PARENTING FOR EMOTIONAL GROWTH

WORKSHOPS

HOW SEX DEVELOPS IN CHILDREN: FROM BIRTH THRU SIX YEARS -- HANDLING IT CONSTRUCTIVELY

by

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The authors are indebted to Patsy Turrini who not only read and commented on our materials, but especially for proposing the model we used in presenting these materials. "Question asked by Facilitator, Answers by Participants, followed by Discussion containing what the authors' research and clinical experience lead them to believe to be growth-promoting factors", this model was proposed by Turrini. She envisioned these materials to be used at the Mothers' Centers—to which she and her pioneering work gave rise—in the hope of introducing child development optimizing knowledge accumulated during the past century by psychodynamic child researchers and clinicians.
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HOW SEXUALITY DEVELOPS IN CHILDREN -- HANDLING IT CONSTRUCTIVELY

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Workshops on Sexual Development
INTRODUCTION

The materials presented in these Workshops are derived from Parenting for Emotional Growth: A Curriculum for Students in Grades K Through 12 (Paren, Scattergood, Duff, and Singletary, 1997). This Curriculum was developed and written in order to formally, educationally prepare our young for the job of parenting, a job which like any other demanding, complex and challenging job requires much preparation, knowledge and skill.

Our aim, in this education for parenting Curriculum, is to spell out principles of how to optimize the mental development and health of every child. We aim to achieve this by securing the most growth-promoting parenting of which each child's parents is capable. The child we have in mind is the human child, the Homo sapiens child, whether Chinese, Hispanic, Italian, Lebanese, American, whether Muslim, Protestant, Jew, etc.

Our parenting education work is informed by the work of many international psychodynamic mental health researchers and clinicians. Important among them, Freud proposed in 1939 that parents are the representatives of Society to their children, and that the greatest contribution psychoanalysis would make would lie in the application of what psychoanalysts learn from their clinical work to the rearing of the next generation (Freud, 1933). In 1978 we were much encouraged to pursue our then beginning work in parenting education by a communication from Anna Freud, who when she saw some of our early parenting education materials responded quickly and with enthusiasm to our strategies toward prevention in mental health by means of formal parenting education for school age children. She endorsed our conviction of feasibility and told us that not enough is being done regarding the application of what psychoanalysts have learned toward the rearing of the next generation.

In addition, in the 1970s, Margaret S. Mahler (1978) was convinced that the education of parents would serve to achieve the prevention of major psychological, emotional, and social problems of our time. Like Brandt Steele (see Krugman, 1987), Mahler recognized decades ago that child abuse had become an urgent social problem.

We assert that optimizing the child's mental health, and therewith adaptive abilities, by means of optimizing growth-promoting parenting can be done no matter what the family circumstances. Growth-promoting parenting can be achieved whatever the socio-economic conditions or strains, respectful of whatever the ethnic and religious mores and customs of each family, whether the family is intact or the parents are
divorced, whether a single parent family, whether one parent works outside the home or both do, part time or full time, and whether the family avails itself of home substitute caregiving or daycare. None of the variations in all these home and family conditions modifies or makes unique requirements of the basic principles of growth-promoting parenting.

Similarly, whatever the child's inborn adaptive abilities and givens, from temperament variations to the wide range of biological givens from normal to dysfunctional and disordered, the basic principles of growth-promoting parenting are the same.

Basic principles of growth-promoting parenting can be spelled out better today than ever before. The Twentieth Century, among other things for which it will be remembered, is the era when we achieved the most advanced ever degree of scientific and humanistic knowledge and understanding of how the depth psychology of the human infant evolves into that of the adult, how the infant becomes the adult who adapts to society for good or for bad. Although more is to be learned, what makes for good or troubled mental health and development has been studied and detailed in this century more than in the entire span of the history of civilization. Our Curriculum is constructed to spell out in some detail central principles of development and how to optimize these in order to secure good emotional development and health.

THE GOAL OF GROWTH-PROMOTING PARENTING

Growth-promoting parenting is to optimize the child's inborn potential abilities to cope constructively with everything the child experiences whether it comes from his or her internal goings-on (e.g., fantasies and interpretations of events) or from his or her external environment (e.g., family life, neighborhood conditions, etc.). To optimize her or his own growth-promoting parenting, it is best for every parent to:

First, have sufficient information on the human child's basic emotional and physical needs. This is required to have a clear enough view of what will be expected of the parent as well as what to provide the child with over the course of development from infancy through adolescence.

Second, have sufficient information on the details and dynamics of every child's adaptive and emotional developments from infancy through adolescence, as well as of those variations that come with the uniqueness of each child. For example, a normal shy child's way of coping differs from those of an assertive-outgoing child. Such information is required to have some reasonable idea of a specific child's age-appropriate abilities and limitations and how to make the best of these.

Third, and perhaps most important, every parent must have sufficient information on how to optimize, how to help the child "be as good as he/she can be", in the child's emotional and adaptive development. Both, a basic general understanding
of how to optimize development and individualization of parenting, or tailoring parenting to each individual child, are needed.

**THE MODEL WE USE**

The model of human development, functioning, adaptation, and mental health, we use is a composite of much cumulative psychodynamic knowledge that has emerged from clinical work as well as formalized direct observational and laboratory research during this Twentieth Century. A number of specific areas of the child's development have drawn the interest of individual clinicians and researchers during the 1900s. At times, such special interests have gotten much attention and have even come to be in vogue, to be believed to be more important than what has been known before. In some instances, efforts have even been made to replace well substantiated explanations of important aspects of human development, functioning, and what can optimize or damage these, rather than to add to the existing pool of information about this very complex system, the mental-psychological domain of the human child. We do not believe that any one of the remarkable psychodynamic developmental theories we now have, each addressing a particular aspect of the child's mental life, is more important than the others. We have found that our understanding is increased by availing ourselves of a number of these models as we try as best as we can to optimize each child's adaptive and developmental potentials.

A century of intensive depth-psychological (psychoanalytic, psychodynamic) clinical work with adults and children has taught us that humans are complex psycho-biological organisms. Each is a single entity, the sum of a number of crucial sectors of experiencing and of development (i.e., of functioning at sequential levels of developing, coping, and stabilizing into increasingly more complex levels of functioning and of adaptation), which in their totality make up each person's qualitative mental health. Among the most crucial sectors of mental-emotional experiencing and development are those that pertain to one's own internal self, to one's human relationships, one's system of adaptive functions (including one's emotional and cognitive functions), one's evolving sexuality (which secures reproduction and the preservation of the species), one's aggression (which serves adaptation, securing one's mastery of oneself, of the world around and one's goals), and the gradual formation of one's conscience (which includes one's code of conduct and morality) and self-esteem. Just as we have found clinically that sexuality is not "the" most important sector of human experience, nor are the development and the vicissitudes of aggression, nor is the development of conscience and self-esteem, nor will a singular focus on attachment prove "more important than" any of the others. Each is enormously important and makes its unique contributions to our understanding of and our ability to help the total, single developing human being "become as good as she/he can be".

The composite psychodynamic model we use is one then, that has been developed piece by piece, has progressively become organized from 1905 to the present (1998). Even if the pieces are not as fully developed as some us wish, each has been.
forged sufficiently both in the research laboratory and in the clinical situation to be usefully applied to effect the promise Freud made to Society in 1933: that the greatest contribution psychoanalysis—which itself has developed enormously in its content and scope since that date—would make would be the application of what we learn from the clinical situation to the rearing of the next generation. We believe we have come to a point where we can propose strategies to do just that. The composite model we have seen gradually evolve over the past 40 years, a model 90 years in the making, is likely to stand for centuries to come, continuing to further evolve as we come to learn more about the child's biology and psychology.

THE WORKSHOPS

Whereas the Curriculum *Parenting for Emotional Growth: A Curriculum* . . . was conceived and developed by Parens, Scattergood, Duff, and Singletary—and a group of collaborating researchers and clinicians—for students in grades K thru 12, the *Workshops* are developed for child caregivers of all kinds, be they parents, daycare caregivers and administrators, teachers, etc. The authors of the Curriculum and of the Workshops, as noted above, aim their efforts at the prevention of experience-derived emotional disorders in children. As we have documented (Parens, 1988, 1993), we have learned that there is much teachable knowledge that can, and we believe must, be provided to current parents and future parents that will significantly lessen the frequency and intensity of experience derived emotional disorders in children. As we emphasized before, our principal aim is to promote the development of good mental health and constructive adaptation in our children by optimizing the way they are reared, by aiming toward their being reared by growth-promoting parenting.

These Workshops can be used in a variety of ways, in total or in part, with leeway for individual implementation by the Workshop instructors and participants. And they can be used for caregiver training purposes with many different groups of "students" including parents, daycare workers, teachers (especially early education), nannies, etc. It is our intention that the Workshop instructors will use their creative skills to optimize the "fit" between any particular Workshop and the participants. It is, however, important that the Workshop instructors be well trained and sufficiently familiar with the subject matter; for this purpose they may want to refer to the actual *Curriculum--Textbook* and/or *Lesson Plans*—cited above, as well as *Aggression in Our Children* (Parens, Scattergood, Singletary, and Duff, 1987).

The major contents of the Curriculum have been divided into a series of sets of *Workshops* (Parens and Rose-Itkoff, 1998). To date these sets of Workshops are:

I. On The Development of Self and Human Relationships,
II. On Handling Aggression Constructively, and
III. On The Development of Conscience and Self Esteem.

The first two sets of Workshops are especially geared toward children from 0-3 years, though these can be improvisingly extended up in years by participants and instructors; the third set of Workshops spans from infancy through early adolescence. In addition to

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these 3 sets of Workshops, others to follow include a set on *The Emergence and Handling of Sexuality in Our Children*, a set *On Optimizing Adaptive Abilities and Becoming a Responsible Member of Society*, and a set on *Basics of Early Child Development* (optimizing patterns of feeding, of sleeping, self care and regulation).

In order to be effective, the Workshop instructors must, of course, be sufficiently familiar with the material presented in the "Discussion" sections of these Workshops. Instructors would be best informed by reading the *Textbook of The Curriculum* (Parens et al, 1997) from which the Workshops contents are drawn. As with any other educational effort, the better knowledgeable with the subject material, the better will they field the questions, address the participants' expressed concerns, and integrate participants' concerns and interests and duly emphasize the salient points of each Workshop. We would hope that during Workshop sessions all the text materials under the "Discussion" sections are covered during the course of answering the questions proposed. Additional questions by the participants would be most welcome, indeed ought to be sought, and addressed *ad lib* as best as can by the Workshop instructor. Likewise, it is highly desirable that additional information be added (via examples, case vignettes, etc.) depending on the participants' grasp of the material, interest, life experiences, etc.

Workshop instructors may want to add additional role plays, interactive exercises, etc. and/or to spend more time on one area of interest or another. It is important to make these Workshops "come to life" to the participants and to encourage active discussion between the Workshop participants as well as with the instructors. It is also important that the Workshop instructors make the materials as applicable to the participants' everyday needs and concerns as possible. For this purpose examples derived from the participants' experiences are most useful.

These Workshops are intended for educational purposes and are derived from the comprehensive education Curriculum. They are not intended to be used for formal psychotherapeutic purposes except for Parental Guidance in the course of doing psychotherapeutic work with children and adolescents. This is so even though participants and instructors may, indeed, find that the Workshops materials invariably touch on intimate feelings and memories the parents have of their own childhood and of their own parenting efforts. Nonetheless participants may want to share varying experiences they have had with their children and parenting and, as we said, this should be appropriately encouraged. Workshop instructors will find, though, that this can take up much time and, therefore, should be weighed against the time allotted for any particular Workshop.

Workshop instructors should bear in mind that parents need special attention and support as they learn how to be effective parents. Empathy (trying to read the parents' feelings), support and respect for parents is, of course, highly desirable during the Workshops as parents become more familiar and comfortable with their role as parents who are learning from their children what they need and want. We believe, and say so to the parents, that to be a growth-promoting parent one needs to be "perfect" 75 % of the time. It is normal and natural to "make mistakes" as a parent; making mistakes within an
overall loving, respecting, and sympathetic parent-child relationship need not necessarily hurt the child. In fact, in such a relationship, how the mistake is handled between the child and parent and what kind of dialogue occurs and develops between them can be highly growth-promoting!

Finally it should be said that these Workshops are meant to be information-imparting and useful. They are intended to provide parents with much information about normal children and their normal needs that can and should be a part of the parents' knowledge base when interacting with their children. Good, growth-promoting parenting is now well known to be the most powerful means to lessen the frequency and mitigate the intensity of *experience-derived-emotional disorders* in children.

We hope that these materials will be useful in a multitude of settings with vastly differing audiences. **Instructors must be cognizant and respectful of, and attuned and sympathetic to ethnic specific mores and customs** of the Workshops participants, and could usefully refer to local idioms, proverbs, lullabies, cultural heroes, etc. to illustrate any points further. It is important that Workshop instructors, where possible, come from the participants' communities, and that both instructors and participants will come from all walks of life, all socio-economic levels, ethnic groups and from all nationalities. With respect paid to our differences it is our intention that full attention be paid to what we all share in common which is the present and future well-being of our children. Growth-promoting parenting aims to optimize every child's inborn givens, to make every child a reasonable and responsible member of society. With this it aims to achieve a better life and a better world for all children, and it is our job to do all we can to achieve this end.

REFERENCES


*Workshops on Sexual Development*


*Volume 1: The Textbook (7 Modules):*
  *Introductory Unit*, pp. 68.
  - Unit 1 -- 0 to 12 Months: *The First Year of Life*, pp. 153.
  - Unit 2 -- 1 to 3 Years: *The Toddler Years*, pp. 169.
  - Unit 3 -- 3 to 6 Years: *The Preschool Years*, pp. 112.
  - Unit 4 -- 6 to 10 Years: *The Elementary School Years*, pp. 74.
  - Unit 5 -- 10 to 13 Years: *Preadolescence*, pp. 61.
  - Unit 6 -- 13 to 20: *Adolescence*, pp. 107.

*Volume 2: The Lesson Plans (7 Modules) [Incomplete]:*
  - Unit 1 for Grades K - 1, pp. 76.
  - Unit 1 for Grades 4 - 5, pp. 119.
  - Unit 1 for Grade 9 and up, pp. 108.
  - Unit 1 Laboratory Manual for Grade 9 and up, pp. 269.
  - Unit 2 for Grade 2, pp. 110.
  - Unit 2 for Grade 6, pp. 137.
  - Unit 2 for Grade 10 and up, pp. 198.
  - Unit 2 Laboratory Manual for Grade 10 and up, pp. 354.
  - Unit 3 for Grades 7 - 8, pp. 125

Further Lesson Plan Modules being developed.
GUIDELINES FOR WORKSHOP INSTRUCTORS

Introduction

These Workshops are developed for child caregivers of all kinds, be they parents, daycare caregivers and administrators, teachers, etc. We emphasize that our principal aim is to promote the development of good mental health and constructive adaptation in our children by optimizing the way they are reared, by aiming toward their being reared by growth-promoting parenting.

It is important that the Workshop instructors be sufficiently familiar with psychodynamic schools of thought and the contents of the specific Workshops. For better familiarization they most likely will find the Workshops source materials useful. These sources include Parenting for Emotional Growth: A Curriculum for Students in Grades K Thru 12\(^1\) (the Textbook and/or the Lesson Plans) as well as Aggression in Our Children\(^2\). From these come the materials presented in the "Discussion" sections of the Workshops. The better acquainted with these or similar materials, the better they will be able to not only field the participants' questions, but especially to address the participants' child rearing difficulties, concerns and interests, while at the same time emphasizing the salient points of each Workshop.

In the following Section we will suggest a set of guidelines that we hope will prove useful to the Workshop instructors. These guidelines are drawn from our experiences in conducting educational parent-child groups, from our developing Parenting for Emotional Growth, A Curriculum for Students in Grades K Thru 12, and most recently from presenting some of our Workshops to a widely diverse population in rural Appalachia. In the Appalachia project, the Workshop instructors Cecily Rose-Itkoff, M.A., M.F.T. and William Singletary, M.D. prepared for this event in


collaboration with Henri Prens, M.D. The guidelines are derived from our shared impressions.

These Workshops can be used in a variety of ways, in total or in part, with flexibility for individual implementation by the Workshop instructors and participants. And they can be used for caregiver training purposes with many different groups of "students". We leave it to the Workshop instructors to find ways to optimize the "fit" of the particular Workshops used and the participants' needs and level of training.

We suggest that it will be helpful to the instructor to bear in mind that these Workshops are models; that is, they can be individually tailored to suit the particular audience that is being addressed. For example, while discussing material under the "Discussion" sections additional questions from the participants can be integrated along with examples drawn from their life experiences. Doing this, the Workshops are more likely to spring to life and take on an immediacy that is most responsive and helpful to the participants. The questions from the participants will typically be "experience-near" and the ways by which the instructors respond and engage the participants in a dialogue can further make the material useful and emotionally meaningful to the participants.

As with any educational and communicational effort, the Workshops are most helpful to participants when the instructors "speak" the language of the group and when they sympathize with the everyday and specific dilemmas, hardships, hopes and aspirations of the participants. Materials are always better taken in when participants are encouraged to raise questions, voice opinions, disagreements, etc. and the instructor, at all times, has a receptive stance toward the input of the participants. It is productive when the instructor conveys to the participants that they can all learn from one another and that the instructor is ready to learn from them.

The following guidelines were useful to us and are offered here as suggestions for optimizing the use of the Workshop format with various audiences.

**Guidelines**

1. As Workshops go, each Set of Workshops in this Series is rather large, consisting of about 8-10 Workshops each. Ideally we would like to see all the Workshops contained in this Series planned over a number of months. Many of you will not be able to present so long a Series except in a long standing parenting educational and/or support setting. Therefore, Workshop selections will need to be made for presentation.

   Each is sufficiently integrated to be able to stand on its own; this applies more readily for some Workshops than for others. The Workshop instructors' task will be facilitated by learning from the participant-audience prior to Workshop time what concerns, difficulties, interests are most pertinent to them. In this way, the selection of Workshops can be more suitably geared toward your particular audience.
2. The instructor will be best prepared the more familiar he/she is with the Workshop materials. Toward this end, instructors are encouraged to become familiar with the *Parenting for Emotional Growth Curriculum Textbook* and *Lesson Plans*. It may be helpful for instructors to pull out the most important themes and "sub-themes" in each Workshop and to articulate them in the instructors' own information-imparting manner. These themes can then be emphasized at various appropriate times during the Workshop and can also be reviewed during the final phase of the Workshop. As in all teaching, the firmer the grasp of the subject matter, the easier the presentation, and the freer will the instructors be to attend to participants' interests and to accommodate to the participants' pace of taking in of the materials.

Workshop instructors can expect that participants may ask questions and raise topics for exploration that tap the instructors' entire range of expertise. Instructors need not be able to answer all questions; it is expected that any instructor might not know a particular answer at the time a question is asked. It is perfectly professional to not know an answer and to say so. Furthermore, if time permits, an answer may be provided at another time after some research by the instructors.

3. In conducting these Workshops, especially when done directly with caregivers, it is important that the instructors convey a non-judgmental attitude, aim to supplement knowledge, and re-enforce the strengths already existing within the participant group.

4. Information is much better received and assimilated when the participants know that such information and whatever informed suggestions instructors make are derived from proven child development research complemented by decades' long clinical findings rather than when they are presented in an authoritarian and dogmatic manner.

5. We all rear our children in highly individualistic and extremely personal ways. This is why there often is disagreement among parents in how to deal with specific child rearing situations. And because we invest emotionally so much in our children and the ways we go about doing so, we are all very vulnerable to feel hurt by any criticism or disapproval of our parenting efforts. This is so whether the criticism comes from one's own mother, uncle or neighbor. But it is especially hurtful when criticism comes from "an authority" in parenting education. Disapproval by Workshop instructors is painfully felt by participants—and may even lead to withdrawal from the Workshop. For these reasons it is important to not approach any participant, any question, or any discussion from a position of criticism or disapproval. It is always best to be respectful and to accept disagreement. In fact, we welcome disagreement since disagreement, when well addressed, can lead to a greater degree of clarification of points made.

6. We have found over many years of parenting education with persons who are already parents that making suggestions for a better way of handling any given rearing situation than the one proposed by the parent, that such suggestions are better accepted
when they are coupled with discernible parenting positives already seen in the particular parent. For instance, "The point you made earlier about (whatever it was) is really on the mark. And, I'd say growth-promoting, to be sure. Here though, you might find it helps your child better to set limits with loving firmness, for this reason (specific reason given)."

7. As mentioned before, these Workshop materials are intended for educational purposes. They are to be used to educate the participants about growth-promoting parenting and how to optimize their child's development. Although the contents of these Workshops can be used in a therapeutic setting in the form of Parental Guidance, these Workshops themselves are not planned to be used for therapeutic purposes and instructors are best advised to use both an educational attitude and their expertise in guiding the discussions.

8. Finding the appropriate balance between personal disclosure and educational goals can be a delicate matter, especially where the subject matter is highly personal as it typically is with many of these Workshops. Skillful collaboration between Workshop instructors, where applicable, and a clear understanding of the purpose of the Workshop should be helpful in this regard. It can also be clarifying to the participants if the educational nature of the Workshop is clearly stated while also encouraging their active involvement. The instructor must use his/her best judgment as to whether and when to introduce things about herself/himself or her/his family.

9. Because the Workshops will likely touch upon personal issues in the participants' lives the Workshop instructor is best advised to have access to information regarding referrals and follow-up in order to be further helpful to participants when and if appropriate and requested.

Knowledge of local agencies and services can also be highly useful. For example, while in Appalachia we were asked for specific advice regarding adjunct services for various cases and were fortunately able to turn to the local sponsors of the Conference to supply this valuable information to the participants when asked.

10. Where there are two instructors in any given Workshop, dividing tasks and labor between the two may be most beneficial. For example, one instructor may guide the formal discussions while the other may direct interactive exercises, role plays, etc. One may be better able to address overt specific, clinical issues while the other may be more attentive to nuances and un-addressed topics. Instructors may want to alternate who has the "Instructor" role and who the "Facilitator" role as well as other tasks.

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3 Parental Guidance is an educational method that can often be highly useful in working with parents of children we see in psychotherapeutic treatments. H. Parens has been teaching this method now for several years to child psychotherapists and psychoanalysts. It is somewhat similar to what S. Fraiberg called Developmental Guidance (in Clinical Studies in Infant Mental Health. Published in 1980 by Basic Books, New York).
These Workshops, of course, can be lead by one instructor quite well and the Workshops are actually written with this in mind. But, depending on the size of the audience, the task may be quite taxing. A skillful team of instructors who work well together can be quite more productive and less taxing on each instructor.

11. It is invaluable to the success of the Workshop to set a congenial learning atmosphere. All educators know this, of course. How the participants view the instructor will depend, in part, on how the instructor portrays him or herself. One instructor may prefer to introduce herself by her first name when addressing the participants and welcome them to do the same. This particular point will, naturally, vary from one Workshop instructor to another and may depend upon a number of different factors. Some participants feel more comfortable if the instructor takes a more formal stance which is, in part, denoted by the use of "Dr.", "Ms." or "Mr.". We feel that a professional and helpful stance is always warranted and should not be compromised and that perhaps the use of names can be left up to the preference of both the Workshop instructor and the participants as well as the local custom.

12. While in Appalachia we dressed casually for our work attire but did not dress too informally. In other words, we wanted to dress similarly to the participants (and were told ahead of time that the participants would feel more relaxed with us if we did that) but did not want to convey the impression that we were there to simply take it easy. The seriousness of our work with them was neither diluted nor accentuated by our appearance and we felt that if our choice of attire could further put the participants at ease, we were glad to do that.

13. Being on site away from home, we made ourselves available to the participants throughout the conference. We ate meals with them, socialized with them and even enjoyed some recreational activities together. This of course has to be determined by both invited instructors and participants. When Workshops are conducted in the instructor's home town, one can make oneself available without participating in out-of-Workshop activities. What is important here is not the actual activities, of course, but the instructor's stance in relation to the participants.

14. How the members of the group interact among one another is a critical variable. Group composition can vary widely depending on size, experience, educational levels, ethnic mix, etc. There may be widely varying audiences (as we had in Appalachia) and there may be more homogenous groupings. It may be very useful to screen the group beforehand, if possible, or at the time of the Workshop, to ascertain the group mix as well as what the group's interests and concerns are and the nature of their experiences (personal, professional, etc.) Where possible, the program coordinator can do this and share the results of this process with the instructor while planning the Workshop event.

In Appalachia, we found that some participants wanted to spend more time role-playing and in small discussion groups while others preferred to cover as much of the didactic material as possible. Some members asked for a private viewing of the audio-
visual materials that we had brought with us and reviewed them after the conference had formally ended. Others voiced the opinion that they would have preferred more time spent on actual skills-building methods. Such issues need to be resolved at the discretion of the instructors even at the risk of displeasing some participants.

15. Joining with the group effectively can also be accomplished through non-verbal means. For instance, in Appalachia we arranged the chairs in a semi-circle to facilitate conversation among the participants. We did not sit behind the table set up for us but pulled our chairs out from behind the table and closer to the participants; we used the table as a place on which to put our teaching materials. In these concrete ways we hoped to be more receptive and available to the group.

16. Workshops are much enhanced when they can be made personally meaningful to the participants. An instructor who feels comfortable doing so can occasionally use personal examples from her/his experiences as a child, as an aunt or uncle, or as a parent; doing this seems to increase the positive interaction between the instructor and participants and also illustrates points and concepts in a tangible manner. Many participants appreciate this teaching method and hear and even accept the material better because it informs the participants of the fact that the instructor has had pertinent experiences which gives more reality to the instructor's information. Likewise, anecdotes either from one's personal or professional life can best illustrate certain principles and increase the participants' understanding of the subject matter.

17. Workshops can be made more lively when the instructor feels comfortable illustrating certain child behaviors, as making young child sounds (e.g., types of infant's cries) or demonstrating particular attitudes and gestures. At times the instructor may choose to emphasize a point by such intoning of a sound or acting out an expression or gestures in an illustrative manner; it usually makes the point more dramatically. Although this is not a requirement, participants generally are engaged by and enjoy the instructor's attempts to illustrate dramatically even if they are amateurish! The instructor can also enlist the help of willing volunteers to assist in such illustrations. An important didactic point can be made more clear through the use of illustration and example.

18. Similarly, if the Discussion text can be augmented by inserting a particular point of much relevance to the participants, such should be done and a good illustration may be very useful to do just that. Generally, participants enjoy learning through examples and the sharing of these; the instructor can use his/her judgment to improvise upon this theme.

In such ways further issues may also be added to the discussions as needed. For example, with a particular group committed to the benefits of breast feeding it is wise for the instructor to ask the group if they think that positive feeding experiences can also occur between a parent and a bottle-fed baby. Lively and productive discussion usually follows this question.

19. Workshops, like with any audience, require of the instructor to be attentive to
how the group is responding and feeling. For example, if participants appear restless, inattentive, unusually quiet, etc. it is often helpful to check with them to see if the material is making sense, if they would like to review a particular point, etc. It can help to briefly review the point that you are making and then to move to where the group's interest lies at that particular time. Although this point is debatable, we feel that it is most important to make and retain an emotional connection with the group and that the actual didactic content is secondary at those moments.

20. When discussing Workshop issues it may be particularly helpful to the participants if specific ages and developmental markers are indicated. It can help participants register the material better when specific age ranges are denoted. Discussion can also focus on differences between age groups and what a parent can realistically expect at a certain age range in terms of the child's emotional and cognitive development.

