PARENTING FOR EMOTIONAL GROWTH: A TEXTBOOK

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TEXTBOOK

UNIT 2

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UNIT 2

THE TODDLER YEARS: (1 TO 3 YEARS)

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UNIT 2

THE TODDLER YEARS (1 TO 3 YEARS)

2.1 PHYSICAL DEVELOPMENT THAT DETERMINES WHAT A CHILD IS ABLE TO DO

2.111 HUMAN DEVELOPMENT: Degree of Adaptive Capability And Helplessness

A great deal of growth has occurred during the first year of life. The next two years are no less dramatic in the detail and degree of growth that occurs. Like the year before, each child has essentially his or her own growth time schedules, although within ranges all children tend to follow similar timetables. The newborn was virtually helpless with regard to providing himself or herself food, and in the ability to move from one place to another. The one year old, by virtue of being able to move from one place to another, whether crawling or walking, is now able to get to accessible food. She or he is also able to make clear his or her wish for food. The one year old is able to understand everyday mother infant verbal communication and is well able to communicate by more and more specific expressions of feelings and wishes using facial and vocal expressions as well as gestures. Whereas the newborn was unable to grasp the breast or bottle, the one year old is able to handle much in his or her environment, shows an enormous curiosity about everything in that environment, and indeed may be a vibrant explorer with numerous interests and endless energy as well as the ability to get where he wants to go and manipulate with his or her hands that which gets his or her interest.

In contrast to the newborn, the one year old has formed a strong, already deeply-felt emotional attachment to his or her mother, father, siblings and recognizes unknown people as strangers. The one-year-old who has a good relationship with his or her parents, uses a remarkable combination of adaptive capabilities to get those in the environment to do for him or her what the infant cannot yet do himself or herself. In other words then, the one-year-old's muscles and bones, their coordination and strength, the eyes, ears, touch (feel), and central nervous system developments have reached a point of functioning whereby by means of gestures, emotional and verbal communications, she or he is able to adapt to a remarkable degree by what the one year old herself or himself can do and by means of engaging and even directing those in his or her environment to fulfill needs and execute wishes the toddler is still unable to carry out himself or herself.

Temperament-based reactivities have become better organized and sufficiently

patterned that the parents can predict and anticipate how a one year old will respond to most everyday situations. Mother by now knows very well, as does a father who has been involved with the infant sufficiently, how long the infant will be able to wait for feeding or for the fulfillment of other wishes, whether the infant will fall asleep easily, will be pleasant or irritated on waking, what the infant's level of exploratory activity will be, whether the infant will cry easily, and much more.

So far as understanding communication, one year olds are not only able to recognize the feeling tone of their parent's communication, they can now also recognize the meaning of many words, even though they may not be able to say any more than a few syllables.

With regard to the child's now vanishing reflexes, the grasp reflect, the one to hang on the longest in the infant, will be lost during the second year of life, as the infant develops increasing control of her or his hands. The more complex reflex systems and the preprogrammed adaptive response systems like those that initiate attachment are now replaced by the well-exercised attachments to members of the family. The need for attachments will continue throughout life, but the built-in mechanisms that started attachment is going to fade gradually. As we will detail further in subsequent sections -- because of the central part these play in every child's development --, the capacity to discriminate that which is familiar and those to whom the infant is attached, etc., is well developed at a primitive level at this time.

<u>Effects of the Environment On Development:</u>

Many of the factors that are critical for healthy development during the first year of life continue to be as important during the next two years. These include good nutrition, the quality of health care and hygiene, the degree of rest and the opportunity for adequate activity. Especially important, we emphasize again, as we did in Unit 1, the emotional atmosphere in which any child is reared plays an important part in that child's physical development. We described in Unit 1 how Richie's physical development slowed down drastically. During the first six months of his life he developed well. At 5 1/2 months we are told and could tell from his pictures that he looked 5 1/2 months old. But when we saw him at 14 months, after severe traumas he experienced (See Section 1.12), he looked about eight months old. Although he may have been fed poorly by his 17 year old mother, neither the doctors nor those who knew Richie believed this to be the cause of his poor development. The emotional atmosphere, the quality of emotional relatedness experience by the infant, makes an enormous contribution to physical development. This is known to pediatricians many of whom have seen infants "fail to thrive" (fail to develop normally) on the basis not of a lack of food, but of insufficient emotional nurturing. A number of studies showed a number of years ago that infants reared in orphanages, although well cared-for in terms of food and hygiene, nonetheless failed to develop at normal expectable rates because they lacked an emotionally gratifying attachment to one key person. Similar studies with monkeys carried out by Dr. Harry Harlow revealed the same key importance of good emotional attachment for the normal development of the child's brain and entire body.

2.112 CHILD REARING: What Can The Parent Do That Is GROWTH-PROMOTING Regarding the Child's Degree of Capability and Helplessness?

The human body is such that when its organs and systems are active, they develop normally (See especially Section 2.131). When organ or organ systems are made to be inactive, be it the eyes, or the muscles, they tend to not develop age-adequately, and may in fact lose their capacity and their ability to function. Of course, we are not speaking of an overnight effect but rather of a long-term effect. The point is that normal function, normal activities insure the normal development of underlying physical structures, be it the eyes or the muscles. Therefore, it is important for parents and non-parental caregivers to insure their infant's activities mostly, not by programming them but by allowing them to occur spontaneously. That is to say, most infants if permitted will devise their own activities in which their entire body and its component systems will be exercised. It is not possible to keep a one year old seated in a chair except by force. One year olds, two year olds, are propelled from within to be active, to be on their feet, to go to sleep when they are very tired, to demand for food when they feel hungry, to want to find out what their environment consists of by means of exploration, etc. It is important for parents to provide an environment in which all of these can be exercised to a substantial degree, in safety, which reasonable restrictions where needed, which we will talk about below.

As we noted in Unit 1, some of the infant's activities (behaviors) are easy to see; not so easy to see are the psychological implications of some of these behaviors. For instance, it is growth-promoting to let the infant try to do things that are new, that require effort, because such efforts stimulate the development of new adaptive skills. On the other hand, if too great effort is required to achieve whatever activity the infant is trying, parents will recognize that such efforts may lead to too much frustration that may then become too discouraging and disruptive of such efforts. Too much discouragement can lead to hopelessness and fear of trying, and the infant may become one who "gives up before he tries". Parents need to estimate when the infant begins to show frustration that is too unbearable and which discourages efforts.

Activity Level:

Parents are already well acquainted with their one-year-old's activity level. They know whether their child is a high, moderate, or low activity level child, whether a predominantly visual explorer or a hands-on explorer, whether a short span explorer or an explorer like 15 week old Jennifer who explored a set of rings for over twenty minutes. And most parents probably have already learned what they can do to be helpful to their toddler. The parents' work in this sphere is not at all finished by year one. Some of the more demanding efforts need to be made by parents whose infants tend to have a

heightened intolerance for frustration, for whom waiting is torture; these one year olds still need to be helped by their parents to wait better. Some infants who tend to be quite active, some overly active, can be encouraged by their parents to slow down, to get better hold of themselves, to take things one at a time, etc. Some one-year-olds, at the opposite pole of activity level, may need to be supported in their efforts by being encouraged to move a bit faster, to persist more in the face of difficulty, etc.

With regard to patterns of reactivity to stimuli, or to stresses, many parents know that children who have difficulty either on the side of being too excitable or of being sluggish to respond, can be enormously helped in moderating their child's reactivity to achieve a more optimal level. Being able to calm, to engage a child's interest into activities, are critical functions parents can achieve. By the time she was one, Suzy's parents had achieved a great deal already in helping her accept their efforts to calm her. By eight and nine months of age, Suzy could be calmed with much greater ease than after she was born. Mother was often drained by the effort she put into it. She learned that to be effective with calming Suzy she had to tell herself to be patient, remind herself that Suzy could not help being so irritable, that she was not being mean. She found that it took longer than she wished but when she persisted in holding, walking with her in her arms, talking to her soothingly telling her to try to calm down, to get a hold of herself, that Suzy seemed to quiet some. By the time Suzy was nine months old Mother could help her calm just by talking to her, thought it did seem to work better when Mother held her on her lap. Of course, at times she did not want Mother to hold her, especially when she was upset with Mom (like when she had to go to work or when she came back from the office). By one year of age, Mother knew she could calm Suzy, she knew it would take time, but she knew she and Suzy could work together to do it. Father could too but not as predictably as Mother and when Mother was available, Suzy would go to her Mother to calm down.

But the point we want to make here is that the experiences of Mom and Dad helping to calm her down led to her becoming a calmer child. At one year she would still be irritable many times, but she could at times not be irritable; and when she was irritable she could calm down much faster than she could when she was a few months old. It is possible, and we believe it to be so, that her parents helping her calm down in a constructive (positive and caring) way led her to developing this ability. At the very least it facilitated this development. She was developing a more optimal threshold for irritability; that is, she became less irritable because a greater degree of unpleasure experiencing was required to make her feel irritated. And she developed greater facility in calming down. We believe, as we shall discuss shortly, that the changes that made this possible had to occur in her central nervous system, especially in her brain. But her work at improving this in herself was not finished and she and her parents would need to continue to work on her becoming less irritable and calming even better and more quickly. Being loving, respecting of her and at the same time demanding that she pull herself together, comforting her when she asked for it or seemed to need it -- all these would continue to help her. We shall talk more about this especially in Sections 2.2132, 2.242 and 2.2512.

Parents can be wonderfully calming, or exciting, encouraging, or patience-inducing. It is important that parents recognize that they can do such things for their children. But

we must emphasize that these increasing capabilities can be produced only over time. Parents often become discouraged that their efforts do not bear fruit more quickly. Our experience tells us that parents often mistakenly think their methods must not be good, even when they indeed are very good. The problem lies in the fact that they fail to recognize that the results they aim for take sometimes much longer to achieve than they wish. It is demanding work for the parents and for the baby. Increasing tolerance for frustration, developing the capacity to calm oneself, to reduce one's too high level of excitement in reactions, for most children require many efforts, over a period of many months (if one starts during the first year of life) and even years. It is a rare child who can gain mastery over such internal dispositions in a matter of months after year one. To be sure professional consultation (with pediatricians or mental health-child development professionals) may be needed and can be decidedly guiding. Many children who at first appear like Suzy did will need specific medication to help them. But the point here is that even when good child rearing methods are used, in the face of it seeming that the parents efforts are not working, parents need to recognize their efforts to help their children take time, and that these efforts along with continuing maturation of the central nervous system will often yield the results they are looking for. It is also important to mention, that children become fully aware of when parents are making efforts in growth-promoting ways, and invariably reveal their appreciation by becoming very loving children toward them, and by forming a positive relationship with them which has life long emotional health insurance attached to it.

2.1 PHYSICAL DEVELOPMENT

2.121 HUMAN DEVELOPMENT: Central Nervous System -- Cognition And Affects

Critical to adaptation are the development of intelligence and affective-emotional experiencing. The central nervous system functions which underlie the development of intelligence, including the function of cognition (the process of knowing including perception, memory, judgment, etc.), of mentation (to think), of problem solving as well as motor functions, including coordination of small and fine hand movements and of locomotion (moving about) are all essential for adaptation and start at the beginning of life outside the mother's womb. Both categories of functions are amply evident in and originate especially in the child's exploratory activities and in the child's acting upon the environment be it in terms of feeding activity or in physical reaction in a relationship. Both categories of functions develop increasingly during the second and third years of life.

Crucial to adaptation as well and working hand in hand with the development of cognitive functions in human intelligence is the development of the child's emotional or affective experiencing. Reacting to experience, to need, is crucial for adaptation in communication, human interaction, at many levels and in many ways. For normal emotional experience to occur, normal brain functioning is necessary. Experiencing feelings (affects) is so basic to living organisms that only the most severe types of brain disorders will interfere with the experiencing of affects.

Affect-emotions are also known to be influenced by hormones and genes. Genes have been found to be involved in severe disorders of moods. In short, the body in a number of ways must be well-enough developed and in good enough health to make it possible for an infant to have a good start at adaptation.

Brain functions that combine to effect the development of intelligence and adaptation, namely cognitive and affective functioning, continue to develop richly during the second and third years. Brain maturation makes for the evolving of increasing representation (recording) in the mind of all experiencing, including the image of oneself and of emotionally invested others, the understanding and conceptualizing of experience (i.e. knowing that mother will nurture and comfort, or, that when mother goes out of sight the infant-toddler will be without her), all are building blocks of what becomes internalized in the mind (brain). During the second year memory develops further and with it comes the capacity for knowing what something looks like without having to have a sample of it within vision; this contributes to a further development in the ability to predict. And, among other functions, intention develops further and so does the enormously important function of fantasy, a critical function for adaptation, prediction, problem solving and creativity. All these allow us to infer brain differentiation (developmental unfolding) we still know too little about.

And increasing abilities in motor functions visible in exploration, play and

locomotion continue to develop at a remarkable rate. With respect to eye-hand-mouth coordination, the one-year-old is already substantially exercised in handling objects which have caught the child's interest; the child will frequently bring the object to his or her mouth for the purpose of exploration. The largest increase in ability to manipulate objects for the purpose of exploration occurs especially during the second and third years of life. Now children can be seen to manipulate small objects with increasing facility, dexterity and security. Whereas a one-year-old will exhibit clumsiness in handling a block, a two year old will handle it with facility and assuredness. Similarly, with regard to small motor movements, the one-year-old handles things with minimal coordination; by the end of the second year he or she does so with substantial facility and assuredness.

Enormously exciting, is the gradual increase in locomotor (bodily movement) capability. A large number of one year olds have already begun to walk but do so with only moderate stability. Those who have and those who have not, during the second year of life will do a great deal of polishing in their walking ability. In fact, during the second year of life many are already able to run. Again, it is important to bear in mind that children have their own schedules of development and that doing things early in life is not necessarily indicative or promising of eventual greater comfort or greater ability for learning nor necessarily indicative of greater capability for eventual adaptation and problem solving. During the third year of life locomotion (walking, running, gymnastics) also, like cognitive functions and fantasy formation, and like small movements, and eye-hand coordination will become further developed; the infant's increasing skills which rely on these abilities will be obvious to the observing parent. All these tell us that along with bodily developments, specifically central nervous (especially brain) developments are continuing, as indeed they will into adolescence.

2.122 CHILD REARING: Optimizing Central Nervous System Development

One of the most growth-promoting factors parenting quite naturally brings is the wonderful excitement parents experience in seeing their young children develop exploratory skills, small motor acts, but especially when their infants begin to walk. It is remarkable and most valuable that parents get such pleasure out of seeing their young children take their first steps. This is a highly desirable reaction, given that it supports a child's early efforts at adaptation. And, of course, upright locomotion is a most crucial function, notably important to adaptation. It is most beneficial to children to find such pleasure reactions by those they value most, their parents, when they do something they have not been able to do before, and when they do things well. No doubt, infants will learn to walk whether their parents become excited by it or not. One cannot but wonder though, whether there is something adaptive built into parents' reacting as they often do to their children's emerging and enlarging skills given that it is enormously growth-promoting and encourages good adaptation.

Consonant with the fact that parental excitement at the right time and in the right places can be enormously growth-promoting, is the fact that infants themselves

experience a good deal of excitement in their emerging and increasing abilities, cognitive, verbal, problem solving, as well as locomotor and small motor skills. Looking closely, parents will see that their children exhibit pleasure when they learn to do something for the first time, whether it is handling a set of blocks, piling them one on top of the other, or a child piling graduated donut rings on a peg. A parent can readily see how applauding a toddler's newly acquired skill enhances the sense of achievement the toddler is experiencing. Such applause or praise, step by step, leads not only to a sense of pleasure in acquiring new skills, but also to a sense of valuing oneself for having acquired new skills which ultimately contribute to a child's sense of self reliance, self confidence, and self value. There are numerous opportunities during the second and third years of life for parents to facilitate, encourage and applaud their children's increasing sensorimotor skills. We want to emphasize here that supporting and encouraging the development of these skills, we believe increases the development of brain functions that are essential for the development of intelligence and adaptation.

2.1 PHYSICAL DEVELOPMENT

2.131 HUMAN DEVELOPMENT: Nervous System -- Other Factors

Of importance during the second and third years, are the residual reflexes and the degree to which central nervous system control of involuntary musculature is developed as for instance, to make toilet training possible. Given that this is the time when toilet training is achieved, a note is warranted on the underlying physical development of the system that makes control of the bowel movements possible.

A word first on the residual simple reflexes. The problem with the grasp reflex as we have noted before, is the infant's inability to release that reflex once it has been activated. Again, when a nine month-old grabs hold of your hair, you may experience this as the infant pulling your hair. The fact is, however, that the infant may not yet be able to let go of the grasped hair at will. During the second year the infant now begins to be able to release that grasp response as a result of which when mother says "Please let go" the infant now can do so. This, of course, is enormously important for the effective handling of things. For instance, if a 14 month-old cannot yet let go of something he or she grasps, that infant will have much difficulty letting go of one block to grab another.

It is commonly during the third year of life that the development of the central nervous system occurs that allows the child's ability to govern the sphincter of the anus and that of the bladder. The muscles which control the sphincters for both bowel and urine elimination essentially function in response to pressures from within these organ systems, namely a relatively full bowel or bladder. Although these sphincters function in response to internal pressures rather than in response to voluntary control at first, clearly control over these is essential for adaptation. Experience informs us that sphincter controls can be taught to children from the end of their first year of life on and, in some cultures toilet training is done at this very early time. The kind of learning involved in teaching such control at the end of the first year of life is simple, behavioral, conditioning. The later type of toilet training, common in our culture, during the latter part of the second or third year of life, is based in learning that carries with it a number of psychological functions which make for a learning experience considered by mental health professionals to be much more advantageous to the child's psychological development. We shall talk further about the psychological implications of toilet training early (at the end of year one) as compared to later (during the third year) later in this Unit (Sections 2.231 and 2.232).

2.132 CHILD REARING: What Can The Parent Do to Optimize The Development Of The Child's Nervous System -- Other Factors

With regard to the remaining grasp reflex, it is of course important that parents understand that the child cannot yet release his or her grasp at will or on demand but that this capability will develop during the second year of life. It is important for a parent to try to sort out whether the infant is indeed persisting in pulling your hair in anger or whether it is at least in part an involuntary act. It is well to know, that infants often feel misunderstood and react with confusion, shame, and self-blame when they are scolded for something over which they have no control as compared to feeling duly reprimanded and even protected when they are scolded for something which is the direct expression of their feeling angry or hostile.

With regard to toilet training, it is of value for parents to know that developing control over sphincter activity is a gradual process, that most children have adequate nervous system function for controlling their sphincters during the third year of life although such control can be enforced earlier. We shall discuss in subsequent sections of this Unit, the implications of different methods of toilet training (See Sections 2.231 and 2.232).

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.21 THE CHILD'S ABILITIES TO ADAPT -- PART I

2.2111 HUMAN DEVELOPMENT: Aspects of Wake-Sleep Patterning, Dreams, Nightmares

The one to three year old child experiences increasingly longer periods of wakefulness and needs much less sleep than he or she did during the early part of the first year. The one year-old may require a nap of varying duration in the morning and in the afternoon. The 2 1/2 year-old most likely will no longer require the nap in the morning but probably will in the afternoon. Long periods of wakefulness make for a full engagement on the part of the one to three year-old with the people around him or her, making the child an active participant in family and social life. In the daycare setting, children this age also actively participate in that social and inanimate universe. Good states of alert wakefulness and good states of sleep are needed for healthy development and well-being.

Good states of alert wakefulness make possible experiences along major sectors of life: family life, social life at home as well as in other places (like daycare), self experiencing of the inanimate world in which the infant lives, the exercise of new skills and the development of intelligence. Much of what is contained in this Unit addresses the child's experiencing during states of wakefulness.

Good-enough patterns of sleep are essential for healthy development and well-being during all of childhood; these will significantly be determined by the sleep patterns established during the first year. For instance, Suzy had much difficulty sleeping well during her first year because of her irritability, but also because she had difficulty being calmed and maintaining a calm state. When less than eight months old she would have jerky body movements even when she was asleep. And she just did not have that wonderful peaceful look normal, well cared for babies have when asleep. But as her experiencing was made gradually better, probably due to both some good maturation of her central nervous system (and probably other body systems as well) and her parents' persistent devotion to help her feel better, her sleep improved. By age one she was still not a reliable sleeper, however, she often could just fall asleep at bedtime (especially when no upsetting thing happened after her evening meal), she then was able to usually sleep through the night and wake up in the morning in a pretty good mood. If she got upset before bedtime, it took her a good deal of time to calm down and she would visibly feel irritable and it took her longer to go to sleep. Mom and Dad knew this about her. Even though these were stressful times and Dad especially at times could not handle it well, Mom just had to give it more time (for bedtime) and put in more effort to calm her. More about this in the next section when we talk about how Suzy's parents dealt with the problem.

But even in children who sleep well enough, there are periods during the one to three year life span when sleep may become disrupted by normal developmental tasks which cause heightened anxiety and which may require a special attention. When sleep patterns are disorganized or irregular they make for disruptive sleep and do not provide the hard working developing child good-enough rest. The developmental tasks the child has to master during the one to three years period will be made more difficult for the child who does not get good-enough, regular-enough rest. Certain developments we shall describe below, like a second period of heightened anxiety associated with experiences of developing a well defined sense of self and others may, in many children, create some sleep disturbance. The separation-individuation process which explains why there is a heightening of separation anxiety at this age will be described below (Section 2.2211) but we can say this here with regard to its possible role as a sleep disturber. Because going to sleep is experienced by all of us as having to disengage and separate from the relationships we experience, at periods when separation anxiety is heightened, readying to go to sleep will cause anxiety which in turn often interferes with a comfortable process of falling asleep.

In Unit 1 we described a number of disturbers of sleep that occur during the first year under Sections 1.211 and 1.212. We shall not repeat these factors here; they do, however, also apply during the second and third years. We will just add that during the second and third years of life, factors from within the child's own enlarging of inner experiencing will play their part in disrupting sleep. Most prominent among these, beside heightened separation anxiety, are dreams which are the product of internal stress experiences and may cause waking during the night or even, in some instances, cause resistance to going to sleep in order not to dream. These are dreams (not actually experienced anxiety) arising out of the child's efforts to cope with issues of developing the sense of self separate from valued others (which we discuss in the context of separation-individuation) as well as problems arising from experiences of intensified hostility toward those the child loves most, namely the parents. These efforts to cope will stretch over a period of time and as happened with Johnny and Jane may lead to some difficulty for both child and parents either at bedtime or during the night. It is especially when a child has frightening dreams, nightmares, that she or he may resist going to bed.

