

SELF-STIMULATORY BEHAVIOR IN YOUNG CHILDREN OR CHILDHOOD GRATIFICATION SYNDROME: RECOGNITION, INTERVENTION, AND PROGNOSIS

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INTRODUCTION

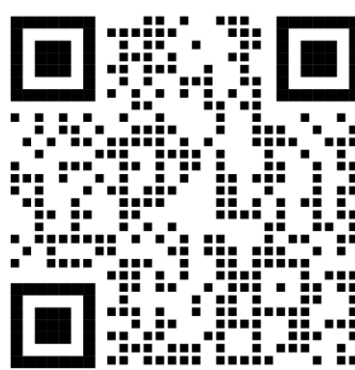
Genital self-stimulatory behaviors in young children often cause significant concern for both parents and clinicians. In Vietnam, this remains a sensitive, rarely discussed topic with non-standardized terminology. Standardizing "Childhood Gratification Syndrome" (CGS) in domestic medical literature is essential to improve clinical practice and prevent unnecessary medical interventions.

LITERATURE REVIEW & CLINICAL FEATURES

Childhood Gratification Syndrome (CGS) is a benign form of self-stimulation, typically emerging between the ages of 3 months and 5 years, with frequencies varying from a few times a week to multiple daily episodes. Neurophysiologically, these behaviors are thought to activate the reward system through dopamine release, helping children self-regulate emotions or soothe stress during critical psychological transitions. CGS is characterized by stereotyped movement sequences such as leg crossing, thigh muscle contraction, or rhythmic body rocking in a prone position, sometimes accompanied by facial flushing, diaphoresis, and tachypnea. These manifestations are frequently misidentified by parents and clinicians as focal seizures, movement disorders, or pelvic pain. However, the core clinical differentiator is that children remain fully conscious during a CGS episode, maintain eye contact, and the behavior ceases immediately upon external distraction or engagement in an alternative activity. Identifying the distinct clinical features of CGS is vital to avoid unnecessary intensive testing, such as prolonged EEG or invasive imaging, thereby reducing the psychological and financial burden on families.

CASE PRESENTATION

A 3-year-old male with a history of delayed language development (undergoing speech therapy) presented with frequent genital rubbing (photo), with an onset specifically noted two months after he started kindergarten. Video (QR link) analysis showed the child in a prone position with legs stretched and crossed, rhythmically squeezing and rocking his thighs against the genital area while making repetitive vocalizations. These episodes lasted approximately one minute, during which the child remained fully conscious and could cease the activity immediately when distracted. Physical examination revealed mild phimosis without infection; neurological exams, EEG, and CT scans were normal. Diagnosis was established as CGS, suggesting the behavior served as a self-soothing mechanism for stressors related to his new environment and communication challenges.



MANAGEMENT & OUTCOMES

Intervention focused on parental reassurance regarding the benign nature of the behavior and guidance on distraction techniques through interactive play. Priority was given to speech therapy to enhance cognitive and communication skills. After 6 months, alongside language improvement, the frequency of self-stimulatory behavior markedly decreased and was rarely observed.

DISCUSSION

The emergence of self-stimulatory behavior in this case shortly after starting school suggests a profound link between environmental changes and the child's psychological adaptation. For a child with delayed language development, the ability to express personal needs or release psychological pressure is significantly hindered; thus, the leg-squeezing and rubbing behavior acts as a "self-soothing tool" against the novel stressors of the school environment. This reflects a tendency for children to seek comfort through somatic sensations when conventional verbal communication channels are insufficient. While physical factors like phimosis require assessment, they should not be viewed as the sole etiology without clear signs of infection. The optimal approach is not punishment or prohibition—which can exacerbate anxiety and reinforce the behavior—but rather improving language skills and enhancing the quality of parent-child interaction. Establishing a diagnosis of CGS through direct clinical observation and video analysis is key to ruling out serious neurological pathologies. This allows for a humane and appropriate psychological and educational intervention plan, helping the child navigate this sensitive developmental phase without lasting psychological trauma.

CONCLUSION

CGS is a benign phenomenon often misdiagnosed as neurological or urological pathology. Diagnosis is primarily clinical, requiring the exclusion of organic causes. Parental counseling, behavior redirection, and supporting language development are effective interventions that reduce both the behavior's frequency and parental anxiety. Further long-term studies are needed to understand the developmental trajectory of this syndrome.