21. If instructors are addressing participants who generally face similar difficulties (e.g. raising children in an economically depressed environment) the instructor may find it advantageous to emphasize particular points rather than others. For example, in Appalachia socio-economic factors often came up during the Discussion and expression of the participants' reactions and solutions were encouraged. "What qualities make good parents?" was frequently raised and were these qualities primarily of a material nature, of an emotional nature, or what? That is, we talked frequently about whether buying children toys and giving them many material gifts is the most meaningful way of promoting a positive parent-child relationship or whether those "emotional gifts" of respect, understanding, empathy and love are more mental health promoting and socially adaptive. It is noteworthy that many parents from all socio-economic environments tend to give more weight to the importance of material giving than do mental health professionals. We need to convey to parents the enormous value and power of emotional giving to the child's developing mental health and well-being.

22. Using a blackboard or flip-chart can be useful in emphasizing certain points. Hand-outs are usually welcomed by the participants and can increase their ability to absorb the material through the activities of listening and writing. They are often glad to have something in their hands to bring away from the Workshop and this can further enhance recall.

23. Reviewing the Curriculum Lesson Plans (for High School Grades) and choosing various exercises to be either utilized verbally or in writing can be supplemental to the Workshops. This depends on the instructors' preference. In the Appalachia project we chose to use one written exercise from the Lesson Plans in an oral manner and found that this was highly effective especially because it was done with dramatic intonation and gesture. This empathy-enhancing exercise was used to increase participant appreciation of this crucial parenting ability and optimized the educational potential of this Workshop.

24. Finally, and not the least important, instructors are best advised to use all available methods to convey to the participants their respect for their ideas, life experiences, innate wisdom, ethnic specificity and local customs. It is critical that
participants feel acknowledged and respected by the instructor. There is no place in our work for judgments and criticism.
WORKSHOP # 1

THE BEGINNINGS OF SEXUAL (REPRODUCTIVE) LIFE

**Question:** What do we mean by "The beginnings of sexual, of reproductive life in children less than 6 years of age?" Are we out of our minds?! What are we talking about?

**Answers** from participants.

**Discussion:** All behavioral and mental health professionals agree that human development is very complex. The total being, it is believed, can best be understood by knowing both details of the development and functioning of each of its various component parts and systems, as well as how these component parts and systems altogether function as one incredible organism.

The sexual parts and system of our being human is enormously important to the primary responsibility of all living things, namely the preservation of one's own species. This is why, we assume the sexual feelings and inner pressures, coming from what theorists call the sexual drive, are so strong. We also assume, that so large a responsibility of living things, to preserve one's own species, would by nature be ensured by a drive that is powerful, tenacious, and that forcefully draws attention to itself. Sexuality serves a crucial function, the preservation of the species by means of the Reproductive System.

**Question:** When does sexuality begin in normal human development? That is, when do children first show evidence of having sexual feelings and thoughts?

**Answers** from workshop participants.

**Discussion:** For centuries scientists, biologists, medical people believed that the normal child's sexual life begins at puberty. Many people, perhaps most people today still believe this. Over the centuries, a handful of poets, tragedians, and philosophers thought that this development begins quite earlier.

The collective observations of young children by mental and behavioral scientists documents that even from the second and third years of life on there are significant indications in children's behaviors of pre-occupations with parts of their bodies and those of others that are directly or secondarily involved in sexual feelings, thoughts and behaviors. The behaviors of normal children amply show that sensations in sexual parts of their bodies create feelings in young children of an erotic nature that resemble exactly what adults experience as sexual. And, when listened to closely, children can be heard to express these feelings in words; and when looked at patiently, non-judgmentally and unobtrusively, one also finds in their play behaviors, evidence of sexual fantasies being enacted in their activities, and in their attitudes toward others, themselves and parts of their bodies.

Sex has a large influence in every person's psychological-mental life, beginning during the earliest months of life and continuing throughout our entire lifetime. Mental-
behavioral health scientists tell us that the development of sexuality begins near birth, that it is then considered to be in the form of "infantile sexuality" in contrast to "adult sexuality" which begins during the adolescent years and is so amply evident in adult human behavior.

The development of sexuality in children is normal, indeed salutary, and this development can be greatly optimized by the parent's and caregiver's recognizing it as such and working along with the child to facilitate and guide its development along healthy paths so that the child's sexual development and gender identity formation proceed in positive and healthy ways.

**Question:** What do you think is meant by "infantile sexuality"?

**Answers** by participants.

**Discussion:** When mental health researchers see sexual behaviors in young children they tell us that they see children's interests in sexual body parts to be quite specific, focused and more or less frequent, that they see pre-occupations with "private" parts, their own and those of others, they see touching of the child's own body parts with facial and bodily expressions of erotic feeling, and as we shall detail, even more.

It is clear, however, that there is much children don't yet know about these sensitive and good-feeling body parts. For instance, they are very surprised and taken aback by the fact that not everyone has the same type of body parts. Nor do they seem to know what sex is for, nor how it is carried out between two people. Nor do they know what some of the consequences of responding to the feelings they have in these body parts might be. And there is much more they don't yet know.

As a result, their sexual behaviors are only partly like that of adolescents and adults, we might say, they are similar only in the very basics and only in the very beginnings of sexual experiencing. But, as we shall detail, these beginnings of sexual experiencing play a large role in the normal child's development, in her/his present and later behaviors and emotional life, and ultimately in the child's eventual adult life, in his/her sexual and love relationships and overall emotional life.

The details of this development have been conceptualized and organized into what behavioral-emotional scientists have called "psychosexual theory".

**Question:** What is psychosexual theory?

**Answers** from participants. Have they ever heard this term?

**Discussion:** Psychosexual theory holds that our sexual development, that developmental line which pertains to our evolving sexuality and our developing identity as a male or a female, occurs in 6 phases. (We will provide an outline of this theory during this workshop.) Psychosexual theory, which was first proposed and developed by Sigmund Freud and further developed by a number of psychoanalytic scientists, holds that sexual development, and with it sexual identity formation and emotional relationships, unfolds through a universally found sequence of six phases (or stages or more or less set time periods) during which the sequential modes of sexual experiencing importantly influence--along with other major determinants--the child's progressively evolving psychological-emotional life. (Instructor: see and distribute to participants)
copies of Attachment A: "The Theory of Psychosexual Development" appended at end of this Workshop).

Note that the word "psychosexual" pertains to both the "psyche" and "sexuality". This grew out of the clinical findings of many mental health professionals that sex has a large influence in every person's psyche, or mental life, and furthermore, that it can, and quite commonly does, play a significant role in the production of moderate mental illnesses called neuroses.

In this series of Workshops, we will focus on the first three stages of psychosexual development that occur during the course of normal development in each normal child regardless of cultural dictates or temporal considerations. What we have in mind is the normal development of the human child.

Question: Why should parents or other caregivers concern themselves with this?
Answers from workshop participants. Have they had some concerns regarding their child's sexual development and gender identity formation?

Discussion: The responsibilities of parenting make it important that the enormous part sexuality plays in the child's developing identity be given as much attention as the other major factors that shape a child's development. The experiences sexuality brings with it by virtue of the feelings it stirs up in the child, the inner pressures and the gratifications it brings which drive much of a child's behaviors, the fantasies it generates in the child's mind, the very serious problems sexual behaviors can bring, and the large role it plays in relationships and in society, all these necessitate that parents and caregivers pay due and deliberate attention to this crucial development in the child from the earliest years on.

Although it has long been felt but has long been insufficiently acknowledged, people are increasingly coming to recognize that being a parent, rearing one's own children, is a very demanding and often difficult job. Dealing with our children's interest in and curiosity about sex, with their engaging in sexual activities, with teaching them what is safe and not safe, what risks and dangers lie in sex, stands out among the most challenging of our responsibilities as parents and caregivers.

It is not in the child's best interest to keep childhood sexuality issues hidden, to ignore children's interests in and questions about sex or reproduction, or to disregard their sexual activities. These are better talked about in reasonable, age-appropriate ways. Sexuality needs to be understood and recognized for the part it plays and the problems it can create in children's and adults' lives. Rather than being suppressed, ignored, or forbidden, it needs to be accepted for what it is and, like all other child behaviors, can and needs to be guided in order to prevent it from bringing harm.

Question: Well, can we be more specific about why parents and caregivers should concern themselves with their children's sexual and gender development?
Answers from workshop participants. (Instructor: expect either reluctance to discuss and/or some extreme reactions to this topic. Try to encourage participants to explore this topic but stay to the point: how to cope constructively with this development in their children.)

Discussion: Both the child's sexual development and gender identity formation have

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large implications for the child's healthy personality development and mental health. Under negative circumstances it can become a most serious source of psychic and physical pain, regret, self-criticism and self hate, and disrupt the fulfilling of the child's hopes, goals and ambitions. Or, under optimal conditions, sexuality in our children can become one of the best cementing factors in their eventual marriage.

In order for the child's sexuality and gender formation to develop in a healthy way, sexuality in the child needs protection, guidance and control; not denial, avoidance or suppression. Normal sexual development, as we shall see, can create conflicts in the child which lead to expectable fantasies the child needs to keep secret--and for which the child should have privacy--and leads to private-personal activity (as masturbation) which makes sexual concerns and activities less accessible to parental guidance. And in addition, the child's sexual behaviors often tap repressed sexuality-based conflicts within the parent that can hamper the parents' reasonable, empathically sensitive, and ultimately constructive handling. We'll talk about these in the subsequent Workshops.

**Question:** What "evidence" do we have of sexual interests, curiosities and behaviors in small children? 

**Answers** from workshop participants. Have they noticed sexual interests, curiosities and/or behaviors in their children? How have they felt about that and, do they feel that they handled them constructively in order to maximize the child's healthy development?

**Discussion:** There is ample evidence of sexual behaviors and experiencing in normal children. (Instructor: it is very useful here to briefly illustrate several examples you have of the following 1):

1. 2 to 6 year old children's interest in and preoccupation with genitals, the child's own and those of others.
2. 1 to 6 year old children's interest in and from about 2 years on, the wish to have a baby (in both male and female children.)
3. Evidence of family romance behaviors (Instructor may need to briefly explain this assuring the participants that this issue will be taken up in Workshop #4.)
4. The 4 or 5 year old's showing anger, disappointment and hurt when mother and father show affection to each other.
5. Conflict between parent and child due to the child's competition and rivalry with the parent.
6. Other sexual behaviors.

**Question:** What are some likely consequences if parents and caregivers do not recognize the behaviors just described as normal but instead view them as cause for alarm and worry? Or, equally not helpful, what are some consequences when the parent/caregiver denies that these behaviors occur at all in their children?

**Answers** from participants.

**Discussion:** Many parents and caregivers who do not know that these sexual behaviors occur in normal, well-reared and well-behaved children become very distressed by these

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1 Instructor: if you need some examples, you will find some in the text material in Unit 3

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of Parenting for Emotional Growth, under Sexual (Reproductive) Development. behaviors. The results are that none of the parents' handling then, usually, is growth-promoting for the child. When parents and caregivers are made anxious by these behaviors, they may not recognize the behaviors they are observing as being of a sexual nature, and will thereby misunderstand the true meaning of the child's behavior and/or may falsify that the behavior has any meaning at all. Both results will not help the child because, the behavior having been misunderstood, the parent/caregiver is not likely to constructively guide the child's handling of such behaviors.

In addition, whatever the sexual behavior or feeling the child shows, not feeling understood by the parent undermines the child's trust in, respect for, and turning for guidance to parents. As mental health clinicians, one of the most constant findings we experience again and again is the remarkable relief people experience (children as well as adults) in "feeling understood", whatever the feeling, thought, wish or behavior.

Also very troublesome for the child is the possibility of being shamed and humiliated as well as harshly chastised and threatened. These reactions, which usually come from parents/caregivers who do not know such behaviors are normal, can cause more harm than good and may lead the child to feel worthless and unduly concerned about his/her normal interest in and curiosity about sexual matters.

As with many others factors pertaining to the parent-child relationship the healthy development of the child will be greatly enhanced when the parent is able to understand the child's behaviors and their general meanings. This understanding will help the parent develop strategies that will facilitate the child's growth and development and will continue to insure the positive relationship between the child and his/her parent or caregiver.

Instructor: having provided the participants with a copy of Appendix A: THE THEORY OF PSYCHOSEXUAL DEVELOPMENT, please tell participants that we use this model for several reasons:

1. To help us recognize, organize, and pull together commonly and regularly observable behaviors that mental health professionals consider to be of a sexual nature.

2. This is the most developed model of sexual development we have, and it has held up under clinical scrutiny for nearly 100 years.

3. This model not only looks at the physical development of sexuality in humans, but also at the psychological influences this particular physical development has on the child's and adult's emotional life and total personality formation.

And, Instructor, please let participants know that if a better model is introduced, we'll gladly consider using that one, either in place of psychosexual theory or side by side with it.

Instructor: Briefly review the six phases, as suggested below. These will be taken up in greater detail in the Workshops that follow.

Focus discussion on the first three phases: the oral, anal and first genital.
**Instructor's Introduction:** As with all aspects of human functioning, sexual and reproductive development begins very early in life, much earlier than has long been assumed. Mental health professionals have recognized that sexual experiencing is an important part of every human being's psychological-emotional life. For this reason they have studied not only the human's sexual development from early childhood on, but have especially studied it from the vantage point of the part it plays in the child's psychological-emotional, or psychic, life.

*As researched, documented and proposed in Psychosexual Theory, human sexual life begins in forms not recognized nor considered to be sexual until this past century.*

Psychosexual development begins with the **oral phase**. This is so labeled because during the first year of an infant's life and well into the second year, the mouth plays a large part in the infant's adaptation to life, in feeding behavior and as an organ for exploring textures and the qualities of things.

In these activities the mouth is a part of the body that becomes a source of pleasure, a special sort of pleasure namely as **erotic pleasure**. This has given the mouth its important place in psychosexual theory, as the body part that becomes the first dominant source of "erotic" pleasure and gratification.

**Discussion:** What are some of the mouth's most vital functions?

1. Communication, sucking, food intake, exploration of all kinds of things the infant can get her/his hands on, comforting sensations, biting, etc.
2. What elements of mouth activities do you think have an erotic quality?
   (Instructor: Foremost, it is **sucking**. The erotic sensation results from specific feelings sucking elicits in the mucous membranes of the mouth. The [inner] lining of all body cavities--mouth, nose, vagina, gastro-intestinal tract, anus--is made of body tissue we call "mucous membrane". Mucous membrane secretes and absorbs fluids much more readily than does the skin. Mucous membrane is to the inside of natural body cavities what the skin is to the outside of the body; both are the covering tissues that protect whatever they cover. Both covering tissues are full of nerve endings which makes them "organs" through which we can feel and tell what something is, what it feels like, tastes like, whether it's hard or soft, etc. The quality of sensations in the various mucous membranes sites differs in ways well known to everyone.)  
3. Bear in mind that much of what eventually develops into normal adult sexual activity includes the mouth, starting for instance, with kissing.
4. Other thoughts from the participants?
   More about this in Workshop #2.

**Instructor continues:** According to psychosexual theory, during the second half of the second year, the toddler begins to be aware of sensations associated with both urination and the passing of stools. These waste discharge activities produce pleasurable

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sensations both by the relief of bodily pressures but also due to the unique feelings the passage of these waste products produces in the lining of the organs in question. This period of psychosexual development, from about 18 months to about 3 years is the anal phase.

The sensations associated with these everyday functions are considered to be part of the total human sexual system.

**Discussion:** What developmental gains does the child make during the successful negotiation of the anal phase?

1. Learning how to control urinary and bowel functions,
2. The internalization of parental dictates, and therewith of societal dictates, that lead to increased conscience development,
3. Feelings of well-being that come with achieving a new level of autonomy ("I need to do", "I want to do", "I decide to do") and of competence ("I can do what I set out to do"); or when gains are not made in toilet training for instance, it may lead to feelings of frustration and failure, shame, etc.
4. Other ideas from the participants?
   More about this in Workshop #3.

**Instructor continues:** We also see, in most normal children 2 to 3 years of age, and in some even from about 18 months on, an increased attention to, interest in, and concern about their own and others' genitals. This is the beginning of the first genital phase.

It is so called because the child's sexual experiencing now becomes most organized by pleasurable sensations in their genitals which, we assume, result from a biological maturation that occurs during this period of development. This period is called the first genital phase because there is, indeed, a second genital phase, namely the adult genital phase which begins in adolescence. This second or adult genital phase is initiated by the remarkable biological (hormonal-physiological-physical, etc.) sexual developments that occur at puberty. It is important and useful for parents/caregivers to understand that the first genital phase in the infantile form of sexuality; and the second genital phase is the beginning of what will mature into the adult form of sexuality.

We shall talk more about this in Workshop #4

**Summary:** Early life is experienced by children especially through the natural workings of their young bodies. They experience much pleasure in its functions and in gaining mastery over these functions.

Eating is a major experience to the young infant both by virtue of the exercising of new functions and by the pleasure associated with the reduction of pangs of hunger. So too, in the young child's life, defecation (having a bowel movement) or emptying the bowel of its contents becomes quite a challenge. Young children experience both hunger and difficulty in emptying the full bowel or full bladder as highly unpleasant if not painful. The young child's experiences are first "body-experiences", and the young child's experiences are first perceived and organized cognitively (intelligence-wise
according to Jean Piaget) by "sensorimotor" actions, namely, by the normal functioning of their sense organs in combination with physical movements, locomotion--crawling and walking--and hand and mouth manipulations, in explorations of their own bodies, the bodies of those to whom they are in the process of attaching and the environment. (Instructor may need to explain this thought more fully.)

**Group discussion (in either large group or divided)**

Discuss remaining questions from workshop thus far.

**Consider the following questions:**

1. What are normal sexual behaviors in children ages 0-6?
2. How can the parent/caregiver best handle these behaviors in order to be growth-enhancing for the child?
3. How can the parent/caregiver address the child's concerns in a way that is appropriate and comfortable for both the child and the adult?
4. How can the adult caregiver know best how to answer a child's questions regarding sexual and reproductive matters?

These and other questions will be taken up extensively in the next Workshops.
APPENDIX A

THE THEORY OF PSYCHOSEXUAL DEVELOPMENT

As with all aspects of a human being's functioning, human sexual and reproductive development begins very early in life. Mental health professionals have recognized that sexual experiencing is an important part of every human being's emotional life. It is for this reason, that they have studied not only the human's sexual development from early childhood on, but have especially studied it from the vantage point of the part it plays in the child's emotional, or psychic, life. This is why they labeled this developmental theory: Psychosexual Theory. Psychosexual theory details an important part of human development.

Psychosexual development occurs in 6 phases.

1. From birth to around 18 months of age is the Oral Phase of psychosexual development. The word "oral" refers to activity that makes use of the mouth. The specific way in which it is important is that oral activity in this theory is considered to be the most dominant form of erotic experiencing of which infants seem capable. Two factors play a part in this "erotic" experience: pleasure in sucking and pleasure in tasting. The most specific "feeling" of the mouth is, of course, taste. Sucking pertains to that critical factor which is that the mouth, the oral cavity as physicians say, is the entry port of that most vital of all functions, to take in order to digest food. Food intake, along with the need for oxygen and the experience of pain, is of such importance that it can waken an infant from sleep, and lead him to exhibit very demanding behavior. Given that, both the inner layer of the mouth (the mucosa) consisting of very sensitive cells, and that the gratification of both sucking and hunger is so pleasurable, and that in addition, the intake of food is vital to life, it is not puzzling that during the early months, and to a significant degree from then on, the child's mouth is a major body structure around which much important special experiencing occurs and becomes organized. Yet another easily observable important use of the mouth is that it also becomes one of the infant's earliest means of exploring his environment. He feeds, feels, tastes, explores, and experiences much pleasure or frustration through the activity of his mouth.

2. Next comes the Anal Phase, roughly from 18 months to 3 years. In psychosexual theory, this part of the body is given special importance during this age period, because this body part and the basic function it serves get a great deal of attention from the child as the child begins to feel the need for developing control over both this body part and its vital functions. Again, this is a vital body activity in that it is necessary for survival. We must rid our bodies of waste products or we would not survive.
Most people have a good deal of difficulty in recognizing that humans (and probably all animals as well) feel a specific form of pleasure in the course of ridding our bodies of the waste products that accumulate within our large intestines and our urinary bladder, the remains of the foods and fluids we take in that we do not digest and take into our cells. Part of this form of pleasure, again, has to do with the fact that the surface layer of the exit port of our digestive tracts, our rectum and anus, consists of "mucous cells" which makes it very sensitive to stimulation. It may be because the rectum and anus are anatomically located quite close to our genitals that the nerves that serve the areas where and by which we feel the need to excrete waste products from our bodies sometimes stimulate our genital parts as well. For instance, all parents have discovered that baby boys will often have an erection when, in the course of being diapered, they urinate.

But there is much else too that leads the child's attention to the anal part of his body and its functions, namely, that it is perceived by the young child as a body function over which the child wishes to gain control and mastery. It becomes a crucial task for the 2 to 3 year old to learn to control those muscle rings we call the anus and the bladder sphincter. This is the period when the young child is concentrating on toilet training, and when this is achieved, he derives much pleasure and a sense of accomplishment or, when he does not, experiences much frustration and feelings of failure.

3. The third phase of psychosexual development, which runs from about 2 1/2 to 6 years of age, is what developmental researchers propose to be the First Genital Phase. This is the era of the human's life when sexuality as most people understand it begins. Now erotic feelings become directly aroused by and experienced in the genital parts of the body, of course, in the boy his penis and scrotum, and in the girl, her clitoris and external as well as internal vaginal areas. This "first genital phase" also includes the Oedipal Complex (which in this Curriculum, in Unit 3, we call the "Family Romance"). During this 2 1/2 to 6 year period, the child is pre-occupied with and usually much concerned about sexual feelings, fantasies, sexual differences, and, when permitted often will ask questions about their own genitals and those of others, and about babies. We talk extensively about the "family romance" as well as major details of the preoccupation with both genitals and the origins of babies in Unit 3 (3 to 6 Years).

4. Then comes the Latency Phase. This phase is so labeled because, in comparison with the 3 to 6 years period child's pre-occupation with genitals and the "family romance" dynamics on the one hand, and the striking sexual body developments and upsurge of sexual interest of puberty, the period from 6 to 10 or so years of age is rather quiet with regard to sexual concerns and interests, or sexuality is relatively dormant and thus, "latent", as if inactive but ready to become active at a biologically prescribed time. This does not mean that there is no sexual pre-occupation or expression of interest at all but that, rather, it is not so dominant as it is before and will be at puberty.

One wonders, thinking of the challenges sexuality is to humans, whether the wisdom of nature has a hand in this since this 6 to 10 year period is when throughout cultures,
children are expected to start the arduous and taxing journey toward becoming a contributor to society by being a "worker". Industrial countries especially have made it obligatory that children be made to put much adaptive energy into learning now not only at home but especially at a much accelerated rate now in school, on building a remarkably wide range of skills, on learning to take responsibility and do homework, and on increasingly developing (nonsexual) relationships with peers.

5a. The fifth phase of psychosexual development is the **Pre-Adolescence Phase**, ages 10 to 13 or so. This period has more recently come to be recognized as an important "transitional" phase, between being a "latency-age" child, or elementary school age child, to becoming an adolescent. During this transitional phase, the biological stirrings that will lead to puberty are believed to be set in motion, and begin to influence the child's feelings, concerns, and behaviors. Thus, while continuing to focus much energy and attention on ever developing skills in schoolwork and elsewhere, the 10 or so year old is beginning to feel those unique bodily changes that come with getting ready for puberty, that remarkable biological process that ushers in and thrusts the youngster into Adolescence.

Two terms that are key in psychosexual theory are puberty and adolescence. **Puberty** is that **biological** process and **time period** from about 11 to 14 years of age that brings about the metamorphosis of the child as sexual being into the beginnings of the future adult as sexual being. It is the biological process that begins the conversion of "infantile sexuality" into "adult sexuality". It does so by virtue of a genetically programmed activation in the child 10 or so years of age of hormones that start the maturation of not only the total youngster into his or her adult form and but especially so of his or her reproductive system. This brings about the well-known physical metamorphosis including marked enlargements of the body as a whole, and of secondary sex characteristics. ** Adolescence**, initiated by puberty, is that decade-long developmental period, physical and psychological especially, that bridges childhood and adulthood. During this long period, the child gradually evolves into the adult. Developmentalists believe this period to be so complex in its development that they subdivide it into 3 phases. In this Curriculum we address adolescence in these 3 phases.

5b. **Adolescence**: As just noted, from about 12 or so years until about 20, in psychosexual theory is the period of remarkable sexual transformation from childhood to adulthood. Physically and psychologically, in terms of his or her evolving sexuality, the child gradually is developing into a man or a woman. Sexuality now becomes a major pre-occupation, source of great challenge, much concern, and it organizes one's experiencing of oneself as an individual person with a clear and stabilizing sense of gender-self. This crucial further organization and stabilization of one's gender-self influences importantly the character of one's relationships to others.

Although not included as part of psychosexual theory, the following notes might usefully be added here.
Adolescence is further challenging to both the growing child and parents by virtue of not only the enlargement of the skeleto-muscular system in both female and male but by a clear upsurge in physical strength and in aggression. This becomes particularly challenging in the face of the normal anger, hostility, and occasional hate that may be experienced by the growing youngster toward those persons he most values in life. This challenge becomes even more daunting for both the growing individual, his parents, and society, when, because of lifelong abuses, neglects and deprivations, the growing young person is loaded with hostility, hate and rage, which now, when discharged can have a powerful destructive impact on himself, those around him and society.

This also is the time when a young person gradually becomes more independent from his or her family of childhood, one of the most challenging tasks of this decade-long developmental period. The adolescent has to enter adulthood having achieved the critical shift of the center of his relationships being occupied by his family of childhood to that center becoming progressively occupied by the peer group. This is essential for healthy development because it is from this peer group that the young adult will eventually select a mate, and achieve the end point of sexual development that is the preservation of the species. This does not mean that all adults must reproduce to fully be adult. It does mean that reproduction when it occurs in the course of normal healthy development is a function of adulthood. We see only too often, the harm done to both child and young mother, when reproduction occurs in mid adolescence, when it too prematurely makes its enormous demands on the adolescent who has not yet sufficiently done the work of development that can take it safely and stably into the rigors of adulthood.

Enormous developments in intelligence, the ability to learn and to develop skills makes adolescence a remarkable developmental period that prepares the growing individual for his/her life work. The adolescent is now setting the stage to either go to college or take an income-earning job.

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6. **Adulthood**: During this over-21 year of age period the person becomes self-supporting, and usually marries and becomes a parent. This of itself, is the end-point of psychosexual development: reproduction. As we noted earlier, one can be a fully mature adult and elect not to reproduce. While sexuality is a major factor of our humanness, it is not the totality of being a human being.

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WORKSHOP # 2
THE DEVELOPMENT OF SEXUALITY IN THE CHILD --
Part I: THE ORAL PHASE (0 TO 18 MONTHS)

Question: Let's review what we mean by the oral phase? And, what activities most pertain to this earliest developmental phase?
Answers from participants.

Discussion: People aren't born with their personalities all developed. Most developmentalists hold that personalities develop in "stages" or "phases" of development. Like the other major physical-psychological developments that all together form our total personalities, the development of the child's gender identity and its complement the child's sexuality both begin once the infant is out of the uterus, and they evolve somewhat stepwise over time into an increasingly more complex psycho-biological organization. This psycho-biological organization gradually evolves into our gender-self, our sexual identity, a key component of our total self.

One can usefully think of this progressive evolution of sexuality in the child in the way psychosexual theory spells it out. According to psychosexual theory which we reviewed in the last workshop, during the first 18 months or so after birth, the infant is in the oral phase.

Observing infants during the first 18 months of life, one finds that major aspects of the child's basic adaptive activities involve the child's mouth. During states of wakefulness, the child spends most of his/her time doing what is essential for survival, namely beginning to form emotional attachments with his/her primary caregivers, and taking in essential body-needed supplies by eating and drinking. Close observation of the less than six month old tells us that the mouth serves not only the vital functions of eating and drinking, but that sucking in and of itself plays a large adaptive role. Observation tells us that sucking seems to be a soothing and comforting activity. It seems at times as necessary for infants just to suck, as it is for infants to eat and take in fluids. Again, sucking seems to have a calming and comforting effect on all infants.