Johnny had no problems sleeping. In fact he had developed the ability to go to sleep and had a good pattern of going to sleep since he was six months old. When he was 16 months old, as best as his parents could pinpoint it, he started to wake during the night. Sometimes he woke up scared once or even twice a night. Sometimes he did not waken but Mom said she could hear him whine and make distressing sounds when she and Dad were going to bed. Mom and Dad alternated in going in when he woke up. He could not talk yet and Mom and Dad just did not know what he was afraid of. We told the parents that since he was in good health, we assumed that he might be having bad dreams. Since things were really quite easy between Johnny and Mom and Dad, we guessed he probably was working on separation-individuation issues, on feeling he is a self actually separate from Mom. It was a bit early developmentally, but we thought this to be the most reasonable explanation for his having bad dreams at this time. If these dreams had just appeared a day or so after the episode when Jennifer pulled his pacifier out of his mouth,

we might have linked his bad dreams with his being upset and angry with Jennifer. But this had happened seven months before and it was doubtful that bad dreams would now be activated by that experience. We shall discuss what his parents did in the next section.

The second major source of disturbances coming from within the child are those caused by transient experiences of distress including illness, acute anxiety created by a hospitalization or while on a trip, etc.

We should also emphasize here as we did in Unit 1, that sleep disturbers coming from outside may play their part as well, including for example excessive noises, light, heat, cold, etc. It is also important to emphasize that emotional commotion, emotional stress within the family will impact on the young child even where efforts by parents are made to mask disturbances within the family. We were impressed with the fact that Bernie's sleep had not been disturbed by the problems and arguments his mother and father had, which eventually led to their separation when Bernie was six months old. Commonly, though, disturbances between Mother and Father, whether or not parents attempt to keep these private from the children invariably become known to them, unavoidably, and predictably cause varying degrees distress as well as anxiety which in turn will interfere with comfortable sleep.

Children who experience significant traumas will most commonly experience problems with sleeping. Fear, which invariably results from traumatic events, whether it is being in an automobile accident where the child or one of the parents is visibly hurt, or witnessing a crime against a family member or against the self, or being physically and/or emotionally abused as Richie was, fear that the event will occur again is unavoidable. This fear of repetition is over and above the feeling of having been overwhelmed with pain and dread during the traumatic event, which the individual will re-experience in waves of intense anxiety and recollection of feeling pain and dread.

We found that 14 month old Richie seemed to sleep adequately according to his great-aunt. But once he began to engage emotionally in relating to his great-aunt and to us in our program, and he began to improve, to experience his outbursts of rage, and his mood began to lift at moments, we found that he also would wake up during the night crying and be very troubled. This continued for several months. We shall talk in the next section about what needs to be done under these conditions.

Some children in the third year of life may experience night terrors although these tend to more commonly occur during the fourth, fifth and sixth years and later. Nonetheless an occasional two year old may experience night terrors. Night terrors differ from bad dreams (including nightmares) which occur during light sleep. When we sleep, we do not sleep at the same depth of sleep from the moment we fall asleep until we wake up. Sleep researchers tell us that sleep occurs in waves of going from light sleep into deep sleep, and back to light sleep, then back to deep sleep, in a fairly well organized pattern. These cycles of going from light sleep into deep sleep and back up into light sleep take about 90 minutes. There probably are variations of this in each of us. When we go to bed, it takes us some time to fall asleep, to go into this process of light sleep, deep sleep, light sleep, etc. Interestingly, we need both types of sleep, light sleep and deep sleep. This is probably why disrupted sleep makes us feel less well rested and why it is important to develop good sleep patterns.

One of the major factors that makes dreams (including nightmares) differ from night terrors is that dreams occur during periods of light sleep. Night terrors are believed to occur during periods of deep sleep. This accounts for the fact that trying to wake a child who is having a nightmare can make the child wake up and interrupt the nightmare, whereas trying to wake a child who is having a night terror does not usually work unless one goes to extremes of noise making in order to waken the child. It also can account for the fact that the nightmare is often remembered on waking, whereas the content or theme of the night terror is usually not remembered. We believe that a night terror is a panic reaction brought on during deep sleep. How to deal with night terrors will be taken up in the child rearing section. Although there is much we still do not know about what causes night terrors, in most instances they are the product of a young child's experiencing excessive levels of fear or of hostility which the child has difficulty coping with and which may then find expression during the night in this form.

2.2112 CHILD REARING: How to Optimize Wake-Sleep Patterning, Dreams, Nightmares

As we suggested in Unit 1, it is important for parents to consider the three major categories which may produce disturbances of sleep in young children: (1) a sleep disturber coming from the child's own inner state; (2) one coming from outside the child himself or herself; and (3) sleep disturbances coming from tensions in the parent-child relationship or in the relationships of family members. It is also very helpful for parents to know the factors that cause stress and anxiety that are part and parcel of normal development during the second and third years of life. Most common are: (1) that during the middle and latter half of the second year of life, heightened stress is a normal by-product of tasks of the separation-individuation process (Section 2.2211); (2) the challenges of toilet training; and (3) that unavoidable anxiety accompanies heightened experiencing of hostility towards the parents which may be created by (a) toilet training itself, (b) difficulties in the parent-child relationship (as is commonly found where there is excessive limit setting), and (c) during the third year especially, in the emergence of sexual feelings and the fantasies that are linked to these feelings (see Section 2.231 and 2.232).

What to do:

When a child experiences either much distress at going to sleep, which often appears as prolonged delaying tactics to going to sleep, or when a child is awakened during the night with or without difficulty in going back to sleep, parents automatically set out to find "What's wrong?". During the second and third years of life, the child's sleep patterns are already well known to the parents. Where problems continue from the first year, of course, parents need to continue their efforts to help their child sleep well.

Suzy's parents knew her well by the time she was one year old and had developed a

fairly good routine for bedtime with her. We found with these good first-time parents as with so many with whom we have worked that whether it is putting a child to bed, toilet training, limit setting, and many other tasks of development, each of which is also a challenge to parenting, that theses tasks invariably take more time, energy and patience then the parents had expected. Helping Suzy get to sleep took a good deal of effort and there just were no short cuts. Fortunately, when she was not upset after her evening meal, mother, but father sometimes did this also, mother gave her bath and dressed her into nightclothes, was good at singing lullabies and gently chatting with (more to) her which she started already as she was dressing her. She did a fair amount of hugging in a calming way, not in an exciting and playful way. She would then put her into her crib, stay with her for a couple minutes more, patting her and softly either sing or slowly humming. This was easy now.

It was more difficult when she was upset after her evening meal. Then each step of getting her to bed took more effort and time, and patience, she then would often ask for Mommy if Dad tried to put her to bed. For the bath and dressing her she accepted her father's care, but to be put down she often would ask for "Mommy". We had told father to try to not feel upset by this, that it is natural for very young children to want to be cared for by Mother (when they have a good relationship with both parents) when they are upset. We told him that during the second and third year he would become every bit as important to Suzy as her mother. Mother would then take over and this is when getting to sleep would drag on. Mother would have to hold her and walk slowly or sway gently as she held her. Singing and humming did not work as well. Mother would chat, "Come on, Sweetheart, try to calm down. That's a nice girl," and, "Come on Suzy, pull yourself together; we love you, Sweetie". Mother had many ways of saying this. It was more difficult when Mom was very tired herself or had a difficult day. Dad could pitch in after Mother had done some of the preliminary calming. Both of them would at times get angry with Suzy. We had encouraged them to say to themselves that Suzy was not doing this to upset them. She could not then pull herself together and she needed their help. Sometimes 20 minutes or longer would be needed before she could calm enough to even be put down. Then Mother or Father knew it would take another 5 to 10 minutes of calmly patting or gently humming (Mother) before she got to the point of falling asleep. This process improved significantly during the second year, as did her irritability in general, though it remained part of her way of reacting, especially when she was too stressed.

The situation is somewhat difficult in children who have not had significant difficulty sleeping before. It is not uncommon for a 16 to 18 month-old to resist going to bed. "What's Wrong?" The difficulty is often anxiety from one or another source; this means that the one to three year old experiences feelings of helplessness in the face of a real or imagined threatening situation with which the child cannot cope easily. In milder instances, it will show itself as the child's wanting to continue to play or in order to stay with parents, resisting the fact that it is time to go to bed. In some children, wanting his or her way against the parents wishes plays its part too. This may occur especially where one and two year olds are put to bed earlier than they are ready for. For instance, when a two year-old is put to bed at 6 o'clock in the evening he or she simply may not be ready

to go to sleep because the child is not yet tired enough. And especially during the third year, many a child's interest and fantasies about what goes on between mother and father when they are alone causes distress (see Section 2.231 and 2.232), and the child wants to share in the parents' time together and has conflicting feelings about his or her parents' private life. During this time also, such concerns lead to angry feelings in the child which may, in turn, lead to anxiety and frightening dreams.

The reason for attempting to distinguish these major types of sleep disturbance, namely of underlying anxiety (helplessness in the face of a real or imagined threatening situation), or of orneriness and resistance to reasonable compliance, is that different forms of handling are warranted. Let's talk about handling orneriness first. Resistance to having to go to bed needs to be considered by the parents at least in the following manner: Are we putting the child to bed too early? Parents will by now have a good idea as to how many hours of sleep their child needs to wake up feeling fairly rested. If the bedtime set is too early, try a bit later. Then, like with any demand the parents make of the child, time to go to sleep has to be presented as fact, not as an invitation. A child needs to know that he is (1) expected to go to sleep and is (2) expected to learn how to put himself or herself to sleep. Developing a pattern or routine for going to bed is useful. First, we will get you washed, brush your teeth, go to the bathroom, read one or two stories, make a short ceremony of hugging or kissing and tucking the child into bed and say goodnight and Mommy and Daddy will be in the next room or downstairs. From there on any complaint or communication from the child can be made but requires that the child stay in bed; there may be no more than one or two greetings from bed or calls for reassurance from bed and it will be time to be asleep. We want to emphasize that it is not the parents' responsibility for the child to fall asleep; it is the child's. It is important for children to learn how to comfort themselves to sleep, and to try to maintain that state of sleep through the night. It is useful to convey to the child that going to sleep is not a punishment, is not a withdrawal of the privilege of social interaction, but rather a necessity for feeling comfortable the next day and for good health. While consideration, explanations, reassurances are strongly indicated, so are firmness and the conveying to the child that the parent means that its time for the child to go to bed. Firmness, as we emphasized, is not to be confused with or equated with hostility. Firmness means that you mean what you are saying, that you intend to do what you say you will do, and that you are acting out of interest and consideration for the child. To be sure, children will resist this kind of effort but, as with most parenting tasks, if the parent holds to a set approach which is reasonable, basically is not rejecting or hostile, is truly felt to be growth-promoting, most children will come around.

When it comes to anxiety being the sleep disturber, the parent's approach needs to include more than firmness and reassurance. Anxiety, the feeling of helplessness in the face of an imagined threatening condition or feeling, cannot be made to go away at will. Anxiety sweeps over a child, as it does over adults, bringing with it enormously unpleasant feelings which need to be quieted, need to be calmed, in order for the child to be able to sleep. We have all known times when we have been anxious, such as when some upsetting event is going to occur the following day, a major test for instance, and how difficult it may be then for us to fall asleep. Young children, ages one and two, are

now able to have frightening fantasies which they cannot rid themselves of at will.

The student should review Unit 1, Section 1.212, "What To Do", reviewing the principles detailed in response to "What's wrong?", and "What do I do now?". Consider: (1) what is causing the problem? (2) What can stop the problem? and (3) How do I go about it? Let us first take up the child's having difficulty going to bed and then the child's waking during the night.

When resistance to going to sleep comes from anxiety the task commonly is somewhat demanding. The experience of anxiety, be it due to feeling angry with Mother or Father, or dread of physical harm, is remarkably lessened when Mother or Father is in the room with the child. Efforts to calm anxiety then usually work well. The problem is, that the anxiety will mount again as soon as the parent leaves the room. This is in the nature of the experience of anxiety in the one and two year old child; the parent has the magnificent capability of melting anxiety in the child. It is therefore not surprising that while the parent is in the room the child will be relatively calmed, and that the anxiety will mount as soon as the parent leaves. It is wise to make an effort to talk to the child about what is causing the anxiety.

Jane began to have nightmares when she was 18 1/2 months old. She would wake up screaming during the night, sometimes twice a night. This led to her then having trouble going to bed and she just resisted getting to bed, made bathing her and dressing her take much longer and then, once in bed, would cry when left alone, would get out of her bed and come out crying that she was "scared". Upset that she and her husband were getting quite angry with Jane, Jane's mother, Gloria, asked us how to deal with this problem. Since this was a recently developed problem we explored what might have recently occurred that might have troubled or be the source of anxiety for her. Mother thought, but she couldn't point to any particular recent event that upset her. She did feel that she and Jane had a few angry times together these days because Jane seemed more stubborn now, although she had always been pretty strong-willed. Watching mother and daughter together, we thought Jane seemed to be more uncooperative and at moments angry with mother. We also saw that she was clinging to mother then and did not play as much as usual with the other project children. Speaking with Mother when Jane could hear us, Dr. P. wondered if Jane was having bad dreams that came from her being angry with mother. Jane just looked up at Dr. P. and looked away. Dr. P. then told mother and Jane that her bad dreams made her afraid and that maybe that is why Jane is afraid to go to sleep. Dr. P. said again that when a person is angry with someone they love they could have scary dreams that come from being so angry. It would be better if Jane and mother could talk about being angry with each other, tell each other why. And that mother needs to reassure Jane she still loves her even if Jane is sometimes angry with her. Jane looked up at Dr. P. again and, looking at him, got close to mother and looked at her. Mother put her arm around Jane and said "That's right". According to Gloria, following that brief talk (putting some pieces of information together, understanding human emotional dynamics, and a bit of clinical guessing based on the behaviors we had seen recently), Jane stopped waking during the night and, in fact, had no trouble going to sleep that same evening. It was not difficult to guess that this might be causing Jane's bad dreams and her brief sleep problems. We shall detail later the anxiety and problems hostile feeling toward Mother

might cause a child this age, and older (see Section 2.241).

One and two year olds can not only understand what is being said to them but many two year olds will be able to verbalize what they are afraid of. Regrettably, if the source of anxiety is one that is intolerable to the child as was the case with 18 1/2 month Jane, the child may not be aware of what it is and may therefore not be able to verbalize it. Probably at times enraged with mother because she was out during the afternoon or Mother's limit was experienced by Jane as too restrictive, finding the hostility toward the Mother she loves unbearable, Jane suppressed that hostility (which appeared in her dreams) and therefore she could not know what was causing her anxiety.

But it is well to know that even where the child cannot verbalize what is causing the anxiety, the parent's comforting and reassurances, followed by the parent's gentle but firm demand that the child try to sleep even in the face of underlying anxiety, all in growth-promoting ways, can help bring about the child's being able to go to sleep. A balance of tolerance of anxiety in one's own child, comforting, and the demand that the child comply is essential. A parent's intolerance of his or her child's anxiety will make the anxiety much more difficult for the child to deal with. But then, tolerance for the child's anxiety, however, with too soft an expectation that the child go to sleep, with too soft a stance of demandingness on the part of the parent, will also not work well in getting the child to sleep. Generally, when going to sleep is hampered by anxiety, by fear of some imagined or unknown threat, the process of helping the child work this through usually takes a matter of days, weeks, and in some cases months. Needless to say, the underlying source of anxiety will determine how long the process will take. In cases where the going to sleep disturbance remains over several weeks, consultation with a mental health professional may be the most constructive step to take. It is well to bear in mind that children experience tiredness, that they know they need and wish to go to sleep but that they may not be able to do so in spite of their own best intentions in the face of substantial anxiety.

What about the child's waking during the night? (1) What's causing the problem? (2) What can stop the problem? (3) How do I go about it? First and foremost, does the quality of the sound coming from the child create in you the feeling that he or she is hurting in some way, or frightened, or is wanting what he wants when he wants it? Is the princess in need of her servant? If in doubt, assume that anxiety is playing its usual, self protective, but annoying part. That is to say, children are more often wakened during the night by anxiety, often precipitated by a troublesome dream or a nightmare, than by orneriness. It is a bit ridiculous to assume that children are going to wake during the night and begin to make demands that mother come in and play with them except if some anxiety has disturbed the child's sleep. For the most part then, when in doubt, assume anxiety. And it is reasonable to also assume that some dream has disturbed the child's sleep. Needless to say, thunderstorms, a transient illness that makes difficulty for breathing may also be a source of sleep disturbance, the latter of course not being a precipitant of anxiety but simply of physical discomfort. Most parents know how to handle the situations with thoughtfulness and consideration even if with some degree of impatience and annoyance.

Having tentatively decided that 16 month old Johnny's waking during the night was

most likely due to anxiety associated with the beginning of recognition that he is a child separate from, not of one piece with his mother, we suggested to Mother (and Father) the following course of action. First of all, do not immediately go to Johnny when he wakes up crying. Wait a minute, listen to see if his distress subsides. If his distress subsides there is no need to do anything further about it now, though you will want to reassure him in the morning and the next evening when putting him to bed. If his distress mounts, it is well to try to calm him from a distance, by staying in your own room and, if it is not in the middle of the night when both parents are asleep, to gently shout either from downstairs or from your room that Johnny go back to sleep, that you are nearby and that nothing will harm the child. If it is in the middle of the night, of course, even gentle shouting is not advisable since it will waken everyone else in the house.

In that case it is well to go into Johnny's room and reassure him verbally that things are OK. Do not immediately pick Johnny up. It is best to first attempt to comfort Johnny by verbal reassurance. If that does not work, leaving Johnny in his crib, gently pat him on the back but again without picking him up. When a child is picked up the process of waking the child is heightened. Parents' efforts should be in the direction of calming and encouraging the child to put himself or herself back to sleep. Obviously if Johnny is standing in a crib it is well to gently get him to lie down, pat, soothe and calm him with words, and make your caregiving under these conditions as soothing and brief as possible. If Johnny at this time is suffering rather intense anxiety, you may need to soothe verbally and by patting until he is well on the way to sleep in order for the process to not be interrupted soon again by anxiety. In short, when trying to put Johnny back to sleep, do the least possible that will tend to waken him further; efforts to calm and quiet the child are most advantageous in helping the child go back to sleep.

Two year old children may be awakened by a dream which they can remember and verbalize. It is not advisable to explore what the dream was about during the night except when the infant has been fully awakened by the dream. The advantage of exploring what the dream was about is that it gives the parent an opportunity to reassure the child that what ever experience the child dreamt about is one of his or her imagination, is or is not likely to happen, and the parent can thereby substantially and more knowingly reassure the child. When the child goes back to sleep without a brief report about the dream, the dream can be taken up in the morning. We caution parents to not be too intrusive in their exploration of what the child dreamt about. Again, as in so may aspects of parenting, from the child's first year through adult life, one's efforts should reflect the parents' efforts and wishes to be helpful and stop short of being intrusive. It is wise to bear in mind that too much pressure in getting a child to tell his or her dreams may be experienced by the child as intrusive into the child's privacy, and is undesirable. We emphasize that two year old children do have fantasies which they need to retain in private because of their own disapproval of the contents of these fantasies. These may have to do with fantasies of hostility, hate and destructiveness, or with sexual or omnipotent or other fantasies which cause the child shame and guilt (see Sections 2.23, 2.24 and 2.26). Bearing this caution in mind, however, interest and an effort to be helpful in exploring dreams can be very useful for even very young children. For example, it is not uncommon for a two year boy to dream that a bear is chasing him. It is not difficult

to reassure the child that bears are not to be found in the area, that the child's fears of a bear may have more to do with the child's anger toward the parent and that being angry with Mommy or Daddy can be dealt with in acceptable ways and will lead to no disaster. This type of dream, much more common during the fourth, fifth and sixth years will be addressed in Unit 3.

When we helped Richie and his great-aunt and Richie's depression began to lift (very gradually), we learned that he would wake up during the night crying and very troubled. Recall that one major factor that traumatized him was that his deeply troubled 17-18 year old mother, unable to tolerate his need and demand for care and his crying would put him in the hall to cry himself out. For this reason, we recommended that once Richie was heard crying during the night, great-aunt should immediately go to his bed and talk to him soothingly, patting him but not immediately picking him up. If his crying did not subside within 30 seconds or so, she should pick him up and try to comfort him. We urged that great-aunt talk to him while soothing him. For example, to say "I know it hurt a lot when Mommy let you cry for so long. Mommy was very upset, or, Mommy was very sick, that is why she could not take good care of you. I am taking care of you now, and I will not let you hurt like before". The exact words are not what counts most, what does is conveying to a 15 month old like Richie that all efforts will be made to help him feel better, to protect against his being hurt again the way he was, that he is a valued and loved child. Also important when caring form him during the night (when he wakes up screaming), if he is standing in his crib or his crying does not diminish in 30 seconds to pick him up and not put him back down until great- aunt feels for sure that he is calmed, that this moment of experience feels like it repaired some of the damage caused by the traumas to which he was subjected. Our recommendations, we told the great-aunt, made a very large demand on her. But there is no short-cut to repairing the damaged caused him and the gains of such efforts could be large and have an influence on Richie that would be long-lasting.

Night terrors are more difficult to deal with than bad dreams (nightmares). Children tend to not remember the content of a night terror even when it wakes them up screaming. Night terrors as we said in the Section before, are distinguished from bad dreams by their occurring during "deep sleep", in contrast to dreams which occur during a lighter form of sleep known as "REM" sleep. REM (rapid eye movements) sleep is that time during sleep when we dream. As we said before, that night terrors occur during deep sleep is probably the reason the children who have night terrors have great difficulty remembering their content. The parent will find the child screaming, terrified, and seeming to be asleep while this violent experience is occurring. Furthermore, the parent will find the child to be unreachable by the parents words or comforting. If the night terror does not subside quickly, wake the child up; this is the best way to interrupt the night terror. After the child is awake, and the night terror is interrupted, the child can be helped back to sleep by calming, soothing and by staying with him or her until the child is back on the way to sleep. Caution: be sure that that child is wakened up gently but sufficiently in order to stop the terror. The child may seem to be awake and not be. A little extra effort and time can go a long way. Night terrors are rather common, but when they occur in clusters, with persistence, over weeks, they are indicative of some persisting

underlying source of conflict and distress in the child and professional consultation may be the wisest approach to the problem. Again then, night terrors are to be handled quite differently than bad dreams. Night terrors are terrifying, the child cannot be reached while still in deep sleep. Therefore, it is helpful to wake the child up and help him or her go back to sleep after the night terror experience seems to have been interrupted.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.21 THE CHILD'S ABILITIES TO ADAPT -- Part I

2.2121 HUMAN DEVELOPMENT: Feeding

Over the span from 12 months of age to age three years the child increasingly develops the ability to feed himself or herself. At 12 months the child is not yet ready to handle utensils but that skill will emerge progressively during the second year, and during the third year using a spoon and fork will be nicely developed. Using a knife is a function that is acquired later by children. Of course, in the early part of the second year the hands continue to be good feeding utensils. Although some infants make clear already during the first year that they do not like certain foods, taste sensitivities tend to become more discriminating during the second and third years. At any time during years two and three some children may no longer want to eat foods they tolerated earlier. For instance, whereas an 18 month-old may have been able to eat string beans, some 2 1/2 year-olds may find the taste nauseating and have difficulty then eating string beans. Why this happens is not clear. While it is important to develop good eating patterns from the first years of life on, some children may be unable to comply with the wishes of their parents that they eat certain foods at this time.

