s masturbatory behaviour in one of three ways. One, she told Jane to stop the behaviour. Two, she asked Jane what she was doing, to which Jane typically responded “nothing”. Three, she told Jane to go to her bedroom if she wanted to engage in that type of behaviour. All three of these responses resulted in Jane stopping the behaviour temporarily, however, the behaviour would frequently re-occur within the specified time-frame. Jane’s teacher did not report responding to the masturbatory behaviour.

**History of masturbation**

Jane’s mother reported that they first noticed unusual behaviour when Jane was in her infancy (approximately 6-7 months of age). They noticed that when she was placed in her car seat she would squirm around a lot and looked uncomfortable. This behaviour became more pronounced when Jane began to sit in a high chair with both squirming, facial gestures of discomfort and sometimes screaming. Jane underwent a medical assessment in relation to this behaviour at 10 months of age. She was initially diagnosed with epilepsy, but a subsequent 2nd opinion was sought and on viewing a video taped episode of Jane squirming in her high chair, a diagnosis of infantile masturbation was established. Jane’s mother
reported embarrassment about the diagnosis but that the neurologist explained the behaviour as normal and that Jane would outgrow the masturbation in a matter of months or years, or at least by the age of 5 years, and to ignore the behaviour in the meantime.

Jane’s mother reported that throughout Jane’s early childhood the masturbation continued and was specifically related to being in a high chair or strapped in a car seat. As Jane became older, masturbation also began to occur on hard chairs. Jane’s masturbatory behaviour was noticed by teachers at pre-school and primary school who queried the possible causes of the constant squirming in her chair (e.g., worms). Jane’s mother reported feeling too embarrassed to tell the teachers about Jane’s masturbation diagnosis, instead telling the teachers that the problems “down there” were being sorted, but did not specify what the problem was.

Jane’s mother reported not knowing how to deal with Jane’s public masturbation. She had tried ignoring the behaviour but was now telling Jane to stop the behaviour. Jane’s mother reported that she did not know how to broach the topic of masturbation with her daughter. She was also concerned that if she discussed the behaviour with Jane, that she would have to fully explain sexuality and felt Jane was too young for this. She did not report any concerns of sexual abuse being a factor in this case.

**Background factors:** There were no difficulties in pregnancy, birth or in Jane’s development other than problems related to the diagnosis of masturbation. There is no history of family psychiatric illness. Academically, Jane was reported to have no difficulties. She was average in most subjects and a good reader. Socially, she had a number of friends and did not have difficulties with socializing.
Formulation

Jane is an 8 year old girl who has a long-standing history of masturbatory behaviour since infancy. Her parents understanding of the diagnosis was that it was within the range of normal development and that Jane would eventually outgrow the frequent masturbation by age 4 or 5 years. Because Jane is now 8 years of age her parents are concerned that she will not outgrow it, and as the behaviour is public (i.e., at home in front of others and at school) her parents are concerned that it may become socially embarrassing for Jane. They are uncertain how to manage or alter the behaviour and have therefore sought intervention.

Factors that are likely to have contributed to and maintain Jane’s public masturbatory behaviour at the age of 8 are largely related to lack of social feedback related to the behaviour. For example, Jane’s masturbatory behaviour was deliberately ignored across her early childhood years as it was expected that she would outgrow it and her parents were embarrassed about the condition. Masturbation was not discussed with Jane, nor corrected (e.g., “no, we don’t do that in front of others”), nor were others informed of the problem, but instead the behaviour was explained as an unspecified issue that would resolve. In this way, the behaviour was allowed to continue at home and in pre-school and school environments with little inhibition. Although Jane has learned to be somewhat discreet with the behaviour (e.g., she engages in the behaviour when she thinks no one is noticing) she has not realized the import of keeping the behaviour private and she has received limited information about the inappropriateness of the behaviour in public.

In addition, because masturbation is positively reinforcing, due to its pleasant sensory sensation and orgasmic elements, it has become a strong maintaining factor. Further, masturbation may also serve secondary purposes other than sensory pleasure (e.g., self
soothing, eradication of boredom) or has become a habit cued by environmental (hard chairs) or emotional stimuli (when tired or stressed).

Data collection
Throughout the assessment, and treatment period Jane’s mother kept a daily dairy noting occurrences of inappropriate masturbation at home. Pre and post treatment frequency of observed masturbatory behaviours were obtained from parental and teacher report. Additionally, a classroom observation by the treating therapist occurred pre treatment. Jane was seated on a chair and the mat during this time period. Jane engaged in the activities as instructed, interacted with other children and displayed no masturbatory behaviours.

Treatment
The treatment goal was for Jane to stop engaging in public masturbatory behaviour (i.e., at home and at school). The treatment intervention was carried out over a period of 8 weeks by the first author. It included one individual session with Jane, 7 individual sessions with Jane’s mother, and one brief session with Jane’s teacher.

Components of treatment Intervention:
1. Education
   a). An education session with Jane’s mother included providing information about appropriate socio-sexual behaviour (e.g., masturbation is normal, may serve a number of purposes, it is a private activity not public, developmentally appropriate sexual behaviours, the need to emphasize with Jane that it is a healthy positive behaviour) as well as discussion, problem solving, role playing and normalization of the masturbation topic with Jane’s mother so that she became more comfortable about discussing sexual, masturbation issues with Jane.
Management of inappropriate masturbation

b). An education session with Jane about masturbation (e.g., labeling and naming body parts, discussed what she knew about bodies, discussed masturbation and why it feels good, normalized the activity, expressed positive aspects of it, discussed private versus public places for masturbation, discussed that it may be a comforting habit).

c). A discussion with Jane’s teacher about the masturbatory behaviour and that if she noticed it to refocus Jane back to her schoolwork and praise on-task behaviour (see below behaviour modification plan).