And, it is especially in sucking that the mouth brings a specific type of pleasure, namely, erotic pleasure. This especially is what has given the mouth its place in psychosexual theory, as the body site most involved in the earliest form of "sexual" activity and pleasure. Clearly of course, in and of itself, sucking--as in kissing and other sexual acts--is only a modest part of what we adult humans consider to be sexual activity.

In the infant's earliest life, the mouth is the body organ by which the infant experiences both pleasant and unpleasant feelings and it is also one of the main body systems whereby he learns what the world around him is all about.

Question: What do we mean by the need to suck? What purpose(s) does it seem to serve for the infant and small child?
Answers from participants. Encourage discussion among participants.

Discussion: Close observation strongly suggests that sucking seems to calm, soothe and...
bring comfort to the infant. From 3 to 5 months of age on, the infant will use his/her thumb or pacifier at times of stress or tension. Most parents can see that this is an effort to comfort himself or herself. It is an act initiated by the infant to comfort her/himself without needing to turn to the mother. It is, therefore, **one of the first efforts an infant makes to take care of his or her own needs**. In fact, thumb sucking or an infant's use of a pacifier is an autonomous (self-initiated) activity that serves the infant to adapt independently to stresses of everyday life. **It is the infant's first efforts to be self-reliant.**

Sucking is an inborn, built-in mechanism in mammals that serves several major survival functions:

1. To feed the self by drawing milk from the breast,
2. To attach to the mothering person or animal and form the first core emotional relationship (attachment), and
3. To try to calm the irritated or stressed body-self. In this function of calming and comforting, sucking has a soothing character, brought about by the mucous membranes' built-in reactivity and the muscular action of the mouth's sucking motion. Thus the ability to suck is critical to the infant's survival in these 3 major ways.

**Question:** But wait a minute. Isn't thumb-sucking or needing a pacifier a problem? Won't it mess up the baby's teeth?

**Answers** from participants. Have they felt this way? Have they heard others say this?

**Discussion:** As we said, most infants use sucking their thumbs or a pacifier to **calm and comfort** themselves. Mental health professionals tell us that using these "comforters" is driven by a strong inner need to be able to control and master one's own body, and when needed to comfort oneself. It is adaptive.

In fact, the need to be able to calm and comfort oneself by giving oneself a soothing type of pleasure, also comes from and has a direct bearing on the experience of calming and comforting the infant gets in his/her relationships with caregivers. In this way, Dr. Donald Winnicott, a British Pediatrician and Psychoanalyst told us that the infant's holding on to a blanket, or Mother's hair, while sucking (breast or bottle) is experienced by the baby as part of the "good-enough" feeding experience. At some moment of need then, a piece of blanket like the one touched during feeding, or the child's own hair, or some other soft thing like a Teddy can become a source of calming and comfort with the remarkable powers only good nurturing mothers and some fathers have, that powerful stuff that resides in TLC (tender loving care), that magical stuff nurses used to use to help patients heal.

In fact, the British call these pieces of blanket, or the thumb, **a comforter**. Technically, Winnicott called it a **transitional object** because he believed it was a **substitute object** emotionally-invested within the parent-child relationship which serves the child to be able to soothe and comfort him/herself on his/her own, self-reliantly. The thumb or pacifier too may become such a substitute object for the mother's providing the calming and comforting feeding (breast or bottle) experience. And commonly, where infants are bottle-fed, the bottle, especially the "night bottle", can become such a comforter.

As the child grows sucking continues to play an important role for the
gratification of these basic physical and emotional needs. For instance, the soothing effects of a comforter (e.g. pacifier, "night bottle", etc.) can be a remarkable source of help to the child's tolerating separation anxiety--that children commonly feel at bedtime--and stranger anxiety during the 6 to 18 months period of life. For this reason, it is important for the parent to allow the child to have a voice in determining when the night bottle or the pacifier or the thumb will be given up. It is important to bear in mind that, in fact, rather than infantilizing, thumb-sucking and the pacifier are among the child's first efforts to do things on his or her own, to soothe the self without mother's help.

**Instructor:** discuss with participants the matter of dealing with the use of night bottles, thumb-sucking and pacifiers. Some participants may feel substantial disagreement with this view of thumb-sucking, pacifiers, and night bottles.

**Question:** We noted that the mouth is the central body part that organizes experience during the Oral Phase and that its serves several functions. What other functions does it serve? Or, how else does the infant's mouth serve the child's adaptation?

**Answers** from participants.

**Discussion:** We already noted that the mouth serves three important functions. Let's look at this from a slightly different point of view. The three functions we talked of earlier can be clustered around the mouth giving the child **pleasure**.

1. **The mouth as a source of pleasure.**
   Foremost perhaps, the mouth yields pleasure as the "port of entry" of food. Eating when we are hungry makes us feel good. It can also comfort us. In fact, the comfort that comes with eating can bring with it problems such as overfeeding which becomes a substitute for the "emotional feeding" we all need that comes from good relatedness. We shall discuss this in detail during one of our group discussions.

   As we said, sucking is primarily important for the intake of food during earliest life; but infants also seem to derive an erotic type pleasure and gratification from sucking apart from the need to get physical nourishment.

2. **The mouth serves as an organ of exploration.**
   Already during the first 12 months of life, the infant will put things in his/her mouth, not to eat them, but to feel what they feel like, perhaps what they smell and taste like, and what they are all about. The mouth then is used for the purpose of exploring those things that will fit into the mouth. Like the eyes, the nose, the ears, and the hands, the mouth is used as a tool to discover and come to know an heretofore unknown thing.

   During the second year of life the mouth continues to be an instrument for exploring; again, the child's putting something in his/her mouth is not necessarily indicative of a child's wish to eat it. Then too the aim is to discover the characteristics of things and come to know them better. The child mouth then, as an exploratory organ, is a major tool for exploration, adaptation and learning about the self and the environment.

3. **The mouth serves as a source of communication.**
   From the first moments after birth, the infant makes vocal sounds, including crying, in order to communicate some state of feeling or of need. The toddler's ability to
make different sounds increases dramatically and, during the second year, she/he begins to use her/his mouth to say words and increasingly communicates with his/her mouth now by making all kinds of sounds including words.

4. The mouth can serve as a weapon.
   Of course, the most basic use of the mouth as a weapon or as a tool is the use the infant and toddler makes of his/her teeth to break down food in order to eat it.
   But, the infant will also bite in order to decrease the pain of teething. Putting pressure on a body part that causes us to feel pain can at times stop the feeling of pain. This is due to the activation of pressure-feeling nerves then interfering with the skin's pain nerves being able to feel pain. It is important to understand that the infant is biting then to decrease the pain of teething, and not because he/she wants to hurt mother.
   On the other hand, the toddler may bite when he/she is angry. Biting seems to be a natural reaction for discharging feelings of distress and of hostility.

**Question:** What should the parent do to prevent the child from biting in anger since this can only get her/him in trouble?
**Answers** from workshop participants.

**Discussion:** During the end of the first year and during the second year of life when a child bites someone when angry with that person, it is, of course, important to help the child learn that biting is not an acceptable way of expressing feelings of anger and hostility. Verbally prohibiting biting as a way of expressing anger is enormously helpful even to the one year old. This of course may require more than one effort on the part of the parent.

**Question:** Do you think there is a relationship between the feeding experience (oral activity) and the development of the parent-child relationship?
**Answers** from workshop participants.

**Discussion:** The feeding experience is one of the earliest and most frequent major events of parent-child interaction. When the parent's experiencing of the infant is predominantly warm and loving, even in children with early problems in adaptation--such as infants with colic or hyperactive infants, etc.--the parent-child relationship commonly becomes predominantly warm and loving. And, when the feeding experience is good, it importantly facilitates the development of basic trust and positive human relatedness. In this way, oral activity is recognized as an important emotional activity not only in infancy, but in fact for years. Simply said, the emotional quality of mother-child interactions, including especially that of feeding, is an important contributor to how the child will feel about himself/herself and in his/her relationships to others. Also, generally--except with children who have colic--the more emotionally loving and gratifying the parent-child relationship, the more comfortable and nurturing the feeding experience.

Of course, fathers and other close family members can readily participate and contribute very meaningfully in the feeding experience. (For more detail refer to the Workshop Series, *On the Development of Self and Human Relationships*, Workshop #1, "Optimizing the Parent-Child Relationship, Addendum 1").
How to Optimize the Child's Oral Activity

**Question:** What can the parent (caregiver) do to optimize the child's oral activity?

**Answers** from workshop participants. Encourage their creative thinking and empathic skills.

**Discussion:** There are several ways in which the parents can optimize the infant's oral activity and thereby contribute to the child's earliest experiences in growth-promoting ways. The principal one is by making the feeding experience an opportunity for a positive emotional interaction between parent and child. Given that making food and fluid intake emotionally gratifying facilitates the child's making positive attachments as well their developing good basic trust and forming good human relationships, let's discuss the following:

**Group discussion:**
- What makes for a good feeding experience?
- How would you want your baby to feel? What can you do to help your baby feel comfortable and good?
- What are the best postures/positions, for the baby and the caregiver, to feed the baby?
  - Does the way the baby is held matter to the baby?
  - Which is better: breast or bottle? What do you feel about this?
  - Does how the parent/caregiver feel make any difference to what the baby feels while feeding?
- Discuss any other points regarding feeding participants want to talk about.

Participants may want demonstrations by other participants or the instructor to illustrate some optimal holding positions and/or feeding positions and may want to discuss the pros and cons of each technique.

**Question:** What about the dangers of overfeeding? How can you tell if you are? How can this be prevented?

**Answers** from participants.

**Discussion:** The use of feeding an infant who is in need of emotional contact, who needs to be held and needs comforting, can create serious problems. When the infant fusses, parents need to sort out whether the infant is "asking" for milk or fluids, or whether the infant is feeling some physical pain, or is anxious, or, most importantly just in need of everyday, down to earth loving, emotional contact and comforting.

Feeding milk or food when the need is simply for emotional sucking or, more importantly, for emotional contact and interaction often leads to the overuse-misuse of food and other products for the purpose of filling the need of emotional sustenance or
emotional feeding. It discourages the infant from the highly desirable normal tendency to turn to human relationships for emotional interaction and relatedness and can set a pattern for later overeating—and all the problems this brings—and other maladaptive food and chemical abuses, that is alcohol and drugs. It is likely to become one of the principle methods a person may use for relieving the very real stresses of everyday life.

If one gives an infant a bottle when he is hungry for a hug, he may accept the bottle, but it will not gratify his emotional hunger the way a hug would. If this happens often enough, that infant may become starved for emotional contact, and may then painfully yearn excessively for emotional contact. The consequences of this will be a feeling of emotional deprivation and will have a variety of negative consequences on the child’s emotional and adaptive development.

Thus, the overuse of food can not only be detrimental to healthy development, it can also lead the infant to feel deprived of basic human needs for love, for emotional contact, and for feeling valued as a person.

**Question:** Is it wise to force an infant or child to eat or drink when the child indicates that she/he is not hungry or thirsty?

**Answers** from participants.

**Discussion:** It is not helpful for either child or parent because this turns meals into a battleground, into a field of battles of wills. Children should be offered and encouraged to eat a good variety of foods, but should not be forced. Over time, they usually will balance their diet. Children, like adults, are very likely to dislike some foods.

Babies have a built in mechanism which will prevent them from over-eating unless they are not getting enough TLC (tender loving care) and love. If that is the case, they may over-eat in an effort to make themselves feel better. When children get enough affection, they usually eat what they reasonably need. Of course, a few children will develop eating problems even when they are loved enough. For example, some colicky infants may retain, for some time, some displeasure—due to anxiety about feeling pain associated with eating—about eating; or an occasional child will associate feeding with some very painful life experience like Mother’s drastic automobile accident or unduly long hospitalization for an illness.

**Forced feeding is destructive.** It is well for parents to encourage good balanced diet feeding patterns. But just as it is important to not force feed, it is important not to punish a young child for not eating foods that make the child nauseous. It is quite OK to reasonably demand and expect that a child will try to eat what the mother or father considers to be a reasonable diet. It is also important to not directly link feeding to punishment such as to punish a child by sending the child to bed without supper.

Also, very important, parents should try to not link loving the child with how much the child eats. This notion may contribute to the child's overvaluing eating to be loved and this will facilitate patterns of excessive eating which often lead to being overweight.

**Discuss** with participants further thoughts, questions and concerns regarding feeding experiences.
**Instructor continue:** All experiences young children and infants have become *internalized* into their minds. These experiences organize what life is like for them. Thus they give rise to what the child will expect and predict of the world in which he/she lives. Of course, some experiences are more powerful than others. The way the infant is fed by Mother or Father is strongly determining of the child's internalizing these experiences as "good" or as "bad". From the beginning of life on, *experiences are catalogued in the mind as "good" and "bad"*. The more experiences while cared for by Mother are catalogued as "good", the more the relationship with Mother is felt to be "good." The more they are felt as "bad", the more the relationship with Mother (or Father, etc.) is felt as "bad." This tendency, of *experiences giving emotional color to relationships*, that is, influencing the quality of relationships, continues throughout life. Though the quality of relationships is most personality determining during the early years, it will have a powerful influence on how they feel about life until the end of life.

Therefore, good feeding experiences contribute greatly to getting relationships off on a good footing.

**Question:** Regarding other ways to optimize an infant and small child's oral activity, do you think a baby should be allowed to suck his thumb?

**Answers** from participants.

**Discussion:** The parent and caregiver can help the infant to use her/his mouth in a growth-promoting way by permitting to a reasonable degree the use of the mouth as a comforting agent or pacifier. With this the infant is helped to find his/her own way of discovering a means of reasonably reducing tension within the self and thereby comforting the self. This enhances his inborn tendency to want to do things himself/herself, to be age-appropriately self-reliant.

Many parents are concerned that thumb sucking may be harmful to the child in that it may push the child's front teeth forward. This may occur in children whose gums are less firm than in most children; it will not do this to all children. In addition, in most instances, before the teeth are pushed forward, this way of finding self comfort will be given up spontaneously, when the child develops other resources and skills. Depriving thumb-sucking or pacifier use too vigorously may interfere not only with the child's first efforts at self-comforting but also at allowing good beginnings to self-reliance and autonomy.

**Discuss** with participants thoughts, reactions, questions to this topic.

**Question:** Again, regarding optimizing oral activity, should infants be allowed to put objects into their mouths? When should the parent (caregiver) intervene?

**Answers** from participants.

**Discussion:** Since a lot is learned by the less than 2 year old by putting objects in her/his mouth and this is an important way of learning especially during the first year, it is wise to discriminate when to allow and when not to. It is not advisable to automatically discourage this behavior. Of course, there are exceptions. If the object is too small--and
if aspirated (breathed into the lung passageways) could block breathing--it cannot be allowed. To be safe, things smaller than a quarter should not be allowed; a regular size playing wood block is quite safe. Certainly, potentially dangerous or things that are too dirty (though infants, according to some pediatricians, seem to be naturally protected against ordinary germs), or in some other way pose a danger to the child, these should not be allowed. In such instances, parents need not hesitate to be firm. But be sure to tell the child (in words), no matter what age, why he/she is not allowed to put this thing in her/his mouth.

**Discuss** with participants further thoughts, questions, reactions to this topic. Discuss what objects may be useful for the infant to explore with his/her mouth.

**Question:** Are comforters (thumb-sucking, pacifiers, a choice Teddy, piece of blanket, etc.) important for the child? How can the parent best handle these?

**Answers** from workshop participants.

**Discussion:** It is important for parents to know that the comforter is a selection **made by the child**, be it a less than one year old infant learning to calm or soothe himself, or an 18 month old trying to cope constructively with the anxiety of the "rapprochement subphase" conflict (to be one with Mother versus to individuate, be separate.) While parents will usually offer comforters to their infant, which is a very nice thing to do, they can't make the ultimate choice of what the infant will use as comforter; this only the infant selects.

Then, it is well to bear in mind that not only is the comforter selected by the child, but in fact it **belongs** to the child, not to mother nor father, nor to anyone else. A comforter is as valuable to a toddler as her purse is to Mother or Dad's car is to him. Therefore, **nothing should be done to it or with it without the toddler's consent**, whether it is taking it away from her/him, or even washing it!

Furthermore, parents are overly worried, and not helpful, when they object to a child's using a pacifier because they fear it will make the child feel like and want to stay a baby. Quite the contrary! A comforter, whichever the child selects, is in the service of calming oneself, of **taking care of one's needs on one's own**. It is among the toddler's **first efforts to act self-reliantly**. Parents can rest assured that a child will give up using his thumb or pacifier when he no longer needs it. Parents can also rest assured that a thumb-sucker will not crave oral stimulation any more, in fact may do so less, than a child who is not permitted to do so.

It is ok to **encourage** a three year old who still sucks his/her thumb to try to find another way to calm himself/herself. It is harmful to shame him/her. It causes the three year old anxiety to be threatened or disapproved of for still sucking his/her thumb. Just encourage the use of a more age-appropriate way such as talking to Mom or Dad about what is stressing the child, or simply verbally reassuring oneself: "I'll be ok; I can always ask Mom/Dad to help me if I need help."

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1. The rapprochement subphase conflict is detailed in the set of *Workshops on The Development of Self and Human Relationships*, in Workshop #6.

*Workshops on Sexual Development*
**Discuss** with participants thoughts, reactions, questions to this topic.

**Question:** When should a child be weaned from bottle or breast (or the combination of both)?

**Answers** from participants.

**Discussion:** The task of weaning from bottle or breast may be most troublesome. Some children may have already weaned themselves by the end of the first year but most children shift from the bottle to the cup during the first part of the second year.

Parents know that most children during the second year tend to use the bottle or even breast feeding when they experience stress or anxiety and that commonly the bottle may now become a comforter more than a feeder. In fact, this is just what makes giving up the bottle or breast-feeding more or less difficult during the second and even the third year for all children.

Quite commonly during the second and also the third years children may need a "night bottle" for some time after they have weaned from the bottle during the day. They select the night bottle as a special source of self-comforting due to the heightened stress created in young children by the separation from the family required in order to go to sleep. It will be easier for the child to give up the need for the night bottle when the separation-individuation process is far enough along that separation no longer creates intense anxiety (see footnote 1 for reference to "the separation-individuation process"). This may not be achieved until entry into the third year. Similarly, as comforters, the use of the thumb or pacifiers tends to wane in many children during the later part of the second and early part of the third year while, in others, it will remain necessary for self-comforting for a longer period of time.

Weaning is a project. It usually does not happen overnight, as all parents know. It is commonly carried out during the second year of life. Foremost, it should be verbalized. Parents should speak in a straightforward manner of their intention to shift the child from a bottle or from the breast to the cup. The weaning process is much facilitated by introducing an infant's cup (like one with a lid and mouth-shaped spout) from near the end of the first year, well before the child is weaned from breast or bottle. It is always best to be open and direct about one's intentions to wean the child. Deceiving children can be much too costly in that it may undermine the child's developing basic trust, that most valuable attribute of good relationships. It's much better to be direct, face the child's displeasure, and try to help the child cope with it.

It bears repeating that where the bottle has become a comforter, it will be much more difficult for the child to give it up and that it may be most helpful to negotiate with the child as to when he/she feels he/she will be ready to give up the night bottle.

**Discuss** with participants further thoughts, questions, reactions to this topic.

**Summary:** During the first year of life and well into the second year, the mouth is of

For a detailed discussion of basic trust see the set of Workshops on The Development of Self and Human Relationships, Workshop #3).

*Workshops on Sexual Development*
special importance.
   Through it the infant **communicates** his needs to his mother.
   It is an efficient **food intake/sucking** apparatus that frees him from the pain of hunger.
   The child soon learns that sucking an object such as his thumb or a pacifier will give him **pleasure** and **comfort**.
   By putting objects into his mouth, he can **explore** how large or small, hard or soft they are.
   He gradually learns to **express** affection by giving kisses.
   He sometimes expresses anger with his mouth by biting. Sometimes he bites to ease the pain of teething. It is important to help him/her know that biting others (or himself for that matter) hurts and is not allowed. Of course, the way this is done should take into account whether the biting was done to ease the pain of teething or out of anger with the intent to hurt another.

**Discussion: How can parents help their infants have growth-promoting experiences during the Oral phase?**

Facilitator, consider the following with participants:

1. They can let him put objects in his mouth, except for dangerous items. Talking with the infant about the object he/she is exploring will increase her/his pleasure in learning.
2. They can allow him to suck his thumb, or pacifier, realizing that this is his way of independently comforting himself when in distress. It is also a source of pleasure.
3. They can recognize that when he uses his thumb or pacifier he may be signaling to them that he is feeling some stress. Parents may then offer to help but should be mindful of the young child's wish to want to "Me do it", that wonderful declaration of emerging autonomy.
4. They can comfort and try to ease his pain when he is teething.
5. They can make feeding times opportunities for close, affectionate interaction with the infant.
6. They can be aware that a good experience in the oral stage contributes to a sense of well-being, and helps to build basic trust.
7. They can be careful not to over-use feeding. Offering more food when the child may need something else, such as comfort, or holding, may set the stage for an over-reliance on food, and lead to over-eating as he grows older.
8. They would be most helpful to not press the child to be weaned during the first year, and when weaning is begun, to have it done gradually and with encouragement, with a night bottle permitted for comfort for several months after daytime weaning is accomplished.
WORKSHOP # 3

THE DEVELOPMENT OF SEXUALITY IN THE CHILD --
Part II:  THE ANAL PHASE  (ABOUT 24 TO 36 MONTHS)

Question:  What do we mean by "the anal phase"?

Answers from participants.

Discussion:  During this phase the child's "sexual" experiencing, according to psychosexual theory, is predominantly associated with his/her elimination functions. The child's "sexual" attention is especially focused on urinary and bowel movement activities; in terms of body parts, her/his attention is on the anus and the urinary function of her/his genitals.

In terms of the child's developing sexual life, the functions of eliminating urine and bowel contents acquire a significant and specific set of sensations and meanings that add to the child's emotional experiencing himself/herself. During the period from about 18 months of age to about two and one-half or three, in some cases even later, these sensations and meanings add to the further development and definition of the child's sense of self.

During this developmental period, for obvious hygienic, social, as well as for emotional reasons, toilet training is an important development which preoccupies children and parents (caregivers) alike. Recognizing that the child's visible elimination concerns and pre-occupations with the elimination of food waste products brings, and identifying the "erotic" sensations in the genitals and anus that come with it, led developmentalists to call this new psychosexual phase the anal phase. The normal child's attention is now especially focused on the anus and to a degree on his or her urine discharge system, as the child's readiness for toilet training emerges.

Question:  Why is this considered part of (psycho)sexual development?

Answers from participants.

Discussion:  The anal phase is considered the second form of earliest sexual experiencing and is associated with the elimination of waste products from the body, through the end part of the digestive tract, the rectum and anus, and through the sphincter (muscle ring) of the urinary bladder and the urethra (the mucous membrane lined tube that carries the urine from the bladder to outside the body). Like the oral phase, which is concerned with the intake of food, the earliest part of sexual development is intimately linked up with obligatory digestive biological processes. The sexual factor itself comes from the fact the inner lining of both the mouth and the recto-anal and bladder-urethra organs are lined with those very sensitive mucosal membrane cells. Mucosal cells are very sensitive to any pressure placed on them by the passage of food-waste solids or fluids and is experienced by humans as producing an "erotic" physical sensation.

Understanding both that the earliest sexual development does not directly involve the genitals but rather the mouth and the recto-anal and urinary systems, as well as the
role of the mucous membranes in "erotic" sensations, will guide parents in the task of toilet training which the toddler 2 to 3 years of age is well prepared to undertake.

**Question:** How does the process of toilet training make a significant contribution to the emotional and psychological development of the child?  
**Answers** from participants.  
**Discussion:** The child does not experience toilet training simply as a physical activity. It is also very much motivated by psychological reasons and has significant psychological effects. The child's complying with the wishes of the parents in toilet training brings with it the child's developing ability to control his body, to begin to develop an invaluable degree of control over his/her own inclinations and wishes. This compliance also brings with it a sense of doing the right thing, of doing what is expected, and of pleasing the parents the child loves and whose love he values. There is furthermore for the child the experience of being able to accept limitations, to accept rules and regulations, to accept compliance with reasonable social standards. The fact that this acceptance is made by the child in response to demands made by his or her own parents brings a growing capability to accept instruction and guidance from those in our world who attempt to protect us and to help us grow into responsible people.

**Question:** When is the optimal time to begin toilet training?  
**Answers** from participants.  
**Discussion:** We know that this is a controversial subject and that it is both very personal and also guided by familial/societal norms and expectations. Knowing when children are capable of controlling their sphincters should be a key factor in scheduling toilet training. The third year of life seems to be a good time for such training. Some children will handle toilet training efforts nicely at the end of the second year; most, however, fare better during the third year of life. It would stand to reason that, if the child's ability to control bladder and bowel sphincters (muscles) does not mature until about the beginning or middle of the third year of life, imposing demands for toilet training prior to this time would create greater possibilities of failure even when the child tries hard to comply with the parent's demands. And, indeed, **successful toilet training is commonly achieved when undertaken from about two to two and one-half years of age on.** We find that most children respond to demands for toilet training with more success during the middle of the third year than during the second year of life.

Obviously, if sufficient pressures are imposed, the child can be toilet trained, as in done in some cultures, even during the end of the first year of life. However, when toilet training is started before about 2 years of age, it is quite likely that the development of the sense of self and of the child's will are not yet sufficient for the child to feel that, indeed, he or she is developing internal controls or a sense of duty or of responsibility.

**Question:** What are some of the major obstacles to toilet training?  
**Answers** from participants.
Discussion: Toilet training occurs at a time in a child's life when the gradual development of the inner sense that he/she is an individual is at a crucial early stage. One of the most important things to bear in mind in the course of toilet training, as with any other behaviors that require compliance with parental dictates, is that the parent's urging the child to comply with "Go to the potty, Sweetie" may be experienced by the child as an imposition on the child's emerging sense of self. The two year old may even experience the mother's urging as a prohibition: "Now, you have no voting rights; your voice does not count!" This is because the 18 month old to the two and one-half year old child is working on issues that pertain to the differentiation of self from mother, from father, the major task during the Rapprochement Subphase and On The Way to Object Constancy. And, the child is then also working on the continuation of his or her evolving sense of autonomy, on the battles of wills the child undergoes with parents in the course of stabilizing that sense of autonomous functioning, that sense of self-experiencing that is so important to the overall growing sense of being an individual, indeed of being a self.

It is at this time then, when demands are made of the self to give up what the self may not wish to, or to carry out a function the child cannot yet carry out at will that parents may, and commonly do, run into some resistance. The demand made by the environment for the child to develop internal controls, to contain some of his or her inner pressures to discharge (not only of urine and bowel content but of one's other wishes as well) may be experienced by the child as a great imposition on the sense of self. The child's self feels encroached upon and disallowed by, of all people, the parent(s) the child loves! This can lead to conflicted feelings in the child and further interfere with toilet training efforts.

A child often has mixed feelings about being toilet trained. In addition to the above, many toddlers fear that, since their B.M.'s come from inside of themselves, they may come to fear that they can lose vital contents or parts of their bodies. This distorted fear may further the child's resistance to toilet training. This especially occurs in toddlers approaching 3 years of age, a time when the question of losing body parts becomes especially pronounced in many a boy and girl. (This issue is talked about in the next Workshop on the First Genital Phase.)

Question: Has your one to three year old made you feel like your demand for toilet training is as though you're trying to take something away from her/him?

Answers from participants.