A note is warranted here. Eating a diet consisting of foods the majority of which are health promoting in contrast to eating foods that are overly saturated with sugars and/or fats is highly desirable. Some doctors and dietitians believe that the body (the cells) becomes accustomed to eating foods containing high levels of sugar or fat, or salt, and that eating these in large amounts and frequently can lead to habitual craving for high levels of sugar, fat or salt. And some children who are fed diets loaded with sugar, fats and/or salt are likely to become adults who will do so as well. We all know that children love sweets. Of course adults do too. While there is no need to totally restrict the use of highly sugar saturated foods (or candy), it is well to govern the amount children eat. If it is true that the body becomes habituated to sugar-saturated foods or fat-saturated foods and will develop a craving for these, it is important to begin patterns of good nutrition early in childhood. "Junk" foods should be eaten only in limited doses. The same goes for high salt saturated foods.

One more word about feeding. Some children during the ages of one to three may continue to require a bottle at bedtime, well after weaning from bottle feeding has occurred. They may demand a bottle at night-time even thought they do not require feeding by bottle during the day. This is because the bottle has become, quite normally, a source of comfort rather than a source of food. The use of comforters, which is a normal, self-help, self-sustaining measure children devise during the first year of life to self-comfort without requiring the assistance of the mother or father will continue during the second and third years. Commonly, at times of heightened anxiety at bedtime, which we

talked about in the prior section, the use of a comforter whether it is a bottle, a pacifier or blanket or teddy bear, is a sure way the infant may have developed for soothing himself or herself in order to go to sleep. While weaning the child for the purpose of food intake by means other than the bottle or the breast is useful, and during the second year of life may be age-appropriate (although some parents continue bottle feeding as well as breast feeding into the end of the second year of life with no harm to the child), weaning the child from the bottle as comforter becomes a more complicated issue. It is well to give the child some authority as to how long he or she is going to continue to use the bottle as a comforter, bearing in mind that it gives the child a greater sense of independence, of self reliance and of finding a means of self-comforting -- something highly desirable. Although it is reasonable to discourage the continuing use of the bottle during the second half of year two and into year three, it is unwise to create a struggle between child and parent around the issue of using the night bottle as a comforter. The same can be said for the child's own thumb (which belongs to the child and not the parent), since thumb sucking is a more favorable source and method of self soothing than are rocking, or other troublesome methods (head-banging). Children will not continue to use a night bottle nor their thumb when they no longer feel the need for it (i.e., when they feel more secure).

2.2122 CHILD REARING: Feeding

As we said in the above section, it is useful for parents to know children develop more discriminating tastes during the second and third years of life, some perhaps even earlier, and that some foods may cause the child to experience nausea (which can cause vomiting) and that neither parent nor child gain from compelling the child to eat foods which cause this kind of discomfort. It is more likely to make being fed by the parent as disappointing and even feel like an act of hostility, as if saying: "Here, eat this; it will make you sick!".

Making the feeding situation an enjoyable one has enormous advantages. Interestingly, good experiences of feeding are less likely to create overfeeding than are poor experiences of feeding. Feeding as a pleasant parent-child interaction can someday make for enjoyable family meals when parents have an opportunity to talk to their children, learn about what happened in school, what is going on with their friends, etc. Good experiences of eating can insure the tolerance for a good protein-based diet and reduce the need for the soothing tastes of sugar which when taken in large doses often causes excessive weight gain, can lead to insufficient nutritional food intake, and can also lead to more serious problems as self-induced vomiting to try to keep one's weight down, or cause severe food restrictions with life-threatening weight loss, all of which have become well known problems in our society.

Equally important, providing healthy diets for children sets the stage not only for reasonable feeding patterns but for developing other health promoting habits like reasonable hygiene, rest and exercise patterns. The state of the person's body when he or she is 40 years old is believed to often be determined by patterns of feeding which were

acquired very early in life. Again as one school of thought asserts, if the pattern of feeding acquired by children continue in later life, then patterns of feeding that include large doses of sugar saturated foods, fat and/or salt saturated foods, will lay the ground for the development of well known diseases that can shorten life dramatically. Some doctors believe that high sugar saturated foods over many years may facilitate the tendency toward diabetes (if one is born with this tendency); high fat saturated foods will facilitate and speed up the development of arterial circulatory disease which may eventually lead to heart attacks; high salt saturated foods will lead to a pattern of salt overload which in many persons so biologically disposed eventually may lead to high blood pressure.

Equally important, the combination of insufficient loving emotional attachment and interaction with the tendency on the part of many parents to want their young children to look "well-fed", who feed them larger quantities of food than children seem to want, may be establishing a pattern of over-eating which may lead to problems of overweight of more or less serious degree. Some theorists propose that habituation of eating large portions will lead certain people to develop a "fat hunger" which may be triggered by some mechanism contained in fat cells which we all have plenty of. The long and short of what we are saying is that healthy food patterning is essential from very early on and that parents need to be cautious about the rather generalized tendency to feel that chubby infants are healthy infants. Chubby adolescents are not healthy adolescents. But they become so if they are chubby infants who become chubby six year olds, eight year olds, etc.

Like everything else in parenting, rigidity, excessive strictness is not desirable in feeding children. For instance we do not mean by the above statements that children should never be allowed sweets or for that matter "junk" foods. It is a matter of dosing these into the diet in such a way that they do not become the principle fare of children's diets.

One more word on the night bottle which some children in the third year of life may still require. As discussed in the prior section, if it is clear to the parent that the night bottle has become a comforter, it is well to treat the night bottle not as a feeding tool but as a comforter. This was the case with Johnny and his trusty pacifier. His father was especially bothered by Johnny's need for it not only at bedtime but even at times during the day. Mother did not like it either and worried whether it meant that she was not being a good mother; but she tolerated it because she sensed that he needed it. Our evaluation of it, which we shared with Mother (and she did with Father) is that several factors might be contributing to his need for this "trusty comforter". Johnny was a sweet kid, a touch soft in aggression and a bit passive. He had been a bit shy too from the start. We had encouraged Mother to encourage him to stand up for his rights, for instance with Jennifer (as when she pulled his pacifier from his mouth). He also felt some stress due to separation from Mother from about five months on even though substitute caregivers Janet and then Mrs. Clark were seemingly really good with him. And then, quite reasonably, he went to Mrs. Clark's home from the time he was one year old. So, in addition to the stresses of normal development of every day life, he needed to deal with repeated half-day separations from mother and leaned not only on his good substitute

caregivers but also on his "trusty comforter" to help him feel stronger.

We emphasized that Johnny, like many normal young children, used the pacifier when he felt he needed it, that is solved a problem (lessening anxiety) and that with it he was handling stress better on his own, self-reliantly. He was in charge of when he needed it and when he did not. We stressed that this encouraged and enlarged his beginning sense of autonomy, of being able to do something to help himself. We also emphasized that as Pediatrician psychoanalyst Donald Winnicott said, this was his first non-parent possession. He valued it dearly. Just as Mother and Father would be terribly upset if I took away their car --or something else they felt they needed badly -- so too would Johnny be upset if Mother or Father took his pacifier away.

It is best, we suggested, for mother and father to tell Johnny they hope that someday soon he will not need his pacifier anymore. That he can handle going to sleep after giving Mom or Dad a good strong hug and then get a loving quieting kiss on the cheek or forehead from Mom or Dad and go to sleep. It was OK for Mom and Dad to express their wish, but not OK to embarrass or shame Johnny such as by calling him a "baby" when he needed his comforter.

We understand that Mom could see Johnny did not like it when she would express her wish that he stop using his pacifier, and that he at times looked angry with his Dad about it. But somehow, when he was about 2 1/2 years old, he lost his pacifier and after a very little bit of fussing, seemed to say "Oh, just forget it!" and slept fine. The pacifier just vanished.

So, it is well to bear in mind that comforters are chosen by infants, parents cannot select comforters for them, that these comforters come to mean a great deal to the child, are enormously helpful to the child's developing self-soothing, self-calming methods, and should be respected by the parents. Like security blankets, they belong to the child and not to the parent. If ultimately, we want our children to become self-reliant individuals, we should interfere only very cautiously with those steps our children take toward becoming self-reliant.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.21 THE CHILD'S ABILITIES TO ADAPT -- PART I

2.2131 HUMAN DEVELOPMENT: Affects

It bears repeating that affects are built-in systems of emotional reactivity with which children are born and which develop over time both in facility of their expression, as well as in their complexity. Of course affects are elicited and influenced by what the child is subjected to by the environment in which he or she lives. This is true from the time the infant is born and thereafter. We saw this clearly in all the children as we shall describe, especially in Diane, Vicki and Richie. But in addition, as we said before, the child's experiencing is highly influenced by his or her inborn temperament and by inborn factors, like Bernie's milk allergy at two weeks of age, and imperfect or immature brain developments as we saw in Suzy. Her irritability and difficulty to calm as well as her gastro-intestinal ("stomach") problems all made her feel very uncomfortable, in pain, and even distressed for much of the time. Fortunately, with devoted care day-in and day-out, and progressive maturation of her brain (we assumed), she gradually became less irritable, easier to calm, her GI problems stopped, and she was generally a pleasant, warm and well-attached one year old. Her irritability continued at certain times as when frustrated or tired, at which times her mood could be a bit morose. We shall talk further about how her parents tried to help Suzy adapt constructively in Sections 2.2132, 2.242, and 2.512.

Affects tell us much about what the child is experiencing. From years one to three, affects continue to develop. Some affects differentiate (biologically evolve) further. What we mean is that, for example, at about 18 months, positive feelings toward valued persons, the persons to whom the child is attached, evolve now into the capacity for what we call "love". Of course, prior to about 18 months of age intense feelings of attachment are experienced by the child. Where the attachment is essentially positive, these early positive feelings consolidate, stabilize, become enduring, and, specifically focused as well as attached to specific people, they now achieve the qualitative level we call "love".

The counterpart to love, namely "hate" undergoes a similar differentiation. It is quite clear among clinicians and researchers that during the first year of life, infants are not capable of feeling hate. It is only from the latter part of the first year of life on that infants begin to attach ideas of wishing to destroy someone who causes them intense pain which rouses feelings of intense hostility. Some clinicians even question whether children are capable of hostility at all during the first year of life. Those of us who have researched that question closely, believe that infants become capable of hostility as we understand it, namely with the idea of wanting to hurt someone, during the second half of the first year of life. The question of hate, a more intense and more enduring feeling of wishing to cause pain to or destroy someone, becomes possible from about the middle of

the second year of life on. We shall talk about this in more detail in Section 2.241.

Of course, the capacity to experience love is a source of valuing both oneself and others. It cements our relationships with one another. On the other hand, the experience of hate, an enduring feeling of needing to destroy or inflict pain on someone, is an enormous disrupter of attachment and of valuing which becomes experienced not only toward needed others but equally toward oneself. We might note here, and we shall elaborate below, that the development of self is completely linked up with the development of others (Section 2.22). That is to say the ideas and feelings or representations we have of oneself as well as of those others we need and value, develop gradually hand in hand. Therefore, feelings of both love and hate the child experiences, that stabilize in and become part of the relationship experienced between self and other, are equally distributed between and attached to the mental representations of self and other. Often these feelings are experienced as so unbearable or threatening that defense mechanisms are devised by the child in order to protect herself or himself against the intense anxiety these cause (see Sections 2.2531 and 2.26 below).

In addition to this all important developing ability to love and hate, the child also develops two new sets of feelings during the second year of life. The first is a mild sense of sadness, a quiet withdrawal from contact with others with an appearance of being-in-thought which Drs. Margaret Mahler and John B. McDevitt have labeled "lowkeyedness". The second is the painful feeling of "shame". Both become observable in normal children who are quite well cared for from the middle of the second year of life on. "Guilt", another important feeling may appear in some children from the end of the third year of life on but tends for the most part to become evident from the fourth and fifth years of life on.

Lowkeyedness, a mild form of sadness, has its beginnings in momentary reactions of disappointment or hurt and often leads to withdrawal from others (which infants may already do during the first year of life). During the second year, however, this mild form of sadness can become more enduring, may be experienced and last for hours, even for days. Most parents experience evidence of such feelings of sadness in our children as uncomfortable, even painful and worrisome. It is important to know, however, that such feelings of sadness are part and parcel of normal development and that given that sadness in unavoidable, children must be helped to learn to at times tolerate it. In fact, it is important for people to learn to tolerate reactions not only of sadness but of depression because these, too, are part and parcel of normal development and life. for instance, "lowkeyedness" according to Mahler and McDevitt, is a normal reaction which accompanies a phase of development we will discuss below, and which they propose is an adaptive reaction to the experience of his particular phase (see Section 2.22). Some of us, following Dr. Mahler's theory of Separation-Individuation, believe the essential challenges of that phase, by the way, to be the child's realization that mother and self are not one, but rather are two separate individuals, and that this realization leads to the infant now experiencing himself or herself as small and vulnerable.

We saw episodes of lowkeyedness in virtually all the infants. It is really common from the second half of the second year on into the third year. We saw these in very well functioning Jennifer, Doug, Bernie, Johnny, Diane and Jane. We noted that Johnny and

Jane were children who also had bad dreams and some sleep problems. We saw these (lowkeyedness and bad dreams) as evidence of their experiencing normal life as being marked by moments and periods of time they felt to be stressful. This of itself is important for parents to know: that growing up is not all joy and comfort, not all fun and games, it is in fact often hard work, often stressful and producing anxiety and depression (at first lowkeyedness) in normal children.

Diane's lowkeyedness episodes were especially clear during the 17 to 22 months when she went through a conflict within herself, clearly visible in her behavior, in which she appeared to be unable to make up her mind as to whether she wanted to stay on the sofa with her mother or go and play with the other toddlers down the hall. We shall describe this in detain in Section 2.2211. During this struggle, Diane showed feelings of impatience, annoyance, and in between, a steady feeling of lowkeyedness.

An episode of lowkeyedness is not <u>deeply</u> painful as is depression, nor is it as emotionally darkening as depression of what is experienced. Depression results when hopelessness and helplessness are felt, and when the feeling that some drastic loss has occurred. There often is much hostile feelings and even rage produced by and associated with depression. None of these are felt with lowkeyedness; the feelings are much milder, as disappointment and anger, and the pain is less intense; and lowkeyedness may last for hours and days; depression lasts for weeks, months and even longer.

Compared to the experiences of Vicki and Richie, Diane's lowkeyedness was a breeze. Vicki's depression was an endless period of heavy rains that led to flooding; Richie's depression and misery was like periods of hopeless ice rain and deep freeze ripped by episodes of eruptive thunder and lightening. Vicki looked deeply sad, her face seemed at times frozen, her cheeks and mouth flat and unmoving. Her eyes were flat and unresponsive to one's efforts to communication with her visually. In the Child Rearing Section we shall comment on what needed to be done.

Fourteen month old Richie's depression had a quality of deeply felt hurt mixed with fear and suspicion. He gave the impression of almost having given up. But he seemed more responsive than Vicki or at least more allowing of an effort to reach him when approached. He did not trust that good could come from others. His affect was very unstable. He could suddenly erupt with pained rage when another toddler took a toy Richie had appropriated and put down next to himself. We shall talk about him further and how we worked with his caregiver in Sections 2.2132 and 2.242.

<u>Shame</u>, depending on the depth to which it is felt, may be experienced as moderately painful to excruciating. By virtue of the enormous pain shame can produce, shame generates much hostility within the self. Shame is a crucial feeling which can influence the way the child feels about himself or herself, can be a major underminer of the child's self esteem, sense of capability and autonomy, and discourage healthy adaptation. It is therefore important to recognize it in young children.

Shame can be produced by a young child feeling incapable of doing something he or she tries to do. This is due to the child's feeling then that he or she is not good enough, or smart enough, or big enough to do that which the child tried. That makes many a child give up rather than try again and again. But equally hurtful is the child's being shamed by the parent whose approval and love he or she seeks. Although shaming at times

pushes a child to avoid being shamed again, it will bring anger and resentment and, more often then not, it discourages a child from trying, making the child's tasks even more difficult.

From year one to three years of age, then, brings with it crucial differentiations (evolving) and developments of affects (feelings) each of which is a major contributor not only to the quality of the child's experiencing, but to the character of the development of self, of relationships, and of the state of well being the child experiences. Love is a prime contributor to good self esteem, to a good sense of autonomy, self confidence, and facilitates adaptation. Hate is a prime factor that undermines a healthy sense of self, of good self esteem, autonomy and indeed, it facilitates the experience of both sadness and shame, and undermines constructive pro-social adaptation. Sadness (lowkeyedness) is an unavoidable experience for every child which tends to be experienced in a benign way unless it leads to depression. Shame is also unavoidable, especially that caused by the child's being disappointed in his or her own performance or appearance. It is an enormously painful feeling that undermines self esteem, a good sense of self value, autonomy and undermines adaptation.

A word about guilt. Shame is at times difficult to differentiate from guilt, a problem which has been a source of research and study by mental health clinicians for decades. Different theoretical models are put forward but one that makes much sense to us is this: shame is experienced when the child (or adult) feels that she or he is not living up to his or her own idealized expectations, ideal self image. One is humiliated (shamed) when one is not living up to an ideal standard one develops for oneself. By the way, when ideals for the self are set too high, much pain can be experienced because attaining such expectations is not feasible. It is important for children to develop reasonable ideal goals for themselves, goals that are inherently achievable; otherwise the individual may be subjected to repeated experiences of self-disappointment and shame. Guilt, by contrast, results from the experience of wanting to hurt or destroy someone we love. That is to say, the origins of guilt lie in wanting to destroy someone we love. Eventually in healthy individuals, by a mental generalization, wanting to destroy people who are innocent will induce guilt as well. In normal individuals this can also be extended to causing harm to non-human creatures. Guilt too is a very painful feeling, but it has the enormous socializing function of making us abide by rules and by laws. We shall discuss guilt further in Unit 3 because this is the developmental period, from three to six years, when it becomes organized as a powerful internal force that can govern the child's behavior.

2.2132 CHILD REARING: What Can The Parent Do That Is GROWTH-PROMOTING Regarding the Child's AFFECTS

Feelings (affects) are a window into the child's or adult's emotional state. Empathy is the major function which we use to help us read these feelings. Empathy is essential in human relationships and especially so in parenting: because it helps the parent understand what the child is experiencing, which itself is essential to figuring out how to rear a child

in growth-promoting ways. We refer the reader to the steps we suggest to enhance the function and capacity for empathy (see Unit 1, Section 1.242).

It is worth repeating; there always is a reason for whatever the feelings a child is experiencing. It is a mistake to assume that a child feels sad or angry or loving for no reason. The child may not always be aware of what the reason is for his or her feeling sad, angry or loving; but it is there.

It is also well for parents to bear in mind that when they cause emotional pain (unpleasure) in their child, prolonged periods of intense negative feelings will generate hostility in the child, one of the principal outcomes of feeling hurt, or neglected, or frustrated, or being abused too long. By negative feelings, of course we mean feelings such as tenseness, agitation, fear, anxiety, panic, depression, anger, hostility, temper tantrums, etc.

The normal average one to three year old child whose expressions of both positive and negative feelings are responded to reasonably tends to express feelings fairly openly and directly. This is enormously advantageous both for the child and the parents. Where expression of loving and of angry and hate feelings is permitted, is well-enough tolerated, and the parent guides the child in learning how to express these in acceptable ways, this will vastly benefit the mental health of both parent and child. (See how Suzy's mother handled Suzy saying to her "I hate you", below.) The child will benefit by being helped to deal constructively with such normal feelings; the parent will benefit by better understanding the child and having a clearer idea of what to do to rear the child in growth-promoting ways.

Suzy's parents had been dealing from early during her first year with Suzy's irritability and difficulty to calm, both of which facilitated the child's getting angry more quickly than occurs in many children. After a poor start, they progressively became able to help Suzy quite well, first by accepting the fact that Suzy was born with an immature central nervous system, that this is why she was so irritable, and that because she could not yet organize well what she experienced, she could not be calmed and comforted easily. Mother especially, but Father too, accepted our recommendations to be patient, to not take personally their daughter's ways of reacting to stress, to persist in their efforts to calm her even if they felt that it was not working, and that we could not predict how long it would take to eventually get her to become less irritable and easier to calm and comfort. Their work was cut out for them; this was one of their major family projects. Between them and substitute caregiver Mrs. Sander, Suzy's irritability decreased significantly and she was much easier to calm and comfort by the end of the first year.

But their work was not completed, of course. Suzy continued to get angry quite easily and quite quickly. During the second year, they continued their way of dealing with calming and comforting her. Now they could begin to help her deal with being irritable by telling her to "Try and calm yourself down, Sweetie" or "Come on, get hold of yourself". We encouraged the parents to move in quickly when Suzy would lose it and get angry. During the third year Suzy's getting angry was in better control but still, she could get angry quite quickly. We recommended now that the parents focus on slowing down her reaction of becoming angry. By now they knew very well the signs before her outbursts. "Get hold of yourself" mother began to tell her when she saw the signs; and by

the end of the third year, the idea of "Counting to 10" was introduced and worked on. In Section 2.242 we shall talk further about handling hostile outbursts and rage reactions and tantrums.

Where feelings of affection and consolidating love as well as feelings of anger, hostility and hate are not well tolerated by parents, and as a result not permitted expression, problems are bound to occur. Some children quickly learn to defend against their direct expression and even against perceiving them in themselves. We have seen mothers and fathers who have trouble being affectionate with their babies and not recognize or, most probably, not tolerate expressions of love from them. Such children are shown that expressing love feelings is not acceptable. Anger and especially hostility and now hate, still by many people believed to be "bad" feelings to have, may be experienced yet be denied and go unexpressed and unresolved. Even though anger and hostility are always caused by differing degrees of emotional pain (unpleasure -- see Unit 1, Section 1.291, and Section 2.241 below), many parents feel that experiencing hostility and hate are evil or suggestive of "badness" in the child. Therefore, efforts are made by both parent and child to suppress the experience and expression of anger, hostility and hate. Because it is such a difficult task to suppress powerful feelings, rather strong measures are required to achieve their suppression; massive inhibitions of feelings, for instance, is a common method children use to achieve this (See Defense Mechanisms, Section 2.2531). Where strong measures are required, the normal, healthy expression of hostility as well as of other feelings (affection, interest, etc.) may be inhibited. Where that happens, the child will not be learning to handle feelings of anger, hostility and hate and the parents will not have access to these feelings in the child to help the child cope with them constructively. In addition, parents will not have the benefit of their child's clearly expressed feelings for their understanding of what is going on in their child which is causing behavior difficult for them to handle. We must emphasize that when large efforts are made by the child to suppress feelings which are intolerable to the child and to the parent, the suppression of feelings that occurs may involve not only those feelings that are undesirable such as hostility and hate, but highly desirable ones as well, such as expressions of affection and love. Children need parental guidance in learning how to express unpleasant feelings; their emotional well-being depends on all such feelings being permissible and that the focus of help needs to be on how to deal with them in acceptable ways.