2. Behavioural modification plan

After education sessions had been carried out the following behavioural modification plan was discussed and given to Jane’s mother to carry out in relation to situations where it was likely that masturbation would occur (i.e., when Jane was doing her homework sitting at the table on a hard chair) or did occur. It was a stage approach.

a). Stage 1. Reinforce on-task behaviour (e.g., homework, drawing) every 10 – 15 Minutes with praise (e.g., “I like the way you are concentrating on your homework”, “it’s great to seeing you working so well”).

b). Stage 2. If masturbation occurs, distract and redirect Jane back to on-task behaviour (e.g., “Jane, do your homework”, “Jane, please do your drawing”, “Jane, please do your computer work”).

c). Stage 3. If masturbation occurs again within the timeframe session (e.g., the hour of doing homework) then remind about the privacy rule (e.g., “Jane, if you want to do that rocking you can do it in your bedroom”, “Remember rocking is for a private place, your bedroom”).
Management of inappropriate masturbation

**Stage 4.** If masturbation continues to occur within that timeframe session after Stage 2 and 3 then send Jane to her room for 15 minutes, to return when she is ready to focus on her homework.

The treatment intervention included review sessions, problem solving of issues that came up, and additional training of Jane’s mother to ensure that she used the reinforcement schedule as written. It also included education and use of stimulus control related to hard chairs (e.g., if Jane was very tired, have her sit on the couch rather than at the table). Relapse prevention education was also carried out at the end of treatment and covered that lapses may occur, identified situations when lapses are likely (e.g., parents busy or preoccupied, stressors) and the planned response to lapses (e.g., use the above behavioural modification plan, be consistent).

**Results**

For result purposes, daily occurrences of masturbation were averaged per week. Pre-assessment, Jane’s mother reported that Jane was engaging in masturbatory behaviour approximately 14 times a week. During assessment and gathering of baseline data, masturbation was reported to occur on average 3 times a week. During the Treatment phase masturbation occurred on average once a week and by the end of treatment was not occurring at all. At 2 week post treatment follow up the behaviour had not occurred (see Figure 1) and at 1 month post treatment the behaviour was not present. Because of difficulties contacting Jane’s teacher, data gathered, only included pre and post treatment occurrences of masturbation.
Figure 1. Average occurrences of masturbation reported at home and school per week.

Discussion

Overall, the treatment intervention was successful in reducing Jane’s public masturbatory behaviour to zero at two week and three month follow up. Following the initial assessment, where the reason for referral was discussed with Jane (i.e., masturbation), there was a large reduction in Jane’s masturbatory behaviour (i.e., 14 occurrences per week to 3) indicating that this discussion may have altered Jane’s behaviour. Further, following Jane’s education session about masturbation, Jane’s mother reported that masturbation had all but stopped and it was only on a few occasions that the staged behavioural modification plan needed to be used. That discussion and information about masturbation quickly reduced the public masturbatory behaviour supports the formulated hypothesis that lack of social feedback related to the behaviour was a main contributing and maintaining factor.

The treatment plan outlined in this case study was in keeping with the published literature surrounding treatment of problematic masturbation. The intervention was targeted at increasing Jane’s awareness of her masturbation, understand when and where it is
appropriate to masturbate and also impart healthy attitudes to Jane about her own sexuality. The behavioural modification plan was set up so that for each occurrence of masturbation, positive and non aversive methods were used first, with the aversive step (time out) used only if earlier steps failed. Reinforcement of on-task behaviour was used to encourage the behaviour that was wanted, and refocusing Jane on homework was used as a way to remind her of what she was there to do, and give her an awareness that she was not on-task. Later steps (i.e., 3 & 4) included reminding Jane that public masturbation was not acceptable (but private was ok.) and the final step was that consequences would occur if the public masturbation did not stop at that time (e.g., negative punishment). Jane’s mother reported that the negative punishment only needed to be used on one occasion and that refocusing Jane back to on-task behaviour was usually successful in stopping the masturbation behaviour.

Although treatment seems to have been highly effective, the follow up period of 2 weeks and again, at 1 month is very short. Because masturbation is a habit in which Jane has engaged in for a long period of time it is likely that there may be occasional lapses, especially over time as the focus on masturbation recedes. For treatment gains to be maintained Jane’s mother will need to ensure that intervention strategies are quickly put back in place if there are occasional lapses. Another factor that will continue to need to be monitored is that restriction of public masturbation does not lead to excessive time alone in private masturbation. At time of intervention and post treatment, excessive private masturbation was not a problem. Finally, in reporting the successful treatment of public masturbation as outlined in this case study of Jane, it is important to note that Jane had no learning or developmental difficulties and no behavioural issues. She lived in a stable family
environment that had some stressors, but not overwhelming ones, and she had a mother who was able to consistently carry out the intervention.

Author note
Verbal parental consent was obtained for the preparation and submission of this case study.

References


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