Discussion: The demand to learn to control bladder and bowel is experienced by many a child as a demand that the child give up things or possessions from within her or his body. And in addition, that he/she give up his/her wishes to discharge body contents at will, that he/she give up "doing what he wants when he wants". It will then mean that the child must give up some of his/her own sense of authority, some freedom of self-expression. The child often seems to experience the parent's demand not only as an imposition on the self, but it may even bring a feeling of depreciation of the self. This adds to why toilet training is often experienced by the child as a restriction of his autonomy and sense of self and thereby leads to battles of wills.

But then, we also see toilet training as a major opportunity for both child and
parents. Pleasing the parent brings the child enormous pleasure, so does being able to do what the parent thinks is important. So does developing the ability of controlling one's sphincters which brings with it a sense of accomplishment, and in turn heightens the sense of self, autonomy and competence.

With all this then, even if there is some resistance to toilet training, dealing with the toddler patiently, respectfully, with loving firmness, can pay off with the gains just noted.

**Question:** Are erotic sensations experienced by children in the course of urine and bowel elimination and also during diaper changes?

**Answers** from participants citing relevant examples.

**Discussion:** Sensations brought about by these activities are pleasurable because they are relieving of unpleasurable feelings and may even be relieving of pain. In addition, though, by virtue of their activating the mucous membranes (the sensitive inner lining) of these organs, urinating and bowel elimination makes the child very aware of some degree of erotic stimulation. And then, to be sure, when Mother or Father cleans the child's genital and anal areas when needed, this also is generally felt as pleasurable and the child then may attach erotic feelings to toileting activity.

Research shows that genital sensations are evident in children during the first year of life, indeed from the first few weeks of life on. Erotic-type feelings associated with the parent's cleaning the child's genital and anal areas begin to be experienced from virtually birth on. Now during the anal phase, from about 18 months to three years of age there is a substantial heightening of the erotic experiencing associated with the functions of these areas of the body.

**Question:** Why then is the toilet training experience so very important to the child's development?

**Answers** from participants.

**Discussion:** The experience of toilet training is important because all the challenges it puts in front of the child are challenges which when met with a good degree of success contribute very positively to the child's developing self. Learning to cope with the almost unavoidable battles of wills, giving up some of one's inclinations and wishes for the sake of doing what grown-ups do, the gains to the child's psychological development that come from accepting external demands, from complying with these, and deriving pleasure from pleasing the parents the child loves, all contribute to the child's feeling of increasing competence and consolidating sense of being an individual, all these make the experience of toilet training an important one.

**Question:** Is toilet training similar for all children?

**Answers** from workshop participants.

**Discussion:** Essentially yes. But every child is unique in his/her personality, temperament, pacing of development, relationship with parents and other caregivers, etc. It is helpful to know that toilet training for urine is usually slower than for B.M.'s and that
this typically occurs with boys; the reasons for this are not really known. Where toilet training is incomplete and toileting "accidents" occurs more than once in a while beyond six years of age, professional consultation is generally indicated and is usually very helpful.

Of course, children who are quite slower in their development due to inborn problems, like many children who have Down's Syndrome or cerebral palsy, for example, will be delayed in their ability to be toilet trained and will need more time to achieve it. Parents of such children know that much more patience, understanding and sympathy is required in rearing such children to make them feel loved and valued.

**Group Discussion:** What, do you think, would be the results of an unsuccessful toilet training experience for the child and for the child-parent relationship?

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**Toilet Training: How to Optimize this Training Experience**

**Question:** OK, knowing when the child is physically best able to start toilet training during the third year of life is great for starts. Are there other, maybe more specific indications as to when a two year old might be ready to begin the process?

**Answers** from workshop participants.

**Discussion:** Cues from the child that he or she wishes to go to the bathroom in the "potty" is the most advantageous indication that the child is ready to begin toilet training. It is best to proceed with the child himself/herself spontaneously wanting to use the potty. It is well to praise the child who herself/himself wants to begin the toilet training process.

Where this does not occur, parents should not hesitate to make reasonable demands for toilet training when they believe their child might be ready for it. As we have said before, young children do need to comply with reasonable demands made of them by their parents and other helpful caregivers. But such demands will usually succeed better and be experienced by the child as in her or his best interest when the parents verbalize their recognition of the child's growing sense of individuality.

**Question:** How can parents and caregivers best handle resistance from the child?

**Answers** from participants.

**Discussion:** Where there is resistance, it is well to try--though it is not always easy--to sort out if the resistance is due to insufficient readiness, to anxiety, or to the continuation from even the first year of life of a child's wanting his way in most things, one with whom all things start with a battle of wills between child and parents, or in more extreme cases where the child is outright oppositional. We will briefly discuss each one in order to help parents consider useful possibilities. Professional mental health or pediatric consultation can be very helpful where parents are at a loss to know what to do.

1. **Insufficient readiness** and **anxiety** may be difficult to sort out except in two year olds who show feelings of worry, fear or anger surrounding toilet training. For
instance, a strong refusal associated with what looks like fear of sitting on the potty is most likely to be due to anxiety. Another child may willingly comply but be unable to produce a B.M. after a few minutes--and then easily have a B.M. in his/her diapers 15 minutes later--this may indicate that the child is just not ready.

Expecting such a two year old to sit on the potty for 15 minutes or more will not produce a positive toilet training experience. The child is more likely to experience it as tedious, as a source of worry and of feelings of failure. Again, asking the child to let the parents know when he or she feels ready to have a B.M. is a good way to start. Except for those children who show facial expressions of worry or fear about using the potty, insufficient readiness versus anxiety needs time to prove itself.

2. With **a child with a strong will** that's been in evidence from the start of life, one with whom it is easy to get into a battle of wills, it is best to try to find a way of making the child feel he/she had a large part in the decision to start the toilet training process. Linking toilet training with the child's wish to be "grown up", to be like Mom and Dad, or do things big kids do, may encourage the child. That the child has a strong will of his own does not mean he/she does not want and dearly value parents' approval or that he needs no encouragement to do things parents think are in his/her best interest.

Being too easy, making no demands to avoid battles of wills is not helpful. **How** the parent states that the time has come for Johnny to start using the potty is where the key factor lies: it has to be said in a way that lets him know that it is in his best interest to be toilet trained, that he'll feel good about himself, that he will have achieved a very worthwhile goal, etc. And, let him know that you stand ready to help him as best you can.

3. With **an oppositional child**, the task is usually quite more difficult. The same approach ought to be tried as with the strong willed child. There are differences between the two type children. The strong willed child was born with this inner need to do things his way; he finds it more difficult to do things the way others want him to do them. He is not trying to be difficult; he is somewhat constricted in the way he sees things should go. The oppositional child, on the other hand, feels a lot of hostility. He doesn't want to do what grown ups tell him to do most likely because he feels he has been hurt excessively by them. Oppositional behavior most often comes from having had very painful past experiences, such as, having been cared for under severe conditions of deprivation due to illness or loss of a job, or having been maltreated by a parent who is convinced that the only way to get kids to do things right is to be tough with them.

**Question:** What are the best parental reactions to difficulties in toilet training?

**Answers** from participants.

**Discussion:** Parents ought to try to balance respect for and allowing of the child's feelings of autonomy and developing sense of self on the one hand, with firmly but kindly and judiciously setting limits. Encouragement and duly complimenting success can be enormously fruitful. Parents need to guard against being pushed by their own hostility.

**Question:** "Pushed by their own hostility." What do we mean by this?

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**Answers** from participants.

**Discussion:** On average, toilet training the child challenges every child and parent. There are many instances where toilet training proceeds like a breeze. Commonly though, and especially with children who put up large resistances to it, it can become anywhere from annoying to outright infuriating. Studies have shown that the physical abuse of very young children is often associated with difficulties in toilet training. Crimes against children have been committed by parents around toilet training resistance.

That a parent experiences frustration with a child who has much difficulty cooperating will almost unavoidably lead the parent to become angry with the child. If this goes on too long, or if there are then also other troubling stresses straining the parent's tolerances, this may well lead to hostility mounting in the parent against the child she/he loves. Toilet training then may become not just a battle of wills but an outright facilitator of child abuse. The parent may then be "pushed by his/her own hostility" and do something the parent may regret. The experience and interaction that then follows is very likely to make the child's development more difficult and significantly worsen the parent-child relationship.

Again, that a parent experiences much frustration in these instances is unavoidable. If parents do not guard against the hostility such difficult and frustrating interactions produce in them, this hostility may pervade their actions and create greater problems between child and parent than before.

And again, toilet training a child who is persistently oppositional may require professional help. Toilet training should be gradual. It should be seen as an opportunity to improve the child's internal controls, acceptance of "do's and don'ts", and all that comes from successful toilet training.

**Question:** What are the positive developments that come from successful toilet training?

**Answers** from participants.

**Discussion:** There are many. To mention just a few, gains include (1) an increased sense of appropriate internal control over all kinds of strong feelings and wishes, (2) a sense of achievement, (3) an enhanced sense of autonomy, and individuality, (4) a feeling of parental approval and respect, (5) a better organized sense of "do's and don'ts", (6) an increasing feeling of competence and self-confidence, and (7) a consolidation of feelings of love, respect, and valuing in the child toward the parents.

**Question:** How can parents best handle "accidents"?

**Answers** from participants.

**Discussion:** Accidents ought to be met with understanding and certainly not with insults, rage, shaming or other humiliating and painful responses. Physical punishment is out. The child should be made to understand that he/she has the responsibility of taking better care of himself/herself. Patience, understanding, accompanied by reasonably firm expectation of better control help a child to accomplish toilet training. Look for opportunities to help the child affirm his "sense of self", develop a feeling of competence, a feeling of pleasure in being able to "do things himself" and these in turn stimulate his desire for further growth in competence and to learn.

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Group discussion

**Instructor provides various examples of toilet training practices.**
Ask participants to consider the examples and discuss pros, cons and ramifications of them. Use examples provided here and also examples received from participants.

1. Mrs. A. believes that babies should start toilet training as soon as possible. "The sooner they begin, the sooner they'll be trained", she says. As soon as Jenny began to toddle about, at about 12 months, Mrs. A. placed her on the potty chair several times every day for about 15 minutes each time, encouraging her to "go in the potty."

2. Mrs. B. learned from her friend who has 3 children that children give their mothers signals when they are ready to start training. She trusted her friend but she did wonder how long she would have to wait for Brian to signal his readiness for this task. When he was two years and 4 months he said to his mother that he wanted to use the toilet, "like big people." He said he wanted to sit on the potty but when he tried, it didn't work right away. This happened 3 times before he finally did succeed. Father had been a bit impatient, thinking that he was trying to get and hold Mom's attention. But Mom had been told by her friend that this is how it started with her kids too. Father did come to see that Mom was right.

**Instructor:** Discuss with participants the pros and cons of Mrs. A and Mrs. B's reasoning and procedures.
- Which child would finish training with a sense of accomplishment and pleasure?
- Why would this be so?
- What would these accomplishments consist of?
Participants should address both physical and psychological accomplishments.

3. Mrs. C. is a very busy mother. To top it off, she suffers from headaches almost every day. It really upsets her when three year old Kevin wets the bed at night, or has an accident in his pants while playing. Terribly distressed, at these times, she tells him that he is giving her a headache, that he is a very dirty boy and should be ashamed of himself.

**Instructor:** discuss with participants the following points:
- How does this treatment make Kevin feel?
- How does the scolding affect his progress in becoming trained?
- How does this affect his feelings toward and relationship with Mother?
- How does this affect the ambivalence--the mix of love and hate feelings--mother and child feel for each other?
(Instructor may need to explain Ambivalence to participants.)

4. Mrs. D. has heard that bedwetting or other toilet training accidents are quite
common as the child makes efforts to learn to control her sphincters. She tells her daughter that she knows Barbara is trying, and that accidents happen to all of us when we first learn to do something hard. She lets Barbara help her take the sheets or soiled underwear to the washing machine, and holds her up to turn the machine on.

**Instructor:** Discuss with participants how Barbara feels about these "accidents", and how her mother's attitude might affect Barbara's toilet training. Consider the effects of Mother's growth-promoting attitude on Barbara's developing sense of accomplishment, sense of doing what she sets out to do, her sense of self, her love feelings toward her mother and toward herself, etc.

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**Implications of Toilet Training on Child's Psychosexual Development**

**Instructor:** Have participants consider the following:

1. Toilet training involves the child's areas of anatomy that also contain the genitals, especially so the urinary structures.

2. When a child feels the need to go to the bathroom, whether to urinate or have a B.M., these feelings often stir up sensations that belong to the realm of "erotic" feelings. It is not uncommon for a boy who has held back urinating to have an erection at the point when he can no longer hold his urine in.

3. The child's efforts to learn to control these anatomical sites focuses their attention to them and with this on the mucous membrane sensations they stir up.

4. Because of these factors, during this period when the child's psychosexual development age-appropriately focuses on the elimination of bodily waste products, the child's awareness of the sensations that come with the need to urinate or have a B.M., and the efforts at toilet training, all contribute to the boy and girl's pre-genital--i.e., before these become focused on the genitals--sexual experiencing.

   It is important to recognize then, that if parents want their children to have healthy sexual lives, including the normal enjoyment of sex side by side with a responsible attitude about it and a reasonable sense of its age-appropriateness (i.e. when one is ready to do what sexually), that the activities of both pre-genital phases of psychosexual development, the oral phase and now the anal phase should be dealt with in a responsible, loving and respecting manner.

5. It is important to understand that premature training, undue impatience, shaming, scolding and abusive treatment of children can cause much harm. In addition, the battles of wills that can arise during the struggles of toilet training when there is a substantially poor parent-child relationship can be extremely harmful.
6. Patience and approval help a child to accomplish toilet training, increasingly affirm the child's "sense of self", develop a feeling of competence, a feeling of pleasure in being able to "do things himself", to be more like Mom and Dad, all of which in turn stimulate his benevolent self-regard and desire for further growth and learning.

**Instructor:** discuss with participants any further questions, reactions and comments about the workshop materials.
WORKSHOP # 4

THE DEVELOPMENT OF SEXUALITY IN THE CHILD --
Part III: THE FIRST GENITAL PHASE (2 1/2 TO 6 YEARS),
Section I: INFANTILE SEXUALITY

Instructor's introduction: As we said in Workshop #1, we have learned during this century that a human being's sexual life begins much earlier than used to be assumed. Whereas evidence of sexuality is amply clear in puberty--which is when we used to assume sexuality began to have its well known meaning for growing young people--many parents have long recognized what they have felt to be meaningful sexual behavior and activity in their children long before puberty.

This has now been documented by mental health scientists to indeed be sexual behavior, to have the kinds of meaning sex has for humans, and that there is clearly genital-associated sexual behavior that starts during the third year of life. We said during Workshop #1 that erotic sensations in the child's genitals can be inferred from young children's genital activities and behaviors, such as little boys having erections during cleaning-diapering, from the first days of life on. These everyday findings and much observational research have led child development theorists to support the psychoanalytic idea that a child's sexual life really begins near birth.

We said in Workshop #2 that during the first 18 months erotic experiencing is most attached with the activities of the mouth and that only occasionally does there seem to be evidence of genital arousal and sensations. Similarly, from about 18 months of age through about two to three years the predominant erotic feelings are attached to activities of the urinary system and the anus.

Except for a handful of writers and philosophers from past centuries, it is only since the beginning of the 20th Century that biological and psychological scientists have found that genital-associated sexual life begins during the period from 2 to 6 years. Psychoanalysts especially, mental health professionals in general, have found that sexual development occurs in 2 major stages. First is a stage of "infantile sexuality", from about 2 1/2 to 6 years of age. Some researchers have found evidence that it may begin even earlier, even during the period from 18 to 24 months of life. This stage of infantile sexuality is followed by a period of relatively less sexual preoccupation extending from about 6 to 10 years. This is then followed by a pre-pubertal period from about 10 to 12 or 13 when sexual interest begins to mount again. This then is followed by the second major stage of sexual-reproductive development, the stage of "adult sexuality", which begins with and during adolescence. Adolescence, when adult sexuality begins, is generally considered to extend in 3 subphases; the first from about 12 to 15; the second from about 15 to 18 and the third, late adolescence melting into young adulthood from about 18 to 24 years of age.

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Instructor: Field any questions on this from participants.

Question: What steps can parents and caregivers take to help their children best cope with their "infantile" or first genital phase?

Answers from participants.

Discussion: Mental health professionals believe that 3 major steps can be taken:

1. to know and understand what happens in normal sexual development;
2. to permit children to reasonably express their curiosity, worries, and to talk with them truthfully, thoughtfully, and age-appropriately about whatever they have on their minds; and
3. to react to their sexual behaviors with growth-promoting guidance.

Let's talk about these as they pertain to this important developmental phase. We shall talk about the first step, the value of knowing and understanding, in this Workshop #4. Then in Workshop #5 we'll talk about permitting children to ask questions and about talking to them at an age-appropriate level, and in Workshop #6 we'll talk about reacting to their sexual behaviors with growth-promoting guidance.

Question: Do you feel there is much to know, much to understand, in how children's sexuality develops? What information can help us with the challenge of handling constructively our children's beginning sexual life?

Answers from participants. Try to get parents to put into words what they already know about young children's sexual development.

Discussion: Parents knowing and understanding what happens in normal sexual--or in any aspect of--development is probably one of the first and one of the best ways to help the child deal constructively with this or any aspect of development. It is especially so with this part of sexual development, the first genital phase, when children's genitals, and a lot of fantasies children have about them, become a major area of concern and preoccupation and a major source of anxiety for children. It is also considered to be a major and crucial stage of the child's psychosexual development.

This first major stage of sexual-reproductive development in children for many reasons also causes much anxiety for parents. Foremost is that eventually sexuality in puberty, by the pubertal child's own actions, can cause many problems as we all know only too well, including the wide range of sex-derived physical problems, behavioral and emotional problems, as well as that major problem of drastically premature teenage pregnancy. All of these are less likely to happen when sexuality is sufficiently paid attention to, when it is thoughtfully talked about with one's children, and when children are sufficiently guided in their early sexual behaviors.

Wouldn't it be nice if sexual feelings, awareness, and fantasies really didn’t begin until puberty, as people have believed for so long. That, however, is now known not to be the case. And actually, there are large advantages to the fact that children's sexual life begins well before puberty. Among these, perhaps the largest advantage is this. Given that reproduction, the ultimate biological reason for sexuality, cannot occur prior to the adult phase of sexual development--which begins at puberty--, the experiences, the thoughts, the fantasies about sexuality, the ideas all these generate, can all be perceived

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and talked about well before the onset of puberty when acting on these can have the serious outcome of premature reproduction. Both parents and children have a number of years to work on preparing the child for the sexual challenges that will come with adolescence.

**Question:** Are any among you worried about what your children might get into in adolescence?  
**Answers** from participants.  
**Discussion:** Fortunately, we do have a number of years to prepare our children for their adolescence. We can't protect them as completely as we would like, but we sure can help them get ready.

Because it causes many parents much anxiety and because it can truly help children, psychiatrists, psychologists, social workers and educators believe that knowing that sexuality develops in children from the third year of life on will make parents and society better able to help children deal with it constructively. It will also make parents and other caregivers better able to deal with it in growth-promoting ways. Parents and all caregivers then, are better served when they know that **young children KNOW about sex from about 2-3 years of age on.** While they don't know about it as adolescents and adults do, they have waves of genital sensations, have deeply felt amorous feelings--believe it or not!--, and they have variably strong and long-lasting wishes and fantasies about it. And this is why, as we shall discuss shortly, children can be seriously harmed emotionally when they are engaged at a young age into sexual activity by persons substantially older than they are. It is sexual abuse and its consequences to the child can be drastic. More about this later.

But when children are sufficiently understood and cared for, rather than causing high levels of anxiety and bewilderment, the emergence of infantile sexuality during the period from 3 to 6 years will be found to be a rich, dramatic developmental period. It is embedded in the simultaneous dramatic growth in adaptive capabilities, including the development of intelligence and language, in the continuing development of self and human relationships, as well as in the development of conscience and morality.

**Question:** What causes these sexual feelings, fantasies, and behaviors to emerge?  
**Answers** from participants.  
**Discussion:** Many people are not aware of the fact that these feelings, fantasies, and behaviors, which are amply visible in many normal children, are evidence of a biological maturation in the 2 1/2 year old of what some scientists call **the sexual drive.** This sexual drive serves the vital function of preserving the species. Every species seems biologically committed to its own survival. Every living organism seems equipped with a powerful inner force to secure the species' survival.

In humans, our powerful sexual drive is biologically programmed to begin to develop in its "genital form" at about 2 1/2 years of age. This biological maturation sets in motion the development of the child as a sexual being. Certainly this sexuality differs in significant ways from what it will later become, but it is the beginning of the biological, and with it the psychological, development of "genital" sexuality. Scientists
emphasize that this is the earliest form of genital sexuality; they speak of it as "infantile sexuality". This they believe is what causes the feelings, fantasies, and behaviors we are talking about now.

**Question:** When we differentiate between *infantile sexuality* and *adult sexuality* what differences do we have in mind?

**Answers** from participants.

**Discussion:** The major distinctions between infantile and adult sexuality can be understood along three dimensions: (1) the age at which it emerges and the duration of its developmental period; (2) the mental experiencing of it; and (3) the biological dimension.

1. As we said before, infantile "genital" sexuality, or as mental health people talk about it, "the first genital phase", begins at about two and one-half years of age and runs to about six years. Adult sexuality has a much longer developmental course. It begins at puberty, organizes and evolves during adolescence, and becomes established by the end of adolescence.

2. The mental experiencing of "the first genital phase" is rich, complex, and presents the child with many concerns, thoughts, fantasies, and with much anxiety and a major developmental conflict. But while infantile sexual life contains much that is fantasy-based and fantasy-experienced, it is generally not actualized, not put into effect. (This will become clear later in the workshop). By contrast, puberty and adolescence become not just a matter of powerful emotional and fantasy-life pre-occupations, but now the actualization of these emotional needs and fantasies is feasible.

3. Of course, the 2 1/2 to 6 year old child is incapable of the biological fruition of his or her sexual fantasies and sexual functioning. By contrast, adult sexual life which begins with puberty, brings with it the capability for fulfilling all of these. Also, it is highly doubtful that young children can achieve orgasm, again a capability generally achievable from puberty on.

We want to emphasize, though, that making a distinction between infantile sexual life and adult sexual life should not be taken to mean that infantile sexual life is not enormously powerful, enormously governing of the child's experiencing and determining of mental-emotional development.

Even though, under normal conditions, infantile sexual life brings with it very little actual sexual gratification for children, what happens during the period from about two to six, how the child's behaviors, questions and concerns are handled by the parents can be critically determining of the degree of health the adolescent and later adult experiences in his or her sexual life.

**Question:** And, so--what does the first (infantile) genital phase look like? What can we see?

**Answers** from participants.

**Discussion:** From the middle of the second year of life on children show evidence of heightened sexual activity in three inter-related areas of experience:

(1) In the genitals themselves, their own and those of others;
(2) In babies; the child's interest in babies becoming quite remarkable; and
(3) In the child's heightened erotic love interest felt toward one of his or her parents and a nearly simultaneous developing feeling of competition and rivalry with the other parent. The totality of these three types of activities are representative of what in infantile sexuality we call "the first genital phase".

These "infantile sexual" behaviors become readily observable in most children, some more, some less, and create a large challenge for the 3 to 6 year old. In fact, it is a major developmental task for the 3 to 6 year old to gain the first level of mastery over the burgeoning feelings the sexual drive activates in the child.

Let's look at these three sets of behaviors. Let's start with the first two in this Workshop and we'll take up the third in Workshop #5.

**Question:** What behaviors do we see that give evidence of the child's interest in his/her genitals, and those of others, during this phase?

**Answers from participants.** What have they noticed in their experiences with children?

**Discussion:** We find a heightened interest in the child's own genitals and those of others. During the third year, and in some children even during the second year, one can see a greater or lesser degree of preoccupation with their own, as evidenced in an increase in the child's touching them and asking questions or expressing concern about the child's own genitals. It is quite common to see expressions of self-absorption and even of a far away look as the child is touching his/her genitals. It is also common for a nearly three year old to sit on a toy and roll his or her pelvis on the toy; or, while watching television, to be quietly touching and manipulating his or her own genitals. This, mental health professionals consider to be "infantile masturbation". Such acts may be of shorter or longer duration and do not seem to have the aim of achieving orgasm as will such activity in adolescence. Given the normal pleasurable sensations associated with touching the genitals, some children persist in this activity, in infantile masturbation, the more they do so, the more this tends to create some discomfort in the parents. In Workshop #7 we'll talk about how to handle this activity.

From about 2 1/2 years of age, both boys and girls, now aware at a new level of interest in their own genitals, will begin to experience and manifest much curiosity and preoccupation with the genitals of others. This will become very clear to a mother and to a father--if they do not avoid seeing or recognizing it. Seeing a parent dress, a little girl may appear quite startled and ask "What's that?" pointing to her father's penis. This may also lead to the child's simply asking of her father, "Can I touch your penis?" Or, similarly initially startled, a little boy might ask his mother, "Mommy, where is your penis?" These are questions normal two and one-half and three year old children ask.

Especially from the third year of life on but in some children even earlier, children's interest in their own genitals and those of others and toileting activities are openly talked about and evident in their behaviors to a greater or lesser degree. Toilet training, usually best achieved during the third year of life, tends to stimulate in children much interest in urinary and bowel functions and the body parts that perform these functions.

Commonly found now, especially triggered by their interest in and reaction to the genitals of others is the encounter with the fact that we don't all have the same type of
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...genitals and don't all urinate in the same way. Both girls and boys will begin to show a wide range of reactions to the differences between their own genitals and those of the other sex. Some will simply show mild interest, or even no apparent interest at all; others though, react to this difference with constant preoccupation, and rather commonly with acute anxiety, anger and even depression. These are normal reactions in normal boys and girls.

**Question:** What anxiety? Why anxiety? And why anger? And you say, "even depression"? Why?

**Answers** from participants using their own observations.

**Discussion:** From about 2 and 1/2 years of age on, and in some children even earlier, two factors may commonly cause children anxiety: (1) any act directed at the child's genitals that the child may perceive or misinterpret to be a threat to harm his/her genitals, and (2) the recognition of differences in the genitals of females and males.

1. For instance, a child may express anxiety when his or her genitals are touched by someone other than himself/herself. For example, a 2 and 3/4 year old boy, suddenly stepped back and showed intense anxiety as his mother had just reached to help him close the zipper of his pants. We inferred that he had suddenly imagined and feared that harm might come to his penis as the zipper was being pulled up. It is common for males, children and adults from 2 and 1/2 years of age on, to react with anxiety when they perceive, imagined or real, that harm may come to their genitals.

2. It is not uncommon for a young girl, usually after having seen a little boy's exposed genitals, for a girl 2 and 1/2 to 3 or so years of age to ask her mother when she will get her penis. A little girl was puzzled and complained when looking at her genital area that "I don't see anything". Mental health researchers have suggested that this may be due to the fact that when a little girl looks at her own genitals--because they are the source of unique erotically pleasurable feelings--that because her genitals are in large part contained inside her body she cannot see or yet imagine where or what they are. When she sees the little boy's amply visible genitals, she may wonder when, and if, she will get genitals equally visible to the eye as is the little boy's.

Due to the same issue of visibility, a little boy puzzled and anxious may ask why his cousin Suzy doesn't have a penis. This question is believed to be most likely driven by the little boy's distortion that everybody has a penis. Since he already values his so much, seeing someone who does not have a penis affirms his imagined dreadful thought that one can lose one's penis. Notable at this age, are the frequent reactions of distorting what is seen, along with rejection of what is seen and what is realistically possible.

Some mental health researchers believe the little boy's placing such a high value on his penis and the little girl's distress at not being able to visualize nor spontaneously imagine the structure of her own reproductive anatomy, comes from the importance of being able to see things for oneself, to have visible proof of things. From very early on, children seem to need proof of what is said to them; in fact we all feel safer when we can believe what is said to us. And it is further fostered by the difficult to explain research finding that already from near the end of the first year of life, children are already hooked on "the wish to have what the other kid's got", be it a toy, or whatever. Furthermore, both the boy's high valuing of his genitals and the girl's distress at "not being able to see" the...
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The marvelous genital system she has, may come not only from the uniquely pleasurable sensations that come from their genitals, but that these reactions may have an inborn biological determinant since the genitals are required for the preservation of the species. It is so important to our understanding of things to be able to see for oneself. All in all, we underscore that children will from time to time express anxiety in association with these questions.