Mother was stung when 2 1/2 year old Suzy, in a moment of despair said to her mother: "I hate you!". After all they had already been through together and all of mother's (and father's) devoted, persistent efforts to calm and comfort her, mother said to us, "This is the thanks I get!" She was so hurt, she said, her heart sank, she was speechless and pulled away from her daughter. And then, she just did not know what to do when, crying painfully, about one minute later, Suzy came to her mother, her arms reaching out, she wrapped herself around her mother's legs. After a few seconds of just standing there speechless and without moving, mother bent down, picked Suzy up, and feeling drained, holding Suzy close, she just half-collapsed onto a kitchen chair. Finally, regaining some composure to calm her, mother said to Suzy, "It's OK, it's OK". Mother said she was not sure if she was comforting Suzy or herself, maybe both.

We told mother that she really did quite well. That what she experienced and how she reacted was quite good for these reasons: (1) She allowed Suzy to tell her what she was feeling, even though it was very hard to hear. This has many advantages. It means that Suzy can tell her mother anything she has on her mind and that mother will not reject her or shame her. It means also that Suzy will feel that hate is an accepted part of life, a feeling even very nice people can feel toward those they love. And it does not mean that she is evil or bad, even though she may feel so anyway (which we shall explain in Section 2.26 and in Unit 3, Section 3.2122 and 3.26). We explained to Suzy's mother that hating someone she loves means that the child feels extreme pain, whatever the cause, and feels mother is causing it, whether she is or not. It does not mean that Suzy does not love her mother. It just means that at this moment in time, for whatever number of minutes, Suzy hates the mother she loves, which -- as we shall explain in Section 2.612 -- will make her feel guilty, we told mother. Mother does not need to reprimand her nor shame her for expressing her feelings in words, so long as they are not insulting. "I hate you" hurts, but it is not insulting. We shall talk further in Section 2.242 about some of the problems saying "Oh, I know you don't mean that" or calling the child "bad" or evil" can create, as well as what refusing to comfort the child after she or he said "I hate you" can do.

We told Suzy's mother that being aware that her daughter's hate is not the only way Suzy feels about her mother, that Mother can help Suzy even more by saying things like: "I'm sorry you feel so upset." and then when she has calmed down, mother can add something like "I know you get mad at me sometimes, but I'm really glad you love me a lot and I love you a lot". This informs the child of the way it often is in a reasonably well functioning family, and that occasional feelings of anger and even hate do not destroy or threaten love relationships. Furthermore, it helps repair whatever damage (hurt) the child and the parent may have caused each other. In Section 2.2412 we shall elaborate specifically on handling hostility in children in growth-promoting ways.

Here is why helping children cope with large doses of negative feelings is enormously important for their well-being. Good feelings lead to the development of good feelings about oneself and others and secure good love feelings in relationships; and bad feelings or feelings of excessive pain which generate hostility in the child, become part of the child's self experiencing and of the parent-child relationship. The consequences of these of course, are large.

We saw, we believe, the consequences of Richie's troubled, abandoned and despairing 17 year old mother's not being able to tolerate her seven month old baby's initially normal demands and crying and then, no doubt, anger. Not able to tolerate these, she would roll his crib into the hall outside their apartment and let him cry himself to exhaustion and eventually, we would guess, despair and sleep. The consequences of handling her baby's crying this way, and probably being abusive eventually, were that from being a healthy, robust, smiling and bright, well attached and trust 5 1/2 month old, he became a depressed, morose, underdeveloped, poorly attached and mistrusting 14 month old who looked no bigger than an 8 month old. The consequences of his being thus neglected and abused were drastic.

Let's talk briefly about dealing with the specific newly developing feelings we find

from the one to three years period on. Love feelings are a prime positive contributor to healthy self-esteem, the continuing emergence of a good sense of self and autonomy (self motivation, self initiation), and good adaptation. Love feelings are also a great gift in a relationship. The best ways to enhance feelings of love from the child is by loving the child, treating the child with consideration, reacting to the child from a position of empathy (namely, by attempting to feel, tune into and understand what the child is experiencing), by treating the child like a person from the beginning of life. Love feelings are not enhanced in children by overly cuddling them when they do not want to be cuddled, hugging them when they do not want to be hugged, either infantilizing or making them older than they actually are, being overly permissive or overly strict.

Hate feelings strongly undermine good self-esteem, autonomy and good adaptation. As a result, it is clear that those experiences of excessive unpleasure which generate hostility, which in turn accumulates into hate, should be made as short-lived, as infrequent as possible. Below, in Section 6.24 we will address this issue more extensively.

Sadness, "lowkeyedness", is best dealt with by tolerance, availability to the child's wish for closeness and/or comforting, by talking about the feelings and the reasons for having these feelings. For instance, the most common time the 18 to 20 month old child experiences lowkeyedness is when mother is not emotionally available to the child. Given that many mothers are working outside of the home, many normal children, like Johnny, will experience heightened degree of lowkeyedness at this age, especially during the second half of the second and the first half of the third years of life, due to the necessary separation for many hours their mothers' work outside the home requires.

Jane's lowkeyedness seemed to come after her bad dreams. She was about 20 months then and we assumed that it simply was part of her dealing with that period of life's major task of separation-individuation which we shall discuss in Section 2.2211. So too, Diane's lowkeyedness was due to the conflict and the experiences that come with recognizing that she is a small child separate from her big and strong mother that Diane feels at times quite vulnerable and at times feels helpless. These feelings are part of the child's real life and are unavoidable at this time. It is important that parents not become alarmed by these feelings in their beloved children. These are not at all like the deep depression feelings experienced by Vicki or Richie. Tolerating the feelings of mild but sober sadness the child shows, allowing the child's expression not only of the feelings but also inviting the child to talk about what is causing the sadness, can be enormously helpful. A parent's sympathy and comforting do a lot toward reducing lowkeyedness and therewith can be highly growth-promoting.

It was different with Vicki. She did not experience lowkeyedness. She suffered a very painful depression which, as we explained in Unit 1, Section 1.331, we understood to arise from her depressed and overburdened mother's inability to meet sufficiently Vicki's emotional needs. Mother's rough handling probably added to Vicki's pain and feeling of emotional deprivation. It is important to understand that this type of infant depression leads to an attachment in which the caregiver is experienced as non-gratifying of basic needs; the learned expectation is that (emotional) needs will not or cannot be met. No hope for this is left. To reverse this then, or to heal this damage in relatedness

and feelings, it was essential to handle Vicki in such a way as to counteract the learned conviction that caregivers cannot meet and gratify her basic (emotional) needs. We shall detail what needed to be done to change the quality of her experience, expectations and mood in Section 2.2212, when we talk about optimizing the child's development of her sense of self and of relationships.

Shame, a feeling which is enormously painful when intense, is a prime underminer of self-esteem, healthy self-love. Although self-love when too enlarged creates problems of heightened narcissism, of too large an interest in oneself only, a healthy amount of self-love brings with it good self-esteem, self-respect, and self-confidence. Shame also undermines the sense of autonomy and leads to troubled adaptation. Unfortunately, we hear too often children shamed by attitudes and remarks of depreciation, of scolding that are insulting, like "You're bad!", "You're good for nothing", "You're evil". This is one of the instances where words can be enormously painful and cause a great deal of damage. Shaming a child often does more harm than good. Parents will be angered by their children, unavoidably, in some cases, many times. It is especially when the parent is angry that shaming the child may occur. It is much more useful if the parent tells the child she or he is angry with the child, that the parent does not want the child to behave the way he or she is behaving, that the behavior is not acceptable and better stop right now! We will talk further about dealing with unacceptable behavior in Sections 2.242, 2.2522 below.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.21 THE CHILD'S ABILITY TO ADAPT -- PART I

2.2141 HUMAN DEVELOPMENT: Intelligence, Memory, and Exploratory Activity

The child's learning behavior became very visible in the upsurge of exploratory activity around the middle of their first year of life. Now, in the second and third years, this exploratory activity continues to be driven by a large push from within the child which is evident on the child's face and body and in his or her persisting efforts. As would be expected, the one to three year old child's exploratory activity becomes better and better organized. By 18 months of age exploratory activity continues to be spontaneous but it also seems to be pre-thought, more planned, and seems to have some strategy. The child's exploration of a particular item will be more rapid (because the child already knows much) more detailed, and may extend over a longer period of time. Also, exploration may become combined with developing skills such as piling up graduated sized wooden or plastic donuts on a peg, as 18 month old Jennifer could do, or building with blocks. Preparation for exploration seems at times to be more deliberate. Certain toys seem to be targeted with interest, suggesting intention on the part of the child to deal with the blocks, the peg and donut toy, climbing the stairs, getting over a barrier, etc.

In these explorations, one can see each child's particular increasing capability for paying attention to what the child is doing, increase in concentration, the stabilizing of patterns of persistence in effort, increase in frustration tolerance, all essential for learning and therefore of much importance.

A crucial development originally described by Piaget and further researched by his students, is the development in the function of remembering, in memory, of the brain activity which makes evocative memory possible. Evocative memory means the ability to recall (remember) at will what something or someone looks like without seeing it actually, within one's visual field, at the moment of remembering. This development was described by Piaget as due to the capability for object permanence. Object permanence means the ability to retain in one's mind what something looks like when it is not there to be seen, when it is not within one's visual field. Piaget's research led him to say that the ability to retain in one's brain and to retrieve at will the representation of an item (a person or a thing) tends to develop from about 14 to 18 months of age. More research has revealed that in children who are well cared for, who have good enough relationships during the first year of life, this ability for object permanence occurs earlier for persons who are valued by the child than for things. This, of course, most applies to the child's parents, siblings, and other persistent caregivers. This specific ability, the function of person permanence, has been found to begin from about 11 months of age on and

gradually stabilizes by the early part of the second year of life into evocative memory for persons well known to the child.

Person permanence and object permanence are essential for the function of evocative memory. Let us repeat here (also see Unit 1, Section 1.321), that recognitive memory, the earlier of the two major forms of memory, is the ability to recognize upon seeing a thing or person with which/whom the child is already familiar; children show evidence of this capability from five to six months of age on. Evocative memory, on the other hand, does not require the actual presence of a person or a thing for its recollection.

Intentionality, the intention to do something, and causality, the recognition that an action will have a particular effect, stabilize further during the second and third years of life which also contribute to the child's increasingly more complex discovery and understanding of the world into which the child was born.

It was no minor accomplishment, when at 18 months of age, Jennifer managed to pile the size-graduated plastic donuts on a peg in nearly the right order. Her mother was pleasantly surprised by it, told Jennifer, "Hey, that's great; you got them right!" Reading her mother's pleasure, Jennifer cheerfully applauded herself (actually clapped her hands) even though mother had not done so.

The same can be said for all the children's increasing skills in body movements during the second year, including walking more and more stably, turning quickly without falling, going up stairs, coming down backward or on their bellies, or during the third year when holding on to mother or the banister, as well as the manipulation of things with increasing ease. Depressed Vicki developed these skills, even though her activity was dramatically slowed down. That is, all her movements were as if in slow motion during the last quarter of the first year and the early part of the second year. We saw that Vicki may have had an inborn gift of body movement and control that was striking. From the end of the second year on, when her activity regained a seemingly normal speed, when she walked across the room, she glided like a dancer, her movement was remarkably different from the other children; indeed, it was beautiful.

During year two, Richie's activity at first was markedly inhibited, and generally slow, except when he would suddenly throw a toy or flail in a reaction of rage. He gradually was able to become less inhibited, at first manipulating toys while sitting near his great-aunt to then moving about cautiously, more due to fear of how others would react to him rather than due to instability of his walking (even though he gave the impression at 14 months to be about eight months old in physical growth). As he gradually improved, by the end of his second year, his movements, explorations, and manipulations of things increased quite satisfactorily though not yet up to his age level. Because we no longer had the opportunity to see him after his second year, we cannot report on his further progress and growth.

Language and Fantasy:

Many a child begins to develop language during the second year, a factor toward which memory makes a major contribution. First, words are used which progress more or less rapidly depending on the child into phrases and eventually sentences and, in some,

even questions. During the third year, language continues to develop at a virtually explosive rate. Now questions are frequently asked, in some cases to the point of mother feeling tired of answering "all those questions".

Of enormous consequence to adaptation, the capacity for fantasy, the imaging of an event, a scene and its unfolding action, seems to begin from the middle of the second year to be used with intention as is readily observable in children's behaviors. For instance, Diane's father (a keen observer of his children's behavior) told us that Diane brought what became one of her favorite books, conveying to him equally with signs and with her "Daddy, read", that indeed she wanted him to read it to her. What struck him though was that as he sat with her, showing her the pictures as he read, at one moment, 18 month old Diane touched a picture with her thumb and index finger, brought her hand up to her father's nose, a sweet smile on her face. In the instant, father understood that she wanted him to smell the flower she pretended to have picked from the book. Father was right to be surprised at this early ability to pretend. Pretend, that important play activity, requires the ability to fantasize.

It is possible that fantasy formation may begin even earlier than 18 months of age, an assumption for which there is good evidence. For instance although other explanations would do equal if not better justice to what the infant experiences, infant observers have proposed that very young infants show what seems to be "hallucinatory" wish fulfillment behavior. They have proposed that the four month old infant quieting after a period of crying may have stopped crying because he or she imagined or "hallucinated" the feeding to occur before it actually took place. (Of course, since no feeding has yet taken place, the infant will soon cry again.) Or one can see a ten month old become pensive for a moment during an anxiety episode associated with mother's leaving. What is he thinking or imagining? Or what about a ten month old dreaming (see Section 2.2111)? All of these suggest that some imagining or fantasy formation occurs prior to 18 months of age. We also assume that acquiring the capability for person permanence during the early part of the second year means that the child can have the mental representation (image) of a person, not just as a photograph but as in a movie, in some brief action context at this age, like the good mother nurturing or soothing, or the angry mother scolding, etc; this of course now becomes an integral part of fantasy. Fantasy, the imagined unfolding of some action, becomes clearly evident in play and in certain interactions. That 18 month old Diane picked a flower from the book and asked her father to smell it suggests a substantial beginning of this enormously important adaptive function.

During the third year, fantasy formation increases dramatically and the capacity to make a brief story, with a theme, becomes evident in children's play as well as in some of their interactions with those in their environment (see Section 2.23 below).

2.2142 CHILD REARING: Optimizing the Development of Intelligence

The developments described in this Section which originate from within the child, like so much of the child's development, can be enhanced by the parents. For instance,

we believe that parents may not be able to directly enhance the development of object permanence because it results from brain maturation primarily; but they can enhance the development of person permanence which seems to be more influenced by experience. Person permanence is best achieved by making the parent child relationship sufficiently gratifying. This, in turn, is best achieved by parents behaving toward their children with love, thoughtfulness, consideration, trying to understand the child's experiencing, not being intimidated by the child's feelings of anger and hostility toward the parent, by setting limits constructively, etc. In essence, this is the aim of all that is contained in these pages, that is, to optimize the parent-child relationship and therewith the development of intelligence and good emotional health in the child.

First, with regard to the development of intelligence, it is important that parents realize that their child learns, that is, becomes a student not in first grade but from the first year of life on. The rich exploratory activity which one sees from about the middle of the first year of life on, made so evident by its remarkable upsurge at that time, make of the child an explorer, a discoverer, a student of the universe into which he or she was born. The parents' facilitating these exploratory activities, supporting them to the extent that it is safe for the child, will protect the child's being a student, the child's interest in things around her or him and will facilitate the learning process. One could see the strong encouraging influence on 18 month old Jennifer of her mother complimenting her for the way, probably the order in which she stacked the donuts on the peg; Jennifer clapped her hands! This very naturally makes the child want to do things in ways that will bring the mother's (and father's) approval. It adds to, reinforces, the pleasure of doing something well. Good attention, concentration, persistence in effort, patience in the face of frustration, all so essential for learning, can be enhanced by the parents within the context of their children's exploratory activities. The parent can do this by (1) first allowing the child to make efforts, and when needed by encouraging and supporting those efforts; (2) deriving and expressing pleasure at the child's growing skills as they become evident in the child's behavior; and (3) facilitating learning by teaching. For instance, although a child spilling a cup of water on the kitchen floor is an unpleasant event given that someone will have to wipe it up, it is nonetheless an opportunity for teaching the child that cups need to be held upright, that fluid flows out of cups unless they are held upright, which we might point out, is a lesson in physics.

All of the above can, of course, also be facilitated by creating an environment which is conducive for exploratory and skill developing activities. Many years ago, Dr. Ben Spock spoke of "baby-proofing" the house for children in the second and third years of life. Of course, this needs to be done for crawlers during the first year of life as well. In circumstances where infants are repeatedly prohibited from touching this knick-knack or that television knob, or that too reachable toaster or hot coffee pot, where too many prohibitions are needed, these will lead to insufficient opportunity for exploration. These will also create too much frustration for the child that will generate large doses of hostility toward the parent that will then, in turn, make the learning experience one contaminated with hostility. Equally important to intensifying hostility in the child-parent relationship, such repeated interference with exploratory activity may discourage interest in the world around and in learning altogether. The task for parents is difficult. Growth-

promoting parenting requires limit-setting; but limit-setting becomes growth-disturbing when it occurs too frequently (see Section 2.2151). Setting limits should be done when truly needed; but this should be kept to a reasonable minimum especially in areas of learning activity. Therefore, baby-proofing the house, putting things that can too easily be broken out of reach, putting items the parent values which she or he does not want the child to touch, placing things that can cause injury such as hot cups of coffee, ash trays, all out of reach can be enormously conducive to safe and un-conflicted exploration. Obviously, one cannot move electrical outlets out of the reach of children. Nor, we emphasize, do we mean that setting limits should be avoided where they are needed; quite the contrary (see Section 2.2152). We mean only that excessive limit setting in the domain of learning can interfere with pleasure in learning and a feeling of freedom to learn.

Parents can also enhance and even increase their child's interest in learning, in explorations. This is best done by

(1) Following the child's lead in what catches the child's interest. That is to say, we have at times seen an interested mother or father unaware of the child's exploration of a particular item, try to change the child's focus of interest and turn the child to what the parent is interested in. One young mother, trying hard to engage in activity with her child, would pick up one thing after another to present to her child in an effort to gain the child's interest in each item; but in the process she seemed to not recognize the child's rich self-generated interest in things the child was exploring. Unless it is the parent's intention to change the child's focus of interest, such as from an electrical outlet to something that is safe, like 18 month old Diane's father did, it is usually better to follow the child's pursuits, recognize what the child is interest in and share in that interest. Of course, a parent can also introduce things to explore which the parent finds interesting. The point simply is: find out what your child is interested in and, if it is safe, facilitate that.

(2) Sharing in the child's excitement about a new discovery, an item or a phenomenon like 18 month old Jennifer's mother did is most conducive for learning. "That's stupid!", or showing a lack of interest in what the child is attempting to do or to show a parent may well discourage the child's interest and learning.

(3) Exploration requires motor activity (crawling, walking, swinging things, pushing and pulling things). The beginnings of intelligence emerge in sensorimotor activity. Some parents are more comfortable when their child is quiet, like in a play pen, and not physically (motorically) active. Sometimes they will encourage their child to not move around so much, to not reach for things, etc. when the child is only moderately active. Of course, some children who are too driven need help in slowing down a bit, in calming a bit. But some moderately active children whose active motor behavior is disapproved of by mother or father may inhibit that activity and with it, inhibit learning. Such early inhibition may be carried into the learning process for many years to come.

(4) Also, it is important to answer your child's questions as best as you can, any question. Children often express interest they have in things by asking questions. Many bright two year olds seem to be full of questions; they may, in fact, ask questions so frequently, sometimes asking the same question over and over, that parents tend to

become tired of their questions. True, there are times when children ask questions for the purpose of irritating their parents. But most of the time, children ask questions because they want to learn, they want to have answers. Parents who take the time to answer their children's questions do many things at once; they acknowledge that interest is important, that learning is important, that what their child feels, thinks and says in important, etc., which ultimately leads to the sense that the child is an important and valued human being.

Interference With The Development of Intelligence:

Interference with the development of intelligence can occur though interference with exploratory activity. One we already noted is by making it too difficult for a one to three year old to explore safely and without too frequent prohibitions. We observed very little exploratory activity in Vicki during the end of her first year and her second year. We knew this to be due to her being depressed. It was when Vicki and her depressed mother's treatment began to make them feel less depressed, that Vicki's locomotion (walking) and exploratory activity increased. The same occurred with Richie who, when we saw him at 14 months, would just sit where he was placed on the carpet and, at first, not reach for anything or move. Only gradually, with the lifting of his depression and the increase in his feeling safe, did he cautiously move and begin to explore things around him and handle toys.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.22 THE DEVELOPMENT OF SELF AND HUMAN RELATIONSHIP

2.2211 HUMAN DEVELOPMENT: Separation - Individuation
(Continuation from Unit 1, Section 1.331)

Dr. Donald W. Winnicott has said that there is no such thing as an infant, there is only an infant-and-his/her-mother. Psychodynamic and psychoanalytic child developmentalists say that the development of the self goes hand in hand and in parallel, so to speak, with the development of relationships to others and the way we come to know, feel about, and perceive ourselves and others. In Unit 1 we began to detail the theory of separation-individuation developed by Dr. Margaret S. Mahler. We emphasized that the separation-individuation theory makes the central assumption that the infant may experience himself or herself during the early months of life as being one with mother, as if self and mother are one unit. This, we said, Mahler proposed to be a psychological "symbiosis". Mahler defined `symbiosis' differently that it is defined in general biology. In biology the term means that two organisms depend on each other for survival in a manner equally beneficial to each. Mahler's term means that the infant emotionally experiences himself or herself to be in a state of oneness with the mother. Separation-individuation is the process whereby the infant resolves this experience of oneness in such a way that by the end of the third year of life, the infant has a stable inner feeling, mental image, and a sense of self and of mother as two separate entities, two individuals who are attached to one another by a powerful emotional bond.

This process of separation-individuation occurs from the middle of the first year of life through the third year, and has been identified by Mahler as the separation-individuation phase. Further, Mahler subdivided this phase into four subphases, those of Differentiation, Practicing, Rapprochement, and Toward Self and Object Constancy. In Unit 1 we described the period Mahler conceived of as the normal symbiosis, the symbiotic phase, and we also detailed the beginnings of the separation-individuation phase, detailing its first two subphases, the differentiation subphase and the practicing subphase. We said that the differentiation subphase extends over several months from about five to nine months of age when the infant seems to, as Mahler said, begin to "hatch out of" the experience of oneness with the mother. The infant does so when sitting on her lap by turning away from her, by separating his or her body away from the mother, and by crawling away from the mother, all giving the impression of the infant pulling himself or herself away from her. Mahler made a point of saying that the infant's first steps (or crawling) are away from the mother.

We also described briefly that in parallel with this differentiation subphase, from about seven or so months of age on, the infant begins to move away physically from the mother in a rather consistent and vigorous manner. This movement away from the mother, it became clear to Mahler, was not only suggestive of a differentiation away from

the mother, but by virtue of specific features characteristic of the infant's efforts, Mahler identified the second subphase of separation-individuation as the practicing subphase. As we described in Unit 1, principal features of the practicing subphase are that the infant becomes a remarkable explorer of the world he or she has been born into and develops a number of sensorimotor skills which the child "practices" with much effort and persistence, skills which serve adaptation and bring with them much pleasure. These pleasure-yielding exploratory and practicing activities become typical of the well-cared-for child's experiencing during the practicing subphase. Because the practicing subphase begins in the second half of the first year of life and continues into the second year, let us take it up further at this time.

The Practicing Subphase (Continuation into the Second Year):

With entry into the second year the practicing subphase is in full swing. Most children, though not all, are upright, moving about for the most part on their own two feet, albeit with tentativeness given that this important new capability has only recently developed. Upright locomotion is a major achievement for the one year old which enormously facilitates adaptation. As in the development of a number of sensory and motor skills, the amount of energy and effort the infant puts into upright locomotion is remarkable and brings with it much exhilaration and excitement. All one needs to do to test the infant's inner pressure, inner need to be upright is to try and keep a toddler down. Of course, some toddlers are more pressingly motivated from within to do things than are others. Important for both child and parent is that the inner pressure which leads not only to walking, but also to the perpetual exploratory activity most young children engage in, is driven by a powerful inner pressure which makes the activity in question almost obligatory.

We believe that this inner pressure is due to a built-in force within the growing infant, which thrusts the child to be an autonomous, activity-initiating individual. It powerfully serves the development of one's sense of self. This is the inner force which when it comes under the child's control shall become his or her "Will". For instance the infant does not elect to walk, does not "decide" to explore, but rather is compelled to walk and to explore, as if pushed, indeed, driven from within. Someday it will be his or her "Will". But now, this pressure, the quality and degree of the effort that goes into these inner-driven activities is readily visible on a child's face and in his or her total body effort. Once this is understood by parents, the child's driven behaviors are recognized to be to a substantial degree, involuntary. This is in large part why children experience parental interruptions (say by limit-setting) of this inner-driven activity as so unpleasureable: (1) because it interferes with the child's inner pressure to do, to discover and to act upon the universe into which he or she is born, and (2) it interferes with the emerging sense of self as an autonomous, activity-initiating individual. This interference by the parent makes the child experience a conflict which arises out of his or her more or less rigorous thrust toward autonomy, what we have called an autonomy conflict.

Diane and Bernie were children in whom this inner-driven exploratory activity and autonomy thrust was especially vigorous from the latter part of the first year on, through

their second and third years. Jennifer too was strongly driven to autonomy and activity and was challenging to set limits with; but she had been a more "determined", knowing-what-she-wants infant from the beginning. This inner pressured determination and demandingness was not as strong in Diane and Bernie until they reached about nine to eleven months of age. It was as if a switch in their brain got turned on then, and they became significantly more vigorously active and autonomy striving (see also Section 2.241).

During year two Diane and Bernie were very busy children. They actively explored and exercised newly developing sensorimotor skills. When she was 13 months old, Diane wanted to push the toy cart into the hall at our research center. For a variety of reasonable reasons, Diane's mother did not want her to push the toy cart into the hall, as she had not let her reach for cups of hot coffee or touch electrical outlets. Diane at first objected moderately to her mother's not letting her do what she "wanted". But now, Diane was getting more and more troubled by mother's prohibitions. At 13 months Diane's objections and vocal complaints mounted, we saw her face redden, and with much effort she tried to squirm out of mother's interfering arms. She began to cry angrily, waved her left arm toward Mother in a striking movement several times, kicked her, and twice actually struck her mother's arm. Once she also struck herself.

The reason it is important to understand that the one year old is as active as he or she is not simply by his or her Will, decision or intention, but also by a more or less powerful inner-driveness, is that the pressure pushing the child to autonomous activity unavoidably often leads the infant to do things which caring and responsible parents, like Diane's mother felt, will find unacceptable. In consequence of this, as we began to describe happened between Diane and her mother, a crucial interaction between child and parent occurs. Every mother and father becomes alarmed when a one year old reaches for a hot cup of coffee, an electrical outlet, or when the toddler is about to run into the street. Not yet able to understand that each of these acts is a potential danger, driven from within, the infant forges ahead to his or her target, the cup of coffee, the electrical outlet, etc. The parent automatically reacts much like Diane's mother did, with an interference, a protective prohibition, which, however, seemingly often creates a most unpleasant chain of reactions. Rather than experiencing the parents prohibitions as protective, the young child feels his or her toes have been stepped on, prohibition has been set up against doing what the child feels he or she needs to do, the reaction of frustration experienced by mother's prohibition leads to an experience of unpleasure in the child. Feeling pushed from within to do what she felt the need to do, and encountering the valued parent's prohibition, Diane experienced a state of distress which began a chain of unpleasure-experiencing reactions.

First, as we saw in Diane, frustration is experienced due to not being allowed to proceed in compliance with the inner pressure that is driving the child to action. This the child experiences as unpleasurable. The higher the inner pressure, the higher the "Will" to do what the child "needs" to do, the higher the degree of unpleasure experienced, the more will anger be generated. The longer the episodes of frustration persists, the more frequently these occur, the higher the level of unpleasure experienced, often to the point of becoming excessively unpleasurable, and the more will anger mount and then change

into hostility and even rage in the child, just as we saw in lovely Diane.

The second link of the usual chain reaction, and the second contributor to the child's distress, is that the prohibition which is set up comes from the caregiver to whom the child is attached and values deeply, namely in this instance, Diane's mother (or father). This means then that the hostility and rage generated in Diane by the excessive unpleasure she felt were experienced toward her deeply valued mother. This now sets up a condition within the infant which the infant experiences as an emotional conflict. After the outburst we described above, Diane stopped struggling and, troubled and surprised, Diane's mother sat down cautiously in a chair, holding Diane less tightly as she felt her daughter stop struggling. Thirteen-month-old Diane looked very upset. For the first time we found (in our observations of them since she was born) that her crying could not be comforted by her mother's very good usual efforts. We noted her crying angrily in mother's arms, and pulling away as if she wanted to get out of mother's now more gentle hold. Responding to Diane's signals, mother put Diane down on the floor, quite nicely. Now Diane cried even more loudly and angrily. Mother could not hold her and could not put her down! She picked Diane up comfortingly while sitting in the chair, continued to hold her on her lap and Diane calmed down a little. As she sat on mother's lap, Diane did not lean back into her mother's body -- which she has always done easily -- but, rather, she sat upright, separated from mother's body. Mother, wanting to comfort Diane, reached to touch her arm; Diane pushed mother's hand away, clearly a gesture of rejection. Both mother and child looked sad and serious. It was clear that the physical struggle between Diane and her mother evolved into a physically quiet but sad and serious experience. What did we see happen so far?

First, we saw the gradual emergence of a battle of wills between parent and child. This is one of the earliest clear-cut conflicts between a well-cared-for child and the caregiver to whom she is well attached emotionally. Diane wanted to take the toy cart into the hall again. It could be a child who wants to grab a hot cup of coffee; or play with an electrical outlet, etc. The loving parent sets up a reasonable prohibition. The degree to which the battle of wills is experienced and the frequency with which these occur is of much importance. From the child's side, the degree of inborn inner-drivenness will determine how persistent and pressured the child will be to achieve his or her own goals. Equally important, the mother's own characteristic ways of handling assertiveness and her tolerance for the child's expressions of his or her own will, also significantly determine what the character of the battles of wills between child and parent will be.

Perhaps the most dramatic and emotionally most important feature of these battles of wills is that the anger and hostility generated within the child by this experience of excessive unpleasure (where the unpleasure indeed becomes excessive) will be directed toward the caregiver most valued by the just one year old. This means that the child, like Diane's behavior showed, feels hostility toward the same caregiver to whom she is attached and values deeply. This then sets up feelings toward the caregiver that stand in conflict with one another: feelings of hostility versus feelings of valuing positively. Note that speaking of 13 month old Diane, we do not yet say "feelings of hate versus feelings of love". As we discussed in Section 2.2131, feelings of love and hate do not become organized until about 16 to 18 months of age. Prior to this, strong positive feelings of

attachment and valuing are felt as are strong feelings of hostility and rage; these can be experienced by the young child. As with Diane now, her strong feelings of hostility (and her attack of mother) experienced toward the mother she so highly valued now seemed to have produced within her an internal conflict which created distress and anxiety. We speak of such conflicted inner feelings toward the same highly valued (and later loved) caregiver as ambivalence. Here is what we believe occurs within the just one year old child which we infer from the behavior we saw in 13 month old Diane. We saw quite similar experiencing in Bernie and Jennifer. First, picking up where we left our narrative, here is what we saw:

Diane now sat on her mother's lap and, looking quite troubled, did not let her mother comfort her nor did she want her mother to put her down. She looked tense, anxious, and restless. Gradually, she positioned herself on mother's lap, sitting on it but separated from mother's body. Twice more she rejected mother's comforting hand. After Diane remained poised, sitting upright on her mother's knees for about one minute, mother got up cautiously and carrying Diane, bent down to pick up a toy with which to engage her. As mother bent down, Diane suddenly began to cry as if she had been struck a blow! Mother and we were startled. When mother rather quickly returned to her chair, Diane calmed quickly and again sat upright on her mother's lap. Gradually, her body tone softened and as she relaxed, mother brought her closer and Diane molded into mother's body, thumb in mouth, where she remained, awake, subdued, for about 30 minutes.

Here is what we infer: Diane, feeling much hostility toward her mother wanted to push and pull away from her, reject her, even hit her and probably hurt her. But she felt very pained and wanted the good mother (which was already quite stably represented in her mind) to comfort her, to make her feel better. But these two wishes were opposite to one another. She was unable to act on either one. We might guess that when she felt she wanted to be comforted, the feelings of hostility and wanting to hit mother came up. What was she to do? She was conflicted then and there. We thought that she was stuck between experiencing those opposing feelings almost at the same time. She needed to not move, and for mother to not move. Thus, immobilized, she sat upright on her mother's knees, until gradually, she calmed, probably her hostile feelings quieted a bit, and she could yield to her need from comforting. We felt that she was somehow "working" on dealing with the ambivalent feelings she experienced during the 30 minutes she stayed on mother's lap.

Thus, the 14-month-old's inner-driven thrust to autonomy and exploratory activity coming upon the responsible-loving parent's protective prohibitions leads through battles of wills (experienced by the child as an autonomy conflict), to an internal emotional conflict because of the ambivalence such battles of wills (autonomy conflict) unavoidably generate. This ambivalence and the internal conflict it creates are of large consequence to both the child and the parent, and to their relationship.

There is another issue of much importance that rides on the self-developing experiences just described. It is that the exploratory activity so amply evident in the child's autonomy strivings represents the child's learning about the new world into which he or she was born. In the discovery of that universe begins the all important process of cognitive learning, the type of learning children get in school. Whereas the eight month

old has begun to explore this new magnificent universe into which he or she was born, that eight-month-old's explorations are brief, less focused, often more interrupted by distraction then one finds in the 14 month-old. The eight-month-old child's interest is short lived. By contrast the 14 month-old now exhibits an interest that is much longer and with a capacity to explore and thereby learn which is a significantly advanced from just four to six months before. The point we want to underscore here is that the practicing subphase is the period when learning as an activity that does not grow out of immediate needs such as the need for food, the need for air, the need to be comforted when in pain begins. Learning about the world that surrounds us, purely cognitive learning, begins at this time. Learning begins not when children go to school but during the practicing subphase. This is a remarkable opportunity for securing a good basis for later school learning. It is important that parents be aware of this. In the section on child rearing we will address this point further.

As we have said, it warrants emphasizing, that this first phase of moving away from mother, of being an individual explorer of being able to tolerate separateness from mother for many minutes now, is a crucial stage of developing one's sense of self and becoming an individual. That is to say, a 14 month old will be able to be engaged in exploratory activities away from mother for as much as 10, 15, 20 minutes without needing to be in touch with the mother. Such periods of exploration, the longest yet initiated by the child himself or herself, may from time to time be punctuated by moments when an internal need will make the infant aware that he or she is separate from mother, will make the child turn from the activity in which he or she is currently engaged and look around as if searching for something, the search then stopping when the infant catches the mother visually. The child will pause momentarily, or may elect to move back toward mother, may either glance at her briefly from a distance or come to touch her briefly, and then return to the business at hand, exploring whatever the infant was exploring. This, Dr. Mahler and her coworkers came to recognize as a brief moment of "emotional refueling." It is as if the infant, drawn by some inner experience of need, suddenly is aware of the need for mother and it may suffice to just look at her in order to feel emotionally reassured, emotionally "refueled", to proceed with the experience of separateness and of autonomous exploratory activity. It is important to note that the experience of separateness of the 14 to 16 month old, is at the same time self experiencing, critical in the evolving of self reliance, autonomy, selfhood, but at this age is still far from being a complete sense of self, a complete sense of separateness. As the next subphase of development will clarify, the sense of self achieved during the practicing subphase is of enormous importance but is only "on the way toward" a distinct and stable enough sense of self.

The Rapprochement Subphase:

At about 16 to 18 months of age dramatic developments occur within the child's central nervous system (CNS). New functions, new capabilities seen in children's behavior suggests the differentiation (a further developmental change due to maturation) of the brain into a new, higher level of organization. This is a continuation of the

progressive growth in function of the brain. During the first year there are two nodal points or periods of further differentiation of the central nervous system, as well as of other physiological and hormone-based systems, each of which brings with it a higher level of brain and behavioral organization and functioning. For instance, scientists have shown that the first such organizational differentiation occurs at four to six weeks of age, evidenced in the physical sphere in a stabilization of the infant's heart rate and of the electro-encephalogram (the brain wave recording a greater stabilization of brain activity than before), and in the emotional sphere evidenced in entry into the symbiosis (Mahler), with a new awareness that "help comes from the outside".

The second such organizational differentiation occurs at about six to eight months of age, manifests in physical sphere by a marked increase in locomotor capability, the eruption of teeth and by new capabilities in the infant's immunological system, and in the psychological emotional sphere by an upsurge in aggression, a forging of attachment with peaks in separation and stranger anxiety reactions.

The third organizational differentiation which brings with it a new level of functioning occurs at about 16 to 18 months when in the psychological sphere, the infant is now capable of object permanence and the now full capability for evocative memory, a more accurate ability to evaluate reality, a higher level of autonomy (self activation) experiencing and functioning, a greater differentiation of affects (see Section 2.2131). With regard to the separation-individuation process, this new central nervous system differentiation and the emotional developments to which these can give rise now make the child aware (better reality recognition) of the fact that mother and self are not one but are in fact two separate individuals.

According to Mahler's theory, the new awareness that mother and self are separate beings, brings with it the child's awareness that he or she is small and vulnerable. Most importantly this brings with it a set of experiences, activities and behaviors which Mahler proposed constitutes a new subphase in the separation-individuation phase; she called this the rapprochement subphase. Furthermore, she said that this subphase usually contains a basic conflict characteristic for this period, the rapprochement conflict. This conflict is caused by these two opposing inner strivings: on the one hand the child continues to be thrust by inner developments toward a new level of autonomy (to initiate and to do things oneself), a new need to separate from mother toward becoming a self, an individual; while on the other hand, the new awareness of being small and vulnerable, side by side with the painful and frightening feeling of loss of a valuable part of self associated with the awareness that mother and self are not one, stirs within the 18 month old a powerful wish to not progress, to remain one with mother. Thus, two opposing forces, one pushing toward individuation and becoming a separate self, and the other pulling toward remaining one with mother, create in the normal child now a second internal emotional conflict, the rapprochement conflict. (The first one was the conflict due to ambivalence that begins with battles of wills during the practicing subphase, which we have called the autonomy conflict).

The basic conflict takes different forms in different children. When Jennifer was just under 20 months old, we witnessed a striking series of events during one of our observational sessions. That morning, Jennifer seemed to stay close to mother, more than

usual. Three other girls and one boy (all about her age) decided to take off their shoes and somewhat excitedly went to the matted playroom. Jennifer, who had been close to mother on the sofa, busily playing with toys she had taken there, took off her shoes too, excitedly readying to join the others. Once her shoes were off, though, she suddenly became subdued and got back onto the sofa, with a little bit of help from her mother. Five seconds after she had climbed onto her mother's lap, Jennifer began to cry and twist her body away from mother, pushing away from her as she did this. Her mother, sensing Jennifer's wish to get down, put her down on the floor gently enough. Jennifer dropped to the floor (she was good on her feet and easily could have stood) and began again to cry, twist and kick her legs in a mild tantrum, which was very unusual for her. Surprised, mother tried to comfort Jennifer by talking to and touching her. Finally, by mutual agreement, mother picked her up. Once in mother's arms though, Jennifer started to cry again, twist herself and push away. Again mother complied, looking a bit troubled and put Jennifer down. Mother and Jennifer went through this same sequence two more times. This behavior wound down after the sixth time, ending with the sixth hold-me-close communication. Jennifer's pain and distress were mirrored in the feelings of confusion and bewilderment mother told us she felt.

Four days later, Jennifer seemed angrier than usual, smiling she threw a football that nearly hit another child, she threw down a lollipop someone had given her, and she threw down mother's emptied plastic coffee cup. At one point, she became irritable, cried and twisted her body in mother's arms. As she had done four days before, she twisted out of mother's arms twice. Three days after, this irritability and the wanting to be held and then pushing away behavior appeared near the end of the two-hour group session. She had stayed near her mother for nearly the entire observation session.

Two weeks after the session when this sequence of behaviors first appeared, Jennifer remained close to mother for most of the session. When she moved away, several times it was within a radius of four to six feet only from mother. Again, much of her anger was directed at things, not at mother. We believe that the anger was caused by the internal distress and pain Jennifer was feeling for which she blamed her mother (see Section 2.241).

Some children became aware of this inner experiencing of opposing inner forces gradually, in small doses; others, like Jennifer, seem to become aware of this conflict in a sharp, intense manner, with full force. At the peak of this conflict, be it a gradually mounting one or a sharp, intense one as we saw in Jennifer, a crisis seems to be experienced emotionally by the child. Mahler and McDevitt spoke of this as the "rapprochement crisis".

The intrapsychic conflict produced by these polar forces brings with it not only anger as we saw in Jennifer but also a substantial degree of anxiety. This anxiety is especially manifest in the re-emergence of separation anxiety and stranger anxiety which we talked about in Unit 1. These anxieties are the product of the emotionally attached child's experiencing separation from mother now, again, but at a new psychological organizational level. The separation and stranger anxieties lead to the child's needing to return to the physical closeness with the mother in a manner that seems to govern the child's behaviors. This is why Mahler identified this period as the "rapprochement

subphase", rapprochement being the French word for "to come close together again". As we shall discuss in the Child Rearing section, this is what makes many children cling to mother again as they did during the first year, and makes many mothers worry that their child is becoming a little baby again! The clinging now is due to a new development, not due to regression in the child. When parents understand this, we have found that not only are they greatly relieved, but that they then deal with their children more constructively.

Indeed, looking at young children during the period from about 16 months to 24 months of age, one finds them tending to stay close to their mothers, to bring their activities to the area where mother is located. The 20 month old who four months before was quite comfortable 20 feet away from mother or even in a different room, now finds it necessary to stay at mother's feet, or to move away from her for perhaps a couple of minutes and then need to return to mother, perhaps climb onto mother's lap to be held and comforted by mother; the child clearly manifests great difficulty tolerating separateness from her, a factor which creates much stress not only for the child but for the parent as well. We shall discuss this further in the Child Rearing section.

Another striking challenge meets the child especially from the second year on as well, which interdigitates with the rapprochement subphase and the subphase that follows, On the Way to Self and Object Constancy. It was described by Dr. Louis Sander, also a remarkable researcher of early mother-child interaction. He speaks of it as the paradox the child has to negotiate of "being able to feel together with" mother (or father or primary other) and at the same time "being distinct from" the other. It is an important facet of the child's developing sense of self and of relatedness to loved ones, again reflecting the complex interplay and pull of forces within the child (as well as the mother- and father-child relationships) as the child develops from a feeling of oneness with his or her primary caregivers into an individual, a distinct self deeply emotionally engaged in one or more love relationships that will have life long implications.

The rapprochement conflict produced within the child during the second half of the second year brings with it not only anger and anxiety but also a soft deflation in mood, a soft sadness which Mahler called "low-keyedness". This differs from feeling downcast (shame) when mother or father scolds or feeling anxious and mildly depressed after being angry with mother or father. Rather, it may be produced by the cognitive and emotional recognition that the child is small and vulnerable (being separate from mother), a feeling sharply in contrast with the prior feelings of elation and excitement that come with the discovery of new sensory and motor skills as well as of the "new" world into which the child was born, the prevailing feeling the well-cared for child has during the practicing subphase.

To be sure 20 month old Diane and her mother had had some pretty hefty battles of wills at the end of year one and the beginning of year two. But Diane had also been quite a lively, cheerful and busily exploring toddler during those times. When she was 20 months old she seemed less cheerful in general. In fact, she seemed somewhat deflated in her mood. She did not look depressed; she just seemed a bit worried, thoughtful, mellowed at times quite apart from when an occasional but now less intense battle of wills occurred.