Contributing to all this is that the 2 to 6 year old child is in the early phases of forming a mental representation of his/her body image, of who she/he is in relation to and in contrast with those the child interacts with, especially so with mother and father. The child is becoming increasingly aware of differences between him/herself and others. The child is also more fully aware of sameness. In a broader sense than just the development of the "sexual self", it is well known that children identify with their parents, with both mother and father. There is a psycho-biological inclination to identify more with the parent of the same sex; in this way the male child begins to feel more like his father and the little girl will commonly do the same with her mother.

This topic of ways of addressing children's questions, concerns and anxieties regarding their own genitals and those of others will be discussed in Workshop #6.

Another large factor that pertains to the child’s interest in his/her own genitals, also arising from the increased sensations the child’s infantile sexual maturation brings, is the child’s emerging “infantile masturbation”. We’ll talk about this in the next Workshop because we link masturbation with the child’s “family romance” fantasies.

Much of children's activities during the 3 to 6 years period center around the wide range of issues that pertain to their beginning sexual, reproductive lives. As we said before, the concerns about their genitals are just one piece of all this. There is also much interest in babies, in babies themselves and in being a baby oneself, and at the same time in being a mother or a father, and in where babies come from, all in all in matters of family life.

**Question:** When does the child develop an interest in babies? How can we tell? What does this interest look like?

**Answers** from participants based upon their observations.

**Discussion:** Since the inherent biological function of sex is the preservation of the species by means of reproduction, it makes sense that at some point in their development, children will show evidence of interest in babies. The question is when do they begin to show interest in babies? Scientific observation of young children as well as clinical work with young children by psychodynamic mental health professionals inform us that, yes, young children from about two years of age on show a notable interest in babies. A number of factors contribute to this.

Based on years of child observation we find that there is a striking progression to this interest in babies. Essentially this progression occurs in 3 stages: First, the young child becomes interested in a younger infant seemingly as if it were an interesting thing to explore. Then comes the first phase of what seems to be an awareness of the baby as baby and of behaving toward the baby in a caregiving way. And, this is followed by a dramatic second phase when the baby seems to acquire very special meaning.

During the earliest stage, a 9 to 12 month old may occasionally be attracted to
another infant, sometimes one as large as the explorer himself/herself. This interest consists most commonly of touching the infant with some fascination and excitement. However, a 9 to 12 month old seems to be drawn to the infant's eyes, to want to touch the eyes with a finger which, of course, can result in the explorer's poking the infant's eye, or the explorer may grasp the infant's hair which then, not yet being able to relax the grasp reflex, leads the parent to believe the explorer is intentionally pulling the infant's hair! These approaches invariably cause alarm and, often, lead the parent to control or prohibit the exploration.

From about 14 to 30 months, the approach to an infant changes significantly. The junior toddler no longer just pokes at the infant's eyes or grabs its hair; a different attitude and approach occurs. During this first phase of interest in babies, in both boys and girls, the exploring child seems to do to babies what is done to her/him. The character of the behaviors toward infants suggests that the 14 to 30 months old not only imitates what her/his parents do, but that she/he **identifies** with the way her/his own parents treat her/him.

Then, from about 27 to 30 months of age on, a dramatic change occurs in the toddler's approach to babies. This has been proposed to be the second phase in the interest toward babies. Girls particularly become interested in infants, some of course more than others, in a manner that is striking, with awe, with enormous excitement and pleasure, with a sense of having made a marvelous discovery. Some will become attached to a particular infant, will say that a particular infant is "My baby" (as can occur with a younger sibling) and some will verbalize the wish to have a baby of their own. This type of behavior is less frequently seen in boys and makes for one of the significant behavioral distinctions between boys and girls.

**Question:** Well, wouldn't you expect that? Don't you think that little girls are encouraged by their mothers and fathers to be interested in babies and dolls, much more so than boys are? Don't many parents discourage boys from playing with dolls?

**Answers** from participants.

**Discussion:** There is a natural tendency in most parents to facilitate or interfere with behaviors in their children according to their child's gender, based on the parents' own acceptance of what we believe to be gender-appropriate behaviors. This is probably the case even among those of us who want to do away with negative biases against a person due to that person's sex.

But the fact is, that cross-cultural studies of all kinds show that there are biologically based distinctions between males and females that show up quite early in life. This is found in brain studies, has long been known in endocrine studies, and has been found in early childhood observational studies of normal subjects. For instance, even before the end of the first year of life, little boys tend to more commonly be interested in objects that turn than are girls—which may be when boys' interests in cars originate! In one study, a reel to reel recording device used in the observational research seemed to just fascinate some of the boys who would just stare at the turning wheels, their heads rotating with the movement of the turning reels. None of the infant girls did this.

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**Question:** Fine, but what does this have to do with children's interest in babies?

**Answers** from participants.

**Discussion:** One of the most striking distinctions between boys and girls, according to one long term study\(^1\), is that girls from about 2 1/2 years of age on begin to react to little babies in a way quite different than do boys; some girls do so more than others. In the girls who most clearly revealed this distinction, they reacted to specific babies distinctively along 3 measurable lines:

1. Their **emotional reactions** were striking, including fascination, amazement and awe at the sight of an infant, even at an infant's hand or foot. These emotional reactions of interest were discernibly intense, persistent, and preoccupying.

2. During two-hour observational periods, more time in their **activities and behaviors** was committed to attending to the baby, be it in direct engagement with the baby or the baby and baby's mother, or hovering around them. When interacting with the babies, the girls of this study were surprisingly gentle, tender, and notably aware and concerned about the babies' feelings and state.

3. This interest and preoccupation **lasted at an intense level over a long period of time**, for months and even years. According to their mothers, the toddlers would talk about the babies or a specific baby many times when not in the observational setting.

This type of behavior, along the 3 lines noted, were not found in the boys. Where interest in infants was observed, the boys were more inclined to try to engage even the very young infant in play; they would playfully poke at them and try to get the infants to react playfully.

**Question:** Didn't the mothers sort of foster this kind of reaction in these children?

**Answers** by the participants. What do they think? What have they done?

**Discussion:** In the group of ten mothers studied, some of the mothers tended to encourage these behaviors in the girls. On the other hand, we also saw mothers compete with their daughters in wanting to hold the infant; one mother even pushed her three daughters away from the infants to do so. This particular mother's interference may have dampened her youngest daughter's interest but did not eliminate it.

The boys' mothers tried to help their sons be less boisterous and more calming and nurturing. Bottle feeding, for instance, was guided and required some effort by the boys to be nurturing.

All in all, this study did not find a general encouragement of girls toward babies and dolls associated with a complementary encouragement of boys away from babies and dolls.

As we discussed previously, much of children's activities during the 3 to 6 years period center around the wide range of issues that pertain to our sexual, reproductive lives. In addition to the above mentioned observational findings pertaining to gender

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Visual Section, Eastern Pennsylvania Psychiatric Institute, Philadelphia, PA. Video copies of these films are available for renting or purchase at cost from H. Parens. Specific behaviors and activities, it is also reported that little girls may now begin to walk in a much more feminine way and behave more "femininely"; whereas little boys may adopt more of a "he-man" or "ape-like" way of carrying and moving their bodies. Also, differences in the ways boys and girls are assertive (nondestructive aggression) and in the ways they discharge hostility (hostile destructiveness) have been found and reported (e.g., H. Parens, 1989, 1990).

**Instructor:** if participants would like, discuss this topic more extensively. What is "feminine behavior", what is "male behavior?"

**Instructor, continue:** In addition to such gender-specific differences between boys and girls, other aspects of sexual and family life will be seen explicitly in what we call the "Family Romance." There is much interest in matters of romantic love, i.e., of the combined feelings of sexual and affectionate love. Much of the child's interest will be evident in the girl's wishing to be Father's favorite (often explicitly Father's favorite female), to marry him, to be a mother, as well as in the boy's wishing to be Mother's favorite (also often Mother's favorite male), to marry her, wishing to be a father, and in a very serious manner many times children will carry out these roles in play. The seriousness of these activities is striking. Depth psychologists--those who do intensive psychodynamic psychotherapies--have found that these early experiences and behaviors influence the way people feel and how they go about eventually being (or not being) a wife or husband and a parent.

In the next Workshop, we’ll take up this issue of the child’s “Family romance”, what it is, what gives rise to it, what it does to and for the child.
WORKSHOP # 5

THE DEVELOPMENT OF SEXUALITY IN THE CHILD --
Part III: THE FIRST GENITAL PHASE (2 1/2 TO 6 YEARS),
Section II: THE CHILD’S “FAMILY ROMANCE”,
What It is and What It Does

[Instructor: This Workshop may require 2 Workshop periods. It is long, highly sensitive, and tends to cause anxiety.]

Question: Let’s pick up where we left off. What is the child’s "Family Romance?"
Have you ever heard this term? Some of you probably have heard of it as "the Oedipus complex".

Answers from participants.

Discussion: From around two and one-quarter years of age, children will in the course of rubbing their genitals sometimes do so on the knee of mother or father. This is also sometimes done with toys. At this time the child, boy or girl, seems to approach mother or father non-selectively, with no specific interest in or preference for one more than the other. Either parent will become a person to whom sexual feelings will become attached. More on this in a moment.

From the middle of the third year of life on, many a child begins to be selective in the parent who is chosen for such genital contact. Many parents are not aware that the child rubbing his or her pubic area against the parent's knee or while riding on the parent's foot is experiencing this activity as sexually pleasurable. The parent may become uncomfortable but not altogether know why. It becomes apparent in many a child's facial expression that these sensations are felt as erotic. And these, tied up with affectionate love feelings are especially directed toward the parent of the other sex, and somewhat less so, but commonly toward an older sibling of the other sex. It's striking that the child begins to be selective in these activities and typically chooses the parent of the other sex. More on this in a moment too.

Many parents have found around this time that when they greet and embrace, they may suddenly find the child between them pushing them apart. Some children will outrightly express annoyance and even anger when mother and father embrace and some may verbalize these feelings. And, as is so frequently encountered with children during this age, the child may express the wish to marry the parent of the opposite sex and express, overtly or covertly, feelings of competition and rivalry toward the same sex parent. These behaviors are normal. And normal as well, they create much conflict, anxiety, discomfort, anger, and even mild depression in the normal child.

Question: What causes the behaviors described? Why would a normal little boy wish to
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marry his mother when he grows up, and a little girl wish to marry her father?

Answers from participants.

Discussion: Here's what many mental health developmentalists say. First, we assume that a normal maturational process is responsible for such universally found behaviors in 3 to 6 year old children from all observed cultures throughout the world. There is a specific underlying bodily maturation which compels these developments. They are probably programmed by genetic factors and an inborn maturational timetable similar to those of other physical, physiological and psychological developments.

There is much evidence that the preservation of the species is a fundamental task in all living things. Every organism then must be equipped at birth with a powerful biological force and program to achieve this task; this is so for all animals and plants. Whatever it is, in the human child this force within us programmed to preserve the species appears to become first activated from about 2 1/2 years of age on, and unfolds dramatically up to about 6 years of age. We see interest in, indeed preoccupation with babies, genitals, wanting to love someone special, we see a new form of jealousy and rivalry, etc. All these factors point to the child's having sexual sensations, feelings and developing a deeply felt love interest in another person.

Question: But you may wonder again, why are these sexual feelings of all things directed toward the child's own parents? Isn't that mal-adaptive? Is Mother Nature that dumb!?

Answers from participants.

Discussion: Well, we should only be as wise as Mother Nature. It actually makes much sense.

To preserve the species, each organism has to sexually interact with organisms of the same species. After all we can't have birds being attracted sexually to bees or snakes; reproduction wouldn't work. In the 1920s-30s Konrad Lorenz, a brilliant German ethologist (student of animal life), found, much to his surprise, that the geese chicks he was studying from the time they hatched would follow him where he went, like ducklings following their mothers. He then found that when they came of age, they would do their instinctively driven mating rituals toward him! A lot of good that did either him or them.

But he then reasoned that these goslings did this because they had become "attached" to him. Further study led Lorenz to propose that these goslings "attached" to him very, very early in life, in fact within hours of birth. Because this attachment happens so early, he developed the idea that these geese had **imprinted** to him. And he found that this "imprinting" was powerful and long lasting, in fact, life-lasting. Study with other animal species led Lorenz and other ethologists to propose that some animal species, including birds and mammals, secure the preservation of their species by making an immediate attachment to a member of its own species by imprinting to its primary caregiver, usually of course, its mother.

Well, ethologists also have helped us understand that the human infant is too immature at birth to form that immediate type of attachment they call **imprinting**. They tell us that in those species that are born most immature, a much longer process takes place that leads to this basic attachment to members of the species. This longer process has been called "primary socialization" by some ethologists. Mental health
developmentalists most commonly speak of this process in humans as attachment and speak of the formation of human relationships or "object relations". (Instructor: Attachment and the formation of human relationships is addressed in detail in the Workshop Series On the Development of Self and Human Relationships, especially in Workshops #2, 4, 5, and 6).

**Question:** How do you go from a baby attaching to her/his parents to having sexual feelings toward them?

**Answers** from participants.

**Discussion:** Attachment and imprinting, which are built-in at least in part in order to secure the preservation of the species, insure that instinctively driven mating rituals will be directed to members of the species. In the human child what happens is that when the sexual drive takes its first big step of maturation during the 2 or so to 6 years period, the sexual feelings that emerge in the 2 or so year old child become channeled to those persons to whom the child is already emotionally attached. Early life attachment is made of what we think of as affectionate love. These affectionate love feelings are attached to those primary caregivers the child most values, those who have cared for and loved the child in a very special way since that child's birth. Then with this first stage maturation of the sexual drive, the child's emerging sexual feelings follow the path forged by attachment to those the child already loves most, her or his own parents. This is why sexual feelings are not just attached indiscriminately to anyone. Sexual feelings are not just attached to someone because that someone is beautiful or handsome. In fact, as they say, "love is blind"; a child's parents don't have to be beautiful to be loved deeply. And, to them then will the sexual feelings be attached when they emerge.

**Question:** OK. But why then does the child especially attach these powerful sexual feelings to the parent of the other sex?

**Answers** from participants.

**Discussion:** Simply because the organism must secure the preservation of the species, these powerful sexual attachments have to be made to a species-member of the other sex. This is so in the large majority of living things, in all those whose reproduction requires the coming together and union of a "germ" female and male factor--an egg and a sperm. (The germ line cells, in contrast to all the other cells in our bodies, are those unique cells in us that have to do with reproducing a new organism.)

Thus the basic biological function of reproduction requires that the sexual feelings at some point be attached selectively to a member of the other sex. Due to these biological factors operating in them and the affectional love feelings forging the path for sexual feelings, girls tend to now channel these amalgamated sexual and affectional love feelings to their fathers, and boys to their mothers. And with these powerful feelings come remarkable and unavoidably troublesome wishes and fantasies in all children.

Of course, these amalgamated sexual and affectional love feelings also become attached to the same sex parent; but due to the biological factors that operate in us, the sexual feelings are usually much weaker, and eventually sexual and affectional feelings become more or less disengaged from one another and the sexual trend toward the parent

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of the same sex becomes suppressed. It is because affectional and sexual love feelings can be disengaged from each other that we are able to love people affectionately without also feeling compelling sexual feelings toward them and, on the other hand, we can sexually desire someone without loving them affectionately.

**Question:** We are talking about different forms of love: sensual, erotic, affectionate. How do they all co-mingle and interact?

**Answers from participants.**

**Discussion:** It really is valuable for parents to get as clear an understanding as we can of "this thing called love". We really mean related but different things when we speak of love. Romeo loved Juliet; Grandmother loves her grandson Johnny; we love our friends, our dogs, our country, etc. We all know that what we call "love" has several forms.

As we said before, the infant's attachment is formed by a unique valuation of her/his primary caregivers. The glue or cement in that attachment, if you will, is that earliest form of "love", affectionate love or "affectional love". Depending on the quality of experiences with our primary caregivers, the degree and quality of affectionate love will be strong, and it will be strongly attaching, securely attaching, or insecurely attaching and burdened with too much negative feelings, too much hostile feeling. Affectional love has a rather steady developmental course; it is not in and of itself modified by characteristics of specific developmental phases. It may deepen or become eroded by experience, not by some in-born maturational influence.

On the other hand, the sexual drive also brings with it a distinctly different form of love, a form of love with an "erotic" quality. This form of love, the sensual form of love, in contrast to affectional love, is determined by an in-born schedule of maturation.

**Question:** What do we mean by this? One form of love changes according to stages of development and the other form of love does not?

**Answers by participants.**

**Discussion:** We can think of it this way. Affectional love and sensual love both begin gradually. Infants are not born loving those around them, nor hating them, either. As the infant's brain functioning develops, driven by an in-born tendency, the infant attaches, generally to those who predominantly care for the infant. That in-born tendency is in turn driven by some sort of instinctive factor, described differently by differing schools of behavior. This instinctive factor is experienced by the infant as "a need". Once the affectional component of this drive to attach emerges, it just keeps growing and deepening.

Not so with the sensual component of attachment. That component of what will become love is given its character by what has been defined as psychosexual development. Thus, during the earliest phase of psychosexual development, during the oral phase, this erotic experience is predominantly limited to activity of the mouth. While it too melts into affectional feelings, it is not as distinctive in character as the erotic feelings that come later. But it is nonetheless the beginnings of the sensual form of love. It is at times distressingly expressed by some people who, wanting to tell a child they...
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love the child will say something like "You look so delicious, I could eat you up".

With the anal phase of psychosexual development come erotic feelings and sensations that tend not to be as recognized as say sucking for the sake of sucking during the oral phase. But they occur in association with toileting. It is however not common for 18 to 30 month old toddlers to show evidence of anal erotic feelings being amalgamated with affectional feelings. These will become more recognizable later especially during the 8 to 14 years era, straddling the latency and early adolescence periods, when boys especially can be heard using all kinds of "anal" type language and make "anal" jokes sometimes linked with expressions of affection.

It is especially during the 2 or so to 6 years period, that infantile or first genital phase, that erotic feelings and sensations now arise in the child that are governed by a genetic program that brings the reproductive system itself into its earliest developmental unfolding. These feelings and sensations are the earliest manifestations of the child's beginning ability to love sexually; they are the earliest genital expression of sexual love feelings. With this, sensual love takes on a distinctly recognizable form. Even though it is not the same as it will become during adolescence (when adult-form sexuality begins), this first stage of erotic-genital love is very real. And it is at this developmental phase that when sensual love becomes amalgamated with the affectional love many a normal young child becomes a veritable little Romeo or Juliet.

Instructor: Review with participants the following points--

1. When we discussed the oral and the anal phases of psychosexual development we talked about the "erotic" quality of feeling that the stimulation of mucous cells can produce.

2. "Erotic" feelings have already been felt by the very young child, but from 2 1/2 on they take on a larger role in psychic life, and they become prominently associated with the genital areas of the body.

3. Scientists speak of "currents" of the sexual drive, the affectionate current and the sensual current.

Question: Given all this then, when a 3 year old begins to feel the sensual current of love, does it not make sense as to where that current of love would most naturally flow? Answers from participants.

Discussion: Again we say that it seems most plausible that given the combination of these two vital early life tasks, that of attachment and that of the preservation of the species, that when it emerges, the sensual current of love would follow the path carved by the affectionate current of love! In other words, it is channeled toward and attached to Mother and Father. What 3 year old in his or her right mind would attach any love feelings to strangers or to anyone to whom she/he is not emotionally attached? The child is innocent, but not dumb. And, the child does not know at birth that he/she will have sensual feelings of love and that these will cause her/him problems. Thus when sensual feelings first emerge it does not immediately strike the young child that these are feelings she/he should or should not have, or should channel elsewhere.

The child’s innocence though is soon unavoidably replaced by difficulties of all
kinds. The erotic love feelings lead to the child’s having wishes that in turn elicit fantasies. These wishes and fantasies lead to a chain of discoveries and reactions that create a conflict and anxieties within the child’s mind of large dimensions. Interestingly, and most important is that although this conflict and the anxieties to which it leads create much difficulty for the child, they also bring with them positive developments of equally large dimensions. Confusing? Let’s take a bit of time and go into some detail.

Instructor: Check to see if participants wish to discuss these findings more extensively. If they do, as we hope they will, here you might elect to read from our Textbook: Parenting for Emotional Growth, Unit 3, some of our observational findings and the well studied schema we have found to unfold. Make clear that you will pause for any question and discussion.

As we said already, “It is . . . readily observable in most children, especially but not only in well cared for children reared in a family where there is a mother and a father, that due to biological factors operating in them, girls tend to now channel these amalgamated sexual love feelings to their fathers, and boys to their mothers. And so these feelings stir fantasies in all children. From our direct observations, we found for instance, just under 4 year old Diane asks her father to take her to the movies and dancing. 4 year old Jennifer wonders what Mom and Dad do together after she and Mike go to bed. Johnny and Doug say they wish to marry their mother. Adults often find that young children think such thoughts. So far, these wishes make the child an untroubled romantic.

“But, the child's life becomes more complicated. [Earlier] we spoke of just 2 1/2 year old Jane whose relationship with her mother Gloria during the first 2 or so years of her life had been very warm and comfortable, seemed rather surprisingly to now have much difficulty with her mother. Mother playfully but exasperatedly asked Jennifer's mother if anyone wanted to have her daughter for one year because she had become so difficult. One morning in our research center while at snacks with half a dozen other children Jennifer’s age, a lively discussion took place between the children as to who they were going to marry. Several of the girls said they were going to marry their daddies, then 3 year old Jennifer being one of them. Perhaps ten minutes later when the children had migrated back to the room where their mothers tended to stay, a research associate asked Jennifer to tell again who she said she was going to marry. Jennifer was about to answer, when she suddenly seemed speechless and mortified. Further encouragement by our research associate that she answer only intensified her mortification, and we reassured Jennifer that she need not answer. The researchers agreed that with her mother there, Jennifer could not say again what she had so freely said ten minutes before, when her mother was not present. We had seen much evidence before of Jennifer loving her mother. Now, other feelings were there as well.

“The 3 to 4 year old child's wishes do not just go away. Wishes that are fueled by as powerful inner forces as the instinct to preserve the species, experienced by humans as the need for romantic love and sexual gratification, persist and press for gratification. In __________

1 See pages 30-32 in accompanying Textbook “Line of Development: The Beginnings of Sexual (Reproductive) Life".
good and growth-promoting parent-child relationships such wishes the child experiences in fact never do get gratified. And they, therefore, lead to frustration. Given the strength of the sexual feelings and wishes, their persistence during these several years, the centrality of the child's pre-occupations with the wishes and the fantasies to which they lead, frustration mounts to a level that the child cannot ignore.” [We’ll continue this narrative, but first let's ask this:]

**Question:** What do you think happens now? What would you feel?
**Answers** from participants. Do they remember from their own early childhood? (Most may not remember due to the normal repression that occurs, but some may.)

**Discussion:** (Continue the narrative)

“Now, in good enough family relationships, where mother and father have a good enough, mutually loving sexual relationship, the child soon discovers, by various cues that: whereas my strongest (romantic) love and sexual needs are being frustrated, the boy feels, my father is enjoying all the pleasures of life with my adored, heavenly mother. This is why, in part at least, Johnny pretended he was Dad going to work, said he was going to marry his Mom, and wishes Daddy would not come home for dinner. The girl similarly learns that her mother is enjoying such pleasure with her beloved, magnificent father. This is why 2 1/2 year old Jane wants to go camping alone with Dad, why 4 year old Jennifer wants to be in on what Mom and Dad do after she goes to bed, and why Diane seductively asked her Dad to take her dancing and to the movies. But Johnny's mother was glad his Dad was coming home for dinner. And Jane's Dad did not take Jane camping alone, nor was Jennifer allowed to sit in on private time between her Mom and Dad, and Diane's Dad did not take her dancing and to the movies (alone). **A seeping, insidious feeling of jealousy sets in.** The boy child, like Johnny, **experiences the hurt of feeling defeated by a rival,** pushed aside by his beloved mother for his Dad, a victorious rival! The girl feels so as well, as did Jane, Jennifer, and Diane, **their rival being their mother! Hate is generated;** that's why Jane and Jennifer were becoming so difficult with Mom and why Diane flushed her mother's powder and perfumes down the toilet.”

**Question:** Have any of you with children 3 or 4 years old seen anything like this?
**Answers** from participants.
**Discussion:** These reactions of jealousy and rivalry with the parent may be visible with some children; some children will even verbalize such feelings, especially feelings of rivalry.

**Question:** What do rivalry and jealousy usually lead to in quite normal people?
**Answers** from participants. Do they remember feeling jealousy and rivalry as 3-4 years olds? Do they remember feeling these in adolescence? Ask them to identify what most troublesome feelings their experiencing jealousy led to?

**Discussion:** Jealousy is so painful that it generates hostile destructive feelings in very normal people. The more intense the jealousy, the greater the pain, and the more
the hostility is intensified. And much clinical work reveals, it is not usually directly expressed by young children, that this common experience of **jealousy in the young child leads to feelings of hate.**

_Hate_ you may wonder? Yes. Let’s pick up the _Textbook_ narrative:

“But, **hate toward whom?** The child's existence now suddenly becomes dramatically complicated. The boy feels something like: "I hate ... the father I love!" And the girl feels and perhaps even thinks: "I hate ... the mother I love, the mother who gave me life!"

This hating of the person to whom the child is most deeply attached, the child most values and loves, **creates an intense internal conflict** (in the child's mind), a **conflict due to ambivalence** -- which means to hate and wish to harm someone one loves. This internal psychic conflict, or intrapsychic conflict, brings with it much pain . . . .”

**Question:** Don’t you think this sounds pretty awful? Isn’t it unfortunate that the normal development of attachment and sexual maturation would make kids go through this?

**Answers** from participants.

**Discussion:** So far it sounds pretty awful. And it gets worse. But, and this is crucial, as we shall detail shortly, it also brings much salutary development and growth. Let’s pick up the narrative:

Yes, “It brings with it much **pain** from several sources, from the frustration of powerful wishes which are experienced as needs, from hating someone one loves a great deal, and from anxiety. The large amount of anxiety comes from feeling helpless in handling the wishes to harm the beloved rival, due to the fear of putting these wishes into effect and due to the following as well. This wish to harm due to hate someone the child also loves produces feelings of remorse; feelings of **guilt** now begin to set in.”

(Instructor: we discuss guilt and its role in the development of conscience in the _Workshops On The Development of Conscience and Self-esteem_, especially in Workshop #4.)

Let’s continue the narrative: “For now suffice it to say that when the child feels guilt, he or she feels anxious (threatened) due to the disapproval and the threat of loss of love **from the child's own developing conscience.** One's conscience is an internal (in the mind) system of morality, in large part a system representative of our parents within our own mind which guides us in "DO'S" and "DON'TS", holding up to us what is right and wrong. All in all, the child's reaction to hating and wanting to harm his/her most beloved parent (of the same sex) includes the establishing within the self of the morality structure, one's conscience, which now produces in the child a large load of guilt feelings.

“The intense feelings of hating the mother the girl loves (the same applies to the boy toward his father), plus feelings of hostility generated by the pain of frustration, jealousy and defeat in rivalry, now encounter within the child an intense reaction of disapproval for feeling such hate and hostility, and produce now much anxiety.

“This state of affairs, this internal conflict, creates much inner turmoil **which leads the child to take steps to somehow resolve this conflict.** The feelings and turmoil are intense and the child's adaptive functioning is still very young. Vigorous efforts are required.
Question: What can the child do “to resolve this conflict?”

Answers from participants. Have they seen behaviors in their children or others’ that show or give hints of what kids do?

Discussion: Because the wishes and the fantasies are so strong, the child needs to do a number of things. There just is not one easy way out. Let’s pick up the narrative:

“First the child sets out to directly tame the feelings of hate generated in her/him. This conflict of ambivalence (of loving and hating the same person) is a major workshop for the child in learning to tame the destructiveness such feelings of hate bring with them. At this age, it is quite normal for a well reared child to wish to throw out her/his beloved parent, fantasize and even wish to destroy the parent! The efforts to tame such inner felt destructiveness lead to the child's developing the capacity to handle hostility and hate in ways that are constructive, socially acceptable and growth-promoting. Children who are cared for well enough are invariably able, with their parents' help, to develop well this capacity to tame hate and hostility within themselves.

“Other adaptive (controlling and moderating) functions, a crucial cluster of psychic defenses mechanisms, are developed now as well, in reaction to this major intrapsychic conflict.”

Question: Wait. This is loaded. How do we know to believe this? How do shrinks get to think kids experience these ideas, these thoughts and feelings?

Answers from participants. Have any of the participants seen any of this in their own children? Do they remember anything like this in themselves?

Discussion: This is loaded. And many people don’t accept these explanations.

But these ideas grew out of psychotherapeutic clinicians treating human beings with troublesome symptoms of neurosis--excessive anxiety, guilt, masochism, inhibitions, depression, underachievement, perversions, and many more--that lead to much pain and misery. And these ideas have been explored and tested in the clinical situation since the beginning of the 1900s. From the 1920s on children have been treated psychotherapeutically for neurotic problems and these ideas have been shown to indeed play a role in their neurotic symptom formations. In addition then, since the 1940s also normal children have been observed, and indeed evidence of these happenings recorded and reported in a vast literature. And from the 1960s on formal observational studies of children have further documented these phenomena and attempts have and continue to be made to further test these theories.

It is possible, and it is so assumed by many, that a major reason for the rejection of these ideas is that they cause much anxiety in normal human beings.

Our position on this is this: We have studied these phenomena both in the clinical and in formal research settings; and we have found rich and convincing documentation of these in normal children’s behaviors. We simply recommend that parents and educators know that these theories exist, that they check them out for themselves, in their children, those of others, and even in themselves.

Instructor: Any and every reaction is acceptable, be it skepticism, rejection, acceptance,
whatever. Then, let’s get back to our questions.

**Question:** So, are we saying that when children experience inner conflicts these can in fact lead them to find ways of resolving these conflicts and that much growth can come from this?

**Answers** from participants.

**Discussion:** Yes. If the conflicts are not too harsh, children will accept the challenge and grow as they struggle to find good solutions to their conflicts. This is just like what happens when any of us struggles to solve a problem. We grow in our abilities to cope and as a result adapt better.

So far then we have said that in reaction to the guilt children’s fantasies and wishes lead to, children

1. Further develop their conscience;
2. Make a major effort to learn to control and mediate constructively their feelings of jealousy, envy, and the hate to which these lead; and that they do these in part by

3. Using new and already developed psychic defense mechanisms such as regression, reaction formations, identifications, and repression, among others.

[**Facilitator:** If time permits and participants wish to do so, some of the defense mechanisms can be discussed. **Regression** is to return to an earlier (younger) more stable level of coping -- new levels of adaptation are always less stable than already much used, familiar ones. **Reaction formation** is the transformation of existing disapproval of feelings and thoughts into their opposites, like loving in the place of hating. **Identification** is to be like someone the child interacts with, and usually admires. **Repression** is the pushing out of awareness, making unconscious, feelings and thoughts the child cannot reduce or resolve by other means.]

Let’s pick up the narrative: “And then, still other adaptive functions develop in reaction to the major conflict of this period, functions or capabilities most desirable for life in society: the capacity for empathy, which is to be able to feel and perceive what another person is feeling; altruism, to be mindful of another person's needs besides one's own; and sublimation, which is the capacity to convert the emotional energies contained in one's unacceptable or conflict-producing wishes and needs into energies that can be used for creative purposes like in sports, art, writing poetry and stories, etc.

**Question:** Do these strike you as important developments?

**Answers** from participants. Do they have examples of these?

**Discussion:** These efforts the child makes are thought by many mental health developmentalists to be of enormous importance to their age-appropriate development.

One of the major tasks facing the 4 to 6 year old child is to resolve the crisis produced in him or her by his or her romantic love wishes and needs which the child recognizes as transgressive and enormously threatening. There is the fear of loss of love from the beloved parent of the same sex and there is the sharp disapproval by the child's increasingly governing and often at this age quite harsh conscience. But that is not all there is. Some further things happen which at first glance might be quite surprising.
The child's genitals play a key part in this drama of the child's family romance. The genitals are the body part from which the child's sensual excitation and feelings come. Two types of behaviors that cause concerns for parents and the child come from this fact.

First, that the child will feel compelled by genital sensations to touch and manipulate his/her own genitals, which is identified by mental health professionals as "infantile masturbation". Because this creates much concern for parents we shall discuss it in the next two Workshops.

Second, boys and girls each have significant reactions to their own genitals and those of others which can cause them much anxiety, pain and fear and also cause parents much concern.

**Question:** Kids touch their genitals, sure. But why do shrinks call this masturbation? It’s nothing like what teenagers do, is it?

**Answers** from participants. Have they seen their children or others’ touch their own genitals? If they have, would they think of it as masturbation? Why or why not?

**Discussion:** It’s so that what mental health people call “infantile masturbation” is not altogether the same as the full range of masturbation activities experienced by teenagers. But there are basic similarities. In 2 to 6 years olds as in teenagers, genital self-touching activity occurs:

1. In reaction to genital excitation and the attention it draws to itself;
2. The genital excitation is of an erotic nature; this is readily visible in the facial expression of the masturbating child--an absorbed, far away look, etc.;
3. The sensations compel the child to try to quiet the excitement he/she feels as a need by gratifying that need--just as hunger compels us to seek gratification of the need for food;
4. This gratification is brought about by some rhythmic, direct or indirect contact, rubbing or pressured movements, associated with a mounting of tension, a natural bodily tendency toward achieving satisfaction, in the case of sexual excitation it is a climax.

There are though differences too between the 2 to 6 year olds masturbation and the teenagers’:

1. The fantasies of the young child are not yet organized as are the teenagers.
2. The masturbatory act itself is not as fully or well defined and patterned.
3. The young child’s activity is not known to lead to climax, although some parents have reported such. And, to be sure, there are other differences. Nonetheless, the distinction is recognized by the label “infantile”.

**Question:** But, isn’t it disturbed children who do that?

**Answers** from participants.

**Discussion:** No, according to the mental health developmentalists. For long, infantile masturbation was mistakenly assumed to be a sign of disturbance. But observers of young children have found that in the first and second years of life already, the child touches his/her genitals in reaction to stimulation that arise in association with diapering and cleansing. Generally such genital manipulation occurs only on occasion, and during
the first 2 years, is not a significant focus of interest for the child. From the third year of life on, however, masturbation takes on a new and more compelled character and is initiated now by the child himself or herself. We now know that due to some genetically preprogrammed maturation, two to six year old children have an increase in genital awareness, possibly in sensations, as well as in sexually based romantic fantasies which lead to their “infantile masturbation” and that this is normal. Of course, children may well need help in learning how to deal with it. In Workshop #7 we’ll talk about constructive ways of dealing with infantile masturbation.

Question: What about children's having reactions to their own genitals and those of others which can cause them much anxiety, pain and fear? What is that all about?

Answers from participants. Have any of them seen such reactions in their own children? In those of others?

Discussion: Boys and girls have worries about their genitals, some minimal, some large. But boys' and girls' concerns differ. Let's take each in turn, boys first, then girls.

[Instructor, if you wish, pick up from the Textbook:] “Boys . . . have their fair share of concerns about their genitals. 2 to 3 year old boys, under the influence of their biologically determined emerging maleness, experience their genitals as vital to their sense of self. It is as if they experience their genitals as being most indicative of their emerging maleness and masculinity. Narcissistically (self-admiringly) exhibiting their muscles seems to do this too.”

Psychotherapeutic clinical experience over the past 75 years with children has led us to uncover thoughts and fantasies they have that tend to be startling to parents. It leads us to suggest the following more or less typical series of thoughts and assumptions children seem to make:

“Experiencing his genitals as vital to his maleness, when the 3 to 4 year old boy discovers that he cannot fully woo his beloved mother, many a bright, imaginative boy blames his small size and the small size of his penis for this failure. . . . Given the importance he attaches to his penis, he assumes that his father's expectably larger sex organ is a very large contributor to father's success with mother.

“Now, given also that the 3 year old boy experiences his beloved father as a rival for his mother's amorous affections and that [whatever hate he may feel] toward his father has intensified, the boy at times entertains the fantasy of undoing his father's success by robbing him of his obviously more effective genitals, thereby acquiring them for himself and destroying his father, all in one blow! Having such a fantasy, which [according to clinical findings] is common among 3 to 4 year old boys, immediately brings with it the feeling of being a treacherous transgressor who deserves only one fate, namely, to in fact be the one who is deprived of his own highly valued, even though admittedly smaller genitals. In fact, given that his father is much bigger and more powerful, the little boy concludes that this would certainly be his fate if he even attempted to attack his father, be it his genitals or any other part of him.

“And he now, from this moment, fears that in some way, by some undetermined circumstance, he might lose his vital genitals. And he suffers then from "castration anxiety". This is why boys from about 3 or so years of age on are in repeated dread of injury to their genitals, in young boys it often being manifest in concerns over things
being broken, if broken whether they can be repaired, or over fears of being injured. They will need attention to the smallest scratch, make a large to do over even the slightest accident or damage to the self or others or things. Girls do the same at this age also because of their linking injuries to their conviction that their genitals have or may become damaged.”

**Instructor:** Address any questions, doubts, and reactions participants have.

Girls too have their fair share of concerns about their genitals. [Instructor, here you can again pick up from the Textbook narrative:] “3 to 6 year old girls experience sexual excitations every bit as much as boys do. They, like boys, focus on the features of their own genitals in reaction to the strong and compelling sensations that come from them. They find that it feels good when they touch or press on their genitals, whether directly by using her hand or indirectly as by straddling Mom or Dad’s thigh or a toy. By touching herself and when by chance she sees a boy’s genitals, the little girl becomes aware that whereas the boy's genitals are amply visible, she can’t see as well what her genitals are. She doesn’t yet know that her genitals are inside her body. And, under the oppressive influence of the powerful universal tendency in all children to "want what the other kid's got!", she wonders why her genitals differ from the boy's.

Here’s an example from our Textbook: “4 1/4 year old Diane when she was 2 1/4 years old became emotionally very involved with Johnny's newborn sister Rose. She had said it was "her baby". At 3 1/2 she had sashayed up to her father and asked him to take her dancing, etc. When she was about 2 years and 7 months, for several months she became somewhat preoccupied with "When she would get her penis." She first asked her mother, then her father, and then her next in line older brother. She did not seem to be anguished about it like some girls are, but she did persist in asking about it. This told us that she had a significantly felt concern but it seemed not to trouble her too much.

4 year old Jennifer made no mention of her wondering why she does not have a penis nor whether or not she would have one. Also, she gave no definite evidence of being concerned about it. When . . . Suzy was 3 1/2 years old she had a hard time believing she would not grow a penis. She seemed convinced her mother had one. On one occasion she insisted that her mother show her, her penis. . . . Suzy then insisted that she be allowed to search in her mother's purse for mother's penis.

“These are reactions of 3 quite normal girls. A number of feelings and fantasies are generated in them: she wants a penis too; hers has not yet grown out; or, hers somehow fell off, or fell out of her body perhaps like a bowel movement, or by her masturbating manipulations; and more.” Distressing is that many a girl blames her mother for the fact that she does not have "her" own penis.

“This is not a light matter. Many a girl is very pained by this, as she experiences it, this "lack", and feels cheated, deprived or, even, "inferior". She may develop envy of the boy, feeling that he is more privileged than she, that he is "better", and have other equally irrational thoughts based on her not being able to know at a glance the marvels of her own genitals and reproductive system.”

**Instructor:** Here too address any questions, doubts, and reactions participants have. [Then, please determine whether the participants would be able to also hear the next two...]

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points. Groups differ in their tolerance for talking about these matters. If this discussion causes too much anxiety, stop here. If it stirs too much objection, stop here.]

Again, these are not light matters.
1. Castration anxiety tends to create much pain and can lead to emotional problems at this age and in later years.
2. These genital concerns have been found to be so anxiety producing in both boys and girls that mental health developmentalists believe they contribute to two crucial phenomena.
   a. The fantasies generated by these concerns, as well as those generated by the wishes and feelings that give rise to the child's family romance, produce much anxiety. To protect against this anxiety the fantasies, wishes and feelings become vigorously repressed, virtually fully pushed out of awareness.
   b. Because these fantasies as well as the child's genital concerns are tied up with the child's sexual excitations, they become tied up with the child's infantile masturbation. Masturbation then of itself becomes a source of acute anxiety. It is as if masturbation itself will cause the dreaded injury. As a result, many a 6 year old child will stop touching herself/himself, stop masturbation.

   It’s felt important that because this infantile masturbation is tied up with those fantasies and wishes which cause so much anxiety, when those wishes and fantasies that are not resolved (given up) become repressed, the memory of infantile masturbation and much that surrounds the child's family romance and this time of life will be pushed out of awareness as well. This is one explanation for the finding that humans tend to remember so little of their life prior to 6 or so years of age, and why people tend to not recall memories of this personal family drama except under conditions when their recall is facilitated by special (psychotherapeutic) uncovering methods.

_Instructor:_ if time permits, review salient points of workshop answering further questions and concerns.
WORKSHOP # 6

YOUNG CHILDREN’S QUESTIONS AND IDEAS ABOUT SEX – HANDLING THEM CONSTRUCTIVELY

[Instructor information: Instructor, bear in mind that parenting research and clinical experience have informed us that many parents do not know that normal children, some from the second and even the first year of life on touch their genitals with pleasure. Many parents also do not know that 3 and 4 children are very curious about their genitals, theirs and others, about where babies come from, and many girls want to have a baby of their own, pretend to be a mother, and boys a father, etc., and that most get upset or worried about their own genitals. Many parents don't know that little boys become remarkably preoccupied with their penis and seemingly unreasonably worried that some harm or damage will come to it. Nor, do many parents know, that many little girls become upset because they believe there is something wrong with them, since their genitals, not being so visible, don't look like little brother's or another male child's and, regrettably often experience their genitals as defective; nor that when a little girl says she wants to have a baby she often means a real live one of her own, made with the help of the man she loves most, her father, and that she is not talking of wanting a doll! ]

Instructor’s introduction: We have emphasized the importance of parents’ recognizing that normal sexual life begins early in childhood and not at puberty. Hoping to facilitate the parent’s task of guiding the very young child toward healthy sexual development, in the next two Workshops let’s talk about (1) how to handle children’s questions about sex
and (2) how to handle their sexual behaviors, both in growth-promoting ways.

Sexual development unfolds gradually, like all development. There are some upsurges here and there—the best known one being the maturational upsurge that comes forth with puberty—that give a new dimension to the child’s sexual development. But all in all, like all development, sexual development from early childhood through adulthood is essentially continuous. What happens in early childhood, in adolescence, and in adulthood regarding the individual’s sexual self is all part of that individual’s sexual development. However, there are features that are specific to each stage of this overall development, and with this there are differences between infantile sexual life and adult sexual life. One of the major differences is that young children know and understand much, much less about sexual matters than do teenagers and adults—obviously!

**Question:** What do you think might be the best way(s) to get children to come to know about and to best understand what sex is all about?  
**Answers** from participants. What did they do with their kids? What did their parents do with them when they were say 3 or 4 years old?  
**Discussion:** It’s not a mystery: One of the most reasonable ways for children to come to know about and understand sexual matters in a healthy, reasonable and realistic way is for them to ask about sex, to ask all sorts of questions. We think that only very personal questions should be barred. Obviously, when parents are the ones who answer their child’s questions, the parents can be best assured that their child will get truthful and reasonable information, and it is the parents’ views on sex the child will come to know and understand.  

Here again we say, what happens during the period from about two to six, how the child's sexual questions, behaviors and concerns are handled by the parents can significantly contribute to the degree to which a child can come to a healthy view of sex, and the adolescent and later adult can experience her/his sexual life in a healthy and gratifying way.  

Children have an inner need and the inborn wisdom to want to understand themselves and the universe in which they live. Some of us believe that this need to know and understand is a center piece of every human being’s—perhaps of all animals’—adaptation equipment; with our basic reactive tendencies, to know and understand is central to our adaptive strategies. **Each of us is born with this need to know and understand.** Some mental health developmentalists have even proposed that children—and adolescents and adults as well—feel anxiety when we don’t understand something that is important to us.

**Question:** How many times have your toddlers asked you questions about all kinds of things? About what kinds of things?  
**Answers** from participants.  
**Discussion:** Some children ask questions more frequently than others. Some tend to ask less and look and try to figure things out themselves more. Some do both. Few do neither.  

However, mental health types tell us and it is well known that children can be
made to ask questions more or they can be made to ask questions less. That is, they can be encouraged to ask questions, about anything, everything. Educators know that this enhances curiosity, something all children are born with. In fact, curiosity probably is driven by this need to know and understand. And educators tell us that curiosity is a vital factor that makes kids better students; it makes them need to learn!

But children can also be discouraged from asking questions by parents’ either not paying attention when they ask, or by a parent making negative comments to a child’s asking questions, or by ridiculing the child’s at times outrageously imaginative questions. Some children may not ask questions out of the fear they will be thought stupid for not knowing or for thinking the things they think. Children who feel discouraged from asking questions may well shut down their inborn curiosity, their inborn need to know and understand, and with it lose a powerful motivator to learning. In fact, discouraging questions about sexual or other matters, which the child experiences as important, may discourage some children from learning other subjects as well.

Mental health professionals who work with children uniformly encourage parents to talk to their children and to answer any questions they have. Many children whose parents discourage their asking questions but who do not thwart their inborn curiosity will turn to others for answers to the questions they have. These others may include some no older than the inquiring child. All in all, these others may not be as good a source of information as the parents—especially so if that other is a peer.

**Question:** But aren’t there times when we should not answer children’s questions? Say for instance, if they ask something very upsetting about the family, like “Why did Aunt Suzy and Uncle Johnny get separated”?

**Answers** from participants.

**Discussion:** Yes, there are times when children’s questions ought not to be answered. For instance, very personal questions need not be answered. If a child wants to know how many times a week Mom and Dad have sex, children don’t need to know that. That’s a very private and personal question. And yes, discretion should be used in answering why Uncle Johnny and Aunt Suzy separated. But then, it is well to tell the child “Heh, that’s important, but very private. What else would you like to know about Mommy and Daddy? Do we love each other? Sure do!”

It is not helpful to give a false answer to a child’s question to avoid answering it. No, babies are not brought by the stork. The risks there are first, that the child is given false information—bad enough, but even more important is that second, the child may lose trust in the parent who gives him false information. If a question ought not to be answered because it is too private/personal, just tell the child you will not answer that question because it is too private/personal. If you decide not to answer the question be sure to tell the child why you decided to do this. Being honest with our children engenders trust in us. Hiding things or giving false answers undermines their trust in us.

Some five year olds’ questions are difficult to answer. “Mom, is there a God? Johnny says there isn’t.” Here, again, one answers as best one can according to one’s own convictions.

Some people fear that answering children’s questions about sex will make them too interested in sex. Child psychologists and psychiatrists have found this not to be the
case. They have found that when children get answers to their questions that are sufficient and give guidance, young children seem to be satisfied and are more likely to contain their sexual interest to a later time.

**Question:** Why do children ask questions about sex?  
**Answers** from participants.  
**Discussion:** Normal children ask questions about sex because they have a compelling need to know and understand their own bodies, their feelings, what body parts do, and they also want to know and understand all these things about other people, including especially those they love.

We parents/caregivers have to listen to children's questions seriously, and with respect. It is helpful to children when we listen to their concerns and ideas and do not ignore them, nor ridicule them, nor silence them. And, it’s most helpful when parents feel comfortable discussing such questions with their children. Of course, the age and maturity of the child must be taken into consideration when we answer the child’s question.

1. It is normal;  
2. It would discourage disclosure and with it the opportunity to get parents' input as to how they should handle their sexual interests;  
3. It probably would make them feel that their very normal interest and preoccupation really means that they are bad, unlovable children, and  
4. It would foster more secrecy than is needed for reasonable privacy.

**Question:** What kinds of questions that pertain to sex do children most commonly ask?  
**Answers** from participants.  
**Discussion:** Observational research--where children are observed in a naturalistic setting with no programming of their behaviors nor are directing suggestions made to their parents--has shown that young children’s most frequent questions and concerns tend to fall into 3 categories:

1. About their own genitals and also those of others;  
2. About babies;  
3. About marrying Mom or Dad when they grow up, and the like.

**Question:** What kinds of questions do they commonly ask about their own genitals?  
And what do they usually want to know about others’ genitals?  
**Answers** from participants. What questions have they been asked by their own children? By other children? What have other parents told them about their children’s questions?  
**Discussion:** In little boys, among the most common concerns they have is: Will their penis get hurt or damaged in some way? They are not likely to ask questions about this; it is more likely to be observable in some behavior. We’ll talk about this in the next Workshop. The little boy’s concerns about his penis may come out in questions about why cousin Suzy doesn’t have a penis. “Where is Suzy’s penis?”, or “What happened to
her penis?” may be verbalized. Or “When is cousin Suzy gonna get a penis?
Another way a boy’s concern about his own penis surfaces is, for instance, by his
simply asking his father, "Can I see your penis?" or asking his mother, "Mommy, I wanna
see your penis?" or, later, “Mommy where is your penis?’
Little girls have a different, yet in some ways similar experience. As we pointed
out in Workshop #4, naturally drawn to this body area where such strong feelings come
from, many a little girl will look at her pubis. But when she does so, she cannot see the
marvelous structure of her genitalia because they are inside her, not openly visible. That
of itself does not stir anxiety or concern. But when she sees a boy’s pubis, the picture is
quite different. Also driven by the burdensome tendency humans have that begins
already during the first year of life of “wanting what the other kid’s got” which leads to
envy and the conviction that “what somebody else has is better”, or “the grass is greener
on the other side!” when she sees cousin Johnny’s penis she may wonder when she will
get hers. She may then ask Mom: “When am I gonna get my penis?” Like the boy she
may wonder “What happened to my penis?” And she may ask her mother to see
Mother’s penis. One little girl was convinced her mother had her own (Mother’s) penis
in her purse.

**Question:** Wait a minute. She thought Mother kept her own penis in her purse?!
**Answers** from participants. Has anyone gotten such an outlandish question?
**Discussion:** To us, such a question may seem outlandish. But it isn’t to the young child.
The child is not quite certain just what can and cannot happen to penises and many other
things. Both boys and girls are open to all possibilities. Those that have one can lose it
and those who don’t can get one either by growth or even by going to the store to buy
one. It can get lost or damaged, or it can even be acquired by theft.
Young children are not dirty little boys and dirty little girls. They are curious,
puzzled, interested, sometimes bewildered and invariably anxious about these issues. To
be sure, they have many fantasies about them. Children have a sincere interest in
understanding why they have the type of genitals they have, why a boy will not develop
breasts like mother (or be able to have a baby like mother); why a girl will not have a
penis like father, or like her brother. These types of questions are on children's minds,
are puzzling to them, and may even be frightening to them.

**Question:** How does one deal with such questions helpfully? If the question is
outlandish or wild, how can parents and caregivers best handle these questions?
**Answers** from participants.
**Discussion:** There is no one answer that is best for any of the many questions young
children ask. But there are some principles that can guide us to address constructively
our children’s questions, whether they are young children, elementary school age
children, or adolescents.

1. **Most parents find these questions difficult to deal with because we all
normally retain within ourselves some residual conflict from the time when we were
children, when we ourselves as normal-enough children had much difficulty dealing
with these feelings, thoughts and wishes. Here’s why. According to mental health professionals who subscribe to Psychodynamic Child Development theories, this first encounter with sexuality in our lives during the 2 to 6 year old era, brings with it the child’s “family romance” and the internal conflict to which it normally leads (discussed in Workshop #5). It is, they tell us, this internal conflict especially that makes sex a problem for all of us to deal with. Yes, there is the problem of controlling one’s sexual thoughts and behaviors because they are driven by such a powerful instinct. This is especially so during adolescence. And yes, societal and religious admonitions play their part in making us feel conflicted about our sexual feelings, thoughts, and behaviors as well. But it is especially the “family romance” internal conflict that leads us to feel guilt and shame about these. None of us escapes this burdensome development. We do want to remind us all though, of the great developmental benefits to which this conflict also leads (see Workshop #5). All in all though, the remains within us of our own childhood “family romance” conflict, in many of us, may make it uncomfortable for us to talk with our own children about sex. But feeling uncomfortable is part of life, it’s OK. Therefore, given the good it can do, feeling uncomfortable ought not to prevent parents from doing the best they can to talk with the children they love about sexual matters.

2. In answering children's questions there is no need to give them a lecture when a simple answer will do the job. It is best to answer what they ask about and no more--unless the child is one who loves to hear you elaborate on things, and some do. If they need more, they will ask. And, in addition to the parent being responsive, respectful and attentive to the child's questions, there are many fine books that can be very helpful to parents who fear they cannot find a good way to answer these questions. There are fine books written for children of all ages, for parents to read and for children to read themselves, and they are done in a variety of styles. Librarians usually love to help parents find whatever such books they may be looking for.

We want to repeat that children three to six years of age, and beyond, take these thoughts seriously. They frequently think about these matters, frequently fabricate explanations that will suit their particular fears and anxieties, and they will often distort the realities they perceive.

3. Answering a question about sex is not different than answering any and all children's questions: make it clear, as simple as you reasonably can, and stick to the truth! It is safest to be truthful. Parents at times fear being truthful; and they fear the child may not be ready to hear the truth about certain things. The fact is though, that when a child asks a question, the child is ready to learn something about what the child is asking. With regard to sex, and other things too, children will ask questions when they are worried about whatever it is. Answering factually and truthfully is the best way to go.

Parents should be informed about the fact that children’s imaginations and the fantasies they come up with often are actually quite wilder, more fantastic, more frightening, more worrisome than reality, than the truth. Given the immaturity of their “reality testing”--which means their ability to judge if something is realistic or not--young children think that magic is possible, that they as well as Mommy and Daddy can be made to disappear, can some day learn to fly, that there are ghosts and monsters, etc. This is why many children’s books are written in the fantasy domain. The best know and

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most enduring for instance are the Grimm's’ *Fairy Tales*, Carroll’s *Alice in Wonderland*, or the large collections by Dr. Seuss and by Maurice Sendak. What has made them so famously fascinating to children is that they are reflective of children’s ways of thinking about life.

**Instructor:** You might here suggest to get down to specific questions children ask and how they may be addressed.

**Question:** What might you say to your child when your 2 1/2 year old girl seeing Daddy dress says: “What’s that?” pointing to her father’s penis?

**Answers** from participants.  
**Instructor:** Father ought to first get some pants on. Most mental health folks feel parents ought to get some privacy principles to operate in homes. They recommend that parents getting dressed and undressed ought to be done behind closed doors. Walking around naked, while very nice, does stir children up and facilitates and heightens the sexual stimulation that will be experienced by them anyway. The issue here is not to hide sexuality, but to not parade it because it heightens sexual stimulation in children.

Furthermore, the privacy principle will become useful when we need to help children deal with their infantile masturbation and their own coming to an age when they will need privacy.

Having put some pants on, Father might say: “That, Suzy is my penis. That’s what boys and men have where their pipi comes out.”

Father now waits to see where Suzy goes with what he has told her. It may be all she wanted to know.