We should say here that given many burdens, normal developments brings to the 18

to 24 month old child, a number of factors could be responsible for this dampening of mood. This age child experiences not only the new awareness that the child and mother are not one, the feeling (due to better recognition of reality) that the child is small and vulnerable, but also the inner thrust to individuate, to firm up the sense of self, to become a source of and the initiator of action (autonomy), as well as experiencing continuing battles of wills, having to deal with limit-setting by those the toddler now loves and at times now hates (ambivalence), each of which produces anxiety, may produce storms of anger and even rage -- and more. And this is not a complete list of what challenges and may trouble the 18 to 24 month-old. Some already become concerned about their genitals, a concern that can then already be quite distressing (see Section 2.2311). In addition there are the daily fluctuations of tiredness, low blood sugar (from about one hour prior to meal times), the occasional tooth pushing painfully through the gums, the common colds or ear infections, etc. This, of course, is in the average healthy toddler; add the burdens of allergy, irritability (like Suzy), etc. in many other toddlers as well. With all this, it is difficult to be certain just what causes the "low-keyedness" commonly seen in the 18 to 30 month old child. It is well to point out here that those who say that childhood is a problem-free period of life do not remember well there own childhood experiences and do not look at children closely.

Side by side with the second upsurge of separation anxiety and stranger anxiety and the appearance of "low-keyedness" that arise from the rapprochement subphase stresses, the child who earlier had acquired a comforter will probably return to it and the child who did not acquire a comforter before may do so now. The comforter, which for some children may be a piece of blanket or a preferred teddy bear or doll, or for many others that very familiar but parent-worrying comforter the child's own thumb, the night bottle or much less commonly a residual pacifier, are items which serve the child exceedingly well in working their way toward tolerating separateness from mother. D. W. Winnicott helped us to understand that the comforter in some way becomes the representative of important aspects of the child's relationship to the mother and that it can often be used as a substitute for the actual presence of the mother. This means that a child's using a comforter is done in place of using the actual mother or meaningful caregiver. It is therefore a very useful and most often growth-promoting tool which helps the child in the process of becoming a self-reliant individual, one who is learning to take care of his or her own independent emotional needs.

Also during this rapprochement subphase, one commonly finds a reaction in children which grows out of the stress created by the conflict contained in that subphase; it is the child's claim that whatever draws the child's interest is "Mine, mine". Taking possession of things, including only too commonly items that belong to someone else, especially to another child, may well be in reaction to the child's new awareness that mother is not part of himself or herself. This awareness, we infer from the child's behaviors, implies the feeling of losing the mother, and that the gradual establishment within the child's mind that although mother is not a built-in part of self, mother is nonetheless deeply attached to the self by an emotional bond, makes for a feeling of threat of losing what belongs to the self and results in an overreaction of taking possession of anything and everything that draws the child's interest. It is, in other words, a reaction that is compensatory to the

feeling and the dread of losing that which is most valued by the self, that most experienced as "mine", namely the mother. This phenomenon leads some children to hoarding toys, particularly in a play setting where a number of children are interested in the toys accessible to them. This is often the reaction that may occur when a child is visited by another child who wants to play with the first child's toys and is told these are "Mine, mine".

The Rapprochement Contribution to the First Conflict of Ambivalence:

The conflict of ambivalence which we described above in the section on the practicing subphase, continues into the rapprochement subphase and receives contributions from two sources: (1) from the continuing battles of wills (autonomy conflicts) like the ones that occurred during the practicing subphase; and (2) from the rapprochement conflict itself.

Battles of wills activated by the child's thrust to autonomy will continue during the rapprochement subphase. In some children those become less intense, easier to contain and to resolve as was the case with quite assertive Diane and Jennifer as well as with difficult to calm Suzy. In other instances battles of wills may intensify. We shall address this further when we discuss aggression in the one to three year olds (Sections 2.241 and 2.242).

From around 18 months of age on, battles of wills are better profiled and more visible by the child's emerging ability to assert "No!". Many a child accompanies his or her resistance to a demand by the parent with a more or less assertive verbal "No!". The acquisition of the "No" is more than a language acquisition; it is the acquisition of a newly experienced strength, underscoring a sense of autonomy, a sense of assertive firmness in the self. At times this acquisition of the "No" seems to give the child a feeling of self that leads to overuse of the "No", as if the integrity of the self depended on this often repeated assertion. Sometimes the overuse of the word leads to the child's saying "No" even before the child has heard what he or she is being told or asked. We smile at the child who so fluently says "No", is so ready to say "No" even before mother or father finishes the sentence that you sometimes get: "Do you want some milk?"; "No". "Do you want some ice cream?"; "No', Huh, yes". Ready to say "No" to anything, the young child sometimes says "No" to something the child likes very much. Unpleasant as it is to parents then, it is helpful for them to realize that the "No" has the capacity to give the child not only an increased sense of autonomy but also a sense of assertiveness, self-possessiveness, self-confirmation. Indeed, it helps the child to define better her or his own sense of self.

Most importantly, the rapprochement conflict contributes to the accumulation or the lessening of ambivalence in the following way. The degree to which anxiety is created in the child by the conflict of wanting to be one with mother and, on the other hand, wanting to separate and individuate from her, the degree to which the anxiety experienced brings with it excessive unpleasure (emotional pain), to this degree will hostility and even hate now be generated toward the also loved parent. We speak now of "hate" and of "love" because this is the developmental period when the child becomes capable of feeling love

and hate which are respectively, positively felt and negatively felt accumulated and organized feelings that now have stability and endure (see Section 2.2131). They can neither be produced all at once, suddenly, nor can they be made to disappear suddenly except by psychological defense mechanisms (see Section 2.2531). In general, the more positive the parent-child relationship to date, the less will hostility be generated at this time. The more burdened the relationship between child and mother with accumulating prior high levels of hostility, the more will the anxiety be heightened during the rapprochement conflict, and the more then will unpleasure be experienced to excessive degrees and further levels of hostility will be generated and added to that already stabilized within the young child.

The conflict of ambivalence, then, which the child carries with him or her into the second half of the second year of life may be either intensified or lessened by the battles of wills that emerges between child and parent, and again, will be either of greater or lesser intensity due to the love feelings or the feelings of hate stirred up by the rapprochement conflict itself.

This difficult and critical rapprochement subphase, the primary task of which is the setting in motion of the dissolution of the child's sense of oneness with the mother, is continued and if all goes well will be age-appropriately resolved during the subphase which follows it. This fourth subphase was entitled by Mahler "On the Way to Self and Object Constancy".

On The Way To Self and Object Constancy:

The subphase Toward Self and Object Constancy spans the periods from about 24 to 36 months of age. The sense of self, which began during the first weeks of life, now achieves a substantial degree of definition and organization. From brief periods of wakefulness, when ten day old infants can be seen to explore visually their environment, have an observable inner sense of feeling hunger, appear aware of painful sensations, experience and in some way register the feeling of increasing unpleasure and crying, from such beginnings of sense of self-experiencing, we assume with little cognitive capability to form an idea of self, now organizes and emerges a sense of self more and more separate from mother, from father, from those emotionally invested by the child, a sense of self with inner cohesiveness and a feeling and perception of being an entity. Children now can verbally identify themselves as "me" -- given that few very young children properly use the pronoun "I", which is however, what they mean.

Equally, other persons, the valued and needed mother, father, other devoted constant caregivers and siblings, go from being experienced as part of the self to now, becoming perceived as other separate entities highly emotionally invested by the child.

It was when we were talking about this process, this specific development that one mother who had twins reported what follows. She and her 29 month old twins were sitting side by side on the bus to come to our program. Mother reported that one twin, with a thoughtful look, touched her own leg; then she touched her sister's leg; then again she touched her own leg, and looked up to her mother with a smile on her face. Mother

said to us that she had wondered to herself if her daughter was checking which legs were her legs and which her twin's. We agreed that this was a very sensitive observation and that her daughter seemed pleased with her discovery. She was distinguishing the entity that is her twin and the entity that is herself. Similarly 30 month old Jennifer said to her mother: "You're Janet; I'm Jennifer". Mother said that she protested "I'm your mother"! To which Jennifer insisted: "You're Janet; I'm Jennifer." We clarified to mother that Jennifer was simply stressing to mother that she, Jennifer, is an entity, is named Jennifer, and her mother as an entity is named Janet. This did not mean that she did not understand that Janet is also her mother, but that rather in addition to being her mother, mother was an entity called Janet. In these examples, the process of further stabilizing these toddlers' sense of self and of other could readily be inferred.

According to Mahler, the process which produces the rapprochement and the "on the way to self and object constancy" subphases leads to the child's dissolving the symbiosis with mother (that earlier experienced sense of oneness of self and mother). This dissolution brings with it a basic identification in both normal boys and girls with the "mother of symbiosis" which makes an important contribution to the personality of the child. Where father is actively engaged with the infant from the beginning of his or her life, a similarly basic identification with the father occurs. This hypothesis grows out of the psychoanalytic developmental theory that we can only give up a past relationship to a highly emotionally invested person by identifying with that person. That is, by taking aspects of that person within our own self. In the course of normal development, this major psychological mechanism is what leads the child to identify with his or her parents. Sigmund Freud said that this important process is what makes the child be the child of his or her own parents, as if, he said, the child carried the stamp "Made in the U.S.A.".

There is much clinical and research evidence to show that the better emotional quality of the parent-child relationships, mother and child, father and child, the less the hostility and hate, and the less intense the ambivalence generated within the child. In parallel with this, the better the rapprochement conflict is resolved during the subphase Toward Self and Object Constancy, the less will be the residual ambivalence experienced in that parent-child relationship. This also means that the remaining ambivalence experienced toward the parent and toward the self will be less.

The task of resolving the rapprochement conflict during the subphase Toward Self and Object Constancy, becomes complicated by the emergence during the third year of life of the next major task of psychological-emotional development, namely, the first major differentiation of sexuality (Section 2.23, below). Again, we emphasize that life becomes complicated and full of challenges for the young child very quickly. This major differentiation of sexuality brings a special complication for the boy; we make the assumption that boys must selectively disidentify with the femaleness of their mothers -- given the basic identification that comes with dissolving the symbiosis --as their masculinity gets its first major differentiation during the third year of life. More about this in Section 2.23.

2.2212 CHILD REARING: What Can The Parent Do That Is Growth-

Promoting Regarding The Child's Continuing Separation-Individuation Process?

It is important that parents bear in mind that the development of self and the development of our relationships to others occur in parallel, influencing each other at nearly every step of the way. Put most simply, the degree and the way the child loves the parents is basically the degree and the way the child will love himself or herself; the degree to which and the way the child hates the parents is basically the way and the degree to which the child will hate herself or himself.

<u>The Practicing Subphase:</u>

The magnificent practicing subphase can be a source of substantial problems for parents. The practicing subphase is magnificent because it is the period when the excitement and pleasure of feeling full of oneself (sense of autonomy and power), as well as of learning and of discovery first bursts forth. Here, the parents have the opportunity to enhance the child's pleasure in his or her sense of autonomy and in learning, or they can undermine, even smash the child's excitement about being himself or herself and the pleasure in and about learning. Given that most parents recognize the value of learning, the value of eventually doing well in school, it is important that they recognize the powerful position they occupy in a child's life and the opportunity this phase of development gives them in terms of enhancing the child's excitement about learning at its beginnings. But it is also very important that parents recognize in the child's behaviors the thrust, the inner push of the child's emerging sense of autonomy and the central part they play in their child's continuing evolving sense of self.

The major source of problem for the parent as well as for the child, comes from the fact that the enormous inner pressure which seems to drive the child's earliest autonomy and learning experiences -- his or her curiosity and explorations--, leads the child to often explore items which parents recognize they cannot allow. As we said, this inner force cannot yet be considered to be the child's "Will" because it has not yet come under the child's control. Knowing that the inner pressure which drives the child is at first not fully controllable by the child, can increase the mother's or father's appreciation of what is going on and make clearer the task of setting limits in a constructive and growth-promoting manner. Any interference, any effort to block the thrust of that inner pressure to explore, to learn, leads to an experience of frustration; and if the unpleasure that comes with this frustration is sufficiently high, it will at first generate anger, and if the unpleasure intensifies or just continues it will generate hostility toward the person who is creating the obstacle to this inner-pressured exploration.

In Section 2.2211 we described that this well-meaning interference by the limit-setting parent leads to the child's experiencing a battle of wills (as does the parent) between self and the valued and needed parent, which creates within the child a conflict due to his or her thrust to autonomy, an <u>autonomy conflict</u>. Furthermore, we said, that as the child experiences unpleasure and as this unpleasure mounts it will generate in the child at first anger, then hostility, hate and even rage and temper tantrums. With this, the

child experiences an internal conflict due to ambivalence. Although we shall discuss more fully the issue of generation of hostility, hate and rage toward parents and how to handle these, including limit-setting in Sections 2.24, 2.241 and 2.242, let us here get a preliminary look at the handling of the child's autonomy striving and battles of wills, the setting of limits, and the healing of hurt caused by battles of wills.

We saw in Section 2.2211 that 13 month old Diane, and quite similarly, Bernie, was a very healthily busy explorer. We also saw a very difficult conflict she ran into with her mother when mother did not want her to push the toy cart into the hall. At our encouragement, mother several times had told Diane she did not allow it because the toy cart should stay in our main meeting area so that it could be available to the other children too. The child should always (at the outset) be told why she or he cannot do something the child wishes to do. But Diane really "wanted" to do just what mother said she could not and she protested more and more as mother nicely enough picked her up to keep her from going into the hall. Diane squirmed, cried angrily, moved her arm, struck her mother, kicked her, and once even struck herself. Mother got increasingly upset, embarrassed and angry with Diane. She had said why Diane could not do what she was trying to do, she then told her she was sorry to upset her so and tried to calm her down. When Diane hit her, kicked her, and struck herself we told mother to tell Diane "It's OK for you to be angry with me. But it's not OK for you to hit me or kick me or try to hurt me. And you are not allowed to hurt yourself either!". The reason we told mother to say this is that letting Diane hit her would eventually make 13 month old Diane feel bad about having hurt the mother she values and (and soon will love), and it would make her afraid of her own feelings of anger, of hostility and later of hate. Mother should also prohibit Diane's hitting herself to discourage her child's attacking herself to protect her and to convey to her child that she loves her even if she is angry with her for being difficult right now!

Mother was troubled too. She was surprised when Diane stopped struggling. Still holding Diane, she sat down. She knew that her child was very upset. We encouraged mother to not put Diane down, to hold her and try to comfort her. She tried to comfort her to help her stop crying, told her she was sorry that Diane was so upset. Diane continued to cry angrily, and she pulled away from mother. Reading Diane's signals (in her behavior), mother gently put her down on the floor. When she saw that this made Diane cry louder, she responded by picking her up again. She did not force Diane to mold into her. She just quietly held her, sitting on her knees, when she thought Diane might let her comfort her, mother tried to gently rub her shoulders to comfort, but Diane brushed her hand away, clearly angry. Mother pulled her hand back. Again we encouraged mother to just sit there and let Diane deal with this, on her own, while sitting on mother's lap. The battle of wills was over, Diane's autonomy strivings and inner push to explore were subdued; Diane's mild rage toward her mother was calming down. Because mother did not reject her child when the child was raging at her and did not scold Diane when Diane pushed her hand away, and was willing to pick her child up when she signaled that being put on the floor felt worse than being on the knees of the mother she felt very angry with, mother facilitated Diane's dealing with her feelings of anger and hostility toward the mother she values, is attached to, and has large positive

feelings for. Mother in this way helped the healing of Diane's hurt feelings. And as she allowed her child to stay on her lap, mother, too, readily felt her anger toward Diane get less and less and her feelings of love for her daughter were the stronger, took over, and made her want to just make her hurt child feel better. As Diane relaxed and molded back into her, she warmly held her child, both healing from the hurt feelings this battle of wills had caused them.

It bears emphasizing that the child will be upset when mother or father stops him or her from getting his or hands on a plug engaged in an electrical outlet. It will lead the parent to complaint impatiently "Why is he so stubborn!" and "Why does he never listen to me!". The answer to these questions is that the inner-drivenness which activates the child to these behaviors is experienced by the child as a need; it is not the child, at will, turning on the switch to this inner energy. In fact, as we will detail in Section 2.2521 below, the development of internal controls over just such inner-drivenness comes gradually and is significantly helped by the parents' constructive limit-setting.

Therefore, the unpleasant encounters every parent has with the average 14, 16, 22 month old child, while unpleasant, time consuming and challenging, are important in that they make a major contribution toward the development of the sense of autonomy and sense of self, of emerging internal controls, toward learning in general (like what things do, how they are made, etc.), toward learning what is appropriate and inappropriate behavior, toward the development of self- protective behavior rather than self-harming behavior, etc.

As we emphasized in the Human Development Section of the continuation of the practicing subphase (Section 2.2211), baby-proofing the house, putting out of reach things which the 18 month old should not touch, items that too easily can get broken, items that the parents value, or those that can cause the infant harm, make for an environment safer for the infant to explore, an environment in which limit-setting will be needed less frequently and, therefore, one that will facilitate and encourage learning. We want to emphasize that limit-setting should not be avoided where it is needed; it is excessive limit-setting that can lead to the discouragement of exploration where there could be pleasure and excitement in discovery and in learning.

We want to emphasize that parents have the opportunity from the end of the first year of life to protect and foster the child's curiosity, interest in the world around, which is the first stage where the child's inner motivated need to learn dominates the child's activities. We emphasize also that this is where "school learning" begins, not in kindergarten or first grade. It may well be that enjoying learning now can be crucial for future learning. With this in mind, it is important for us all to know that the parent's enjoyment of the child's learning, of the child's excitement about discovering new things, the parent's enjoyment in helping the child to learn (be it parts of the body, colors, numbers, etc.), all contribute to the child's own pleasure in his or her first experiences in learning.

Most two year olds ask questions, some ask many questions. It is highly valuable to answer a child's questions, to answer them in a way that the child can understand. A word about this. Parents tend to underestimate how well children can understand words that are spoken to them. It is important for parents to realize that children understand

words well before they can speak. As we said in Unit 1, when 12 month old Johnny's mother -- who had just spilled trash on the floor -- without thinking asked him to get a broom, the 12 month old who did not yet speak, left the observation room, went into the hall, into the work room, into a closet and brought out a broom he could barely carry. Of course, the parent has to guard against assuming that the child understands more than he or she can. Some parents make the mistake of expecting too much understanding, but most often we have found parents of young children tend to underestimate how much children understand. Close observation will reveal to parents how much their children understand and how much they do not; it is valuable that parents try to ascertain what their children understand and what they do not, and that they guard against both underestimation or overestimation of it. Thoughtfully, answering questions is valuable for the child's learning, and will eventually prove to be rewarding given that this is where becoming a good student begins. It will also help the parent learn how much the child does and does not understand.

Of course, children will sometimes use asking questions as a means of badgering their parents. Parents have a right to say that they have had enough of the child's questions for awhile. They also would do well to try and sort out whether the child is trying to badger them or whether the child is really in search of information. Parents should not be discouraged by the fact that children tend to ask the same questions over and over again. Again here, the task is sorting out: Is the child trying to badger me or is the child trying to gain mastery over an idea that does not yet make enough sense to her or him?

Certain parenting activities clearly contribute to a child's interest in learning. For instance, the parent's approving and applauding a task her or his child is undertaking will facilitate the child's performing that task. The caution here, is that the parents not take over; that they follow the child's lead, give the child enough space, enough opportunity to select and try to achieve the task himself or herself. If the task is too difficult, help should be offered before the child becomes too frustrated in trying and gives up, with the feeling of being incompetent. But parents who do not let their children try enough on their own, discourage their children from trying. Parents who are too impatient in getting certain tasks done, and do not give their young children an age-appropriate opportunity to help or to do it themselves, are depriving children of just that, the opportunity to try, to learn to do something. This, of course, applies not just for the one and two year old child but for children from this age on.

Reading to children is wonderfully enhancing of interest in reading, in learning. It is well to bear in mind that from the end of the first year on, in addition to exploring and beginning to play with toys, children become able to participate in being read to. That the parent the child is attached to is reading to the child will heighten the child's interest in learning to read. It is not necessary to provide children with large libraries of books or many toys. A few well-chosen books, a few well-chosen toys are enough for most children. Children become interested in all kinds of things besides toys like pots and pans, stoves, refrigerators, buckets of water, cartons, silverware, etc. Providing good learning experiences for very young children, children from one to three years of age, does not require large expenditures of money on toys, and furthermore, all local libraries

have many books for young children.

One more note before we leave this exciting practicing subphase of separation-individuation. Mahler described a striking behavior which most 10 to 18 month old children, and older ones too, show. During this period of development the young explorer usually moves away from where the valued caregiver is sitting or working. After all, there are fascinating things that seem to beckon the toddler's curiosity farther and farther from where the caregiver is. Now and then, Mahler observed, as we described in Section 2.2211, the young explorer suddenly stops his or her exploration, looks about to where mother (or father) is, usually smiles (especially when mother or father is then looking at the toddler), and in one or two seconds is back at work exploring. Mahler thought that the busy toddler may suddenly remember he or she is not near mother (or father) and feel the need for "emotional refueling" which can occur at a distance, not requiring that the child be physically comforted then -- which would interrupt the exploratory activity. It is well for the parent to simply smile back, to not get up and go to the toddler, to thus give the toddler permission to be on his or her own in this autonomy enhancing exploratory activity.

The Rapprochement Subphase:

New developments at about 16 to 18 months within the central nervous system and within the range and details of emotional experiencing now make the child increasingly aware that mother and self are separate persons. This now brings with it the conflict which we describe in Section 2.2211 on Human Development, namely, the inner push or wish to separate and individuate, to become an autonomous entity and an individual person, side by side with the fear of separation and individuation, the wish to remain one with mother, attached to her as emotionally experienced up to now. This basic rapprochement conflict creates anxiety, especially, but not only, because the child's growing ability to accurately perceive reality makes the child aware that she or he is very small compared to the adults around and vulnerable.

We have found that when parents do not know of this normal developmental conflict they often become alarmed when -- due to this increase in anxiety -- they see (and feel) an increase again in separate anxiety which then again makes the toddler cling to the mother. The renewal of clinging, due to both separation anxiety and often also to stranger anxiety, make many a mother fear that the child is "regressing", that the child is losing the level of development to which she or he had advanced only two or three months before. "He's becoming a baby again", say some mothers with distress. No, this is not a regression, as we have told many a mother, this is a step forward in development. The parents we have had the privilege to talk with are greatly relieved by this information. What they assume to be regression is not a regression but developmental progress. When mothers know this they are able to experience their child's renewed clinging with much less distress and it frees up the parent's wishes to comfort and to reassure. And it works.

Now let us go back to what happened to Jennifer and her mother during her clearly detailed rapprochement conflict. We said that when Jennifer was just under 20 months

old, what seemed to mother to be a very troublesome series of events occurred. Jennifer had been sitting with her mother on the couch. As her peers were milling about and in excitement taking their shoes and socks off readying to go into our matted activity room, Jennifer joined in the excitement and took her shoes and socks off as well. She got off the couch to join them when suddenly she stopped, became somber, then acutely distressed, turned around and reached for mother to pick her up. Taken by surprise but nonetheless positively responsive to her child, Jennifer's mother picked her up and put her on her lap. Jennifer was there for about two seconds when she began to squirm in distress and wanted to be put down on the floor. Mother, not sure what to do, put her on the floor. No sooner was Jennifer on the floor then she began to whimper and again appeared distressed and turn to her mother, arms up, wanting mother to pick her up. Mother a bit baffled, picked Jennifer up and put her on her lap. Calmed for perhaps two or three seconds, Jennifer began to fuss again, and so on. This back and forth, wanting to be held, wanting to be separated from mother was repeated six times. We said that Jennifer was much distressed and appeared conflicted; seemingly not sure whether she wanted to be held or put down. We recognized in this that Jennifer was not certain whether she wanted to be one with mother, or to be separate and individual from her. Mother mirrored this distress as well; she did not know whether to hold Jennifer or to put her down; furthermore she sympathetically mirrored Jennifer's distress by means of the "contagion of affects" which is a critical contributor to people's understanding of one another, particularly so important between child and parent.

Jennifer was experiencing an acute rapprochement conflict; mother shared in that distress. But mother was baffled by what was going on, understandably so. When we explained to mother what we understood to cause Jennifer's behavior, namely that Jennifer was torn by the conflicting wishes to be separate, be an individual, and on the other hand to remain one with mother, mother calmed immediately. Now understanding what was going on she could make herself emotionally available much better to her child's difficult experience. No longer upset herself, although she could feel (it was easy to see) her daughter's distress, she could calm her better, reassure her that she will be fine and make herself available to accommodate Jennifer's quickly alternating wanting to be held or let alone without experiencing either as worrisome.

Parents then also understand that the clinging behavior that may reappear during the second half of year two is not due to regression but rather to forward progress. It is important for parents to know why a child feels the need to cling. No child clings to parents without reason. It may be due to the need for comforting, reassurance, "emotional supplies", hurt feelings, anxiety, fear, etc. Parents have to seriously weigh the consequences of not allowing the troubled child to cling. The need to cling is better gratified than frustrated; to gratify usually does not harm, to frustrate usually does. To gratify with feeling of resentment does not work well. To hold the child who needs to cling should be done on the basis of understanding the child needs this at the time. Sometimes, at this age, the need to be held can be delayed; it is useful to then tell the child you cannot hold the child now but you will after you have finished what you are doing. But then, do it. Do not say you will and not hold to your promise, unless you have a very good reason and explain it to your 18 or so month old child. The need to

cling, the increase in separation anxiety, stranger anxiety, in the use of the comforters in the 16 to 30 month old, are all usually due to a normal step in development.

On the other hand, the need to negotiate the paradoxical feelings of "being together with" and "being distinct from" can also be facilitated by the parents' themselves feeling of "being together with" and "being distinct from" their own children whom they love dearly. Jennifer's mother's being able to put Jennifer down and to as easily pick her up, back and forth at Jennifer's request supported Jennifer's efforts to deal with the crisis feelings she had and with this, was also dealing with the paradox Dr. Sander has described. "Being together with" the mother Jennifer loves but also "being distinct from her", being an individual got set in motion dramatically in Jennifer and was very well supported by her mother.

This age child's hoarding of things, toys particularly, at times, is also a spin-off of the rapprochement conflict and development. Knowing this will make it easier for a parent to help her or his child deal with this phenomenon. Of course, this will arise when a child in play with other children, grabs other children's toys saying "Mine, mine", or when another child wants to play with a toy which your child is holding. Certain principles ought to be developed on this issue. For instance, it is useful for parents to identify certain toys as their child's favorite toys and that these toys should be safeguarded; and when your child says "That's mine", about a toy that a mother knows is one of the child's preferred toys, then that toy should not be made accessible to other children without the toddler's consent, "Is it OK for Johnny to play with your truck or rabbit for awhile?". This makes it possible then for a mother or a father to determine which toys a child should be expected to share and which should be the child's private property. Not all toys should be private property, nor should all toys be shared. Those the child deems special should be made private property; for the others, it is reasonable to expect, and tell this to him or her, your child to be able to share things with his or her young house guests given that when your child goes to that friend's house your child will want his or her friend to share some of his or her toys with your child as well.

Parents are very wise to be attentive to how their children feel, from the day of birth through their years of development, until they leave home and beyond. Among the many feelings we find in 16 to 30 month olds, low-keyedness too needs to be recognized and dealt with sympathetically. Seeing 20 month old Diane who was a lively toddler, whether she was exploring or asserting herself with her mother or others, now appear deflated in mood was noteworthy. Mother was initially concerned about it. We pointed to the many stresses Diane was experiencing by the demands made on her by normal development and that Dr. Mahler took special note of it and that it usually occurs at this age. There is no need to try to do away with this low-keyedness. It seems to be part of learning to deal with the now very taxing tasks of development. It is important and helpful for parents to try to make time to just spend some quiet activity time together, like reading a book, sitting comfortably close together, or going for walks together.

The Continuation of the Conflict of Ambivalence:

As we said in Section 2.2211, the conflict of ambivalence (love and hate feelings

toward the same person) during the rapprochement subphase is either intensified or lessened by two factors (1) by continuing battles of wills caused by the child's further evolving thrust to autonomy which is now amplified by the child's newly emerging ability to feel and say "No!"; and (2) by the degree of hostility generated by the rapprochement conflict itself. Let us take one at a time.

Battles of wills emerge and need to be dealt with by parents most commonly in the context of limit-setting, which we shall discuss in detain in Section 2.24 (The Development of Aggression). Where much ambivalence caused by earlier life experiences has become and remains in the child's relationships with the parents, the continuing battles of wills that occur during the rapprochement subphase may, depending on the current quality of parent-child interactions, either intensify or decrease the already accumulated ambivalence the child experiences. It is helpful for parents to bear in mind that child rearing consists of a complex set of functions which parents learn and, therefore, which can be improved; every parent who has a second child knows this. The exception to this is where the second and first child are vastly different. For thousands of years, our first child has been the workshop in which we become parents. But this also means that parents can grow in their child rearing functions. Therefore, even where battles of wills were difficult during the practicing subphase, a parent whose skills in handling battles of wills improves, may now be able to deal with such battles in ways that are more growth-promoting. This can then lead to an amelioration of the ambivalence unavoidably generated between child and parent.

It was most advantageous too that Suzy's parents, especially mother, were committed to and were able to continue to help Suzy try to calm herself and cope more comfortably with everything. It was rewarding to see that with the new maturation (biological evolving) of the central nervous system that occurs during the middle of the second year, and the gradually improving interactions between 26 month old Suzy and her parents, their battle of wills became less intense and Suzy's reactions of hostility were less intense as well. So too, according to mother, it was with Mrs. Sander, her substitute caregiver. In fact, we wondered if each battle of wills now between Suzy and her mother seemed to be an opportunity for Suzy to practice having better control over her reaction of hostility, of reacting with less hostility, of having a better recognition of mother's efforts to help her and in the end, each episode seemed to lead to a lessening of Suzy's feelings of hostility toward the mother she clearly loved. This usually also decreased Mother's unavoidable feelings of hostility toward her own beloved somewhat biologically troubled daughter. It also seemed to us that Mother's handling of Suzy was increasingly becoming self-assured as she could see the gradual good growth that was occurring in Suzy. We shall say more about what mother did in setting limits with Suzy in Section 2.242. We are of the optimistic school which says that parents can learn to improve their parenting even up to the time when their children become adults; therefore, one should never stop trying to improve one's parenting.

With regard to dealing with battles of wills and limit setting, a very important new ability develops during the rapprochement subphase. From about 16 to 24 months of age, children feel yet another burst (the first major burst occurring from 8 to 12 months) in their highly important developing sense of assertiveness, of self-confirmation, manifest

now in their ability to say "No!". Most parents do not like to hear that "No!". Indeed there are times when a "No" should not be accepted by parents. But it is important for parents to understand that this "No" brings to the child a growth-promoting, increasing sense of being a self, of being an individual. Think of it: someone tells you to do something you do not want to do and with firmness you say "No!". This at time unpleasant "No" is a uniquely effective way the child finds of drawing a clear line around his or her self, of feeling a sense of power, a sense of entity. Therefore, when the child's "No" is always experienced by the parent as an offense, as a resistance to doing what the child is told to do or not do, as an undesirable reaction, it robs the child of an increment of sensing herself or himself as an individual with rights.

Given that this "No!" is an invaluable asset to the developing self, parents need to select when to protest the child's "No" and when to accept it, when in fact to derive some pleasure from it. Some parents cannot tolerate a child saying "No" to them because they experience it as defiant, insulting or whatever. This can be regrettable, because it may rob the child of a sense that he or she can decide things, can assert herself or himself, and will undermine the budding sense of autonomy and individuality. For this reason it is well to bear in mind that one can just as easily say to a child when telling her or him it is time to go to bed and the child reacts with a "No!": "Don't you ever say `No' to me!" as it is to say "Look, I understand you do not want to go to bed yet; but, it is time for you to go to bed now; I do not want you feeling cranky tomorrow because you did not get enough sleep!". In other words, the child's saying "I am a self", which is contained in the "No" can be respected while informing the child that although the child has the right to express his or her feelings, it still is time to go to bed and is expected to do so. Children experience feeling put down, being insulted, every bit as much as we adults do, and react to that experience much the same way we do. If anything, it is more hurtful to them because their sense of self is then just burgeoning, just emerging.

We have seen that when parents understand the behavior we saw in 20 month old Jennifer and her mother, when they understand what we believe to be the cause of the child's renewed clinging, heightened separation anxiety, renewed use of the thumb (or other comforter), that this understanding makes it possible for the parent to handle the child's distress due to her or his rapprochement conflict, with more patience, more sympathy, and makes possible the parent's developing strategies for helping the child tolerate anxiety in ways that are more growth-promoting. The result of this is that anxiety will be less prolonged, made less intense by the parent's empathetic and sympathetic (and when needed, firm) interventions, that the excessive unpleasure generated by the anxiety experienced by the child will be less and therewith less hostility will be generated within the child (see Sections 2.241 and 2.242, below). Then too, less hostility will be generated toward the parent during the child's normal rapprochement conflict and therewith, as we saw in Suzy, the existing ambivalence from before will tend to be lessened substantially. Where parents do not understand the source of anxiety, handle that child's anxiety poorly, unsympathetically, anxiety will be intensified, more unpleasure (pain) with it, and more hostility thereby generated toward the parent. In consequence of this, the ambivalence experienced toward parents and toward self will be further intensified and continue to stabilize as part of the child's developing ways of

coping and personality.

Toward Self and Object Constancy:

During the third year of life parents will have continuing opportunities to help the child further work through the normal developmental conflict inherent in the rapprochement subphase as the child attempts to grow out of the emotional experiencing of mother and self as one. Understanding that the child experiences a good deal of anxiety and internal conflict with the dissolution of the feelings of oneness into a meaningful emotional relationship between self and other, can be of large consequence to the development of a healthy sense of self, which is essential for good mental health and emotional well-being. Equally understanding that other human beings are also individuals, makes for healthy adaptation and good relationships.

In the example given in Section 2.2211, Toward Self and Object Constancy, where Franny touched her twin's leg and then her own, and 30 month old Jennifer said to her mother "You're Janet; I'm Jennifer", the mothers (and fathers) who can appreciate what this means to their children are likely to confirm that the child is quite right in her understanding and construction. By contrast, the parent who is not aware of the meaningfulness of this experience may give the child no confirmation and some may even ridicule the child.

Knowing that the work of this period of development, namely the resolution of the rapprochement conflict, brings with it identifications with (taking on characteristics of) the parents, that these identifications contribute to making the child the specific child of her or his own parents, should enhance in parents thoughtful and concerned parenting. Helping the child to constructively work through the rapprochement conflict which is facilitated by understanding what it's prime conflict is, will facilitate and stabilize the child identifications with the various features of the parents. The more likely it is that the child will accept those viewpoints, values, philosophies and religious beliefs that govern their specific family. We will talk about the question of boys selectively disidentifying with the gender features of their mothers in Section 2.23, when we talk about the emergence of sexuality. There as well, we will address the emergence of the next major task of psychological-emotional development which occurs during the third year of life, namely, the first major differentiation of sexuality in both boys and girls.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.22 THE DEVELOPMENT OF SELF AND HUMAN RELATIONSHIPS

2.2221 HUMAN DEVELOPMENT: The Earliest Human Relationships

As we said in Unit 1, there are variations in the distribution of caregiving responsibilities in each family, each family determining how much and which responsibilities will fall to the mother and which to father. There are also cultural as well as personality differences among caregivers. Bearing this in mind, we continue with the model of Mother and Father being the prime caregivers, even with daycare use, mothers usually being most involved with early child rearing and fathers varying widely in their degree of parental caregiving to their one to three year olds.

On the average, Mother is the central figure of the child's feeling of oneness with the prime emotionally invested caregiver, what Mahler called the "symbiosis". We reiterate that this is the product not only of emotional factors but of biological ones as well -- the mother having carried the infant in her uterus for 9 months and the remarkable biological influence on emotional life that goes with it -- , and that Mother therewith becomes the central figure for the one and two year old child as the child traverses the Rapprochement subphase as well as the subphase Toward Self and Object Constancy we just talked about in Section 2.2211.

We here discuss the hierarchy of the child's earliest relationships especially in the context of the theory of Separation-Individuation (Mahler) because, we believe, at the time of this writing it is the most developed model which explains what happens to the child during the first three years of life in the context of the child's relationship to others. But other component models are integrated here as well including especially those developed by psychoanalytic theorists on the development of attachment (J. Bowlby and M. Ainsworth), on the development of affects (R. Emde and D. Stern), the development of aggression (H. Parens), of adaptive interaction (L. Sander, B. Brazelton, and D. Stern), and on the development of self (Erikson).

The mother, when she is the central caregiver in the child's first three years of life, is the person most drawn into the child's experience of oneness and into the task of its resolution (through separation-individuation), becoming then the person most emotionally invested by the child with feelings of need, valuing, and dependency. But she also becomes the first person to be the object of her child's ambivalence, that is, side by side with developing love feelings are the child's feelings of frustration, anger and hostility as these emerge during the first, second and third years of life. In other words then, the person most important in the child's life becomes the first person to be loved but also the first to be hated by the child (see Section 2.24).

The first signs we saw in Diane, Bernie and Jennifer of "being angry with" during the end of the first year was toward their mothers. We talked about it in Unit 1. During year

two, this appeared especially during their battles of wills and limit-setting which almost always occurred together. That is, limit setting often leads to battles of wills, which in turn often lead to the need for limit setting. These occur to a greater or lesser degree in all child-parent relationships during the second and third years, as well as from even earlier (in year one) and well into adolescence.

During the second and third years, we saw a good deal of hostility on the part of Diane, Bernie, and Jennifer toward their mothers. In 13 to 14 months old Diane's dramatic battle of wills and autonomy conflict, her rage toward her highly emotionally valued Mother was so intense that it created a virtually paralyzing conflict within her mind. Although neither Bernie's nor Jennifer's battles of wills nor their resulting internally felt autonomy conflicts were as intense as the one we described between Diane and her mother, there were a number of times that limit-setting was required and hostile feelings toward Mother were readily visible. Each such episode activates and makes for the child's experiencing ambivalent feelings toward the most important person in their young lives. More on this in Sections 2.241 and 2.242.

A very difficult picture was found with Vicki and her mother during the second and third years. Because Vicki had become quite depressed during the second half of year one, and her mother was depressed as well, we worked with them therapeutically. We shall describe in Section 2.2222 what we did. Here we can say that very fortunately both Mother and Vicki gradually responded very well to our psychotherapy. Vicki had formed a meaningful and stabilizing attachment to her mother, but their relatedness was severely dampened due to their depression. Her over burdened Mother not being able to be sufficiently emotionally available to Vicki during her first year made it so that Vicki's emotional needs (to feel valued, loved, important to Mother, through the way she fed her, diapered her, help her, talked to her, etc.) could not be met well enough. This made Vicki depressed. The changes in her actually devoted Mother's caring for her led to a slow but gradual lifting of Vicki's depression and a welcome improvement in their relatedness with much more communication between them, more holding, comforting with warmth and the feeling of being together. Interestingly, we saw few battles of wills between them through years one, two and three, as well as later. Perhaps it is because the repair work each was doing to mend their troubled relatedness made them extremely sensitive to not upset or challenge each other too much. We could not be certain that Vicki's thrust to autonomy, self-development and self-reliance were troubled by these beginnings. She was less self-assertive during years two and three than the other children. However, her relatedness with her mother and her siblings improved very well so that in this, we felt Vicki was having a good recovery of normal functioning, adaptation, and relatedness. There was no clear evidence in Vicki of ambivalence toward Mother.

With regard to the father, the attachment by the child to the father, as with the mother, is totally determined by the degree of the father's emotional engagement in the relationship with the child, especially how much time and what quality time the father spends with the child and from how early on he becomes involved in the care of, in interaction with the infant. We want to emphasize here, that early involvement by fathers in the care of their young make for a highly meaningful engagement to the father on the part of the child which can have life long reverberations. Generally, when a father does

not relate to (interact emotionally with) his infant and delays his involvement with his infant until the third year, and sometimes later, the child's feelings of closeness to the father will seldom (if ever) become as strong as the feeling of closeness children develop towards their mothers. We have all heard of fathers who make this discovery too late and then live to regret it profoundly.

During the second year of life many a father becomes a "knight in shining armor" as some child developmentalists have said, a person full of splendor who will help the child separate from the mother of infancy, separate and individuate out of the experience of symbiosis with her, by means of the excitement, the fun and adventure of discovery of the world outside the oneness with mother, a world full of new things to discover and learn about opened to the child by an emotionally involved father.

Throughout cultures, Father becomes prominent as a primary person in the child's life from the middle of the second year of life on, in many cases from the end of the first year of life on as the person who can be there as the child begins the process of differentiating out of the oneness with Mother. Throughout cultures, Father is the great facilitator to activity and the excitement of action and discovery, and uses play and learning about the world as major pathways by which he approaches his very young child and engages the child in meaningful interaction. Studies show that for the most part, fathers throughout cultures play with their children. Why this occurs is not clear. Some 1980 and 1990 studies also show, however, that when fathers are the principal caregiver during the first year of life (and after) rather than mother, that the child's attachments to both Father and Mother can be of very good quality, secure and lead to very good overall development in the child. Observing elementary school-age children in interaction with infants, we have found many a boy's approach to a baby to be one of trying to make the baby laugh, rather commonly by poking it, by tickling it. Girls by contrast, tend to approach babies with awe, with a quieting, a wanting to gently touch and hold the baby. This is not uniformly the case, but we have seen it as general trends. Nonetheless, when they are adults, many fathers approach their babies very gently, comfortingly and are very sensitive caregivers, we believe that sensitive and effective, loving caregiving is not just "maternal"; it is also "parental". Many men are equally good at it as women. We reiterate, that those fathers who also engage with their children from birth on, who participate in feeding, changing diapers, and especially those who can also comfort and calm their young ones -- i.e., nurture -- become more fully and comfortably, emotionally invested by their children.

Like with mother, during the years from one to three, father too becomes emotionally invested not only with feelings of love and admiration, but also with hostility and hate. Interestingly, this especially occurs in the context of father's playing with his toddler as in his becoming too stimulating (not reading the child's varying tolerance for level of excitation), and/or becoming too rough in physical "rough housing". Also, when he is involved in limit-setting, the same ambivalence is generated by battles of wills between child and father as occurs with mother. We shall talk about other than biological parents as caregivers in a moment.

Siblings also are critical persons to the young child. By 6 months of age the infant will begin to predictably respond to and by 12 months to value, to have formed an

attachment to a sibling. One 12 month old had the serious misfortune of losing a sibling who died in an accident. For a number of days, according to E. Furman who reported on this case, the 12 month old kept searching for something and it became clear from his depressive reaction that he was searching for the sibling he could not find. In a similar vein but more cheerful circumstances, we have often seen less than 12 month old infants smile broadly, kick their legs and wave their arms excitedly on the approach to them by their 3 or 4 year old siblings. This despite the fact that most if not all siblings are at times hostile to each other and especially to the newcomer, the infant. For instance, sitting on her Mother's lap, seemingly deep in thought and her thumb in her mouth, 2 1/2 year old Jane looked subdued, somewhat sad. Her by then 6 month old sister Sara was asleep on the floor at Mother's feet. Impressed with this seemingly meaningful state of being in a 2 1/2 year old, one of our observation team, half-directed to Jane, said "I wonder what Jane is thinking about?" Jane pulled her thumb from her mouth and, (pointed to her sleeping sister) soberly said: "She stole my Mommy". We were not surprised that she felt so. But we were surprised by how clearly the experience was organized in her mind and how clearly and directly she said it. Her mother and the other mothers too were surprised they said both by how Jane felt and by her saying so. We shall say in Section 2. 2222 how mother dealt with this state of affairs.

During the one to three year period siblings continue to grow in importance to the child. Although siblings do not achieve the level of importance in emotional attachment as do mother and father during these first three years, the attachment to them usually reaches a high level of importance and we have occasionally seen an older sibling to be used as a substitute for a brief period of time in the place of parents. Like with mother and father, siblings are experienced emotionally by the child both positively and negatively depending on the circumstances and the quality of relatedness. Positively, siblings can be fun, can be a substitute caregiver, can be a teacher, a protector, a helper; siblings can also be provocative, hostile, mean and nasty, a source of jealousy and envy, etc.

From our research with mothers and their young children, here is an example of the sibling being experienced as parent substitute. One morning, two-year-old Bernie was brought to our program by Diane's mother, one of the other participating mothers. His mother told him that she would come later, after she had finished a chore she needed to do. This morning Bernie seemed particularly uncomfortable, experiencing some anxiety, we assumed, at being here without his mother. At one point in the course of our observing him he suddenly brightened and moved toward the door. Not having seen the person's entry, we assumed that his mother had just walked in. We turned to find that it was not his mother who just came in but is 4-year-old sister, Terry. The two-year-old greeted her much as if it was his mother; the difference may have been mostly influenced by the fact that the 4-year-old's greeting was not similar to the one mother might have given him. That is to say, whereas mother would probably have responded by picking Bernie up, 4 year old Terry was satisfied to just put her arm around him, giving him a squeeze and moving on to something else. All parents know how older siblings can be most unpleasant to younger ones. They often though do not sufficiently appreciate that older siblings can be enormously valued by younger ones in a wide range of functions.