**Question:** What if Suzy now says: “Can I touch it?”

**Answers** from participants.  
**Instructor:** “No, honey; it’s a private part of my body.” Here it may be useful to say that “people have parts of their bodies that they let others see and touch, like their hands, their shoulders, you know, and it’s really nice to hug. But we also have parts that are private and that only I can look at or touch, you have parts of your body that only you can look at or touch, and Mommy and Daddy can touch when they clean you.” It gets complicated, but let the child dictate where this conversation goes. Let reasonableness and the child’s best interest be your guide. Dad might add that when Suzy gets older she’ll learn a lot more about all that.

Instructor: Invite elaboration of this conversation and consider together what might be instructive and constructive to say.

Similarly, by the way, if Johnny asks his father if he can see or if he can touch Father’s penis, he would get similar answers.

**Question:** What if Johnny says to Mother: “Where is Suzy’s penis?”, or “What happened to her penis?”, or “When is cousin Suzy gonna get a penis?”

**Answers** from participants.
**Instructor:** This question presents Mom with the very useful opportunity to begin the process of her son’s learning from her about the anatomical and functional differences between male and female. Mother might say:

“Well, one of the really nice things about all of us is that boys and girls are different. In so many ways we’re alike but in some ways boys and girls are different. Boys have penises. Girls are made differently; they have vaginas and a lot more, but they don’t have a penis. They don’t need to have a penis.” Here then Mom waits to see where Johnny goes with his inquiry.

**Question:** Johnny may simply ask his mother, "Mommy, I wanna see your penis?" or, later, “Mommy where is your penis?”

**Answers from participants.**

**Instructor:** Mother might say: “Well, Sweetie, that part of my body is private and I know you’d like to see it but no, you can’t” See what follows. And taking up the second question Mom might say: “Oh, Mom doesn’t have a penis. Boys and girls are made different in their private parts; it really is very nice that it’s so. Girls don’t have penises. They have very nice vaginas and a baby sac and a lot more. When you get older you’ll learn more about that.”

**Question:** How would you help a three year old girl feel glad that she is a girl, and a three year old boy feel glad that he is a boy?

**Answers from participants.**

**Discussion:** It is vitally important to help the child feel and see that in her/his home both mother and father are equally important, one not more than the other. It is very useful and helpful for the parent and/or caregiver to express appreciation for what the child can do, as a boy, or girl and to encourage the child in his or her interests. It is essential to love the child as he or she is. A child should never be made to feel that he or she "made a mistake" in being born a boy or a girl or that the parent feels this way.

**Question:** What if when you tell him that “Girls don’t have penises. They have very nice vaginas and a baby sac and a lot more”, Johnny comes back with “A what did you say, a baby what?”

With this question we get into the second cluster of questions young children ask: all about babies. What might a mother answer?

**Answers to this question by participants.**

**Instructor:** “I said a baby sac. See when girls get old enough to become Mommies, they have a wonderful part of their body, inside their tummies, that’s a very special place where a baby can grow. It’s just great, see.”

**Question:** “What about me?” Johnny asks “Can’t boys, can’t I have a baby in my baby

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thing?”

**Answers** from participants.

**Instructor:** “No, men can’t have babies in their bodies. See, men and boys don’t have a baby sac. The real word for the baby sac is “uterus”. But, you know, a man is needed for a Mommy to be able to make a baby grow in her uterus. It takes both a Mommy and a Daddy who love each other to make a baby grow in the Mommy’s uterus. Like your Daddy and me.”

**Question:** Can we use words like uterus, vagina, penis, etc. with children 2 to 6 years of age?

**Answers** from participants.

**Discussion:** Absolutely. It is well to start with a descriptive word, like “baby sac” for uterus. Families find their own vocabulary, often very cleverly too. The important point is to explain things to children based on truth, clarity, and age-appropriateness--both in terms of language and of readiness to receive the information.

**Question:** Johnny asked my mother where babies come from. My mother (Johnny’s grandmother) didn’t know what to say and just blurted out that the stork brings babies. What do I do now?

**Answers** from participants.

**Discussion:** It is advantageous for Johnny to continue to respect and trust his grandmother and to feel that he can ask her questions. It is also well for Grandmother to know that you feel it is really beneficial for children to know about babies and sex when they want to know and to tell them the truth about these and other things they want to know--except, of course, very private things. So you need to talk to both Johnny and Grandmother.

No problem telling Grandmother who probably will appreciate knowing what you want to do with your children.

With Johnny it is well to explain that Grandmother told Johnny what they used to tell children years and years ago. People used to think it was a nice way to help children come to know how babies come into families. But we now know that it’s much better to tell children the way it really happens. Do you want us to talk about that now?

If Johnny says “I wanna play now” or the like, you let it go.

If Johnny says “Yeah”, you’re on.

**Instructor:** You might go two ways here:

1. Let parents know--most probably know already--that there are many very good books that are written for children of various age levels that can greatly facilitate this task for parents who don’t feel altogether comfortable talking about these matters with their children. The books have the advantages of (1) having been well thought out by very knowledgeable people, (2) being available to go over as needed, and (3) to progress through the subject as best suits your child. There is also the advantage of some usually nice, clever illustrations of sperm meets egg cell, of mother animals with baby animals, etc.
2. Have a discussion of how the participants would explain to their child how a Daddy’s sperm meets Mommy’s egg, how these two very little cells then grow little by little in the mother’s uterus. The most sensitive task is explaining how the sperm gets into the mother’s uterus. The child’s age, curiosity, tolerance for this anxiety producing discussion should help the parent decide what to say. “Daddy’s private part and Mommy’s private part come together.” Or, “Dad puts his penis/private part in Mom’s vagina/private part. Think about it ahead of time; imagine a scenario, it helps. Choose what you’d say. Don’t think of it as a one-time conversation. It can be thought of as a subject that you’ll elaborate on when the child asks or when you feel it to be opportune.

It’s best if mothers talk about these matters with their daughters and fathers talk about them with their sons.

Instructor: See if there are more questions of the issue of babies, and of genital preoccupations, and discuss how they best might be handled. Then go into the third set of questions that children ask: questions that have to do with the child’s “family romance”, such as about wanting to be the favorite of the parent of the other sex.

Question: What kinds of questions have you gotten from your children that suggest to you something of your child’s “family romance”?
Answers from participants. (You may get none; you may get some. No need to push, on this or anything else.)
Discussion: Here are a few examples of what we mean:

1. According to her father, when she was less than 4 years old, Diane “sashayed up to [her father], fluttered her eyelashes and said ‘Will you take me to the movies and dancing?’” Father was surprised to say the least.
2. 4 year old Jennifer asks her mother “What do you and Daddy do after Mike and I go to bed?”
3. 3 year old Johnny and Doug each said they want to marry their Moms. What would you say?
4. When she was 3 years old, Jennifer told her mother she wanted Daddy to take her camping on the weekend, and it was to be only she and Daddy, no one else--Jennifer had several siblings.
5. 3 year old David asked his mother if Daddy was coming home for dinner. Mother said, “Of course, honey”. “Oh, does he have to?” David said. What might you say to that?

Question: Well, indeed, what would you say to David?
Answers from participants.
Discussion: From his tone, and the words, David who loves his father seemed to not want Daddy to come home for dinner. He wanted to be alone with Mother. Mother could say something like: “Oh, I’m real glad Daddy can come home and we can all have dinner together. It’s so nice that way. See, I love to have dinner with my wonderful son and my
wonderful husband. I’m very lucky, see.” David’s comment is not ignored though it does not address his inferred wish that Daddy not come home. Mother could add: “You know David, it’s real nice that I love Daddy so much. Some day, you’ll see, you’ll have a real nice wife and you’ll love to have dinner with her too.” With this Mother is letting David know that some day, he’ll find himself a very nice wife.

**Question:** Now, what if David follows this, as have Johnny and Doug, with “I wanna marry you, Mommy.”

**Answers from participants.**

**Discussion:** Mother could say: “Oh my, that’s very sweet of you. I know you’ll be a very nice husband. But, you know, I’m already married, to a very nice man, your Dad, as you know. And you’ll find some very nice woman when you grow up, and you’ll love her a lot, and you’ll wanna marry her. Oh, that’ll be so nice. You know, David, Mommies and sons can’t get married to each other.” This doesn’t need to be said all at once. But these contents ought to be said at some appropriate moment, with warmth, and quite straightforward.

The same type of answer holds for a girl’s declaring that she wants to marry her father.

**Question:** What about Diane’s wanting her Daddy to take her dancing and to the movies, and Jennifer’s wanting to go camping alone with Daddy this weekend?

**Answers from participants.**

**Discussion:** Perhaps the most important factor here is to not ridicule or laugh at the child who makes this quite startling request. It comes from the child’s really loving the parent. But obviously, the child’s wish has to be benevolently frustrated.

Diane’s father could say, “Mh, that’s very sweet of you Dee, but you know I can’t do that. You know what we can do though; you, Mom, your brothers and I can all go to a movie together. Let’s see if we can do this soon. You know Sweetie, Daddies and girls don’t go dancing together. That’s for husbands and wives. Some day, you’ll find yourself a real neat husband and, for sure, you’ll go dancing and to the movies together and have a really nice time. Won’t that be nice.” Clearly the message is “You and I can’t go on dates”. It ought to be said with warmth, respect, pleasure, and with the aim of informing and guiding the child.

**Question:** And what about 4 year old Jennifer’s wanting to know what Mom and Dad do after the kids are in bed? Where do you go with that?

**Answers from participants.**

**Discussion:** We don’t make the assumption that 4 year olds know that Mom and Dad are having sex. They may, whatever they envision this to be. Of course, if they have witnessed their parents having sex they will have an idea. (It is highly inadvisable for children to witness parental outright sexual interactions--other than hugging and socially appropriate touching--, because it over-stimulates, often leads children to distort the meaning of the behavior and it may bewilder children. But even though children may not

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have seen, they may well have heard sounds coming from the parents’ bedroom which they interpret as being due to some intimate type of interaction between the parents. Given the natural ability children have to “read” affects (feelings) they may have some idea of meaningful pleasure the parents are engaged in “after the kids are in bed”.

All that aside, here’s what one might say: “Well, Dad (Mom) and I have a lot of things to talk about, and things to do together. It’s private time for Mom (Dad) and me. Husbands and wives need private time, you know. Sleep well, kiddo, don’t worry about us.”

Instructor: Invite more questions.

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Instructor if you feel the following is needed, go over it once more. It may be too repetitious!

Discussion: Let’s once more take up the now well established fact that there can be significant consequences to parents’ avoiding recognizing the emergent sexual life of young children.

First, it means that parents will not adequately understand what their child is doing or is experiencing and are, therefore, not likely to know how to best handle their child's sexual behaviors, nor the conflicts to which these give rise, nor the defensive behaviors, nor the sharp guilt the child may feel and show evidence of. We have emphasized that the more a parent or parent-to-be understands a child's behavior, what may cause it and what it means, the more likely that parent will know how to handle the behavior in growth-promoting ways.

Second, it means that, not feeling understood, the child will not be as likely to turn to her/his parents for help in solving the problems that may and do arise out of the child's emerging sexual life. Not feeling a sympathetic understanding from the parents, robs the child of the best and most influential source of help. The child is likely to not turn to anyone for help or turn to young peers—who, for many years to come still, are the weakest source of information on matters of sexuality.

Third, because sexual experiencing is central to the 2 to 6 year old child's life, sexual activity is intensely experienced, creates much anxiety, intensifies the child's already intense conflict due to ambivalence, intensifies guilt and may lead to serious emotional problems including symptoms and life long inhibitions and distortions in relationships and in the child's eventual sexual life.

Instructor: Here might be a good place to introduce the following topics for discussion:

Among the most important of the possible negative consequences to the child of parents--and other adults--not recognizing the seriousness to the child of

(1) the young child's being capable of experiencing sexual stimulation and excitement,

(2) the nature and content of the 2 to 6 year old child's sexual wishes and
fantasies, whether conscious (in awareness) or already repressed,

(3) the dynamics of the “family romance” conflict these create in the 3 to 6 year old, and

(4) the anxieties and guilt the child's wishes and fantasies bring,
is that such parents and other adults may not be aware of the potentially enormous harm
engaging in actual sexual activities with children will create for them. Mental health
professionals have found that adults engaging young children—and older ones as well—in
sexual activity very often causes children to suffer great anguish, long persisting
emotional symptoms of all kinds, even the essential destruction of a person’s life. Mental
health professionals consider such acts to constitute one of the major forms of child
abuse.
WORKSHOP # 7

YOUNG CHILDREN’S SEXUAL BEHAVIORS --
HANDLING THEM CONSTRUCTIVELY, Part 1

Instructor introduction: Like addressing questions children ask, addressing young children’s behaviors can be usefully considered in terms of their concerns and interests:

1. About their own genitals and also those of others;
2. About babies;
3. About marrying Mom or Dad when they grow up, and the like.

Question: Have you seen your young child touching her/his pubic area with some degree of pre-occupation, and seeming to derive some pleasure from doing so? Or have you seen your young child rocking on a toy or rubbing his/her pubic area against something, seemingly pre-occupied while doing so.

Answers from participants.

Discussion: Not so long ago, Dr. Parens received a call from an anguished mother who wanted a consultation for her daughter because this mother was “afraid she is becoming a pervert.” The reason for her anguish was that her 4 year old was “touching herself, you know where!” A telephone consultation then and there seemed to dramatically calm this mother. Dr. Parens explained, and reiterated sympathetically several times that young children touch their genital area, and that it is normal. She was encouraged to also check with her pediatrician, and if she wished to go further to get Dr. Spock’s Baby Book, or any other current child care book of her choice.

It commonly makes parents uncomfortable to see their young child rhythmically rub their genitals and seeming to derive pleasure from these direct or indirect genital contacts. These behaviors are unavoidable because the stirrings in 2 to 6 year olds’ developing bodies more or less emphatically draw children’s attention to their own genitals.

We want to also emphasize here that masturbation is a means of discharging high levels of more or less bothersome sexual tension that usually causes no harm to the child’s body nor to anyone else. In fact, during periods of high level sexual excitation, such as during adolescence for instance, masturbation becomes a safety valve. It makes possible the discharge of sexual tension without having to resort to actual sexual engagement with another person, i.e., to seek sexual intercourse, at much too young an age. It may be considered the best line of defense against teenage pregnancy and premature entry into interactional sexual activity, well before the youngster is psychologically ready to handle this activity responsibly. Thus, generally, rather than being a troublesome behavior, masturbation in reasonable doses is self protective.
**Question:** A reasonable dose? What’s a “reasonable dose” of masturbation?

**Answers** from participants.

**Discussion:** We use the word reasonable just because there are no exact figures. Masturbation frequency varies from child to child, from age to age, from time to time.

Some children seem born with more sexual arousability, with lower thresholds for becoming sexually stimulated; some seem to have higher thresholds and are therefore not as easily aroused. Clearly those who are easily aroused need to be better protected against undue arousal than the others. For instance, it’s not a good idea to be bouncing an easily aroused youngster on one’s knee all the time. Such a child may in fact often seek to be bounced on a parent’s knee and this of itself may alert the parent to this child’s facilitated sexual arousal.

There do seem to be developmental periods when masturbation is more likely to occur with greater frequency than at other times. High frequency periods seem to be between 3 years to 6 and from about 10 years through adolescence. But in addition, during the 3 to 6 years periods for instance, times of heightened sexual stimulation occur that may engender more masturbation, such as when the cousins visit for the holidays or vacation times and there is more public diaper changing, or bathing, or playing Dr. games. Of course, during adolescence, talking with peers, seeing TV or movies love scenes, looking at Playboy magazine or the like, or being attracted by a particular other-sex person, peer or idol, parties, etc. all are occasions for sexual arousal in both girls and boys.

Also, though, of much interest is that masturbation is often used as a means of lessening anxiety, stress, and is then used in the service of self-calming. It is assumed, for instance, that masturbation frequency peaks in College students during exam times. It then serves to discharge some of the bodily tension and nervousness brought on by exams.

Regarding frequency, a rough guide might be that during the 3 to 6 years period a young child’s masturbating--quietly rocking, hands between his/her legs or rubbing her/his pubic area against something--several times a day ought to be of no concern to parents. A child who is found to be masturbating (for minutes at a time) ten or more times a day could be manifesting some stress and talking to a mental health child professional would most likely be very helpful. A child who is rather constantly masturbating and looking miserable in the process needs help and consultation is highly desirable. Scolding may stop the child’s overt activity but may not stop what is driving it; discouragement may work with guidance to doing something else the child enjoys doing, is good at, and can hold the child’s interest. More about this later.

Let’s not parenthetically that in adolescence, masturbation is often quite driven and most adolescents try to control its frequency, often with moderate success. Boys tend to masturbate with less inhibition and guilt than do girls. The reasons are complex and we won’t take them up in this Workshop. Interestingly, more obsessive teenagers are more successful in stopping their masturbation, but they tend to do so at the price of being very severe with themselves, and often inhibiting positive behaviors along the way such as spontaneity, creative open thinking, enjoyment of all sorts of activities, and more. Many a normal adolescent will masturbate daily, some more, some less. Rather constant masturbation and the absence of masturbation are both causes for concern.
**Question:** Wait, this may be confusing. Are we saying that you should encourage children to masturbate!? That sure goes against everything we were led to believe, no?

**Answers from participants.**

**Discussion:** It may be confusing. But not because it is difficult to understand. Rather, it’s confusing because masturbation is driven by two factors, (1) one biological, the inner sexual tension created by the young child’s maturing reproductive system (and hormone activated bodily feelings) and (2) the other psychological, that is the fantasies these sexual bodily sensations and feelings generate in the young child. These fantasies are part and parcel of the child’s normal “family romance” (discussed in Workshop #5).

Simply put, these feelings tend to make the child seek sexual contact with someone for whom the child already feels much affectional love. It is from here that confusion sets in for normal parents, from the residua in their own psyches of their own anxiety-laden childhood sexual fantasies and experiences.

Children should **not** be encouraged to masturbate. They will do so according to their own bodily need. Discouraging masturbation should occur only if it is too frequent. Making masturbation a private activity is desirable.

What is useful to do is dictated by 2 important considerations:

1. As we already noted, masturbation is generally a benign way to discharge high levels of sexual tension without having to resort to premature interactional sexual activity. It is a safety valve for a high-pressure system.
2. Medicine and mental health in particular have come to recognize this century that sex is a normal and healthy part of life, that it is not something that in and of itself is “bad”. Much of society has come to accept this as fact. The preservation of the species depends on it. Mental health in particular has also come to recognize that gratifying sexual activity between consenting married adults is a cementing factor that positively binds the relationship between them. It is known to optimize the relationship between wife and husband.

For these two reasons, the young child’s masturbation ought to be handled with due care, in growth-promoting ways.

**Question:** How can we handle in growth-promoting ways a child's beginning to "touch" his or her own genitals?

**Answers from participants.**

**Discussion:** As with everything else, a child will pick up his/her parent’s attitudes, the parent’s feelings about whatever it is the parent is reacting to. First then, to be forewarned is the best preparation. Your child is very likely to masturbate. And, he/she is quite likely to do it in full view, to be unaware that the parent may be made uncomfortable by it. Prepared then with this knowledge, and aware of the two important considerations noted before, the parent is likely to not be taken off guard, to not automatically react with anxiety and discomfort. Thus the parent will not send the child the message that what the child is doing is “bad”. Again, let’s bear in mind that children are inclined to believe that sex is bad; they are led to this conclusion by their developing family romance conflict. This feeling on the part of the child would be easily re-enforced by a parent's alarm and disapproval of masturbation. Needless to say, this in turn can
lead to later sexual inhibitions and problems in relationships.

Seeing the child masturbate, it is well to tell the child that this is a private activity he or she can engage in when in her or his room, that it’s not something to do in public. It is best to be respectful and responsibly gentle about trying to guide the child in when and where it’s OK to touch their genitals. It is helpful to tell the child she/he will understand these feelings and know what to do about them much better as the child gets older. It is also well to convey to the child the need for a reasonable self-controlling attitude about it. This is best done when the parent finds that the child is “constantly” touching him/herself. For instance, a parent could then say: “I can understand that your body makes you feel like you need to touch it a lot. But look, first of all, do this when you’re alone. It’s private, see. And then, try to think of other things you can do when you start feeling like you gotta touch yourself. Like why don’t you (and choose something your child likes to do and is good at, whether it’s drawing, or writing his letters and numbers, or practicing some skill the child is developing like catching a ball, doing gymnastics, building with LEGO’s, etc.). Here the parent would do well to try to direct the child to a solo creative activity, to help the child learn to channel some of this sexual energy into a worth-while effort at independent activity.

Instructor, you may want to continue discussing this topic if participants request it. It will help them with what follows.

Question: What behaviors have you seen in normal boys and girls that lead you to think they may have surprising interests and worries about their genitals?

Answers from participants.

Discussion: It is common for 3 to 6 year old boys and girls to show rather unreasonable worry and even distress at something being even slightly defective. For instance, as we said before, many a child will refuse to eat a cracker or cookie that has a chipped off corner. Or a child may make quite a to-do when she/he gets a minor scratch or scrape when she/he falls.

Mental health clinicians who treat young children and researchers inform us that such exaggerated and at times seemingly unreasonable concerns come from the way children displace their worries about their own bodies onto things in their environment. Intensive therapeutic work with and observation of young children has documented that the worries underlying the above stated behaviors have to do with the child’s reactions to and fantasies about their genitals.

Question: What behaviors suggest that little girls have worries about their genitals?

Answers from participants.

Discussion: First of all, as we inferred in the previous Workshop, 3 to 6 year old girls experience sexual excitations every bit as much as boys do. Like boys, they focus on the features of their own genitals in reaction to the strong and compelling sensations that come from them. And we said that when she touches herself and when by chance she sees a boy’s genitals, the little girl often comes to feel troubled that she does not have easily visible genitals. She makes the mistake to think that somehow something wrong

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has happened to her genitals.

When she displaces this worry to things around her, she may link it to a broken cracker and be made anxious by it; she refuses to eat it; she wants one that is not broken. Similarly when she falls and gets a scratch or scrape, she may come to think that this must be how her genitals got to be different than a boy’s. For instance, she may think she fell and her genitals broke. She then wants to be sure that her scrape is well taken care of and repaired. Normal girls have various reactions. A number of feelings and fantasies are generated in them: she wants a penis too; hers has not yet grown out; hers somehow fell off; or fell out of her body perhaps like a bowel movement, or by her masturbating manipulations; and more. As we said before, this is not a light matter. Many a girl is very pained by this, as she experiences it, this "lack", and feels cheated, deprived or, even "inferior." She may develop envy of the boy, feeling that he is more privileged than she, that he is "better", and have other equally irrational thoughts based on her not being able to know at a glance the marvels of her own genitals and reproductive system.

Regrettably, in some cultures this kind of thinking is highly facilitated in girls by the fact that, indeed there, boys are preferred over girls for economic (e.g., girls require dowries when they get married) and other reasons.

Question: What might a parent do when these kinds of behaviors occur?
Answers from participants. Have they had such experiences with their children?
Discussion: Calling the very upset youngster “a cry-baby” or such a hurtful label only manages to further upset the child. Yes, she may stop crying to protect herself against further insults, but the hurt is there and the anxiety she experiences is not relieved.

A parent might say something like, “Yeah, you’re right the cracker is broken. But you know it tastes just as good as one that’s not broken. Do you think that maybe you’re sort of worried about more important things not being just the way you think they should be?” the aim here is to open the possibility for talking about your child’s worries. But don’t push your question too far, don’t ask a specific question such as, “Are you worried about your genitals?” Let the child be specific; don’t plant ideas in her mind. Just invite her to put her worries into words. This does not have to be achieved in one sitting. It is well to bear in mind that how the parent(s) deals with this makes a large contribution to how the girl deals with it.

Instructor: discuss with participants this final point and discuss how parents (mothers, in particular) can help their girls to feel comfortable with and be aware of the uniqueness and marvel of their reproductive system.

Question: What concerns about their genitals do little boys show in their behaviors?
Answers from participants.
Discussion: As we said in Workshops #4 and #5, boys too have their fair share of concerns about their genitals. In them, their behaviors suggest substantial concerns about the size of their penis and about any damage being done to it. To recap briefly here, many a bright, imaginative 3 to 4 year old boy blames his small size and the small size of his penis for his inability to woo his mother as successfully as his father (who is larger, he
assumes, in all dimensions). A variety of comparative and competitive fantasies with his father lead the boy to fear punishment from his father, usually in the form of losing the father’s love and also fearing losing his highly valued genitals. This is what has led psychoanalysts to speak of the boy’s “castration anxiety.”

The assumption is that this is why males from about 3 years of age on are and continue to dread injury to their genitals. In young boys it often manifests in concerns over things being broken, if broken whether they can be repaired, or over fears of being physically injured. They may need elaborate attention to the smallest scratch, make a large to do over even the slightest accident or damage to the self or others or things.

A 3 year old boy had just gone to urinate and came back to his mother who duly complemented him on having done so. However, noting that he had not zipped up his pants, Mother reached down to do so when her son, suddenly terrified pulled away from her, anxiety clearly evident on his face! Mother was startled.

**Question:** How might you help this boy? What would you say, what would you do?

**Answers** from participants.

**Discussion:** To be sure, scolding him or laughing at him for his irrational fear would not help. It would only hurt him. One might say, “Oh, I’m sorry I scared you. I was just going to pull up your zipper. You did such a great job going to urinate (use whatever word your family uses for this function), but you forgot to zip up your pants. I just wanted to help you. Next time I’ll just tell you to do it yourself, OK?” You can stop there or you can add something like, “I wonder what you got scared of?” Then you wait. If he says nothing, the subject is closed for now. No doubt such signs of “castration anxiety” will occur in other ways. If he takes up the opportunity to talk, it is then an opportunity for you to reassure your son that no harm will come to his penis or any other part of him. Of course, he has to take good care of himself, like watch where he’s going, and be careful when he crosses the street and stuff like that.

**Instructor:** See if there are any other examples and questions.

**Question:** What about children being interested in others’ genitals? Like in “playing doctor games”?

**Answers** from participants. Have they found this in their children?

**Discussion:** Let’s consider this question this way. Let’s take it as

1. Interest in their peers’ (playmates’, little friends’) genitals;
2. Interest in their sibling’s genitals; and
3. Interest in their parents’ genitals. Although the same principles apply to all, let’s consider each separately.

**Question:** How can a parent handle constructively his/her child's sexual curiosity or play with peers?

**Answers** from participants.

**Discussion:** To turn to peers to learn, to discover, to test their ideas about all kinds of
things--children need explanations for everything--is a most natural tendency. Children also find clever ways of satisfying their curiosity and testing their hypotheses. What we all think of as "play" is actually "problem solving". Children use this vehicle "play" to solve problems. For instance, it is common for children to play doctor games after they have been to the pediatrician where they got a shot. Thus in their sex "play" they are addressing their questions and making discoveries.

But, their need to know is pressing. It is well to help young children learn some patience in what they want to know and do. It is well to guide them in using judgment about what they do in their efforts to learn and know. In the sphere of sex, doing is not the best way to start to discover and learn. It is therefore, wise to let young children know that while their curiosity is laudable, their play to discover is not. So how do we go about it?

First, upon finding your child playing doctor-patient with another, it is well to say something like: "Ok, kids, I can understand your wanting to know what each other’s got in their private parts, but you’re too young to explore. You’ll learn more when you get older. Johnny, whatever questions you have, you know that Daddy and I are very glad to talk with you about. Timmy you can ask your Dad too. How about you two going outside and playing (whatever other game/activity they enjoy together)."

It often is harmful to shame the child for his/her sexual curiosity because (1) it is normal; (2) it would discourage disclosure and with it the opportunity to get parents' input as to how they should handle their sexual interests; (3) it probably would make them feel that their very normal interest and preoccupation mean that they are bad, unlovable children. And, (4) it is likely to foster more secrecy than is needed for reasonable privacy. In addition, being made to feel shame is very painful. Because it is very painful it generates hostility in the child, hostility that will be directed toward both the shaming parent and the child her/himself.

It is important to set limits on the behavior (e.g. the behavior is to stop now, that they are not old enough for such activity but that their questions can be discussed.)

This parental action would serve several functions: the normalcy of the children's interest would be acknowledged and it would also suggest via questions how to deal with that interest without "getting into trouble" with Mom and Dad. It is important to convey to the child that all-important questions deserve discussion. Additionally, when the parent sets a firm, reasonable limit on the behavior it also models for the child how to deal with her/his sexual interests in constructive ways.

**Question:** What is a most constructive way to handle sex play, actual and symbolic, among young children?

**Answers from participants.**

**Discussion:** When we discussed infantile masturbation we described the activity as normal and expectable. But, limits are needed when during such activities objects are inserted into the vagina or the anus, or when the child engages in any activity that can cause self-injury.

Mutual explorations by children are best discouraged and restricted during this age period, with explanations that the child is too young for this type of activity, will be able to use better judgment about it in later life. In addition to the reasons we have
already given, like with self-explorations, these activities are initially carried out in the open, but as family romance fantasies associated with them begin to produce conflict, self explorations as well as peer reciprocal explorations tend to be done more and more in private and in secret. Both then tend to be done with excitement but they also soon begin to create guilt.

For the most part, symbolic sex-play--i.e. children embracing, pretending they are Mommy and Daddy, but not enacting the actual sex act--causes no problem except when it is excessive, is a more than usual preoccupation, or when it leads to too much excitement and/or irritability, or when it gets out of control in one way or another.

**Question:** What about sex play between siblings, isn’t that pretty bad? How does one deal constructively with sex play between siblings?

**Answers** from participants.

**Discussion:** Sex play between siblings is much more common than we all tend to assume. It is actually quite understandable. But it needs to be attended to and stopped.

Because of the problems it usually creates, we tend not to want to know that sex play between siblings happens much more commonly than we would like to think. The age at which it happens and what happens both matter. Sex play between siblings under 6 or so years of age is much more benign than sex play between teenage siblings; it is also less likely to be as secretive and as cleverly disguised. As to “what happens”, mutual anatomical discovery and exploration is likely to be the motive of less than six year old siblings and is much less problematic than the goal of gratifying sensual excitement and tension that occurs in adolescent sibling sexual activity.

It is understandable that it happens because of this. When the 4 to 6 year old begins to accept the fact that he cannot marry his mother, or she cannot marry her father, the child will take steps to attach his/her romantic love feelings to another person, usually but not exclusively, of the same sex as the idealized parent the child wants to marry. Given that the child already has formed a more or less affectionate relationship with his or her sibling, we shouldn’t be very surprised to find then, the romantic love (and sexual) feelings becoming displaced onto and attached to this sibling. This then heightens the tendency to engage in sexual exploratory or gratification activity between them.

Although hearing a 5 year old declare he will marry his sister when he grows up is usually experienced by parents as cute, it should alert them to be aware of the facilitated potential for sex play. The sex play need not be between other-sex siblings. Here is a clear instance.

A set of twin girls got along quite well from very early. By the time they were 3 years old, usually when they played Mother tended to know that for the most part, the kids would manage reasonably well. Of course, she could usually gauge how things were going by the sounds they made. One morning, in fact, she was impressed with there being no sound coming from the room where they were playing. Surprised by “no sounds” she went to see what they were up to. To her surprise, there they were stripped naked, in bed, one lying on top of the other in an embrace. Shocked, Mother said “What are you doing!?” One of the girls simply said, “We’re playin’ Mom and Dad.” Duly informed, Mother said to them, “Well, you better get out of bed, put your clothes back on and come downstairs right now.” Knowing their mother meant what she said, the kids
dressed and came down. While somewhat sheepish, seeming to know their mother to be a non-spanking and non-shaming mother, they came to where she was. Perhaps having worked with us at parenting guided her. Mother said something like, “Listen you two, it’s nice that you play at being a Mom and a Dad but you’re not to go that far in your play. You’ve got plenty of time to learn what being a mom and a dad is all about. For now, I want you to keep your clothes on when you play. If there’s anything about being a mom you wanna know, hey ask me, I’m an expert on being your mom. Any questions?” No answer. “Well, whenever you’re ready, you can ask me. For now, please find another game to play.”

Benevolent awareness of this possibility, and benevolent limits when needed are recommended. “You kids aren’t old enough for this: why don’t you draw or color, or something," and at some point something like this will be needed: "Heh, I want you to know that brothers and sisters aren't allowed to get married to each other; it’s against the law. But you know what, you'll both find somebody real nice to marry when you get big, and that’ll be very nice."

**Question:** What might one do when a young child impulsively or seductively touches Mother or Father in their pubic area, or so touches Mothers’ breasts?

**Answers** from participants. Has that happened to any of the participants? What did they do?

**Discussion:** We have found that when a 3 to 6 year old child touches a parent’s genital area or touches Mother’s breasts, many a parent tends to assume that this touching has nothing to do with sexual interest. As a result, the parent ignores the behavior and does not help the child well. Child psychiatrists and psychologists think differently. Their work leads them to think that this grows out of the 2 1/2 to 6 year old child’s growing interest in sexual body parts and the sexual feelings that get stirred up in her/him. Mental health people think it is not accidental and that reasonable attention to this behavior can be guiding to the child.

There is no need to be alarmed by such behavior. The parent can simply say something like, “I guess you’d like to touch me to find out what my private parts are like. But listen, they are private parts. And though I love you very much, I don’t want you to touch my private parts. When you get older you’ll have plenty of chance to find out how somebody you love is made.” A parent may also say, “It makes me feel uncomfortable when you touch me in my private parts. They are private, you know. And even though I know you touch me there because you love me, and I sure like it that you love me, when you wanna touch me because you love me you can give me a wonderful hug, or a kiss, OK!” (Here you are not seeking agreement from the child. You are asking if he/she understood what you said.)

**Instructor:** see if there are other behaviors that pertain to genitals participants may want to talk about. For instance, has any participant been asked by a child to “Please touch me here, it feels good”? How would they deal with that?
Instructor: here is an important and difficult issue.

When we talk about sex play between siblings, and when we talk about children’s sexual behaviors toward their parents, we are on the threshold of talking about incest. Incest is a critical subject, one that concerns mental health clinicians greatly because of the often serious clinical findings associated with incest. Important distinctions need to be made. Let’s start with definitions, then let’s categorize sexual activities, distinguish them by their essential characteristics, and then let’s talk about potential consequences to kids of each.

1. In terms of definition, sex play is interactional mutual exploration of body parts that pertain to the genitals of each child. It may be direct and simply in the service of discovery and the satisfaction of curiosity about anatomical differences between girls and boys. Incestuous activity is interactional sensual genital activity that is in the service of gratifying sexual excitement experienced between members of a nuclear family, i.e., between a child and mother, a child and father, or between siblings. It aims toward erotic gratification that is driven by mounting sexual desire.

Sexual play is typically found in normal children under about 6 years of age. It may also continue in children between the ages of 6 to 10. Beyond ten or so years of age, sexual activity tends to be drive more by sexual excitement and desire than by sexual anatomical curiosity. Beyond 13 years or so, sexual activity is invariably driven by the search for sexual erotic gratification. When sexual activity occurs between children of quite disparate ages, say a 15 year old and a 5 year old, the aims of the two involved are likely to be different, the older being driven by sexual desire, the younger predominantly by curiosity and the wish for attention.

2. Regarding their specific activity characteristics, sex play often occurs in the context of family role playing or doctor-patient role playing. In these instances it arises out of identifications with family members, usually mother, father, and baby, or it may follow on a visit to the doctor’s which created anxiety. Some sex play often consists simply of looking and touching. When it is repeated, it may progress to genital manipulations both out of curiosity but also in reaction to the mounting stimulation that unavoidably occurs. Some sex play may go so far as the insertion of objects into a girl’s vagina or of the anus of both girls and boys. There, of course, curiosity is bringing some risk of hurt.

Incestuous advances (and activity), being driven by the “need” for erotic sexual gratification--that is by intense sexual excitation that presses for gratification--is generally very arousing and may eventually, if continued over time, lead to outright sexual intercourse.

3. Regarding some potential consequences to children of sex play and of incestuous activity, mental health professionals say the following. Sex play between children varies in its potential effects depending on whether the sex play is between siblings or non-sibling peers.

Sex play between non-sibling peers of about the same age (say 1 or 2 years difference) is generally benign, unless some hurt is caused by one of the peers to the
other. The hurt can be physical or emotional (like one child saying to the other “I’ll never play with you again if you tell”); it can be mild or harsh. When the age between non-sibling kids is more than say 4 years, and the older peer is pressuring the younger child against the younger one’s wishes, anxiety can be activated in that younger child. We know of instances when a young teenage babysitter has explored sexually the young child she was sitting for. This may come to no harm. However, physical hurt, threats to not play with, or worse, threats to harm (one troubled babysitter told her young charge that she would kill him if he told what she did with him), of course will cause anxiety in a young child. But the everyday variety sex play between non-sibling peers where no hurt is inflicted on neither child is generally quite benign.

Sex play between less than 6 year old siblings may be benign but it may be problematic. The principal reason it may be problematic is that although sex play between siblings may be a one time event, in which case it is no more a problem than sex play with a non-sibling peer, because of their constant togetherness, sibling sex play may become repetitious. Because the sibling is emotionally invested, and, as we said earlier, it is very common for siblings to attach to each other feelings and fantasies displaced from their “family romance”, repeated sex play can lead to its becoming a means of gratifying sexual excitement and desire, at which point it becomes “incestuous”. When in adolescence sexual tensions mount and sexual desire becomes difficult to control, then sexual activity between siblings will predictably lead to lead to anxiety, conflict, guilt, shame, and consequent emotional symptoms. For this reason, sex play between siblings of all ages is best just simply, benevolently but firmly disallowed.

Sex play between a less than 6 year old and an adult is a problem. It is a complex topic; we will not take it up here. Suffice to say the following:

Much more sexual abuse of children occurs than we like to think. When it occurs it is not usually intended to hurt the child. But most mental health clinicians tell us that it does. With this in mind then when incest occurs, **incest has not been found to be activated by children under 6 years of age.** While some quite young children may behave seductively with an older sibling or a parent, even the boldest of less than 6 year olds tend to not go beyond seductive behaviors such as flirting. Where incest involves a child younger than 6 years, it invariably results from its activation by an older sibling or a disturbed parent. It has been found, however, that when a less than 6 year old has already been sexually abused, that child may in order to get someone’s affection or attention or in the hope of getting some reward, act physically quite forwardly, such as reaching seductively for an adult’s genital area. The underlying motivation of such behavior in individuals who have been abused is psychodynamically understood to result from (1) the hope to gain some favor and/or gratification--conscious and unconscious--from the person being enticed and (2) it is predominantly an effort to master the trauma--which can have long lasting effects--that often comes from incestuous (and non-incestuous) sexual abuses of children and adolescents.

**Instructor:** This topic may stir many questions and even anxiety in the participants. Certainly the questions ought to be given due discussion time. In fact, discussion of this topic can be continued into the next Workshop.
WORKSHOP # 8

YOUNG CHILDREN’S SEXUAL BEHAVIORS --
HANDLING THEM CONSTRUCTIVELY, Part 2

Instructor: You can start this Workshop by inviting further thoughts and discussion of the issue last taken up in Workshop #7. Then, continue with Workshop #8.

Question: How about children’s behaviors toward babies? For instance, how might you best handle your child’s saying the baby she’s holding (your neighbor’s) is “My baby”; yes, your just 3 year old girl saying “[This is] my baby”?

Answers from participants.

Discussion: As always, an honest, sympathetic answer is the best answer. It is well for parents to know that when a little girl, 2 to 6 years old, says "This is my baby", the child means just that. We infer from it that she wishes this were her own baby. Research shows that the child does not mean she wants the neighbor to have this baby, nor that mother have another baby, nor that she wants Mother to buy her a doll from the store, she means that she wishes she could have a live baby of her own. As one 4 year old girl, losing patience with her mother said when Mother offered her a doll, “I don’t want that, I want a real baby!”

During the third year of life, especially so with little girls, this can become a very real preoccupation. On average, boys react much less dramatically than girls. However, not all normal girls express such an awesome wish for a baby. This interest is likely to emerge to a greater or lesser degree later. Quite a number of girls do not show such interest; and, some boys may.

In terms of handling this expressed wish, a mother (or father) might say, “Well, I can understand how you feel. [If it’s so, a mother might add:] When I was a little girl I wanted to have a baby too. I’m sure glad I have you. This is Mr. Smith’s baby, you know that. I bet you, when you’re a grown woman, and are married to a real nice man, you’ll have your own baby; maybe even more than one.”

The child may be satisfied with this or she may say, “No, I want one now!” Again, reality is best. Mom might say, “It’s so hard to wait when we want something very much. But see, little girls can’t have real babies yet. You have to wait until your body and your mind are grown enough to have a baby. That won’t be until you’re a grown woman. Heh, I had to wait too.”

Question: What do you do when your 3 year old son stuffs a pillow in his shirt and says, “Look Ma, I have a baby in my tummy!”

Answers from participants.

Discussion: A mother (or father) might say, “You sure look cute with a pillow in your shirt. But, I’ll tell you. Boys don’t have a uterus, you know, a baby sac where a

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Mommy grows the baby. Women and girls have a uterus/baby sac, and they sure are lucky. But men and boys don’t. But they too sure are real nice the way they are."

When girls and boys are told they have what they have and its really nice, that pleases them greatly. Needless to say, what distresses many a child is to be told she can’t have a penis, or he can’t have a uterus. This needs to be said with sympathy and the realization that it really is helpful for young children to learn that they can’t always have what they want. None of us can. They need reassurance that what they do have is good, no the grass on the other side really is not greener, and they need to be comforted if this tough to take news--you can’t always have what you want--this time seems to be more difficult to accept than when it comes to wanting another cookie or popsicle.

**Question:** How can we best handle children's sometimes negative or disruptive reactions to mother and father being physically affectionate with one another? For instance, what do you do when your son/daughter scowls when Dad and you give each other a hug?

**Answers** from participants.

**Discussion:** Of course, as with everything else, understanding what causes negative reactions to parents showing affection to one another like hugging and kissing, is essential to knowing what to do about the child’s negative reaction. It is normal for children to behave in this way.

So again then, in so many everyday instances parents can help their children by

1. **recognizing whatever expression of feeling** the child may be experiencing,
2. **understanding the meaning** of the child's behavior,
3. **being empathic**, that is, putting oneself in the child's place and asking "How would I feel if I felt what he or she feels?" and then,
4. **being sympathetic**, that is asking oneself "How would I like to be dealt with if I felt like this?", and
5. **respecting** both the child's feelings as well as his/her need for honest, appropriate and realistic handling.

Given this then, what might a parent do and say when your son/daughter scowls when Dad and you give each other a hug? First, you don’t just yield to the child’s scowl by stopping the hug. You enjoy it. You smile lovingly at your child and might say warmly, “Isn’t it nice that Daddy and I love each other. Someday you’ll have a real nice husband to hug. I like to give Daddy a hug. I know you like to hug him too. We can both hug him.”

What if your child then says “But I don’t want you and Daddy to hug.” You might say something like, “Heh he’s my husband. You know Daddy and I have been giving each other hugs for a long time. You know, someday you’ll have a real nice husband/wife to hug. You’ll see.”

Sometimes the child’s objection may become physical. It then may require the setting of limits. You might get a bit peeved too, and say something like, “That’s enough Suzy/Johnny. I don’t want you interfering with my giving Daddy a hug. We give each other a hug because we love each other.” Use your own words, style of doing things; don’t be shy about showing affection. In addition, warmth and humor, not teasing or ridicule, can make this situation (not being able to have the desired parent all for oneself) easier to bear.

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**Question:** But isn’t it bad for parents to show **physical expressions of love** in front of their kids?

**Answers** from participants.

**Discussion:** This too is a very important question. It is highly advantageous for parents to let the children know they love each other. But here’s an important note on this question:

It is important to distinguish between **physical shows of love between parents that are affectionate in contrast to shows of love that are sensual.** Similarly, it is important for parents to distinguish **physical contacts from and with their children that are affectionate from contacts that might be sensual.**

First, parents should feel free enough and comfortable to kiss and hug, and they have the right to privacy in and about their sexual relationship. It is in fact desirable that children see evidence of affection and **signs of** romantic love—though not overt sexual behavior—between their parents. True, children may feel jealous by such behavior. But they are also reassured by it. First they are reassured that feeling love, expressing love feelings, romantic love feelings where appropriate, is not only permissible and safe but is, in fact, desirable. Secondly, children are reassured that their parents will not separate/divorce when mother and father express love for each other, that they feel that their family life is secure.

On the other hand, exposing children to sexual acts (well beyond affectionate kissing and hugs), from passionate kissing to sexual intercourse, is highly conflict-producing. It is so by being too stimulating and by the fact that seeing sexual intercourse is too bewildering for children. Children tend to distort the quality of the parents' sexual experience. Quite commonly because of the child's own hate feelings color what the child sees, the child not uncommonly distorts the love (sex) act as one of attack and fighting. This contributes to the child's experiencing such exposures as bewildering.

**Question:** What about **children** behaving with a parent, or each other, **in sensual ways**? How can you tell anyway if the child’s show of love is sensual or it’s affectionate?

**Answers** from participants. How do they decide if a given show of love is affectionate or sensual?

**Discussion:** It’s generally not easy. But this is because most parents are made anxious by the idea that our young children can have sexual feelings toward us. To be able to distinguish whether behavior is affectionate or sensual requires an open mind and being able to tolerate what we ourselves may feel and what our young (and older) children may feel.

**Here is yet another important note.**

**Question:** Oh, oh, another important note!? What now?

**Instructor:** (Here you are not asking the participants to guess what you want them to think about now. Just continue.)

It’s just not all that easy to be a responsible Mom or Dad. But, it can be done
We said in Workshop #5 that there are two major trends in what we call love, the affectional trend and the sensual trend. We said that it is in romantic love, the unique love that binds two people together as mates, that the two trends combine in that marvelous mix most of us know. We also said, however, that (1) when we love someone deeply affectionately, the strength of this love facilitates the activation of and may then draw the sensual trend to itself as well. And (2), we said, that when in the course of normal development the 2 year old child’s genital sexual feelings emerge due to the maturational beginnings of the child’s reproductive system, the genital sensual trend of love reasonably enough follows the path carved by the now well established affectional trend of love. The young child’s sensual feelings are naturally attached to those the child loves affectionately most, his/her own primary caregivers, usually the child’s own parents.

Question: We have already talked about this. So what does this do that’s so important for us to know?

Answers from participants. (Instructor: use your judgment as to whether you want to pose this question because it’s a “What am I thinking?” question, a very poor teaching technique.)

Discussion: Here’s what’s important about this. Given these two factors, it is quite natural that

1. Normal parents who are very devoted to and love their children well will from time to time feel sensual love feelings toward their own children, even quite young ones. And,

2. It is quite natural for normal children who love their normally devoted parents well to feel sensual feelings toward these parents.

In both cases, this tendency is facilitated by the gender of both the child and the parent. It is more commonly found that girls’ sensual feelings are strongest toward their fathers and fathers’ sensual feelings are more readily activated toward their daughters. Equally, boys’ sensual feelings are strongest toward their mothers and mothers’ sensual feelings are more readily activated toward their sons.

Instructor: open the floor to any questions, expressions of objection, rejection by the participants. That normal parents tend to have sexual (sensual) feelings toward their own children creates anxiety in many very good, very responsible parents. And it is exactly this fact that makes it difficult for parents to sort out whether their children’s expression of love are heavily sensually weighted or are predominantly affectionate. Don’t expect admissions of having such feelings toward their children. It is not necessary to go on.

Question: Ok, let’s assume your child touches your breast. You may then wonder, “Was this an accident, was it simply an innocent touching of your body, or was it a sensual act?” How did you feel when your child touched you?

Answers from participants.
**Discussion:** To sort this out, let yourself feel what you felt. If you felt uncomfortable about it, consider:

1. What did your child seem to feel when he touched you? Look at his/her facial expression and words for “lovey-dovey” feelings, that is, for soft romantic feelings. We all know that the feel of affection is different from the romantic feel. If you feel it felt sensual, don’t be afraid to think it was. It’s normal for children to express such feelings.

2. Be brave. Did you feel sexually aroused? If so, did it come just from your normal sensual reaction to being touched in a sensuality-responsive area of your body, or are you indeed reacting to what your child is conveying in his/her feelings toward you? It is not always easy to decide this.

If you are uncertain, wait to see if this happens again. It could happen again soon or it might not. Just be aware. If this kind of love expression occurs a couple more times you may be more helpful to your child to assume it is sensual.

**Question:** Ok, so what do you do now that you think it was sensual? How can you be helpful to your child?

**Answers** from participants. How would they deal with this?

**Discussion:** A mother or father might say, “I know you love me and I sure like that; and you know that I love you very much. Now, when you touch me here, though, it makes me feel uncomfortable. It’s a real private part of me, see, that only Daddy/Mommy can touch. When you get older you’ll learn more about all that stuff. But you can touch me any place that’s not a private part and that’s nice. Of course, you can touch all the private parts of your own body and that’s fine.”

As always, the idea is to be age-appropriately open enough, truthful, factual, guiding to your child, considerate and permitting of curiosity because it serves the need to know and understand. All of these promote the child’s healthy emotional growth.

In whatever way the child follows this up, the parent’s taking the time to talk in such growth-promoting ways with her/his child then and there or a bit later is sure to serve the child’s best interest. Bear in mind that there are times when the child’s questions and remarks can be followed by claiming the right to privacy, such as if the child wants to know under what circumstances Daddy touches you there. “Listen, trust me, you will learn more about this when you get older.”

**Instructor:** Continue with any remaining questions and concerns before proceeding further in Workshop.

**Instructor:** This may be a good place to practice various scenarios with participants to further facilitate points that seemed difficult for them to deal with. Bear in mind that in some instances, participants may have serious doubts about the things we are saying. Their skepticism may persist. But we have also found that in many instances the initial resistance caused by the anxiety these topics arouse in many people gives way to a lessening of this initial resistance. As questionable behaviors are repeated by the child, the parent may allow that what we are saying may indeed be so, and the parent becomes then better able to guide the child constructively to more appropriate behavior.

Here is an illustration. A very devoted mother of four in one of our observation
groups, after having 3 boys finally had the good fortune of having a baby girl. Father and Mother were thrilled by her. When this girl was 2 and 3/4 years old, she asked her mother when she would get her penis. Mother was startled by the question. Nonetheless, she answered her daughter very nicely. But the child was not satisfied. She also asked her father. She also got a very nice answer from him. Much to everyone’s dismay however, that still seemed to not satisfy this very bright little girl. She asked her next in age brother when she would get her penis. Probably made anxious by her question, according to Mother, his answer was something like: “Girls don’t have penises, stupid!” in a tone that jarred her and sent her running to her mother. Mother reported to us that actually she had never believed this theorizing that many a little girl will express the wish for a penis--in addition to what she has. She did not remember having such wishes as a child herself, and she was actually shocked when her little girl asked when she would get her penis.

By the way, bear in mind that most little girls want a penis in addition to what they do have, not instead of what they have. Some theorists have asserted that both boys and girls want everything, not just what comes naturally to them.

Instructor: If time permits and you feel it warranted, further discuss with participants how engaging in sexual activities with children 3 to 6 years of age especially, but earlier and later as well, has consequences ranging from non-harmful to severely harmful depending upon certain conditions.

Review the following findings from current research:

1. Sexual play between 3 to 6 year old children (playing doctor, etc.) is common and usually causes children no harm. It is especially helpful when parents and other caregivers duly and reasonably set limits on such play and guide children to other activity.

2. Sexual activities between 3 to 6 years old with non-sibling older children and adolescents can create problems for the younger child (and the older one too) when there is physical hurt or threats of harm if the 3 to 6 year old does not comply or if he or she tells what happened.

3. When the older child or adolescent is a sibling, the hurt to the 3 to 6 year old (and older than 6 as well) usually is greater than when it is not a sibling. This is because the sibling is often experienced as a substitute for the parent(s) and the sibling is loved as a “primary love relationship”--those to whom we are closest in life and in whom we invest much love. Both these facts may make sex play between siblings reach into the arena of incest--which is loaded with emotional consequences.

4. Physical hurt and threats add to the severity of the potential emotional hurt the 3 to 6 year old (or younger or older as well) may experience and carry with her or him for many years to come.

5. When an adult sexually transgresses a 3 to 6 year old child the severity of the consequences tends to be greater.

6. The degree of severity of the consequences for the child increases from less severity by non family adults to highest severity when by one's father or mother. Again, physical hurt and threats intensify the emotional assault on the 3 to 6 year old.

_Workshops on Sexual Development_
Discuss with participants reactions and further questions.

**Question:** Why is sexual activity carried out by parents and older siblings more damaging to children, especially children from 2 to 6 years of age (but to children less than 2 years and older than 6 as well) than when done by non-family individuals?

**Answers** from participants.

**Discussion:** Because, to begin with, they are the people the child expects he or she can trust most to do them no harm.

But it is most helpful to understand this question by placing the sexual transgression against the child in the context of the child's fantasied family romance.

When a father engages his 3 to 6 year old daughter into sexual activity (always an emotionally troubled man), he is fulfilling not only the child's wish and fantasy that father will be her lover and give her a baby, but also the girl's wish to take father from mother, that he prefers her over mother, which the girl knows would make her mother very unhappy.

Furthermore, the girl now comes to believe that she is the cause not only of mother's being rejected by father, but of her mother being harmed and eventually even being destroyed. All the fantasies of removing her rival for father from the scene now are possible, including the fantasy that the hate side of her ambivalence (remember she also loves her mother) will destroy her mother. This leads the little girl to feel intense and long lasting guilt. She is likely to believe that she is the one who caused father to do this with her; everything that has gone wrong in the family, she believes, is caused by her. She is very likely to feel she is bad, even evil, and surely unlovable. The same can be said for the boy whose mother engages in sexual activity with him.

This sequence of thoughts is not an invention of ours. It is found repeatedly in psychotherapeutic clinical work with children and adults who have suffered sexual abuses by a parent, or a sibling, or a close relative.

**Question:** Why is sexual activity by an older sibling more hurtful than by an older non-sibling peer?

**Answers** by participants.

**Discussion:** As we said before, the major reason this is so is that an older sibling is commonly experienced by a younger child as a substitute for their parents. And, in addition, there is a “primary relationship” between siblings and this, at certain times facilitates the older sibling’s becoming a substitute for the parents to the younger child. Similarly, this also applies to aunts and uncles.

As we have said, many problems come with incestuous activity. Among one of the costliest is that incestuous activity erodes the trust a child naturally has in those she/he loves, her/his parents, siblings, aunts and uncles, etc.

**Question:** How can we best protect children from this abuse in families?

**Answers** from participants.

*Workshops on Sexual Development*
Discussion: The greatest protection against children's being sexually abused will occur when parents recognize the harm it causes, and when they understand the normalcy of and the nature of the child's fantasied family romance.

Also, protective against child sexual (and physical) abuse is for parents to recognize that young children do understand what the parent is doing when they engage in sexual activity with them, that they are made anxious and guilty by it--which is the major reason they do not tell the other parent it is occurring--and that they do not forget (even if they repress the experience into their unconscious mind for years.)

Question: What happens when children are guided constructively through the family romance period?

Answers from participants.

Discussion: When children are helped through this very enriching and development inducing period of life, they grow in the ability to love, to form meaningful love relationships, and they also grow in many adaptive abilities and in conscience formation.

Parents and caregivers can be enormously helpful to their children during this phase by reassuring their children that they will get to have what the parents have and that it will be very nice for them too. The child's jealousy softens a bit when the parent understands, is sympathetic and reassuring.

Instructor: discuss with participants further thoughts, reactions and questions regarding all of this material.