Relationships the one to three year old experiences do not consist only of attachments to mother, father, and siblings. There are also grandparents, aunts and uncles, cousins, and nowadays especially, substitute caregivers be it in home care or in daycare. As we have emphasized, the degree to which and the quality of the ways the child engages emotionally with, and becomes attached to, his or her caregivers is most co-determined by the infant's inborn dispositions and the experiences he or she has. This, the experiences the infant has, are most determined by the degree to which the infant is invested emotionally by those who daily care for him or her and the ways the infant is reared. It is especially the way the infant feels emotionally meaningful and valued by those constant-enough caregivers that influences the quality and degree of attachment.

This is why and how, as in the case of adoptive parents, alternatives for the biological parents can truly become the child's "emotional parents". It is what the child means emotionally to them that makes the attachment more or less (depending on how positively they feel toward and how much the baby means to them) secure, meaningful and stable. This is also why and how, adoptive child-parent relationships can have just as much depth of meaning, love and life long stability as "biological" child-parent relationships. There are many variations of depth and quality of attachment to non-biological parents.

Another case in point is where grandparents become actively engaged to take care of their young grandchildren. For example, Victor's Mother and Father, two full time employed professionals, valued their child deeply. But because of their work outside the home they, needed alternative care for Victor (and his later to arrive baby brother) and they engaged the Mother's parents to care for Victor during the week. Because of the variety of factors, including personality traits, patience, ease with feeling close and showing affection, acceptance of infant's demands and needs, Victor made closest attachments to his mother and his grandfather. He was well attached to his father and grandmother too, but his grandfather seemed the one he most reliably and predictably turned to when Victor felt stressed and would initiate physical contact. Each of these familial caregivers could comfort him and make him feel secure; but Grandfather and then Mother were the first he would turn to. There was no doubt from what we saw, that Victor's grandparents were very important emotionally valued persons for Victor. We have seen this with other children as well, with variations in the order of preference by the child.

We also have seen such very valuable attachments to substitute caregivers outside the family. For example, live-in substitute caregivers, and even some who do not live-in, can be highly emotionally invested by a child. In some cases the child's attachment to them may outweigh the attachment to the parents who do not make themselves sufficiently emotionally available to their child, in either the amount of time they spend with their baby or in their ability to feel close emotionally with the baby. In several instances we know of, being separated (by moves out of town) from substitute caregivers (as live-in caregivers) led to the young 1 to 3 year olds suffering significant, painful reactions of loss (depression). We should also note that young children who have been in foster home placements from early in life (e.g. during year one) for two to three years or more years and who have formed sufficiently loving, attachments, may suffer serious loss

reactions (anxiety, rage, depression) when retrieved by their biological parents or adopted by others than the foster parents to whom the infant is attached.

And then, there is what happened to Richie who separated from his troubled 17 year-old Mother after she was alleged by authorities to have excessively abused him when he was 9 1/2 months old. From the time we saw him with his great-aunt, his attachment to the aunt did not appear at all to be secure. In fact, he seemed to feel threatened all the time and was hyper-vigilant we assume due to his dread of being maltreated by whoever would care for him. Only very gradually and to a limited degree did we see the attachment to the aunt improve during his second year of life. We saw that the quality of attachments, which were stable, was poor, made him expect being maltreated and hurt. Only gradually did his expectation of being hurt lessen.

We point out here again, as we did in Unit 1, that it is useful to understand that the attachments made by children during their first three years and later can be understood by consisting of primary and secondary types of attachments which is the basis for relationships being primary or secondary. Both types of relationships are of enormous importance to the child. Human beings need primary relationships throughout life. It is especially so for children under 6 years, and these are obligatory for children under 3 years. We believe, in fact, that they are obligatory throughout life. In the first six years they are needed for healthy, socially adaptive development. As we mentioned in Unit 1, children reared in orphanages, like those studied by Provence and Lipton[5], although well cared for in terms of feeding, hygiene and dress but who were not attached to one specific caregiver, were found to develop abnormally. Provence and Lipton found retardation in their development of specific adaptive functions such as language, or age-appropriate internal control, which we will talk about below. Some of these children developed depressive moods, while others developed shallowness of emotional reactivity, etc. Primary relationships are essential for the experience of symbiosis, which forges attachment and the separation-individuation process, including the experience of the rapprochement and the developments these experiences bring. Primary relationships as we will see in Unit 3 also bring with them the development of the ability to love deeply and romantically, as well as, the development of conscience, of morality, and many other factors. Primary relationships become the prototype, the model for the formation of eventual relationships to one's future wife or husband, and to one's eventual children.

On the other hand, secondary relationships are also important. They are important for the transient types of attachments we make in life which carry us in critical ways. For instance, preschool teachers are often the object of a 2 to 5 year old child's transient attachment. It is so as well during the elementary school years. Even in adolescence, teachers can be critical, as they can be even in later years. Teachers become critical as persons even very young students fall in love with, as persons who become models for the self and as persons who can be counted on to help us learn. Some young students may be so influenced by the love they feel for a teacher that they may identify with the teacher and want to become teachers themselves. Unfortunately, however, the young child can also be so hurt by a teacher as to come to hate the teacher and school or, later,

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[5] Provence, s. & Lipton, R. (1962). *Infants in Institutions.* New York: International Universities Press

the subject that a particular teacher taught.

Friends, secondary persons in our lives, are of course, of enormous consequence. Friends can carry us through bad times, they can be a source of support, someone to whom one can complain about one's parents, etc. The degree to which we invest emotionally in friends or course is variable, some can be friends for life in which care they may achieve a level beyond secondary relationships, touching into the quality of primary relationships.

When psychoanalysts Anna Freud and Dorothy Burlingham and their staff cared for World War II orphaned infants they found the remarkable extent to which one, two and three year olds can turn to each other for nurture, including feeding, comforting and soothing, when they live in a group home. Of course, one sees some of this in children from normal homes as well. It is important to recognize that these caregiving behaviors in one to three year olds with one another, are not just seen in play; they are also seen in real situations of need. We shall talk about 1 to 3 year old's emerging empathy and altruism in Section 2.2531. Although developing friendships does not truly appear until several years later -- and does not become crucial until entry into adolescence --, some 1 to 3 year olds may prefer one or two young children in their neighborhood, or daycare, or pre-school over others and can be said to be forming a friendship. Of course, peers or "friends" as the children in our project came to be thought of, can get into, in fact usually do, get into a good deal of trouble from time to time with each other, as Johnny and Jennifer did. Of course so can siblings, as we said before. Some people have the good fortune of experiencing their doctor as someone special, or their neighbor as someone they can always turn to, etc. There is a place in our lives for both primary relationships and for although less emotionally invested but nonetheless at times very important secondary relationships.

It is important to emphasize, though, that even good secondary relationships cannot make up for the need for primary relationships. What is not present in a secondary relationship is the depth of and the enduring emotional investment we make in persons with whom we have a primary relationship. One mother described it well, as we related in Unit 1, how could she attach equally to her neighbor's children as she did to her own if at the end of the day the children would go home to their own mothers. The depth of emotional investment we make in primary relationships brings with it the gratification of very basic needs we have, needs which begin from soon after birth, of valuing specific others deeply, of loving them and of being loved by them. We do not make that demand of secondary relationships. Although we want to be cared about, admired, respected, loved by everyone, the need for love from secondary relationships does not reach the depth that it does in primary relationships. And we can add that although a 1 to 3 year old, and later, may miss a friend who has moved, it is not experienced as a terribly painful loss and does not lead to the need to mourn. There are exceptions to this, especially in adolescence. And there are complexities about the question of loss and mourning in childhood we need not address at this time.

2.2222 CHILD REARING: Optimizing the Child's Earliest Relationships

From one to three years of age human relationships expand. Parents make an enormous contribution to the quality of relatedness children develop to them. The more the parent is able to empathize (perceive what the child may be feeling) and the child is treated with consideration, respect, and love, the more will the relationship be a positive one. It is not necessary for parents to be perfect in their parenting for children to develop optimal relationships to them. We like to say that being perfect 70 percent of the time tends to be enough for most children to develop a good relationship with their parents.

We have already remarked that the normal 12 to 36 month old child's relationships to mother and father will unavoidably be burdened by feelings of anger, hostility and hate. We have seen this in all the children we have seen over many years of research and clinical work. Because this strongly determines the quality of the child's relationship, state of well-being and total development, we shall speak of it in Section 2.24. There we address the child's experiencing of anger, hostility and hate (Section 2.241) and what parents can do to handle these feelings in growth-promoting ways (Section 2.242).

As we noted in Section 2.2221, we worked with depressed Vicki and her mother during Vicki's second and third years of life. Vicki's traumatized and over-burdened mother was herself somewhat depressed. She was surprised when we told her that her baby was depressed, so we helped her see it better by drawing her attention to the sadness on her face (her sad eyes, her flat forehead and cheeks, the slightly drooping corners of her mouth), the slowness of her movements, her lack of interest in the things around her, her seeming tiredness and sluggishness. As Mother came to see these things about her daughter, we encouraged her to hold her not only when feeding her but also to comfort her. When she seemed sufficiently fed and after periods of just holding and comforting, we encouraged Mother to try to play with her (as by gently over-rocking her, or by holding her hands and gently clapping them, or gently tossing a small ball into her hands while holding her nestled in one arm).

In all of these activities we encouraged Mother to talk to her lovingly, gently. Mother at first wondered why she should talk to her since, she believed, Vicki would not understand what she said. We told Mother that we have evidence that one year olds, and younger, even infants, do understand words and most important, that they feel the feelings conveyed by the parent as the parent talks to the infant. We suggested that Mother tell Vicki that she is sorry that she did not realize that Vicki was feeling sad, that she loves her, that Vicki really is a pretty girl and she is so glad Vicki is her daughter. It was not so easy for Mother to say these things at first, but she tried and gradually it came more easily. From time to time, the therapist would work with them, picked Vicki up, held her, talked to her gently and reassuringly and played with her, all to let Mother see how he did it and to encourage Mother to do it her own way; mostly the child psychiatrist did this to help Mother overcome her discomfort and embarrassment about talking soothingly to her one year old. Many parents think it is silly to talk to babies, but, he told her, it is not silly at all. It may have helped Vicki's mother also to see that Vicki seemed to respond nicely to their doctor's efforts to make her feel better. In fact, Vicki seemed to respond favorably while Mother held her, talked to her and played with her,

which Mother came to see as well. Most important, we felt, was that Mother came to recognize that Vicki needed to be paid attention to, to be held when fed and comforted, and to be played with.

Gradually Vicki became less sad, more active in her movements and engaged more not only with Mother and the therapist but with the other group children as well. By the end of the second year she readily turned to the other children and guided activities (guided by one of our nurses).

By the beginning of her third year, Vicki seemed no longer depressed. She tended to be a quiet child, but she seemed neither sad, nor slow in her movements, nor withdrawn from the other children. We did note that she was not as assertive as the other children, and we saw no expressions of anger, hostility or hate on her part. With this we were concerned about her feelings of autonomy and her sense of self. We saw that she did have a mind of her own, but she was not as insistent about it as the others seemed to be. We believe that her depression might have dampened her standing up for herself, as well as her autonomy and her assertiveness, at least for her first three years of life. But her relationships to her mother, her siblings and her doctor became quite stable, positive and deep.

This was not the case with Richie during the time we saw him. When we first saw him at fourteen months, he had (at least for the time being and during the year we saw him) lost his mother to whom he was attached in a very hurtful, neglected, emotionally and physically abusive relationship. Such a relationship, much overloaded with hostility and rage feelings the child feels, becomes every bit as internalized (taken into the child's mind and soul {psyche}) and stable, as a deeply loving relationship. This basic internalized emotional relationship would, when Richie's development made it possible, become one where hate seriously over weighed feelings of love for the mother and himself. Even though he had now been returned to his great-aunt for three months (and he had lived a quite good first six months of life in her home with his 17 year old mother and his young father), the neglect, rejection, and traumatic caregiving he received between 7 and 11 months of age (from 7 to 9 1/2 months with his abandoned mother and then from 9 1/2 months to 11 months in a city shelter) made him unable to trust, feel safe, and be comfortable with the great-aunt in spite of her efforts to make him feel so. He came with her, went with her, a waif of a child who looked 8 months old, thin, painfully sad and subject to sudden outbursts of rage at even minor displeasures. The relationship to his great-aunt which at 6 months of age was becoming trusting, positive and would have become loving was now, at 14 months, seemingly barely meaningful to Richie, and little if any a source of supplies for his starved emotional needs. She was there, emotionally available; but he seemed unable now, despite his emotional starvation, to accept what she held out to him. We encouraged the aunt to do more than just be emotionally available, taking good advantage of the project mother (a friend of the great-aunt) who brought them to us, reaching out to Richie on a number of occasions, picking him up gently and holding him "just because he looked so hurt". We talked about Richie's needs to be held, comforted even at times when he did not ask for it. If he had resisted, which he did not, we would have suggested that the idea to do so was very good but that great-aunt or Mrs. S. would have to first gain his trust more, by responding to

Richie say by saying "OK, Richie, you don't want me to hold you now. It's OK. You let me know when you want me to hold you." Even though he might have resisted, some time later or the next day, great-aunt ought to try to hold him even before he asks for it. The idea is to convey to him the wish to make him feel better, feel paid attention to, valued, to overcome his having been neglected and rejected. Most important was to explain to great-aunt that repair of damage to his ability to relate is what was needed and that this needed to be done in words and by actions.

It was a project to help Richie deal with the outbursts of rage and we shall talk about what we suggested to his great-aunt on this matter in Section 2.242. Richie's relatedness improved slowly. He seemed to especially respond to the way Mrs. S. approached him. Mrs. S. seemed to have a good feel for how hurt and stressed Richie was and he clearly responded with more security with her than when his great-aunt reached out to care for him. We could not be certain why great-aunt seemed not as gentle and tender as Mrs. S. with Richie. Perhaps she just was not so as part of her personality. But we also wonder if Richie was not as accepting of her efforts, because he had had a developing attachment to her and perhaps he was very angry with her for letting all the hurtful things that happened to him occur, and she did not put a stop to what her niece was doing to her baby Richie. Richie "knew" his great-aunt from before 7 months of age. Could he have felt: "Why did she let all this happen to me!" We encouraged the aunt to be patient but to try to regain his trust. Unfortunately, she could not tell him she was sorry that she could not help him and his very troubled mother sooner; great-aunt did not accept our ideas about talking to babies, we thought perhaps because we had not worked together long enough. We were very concerned when they did not return to our project after the summer break and we could not follow up on helping them. Our impression is that although relating to others improved, much more work would be needed to regain the level of relatedness he showed himself capable of in the first 6 months of life.

We have emphasized that there are strong psychobiological factors that make for the unique relationship that develops between child and mother. Because those psychobiological factors make for the child's experiencing the relationship to the mother as a "symbiotic" one, without being aware of it, there is a tendency in some families to making the mother-child relationship a "closed system" which does not allow the admission of other primary members of the family, especially of father and siblings. When this happens, which may not be recognized by the members of the family, it can create problems for all concerned. There is a natural tendency for children under two years to turn to their mothers for calming and soothing when distressed. This is not always the case, especially when fathers have been intimately involved in the care of the baby and have been able to be calming, soothing, and comforting. Nonetheless, in many instances, many a father has become discouraged when the child's symbiotic experiencing of his or her relationship to the mother makes the child call for mother when upset. This state of affairs is intensified when this closed system is overly enhanced by the mother's own needs, by a mother's overly enlarged need to "keep the baby to herself", so to speak. During a child's first years of life, many a father has felt rejected by his own child because the child invariably turns to mother for comforting, for nurture, for calming and, as a result, the father has developed negative feelings toward his own child. Mothers

needs to be aware of this common phenomenon and to promote rather than to discourage fathers' becoming involving with their infants. The foundation of the father-child relationship in many ways, can be laid down through the first three years of life side by side with that to the mother. (Of course, the next period of development, from four through six years also makes its major contribution to the father-child relationship as we shall see in Unit 3.) It is worth repeating that we have found that fathers who become involved with their infants from birth on, and interestingly, when fathers are involved, observe or participate in the actual birth of the baby, such fathers tend to form a relationship with the infant immediately at birth, do so with much more comfort, much more fully, more deeply and meaningfully, than those who wait until the third or fourth year of life before trying to engage in a relationship with their child.

Similar principles apply to the relationships with siblings. It is enormously harmful to children of all ages when a new baby is born to whom the mother reacts with an attachment that excludes the children who are already there. Children feel rejected and displaced when a mother (or father) buries herself (or himself) into the relationship with the new baby at the exclusion of those already there. Of course, this is an unusual occurrence; most parents, most mothers and fathers continue to show that they are emotionally invested in their other children even when they have a new baby, and often draw the siblings into a relationship with the new baby, encouraging the siblings to share in the care of the new baby, a most salutary thing to do.

There is a usually remarkably effective rearing strategy for facilitating a positive response in young (and older) children to the birth of a new sibling. We encouraged two and one-half year old Jane's mother and father to do two things when Jane said somewhat sadly and angrily of her six month old sister, Sara, "She stole my mommy". First we suggested that they reassure Jane by words and activities that they love and value her just as much as they do Sara, and that Sara had nothing to do with being born. It was mommy and daddy who decided to have another baby; because they find having Jane to be so great, they want to have another (or others). Second, we suggested that the parents find ways of getting Jane to help with the care of Sara. Here the parent has to be sure that, for instance, Jane feels that she is directly involved with Sara as by holding her, or by patting her gently when she is fussing, letting the child hold her while bottle feeding (where bottle feeding is used whether only or as breast feeding supplement) as mother sits close by supervising. Do not just ask the older sibling to get things like a diaper or a rattle which might lead her to feel she is a servant. The idea is to directly involve the child, girl or boy in the actual care and handling of the baby. It is important to compliment the child for being loving, gentle, appropriately responsive to the baby's cues; and it is also important to not allow, to help the child control herself or himself from being unkind, too rough or outright hostile to the baby. In such instances, it is better to say to the older child: "I wouldn't let her do that to you and I don't want you to be mean to her!" Or, "Look, don't act mean. Treat her like you like me to treat you." These are better than "You're bad! I won't let you help me with her anymore", etc. Most parents realize that older siblings feel pushed out by a newborn; and that anger toward the baby will especially be activated when that newborn becomes a toddler, and actively gets into the older child's things, which unavoidably occurs when the new sibling is from years one to

three. Anger, and even hate, toward a younger sibling who is truly favored by mother -- siblings often feel this even when it is not true -- can, of course, continue through a person's life.

Parents realize that one to three year old children can benefit from secondary relationships even though they are not needed as are primary ones. Some parents place too much importance on the need of one to three year olds for peers relationships; it is useful, however, for parents to secure their one to three year olds' with occasional peer interactions. The opportunities having same age or a bit older or younger peers brings for helping the one to three year old learn to adapt and socialize makes having peer interactions well worthwhile. For example, when spunky 11 month old Jennifer repeatedly pulled the pacifier from 11 month-old Johnny's mouth, it presented both children and their caregivers the challenge and the opportunity to help each child adapt constructively (see Unit 1, Section 1.261 for a description of the event). Jennifer's mother had the opportunity to help her 11 month old begin the process of controlling herself from grabbing what belongs to someone else, to learn some things belong to her and some to others, to learn there are things she can do and things she cannot do, that if she wants other kids to like her and want to play with her, she cannot be inconsiderate or mean, and much more. So too, Johnny's mother could see the need to help her 11 month old stand up for his rights, protect what belongs to him, not let others just grab things from him, learn how to deal with other children's aggression and his own. We shall address this further in Section 2.242, in dealing with aggression. Thus peer relationships, as well as having other family members to relate to, and of course when there are grandparents available to insure the young child's relationship to them is enriching for the one to three year old.

Because daycare is increasingly used by young parents, a word is warranted here on how the parents can be helpful in facilitating their child's relationship to caregivers when in daycare. However capable and talented in caring for young children daycare caregivers are, and of course the better they are, the better for the children, children do not experience daycare caregivers in the same way they experience their own mothers and fathers. Let us pause for a moment.

Daycare is here for very good reasons and for very good reasons it is here to stay. The research to date leads us to hypothesize that young children who have good relationships with their mothers and fathers, for the most part will be able to tolerate the daycare experience without substantial problems being created by it. But, to secure that daycare does not create problems that will interfere with personality development and growth, it is well for parents to understand what the daycare experience may be for a child one to three years of age. To expect that the child will have no reaction to being separated from mother for a number of hours during the day is to ignore an unavoidable normal experience. To ignore it will make the parent not able to deal with it constructively. It is important that mothers and fathers recognize that a normal 18 month old, with entry into the rapprochement subphase, will probably experience heightened separation anxiety, stranger anxiety, or the need for comforters, all in response to being separated from mother and father for a number of hours during the day (see the experience Jennifer had when which we described in Section 2.2211). To ignore the

child's reactions will rob the parent of the opportunity to help her or his child cope better with the distress the child experiences from being separated from mother and father for those hours. It will mean that the child's reaction of distress will not be recognized, not be permitted expression, and rob the mother and the child of the opportunity to talk about, yes, talk about, not only the child's distress but also the anger the child feels toward the mother. It is important to bear in mind that parenting is not fun and games, it is a very serious enterprise; issues of pain arise between child and mother, between child and father, and this pain is not necessarily bad if expression of it is permitted and if children are helped to cope with it constructively. To disregard an experience of pain that is caused by a mother's going to work outside the home, father's going to work outside the home, is to disregard an experience that can usually readily be resolved, and that can work to the advantage of the child and parents. Young children can feel pain just as adults do; young children are not fragile just as most adults are not fragile; young children can tolerate frustration, even moderate deprivations, some better than others, just like adults can. But these need to be recognized as such, so that learning to cope with them constructively can occur; denial that they occur is often harmful to the child and the parents. For example, denying that a painful experience is taking place leads many a child to learn to deny his or her own feelings; this may then lead to the inability to express his or her feelings well and reasonably, and it then leads to the accumulation of resentment and hostility which also will not become expressed; and more.

Let us underscore again, daycare which is needed by many young parents, does not have to become a source of trauma; it is less likely to become traumatic when the parent-child relationship is predominantly good and when opportunity is given for reasonable expressions of the feelings engendered by the separation from parents as well as whatever experiences the one to three year old may have in daycare.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.23 THE BEGINNING OF SEXUAL (REPRODUCTIVE) LIFE

Introduction

First and foremost, it is important to understand and recognize that our sexual bodily system is an inborn part of each of us and that its major function is the preservation of the species. Its foremost biological function is reproduction. It has an obligatory function in all living organisms, animal or plant, without which many species would long ago have died out. It therefore, is not surprising that our sexual reproductive system must be sufficiently strong to withstand the many obstacles that occur in nature to the reproduction of the young.

Many people still believe that the normal child's sexual life begins at puberty. But collective observation of young children shows that from even 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 the sex act. Furthermore, sensations in certain body parts have been found to create feelings in young children of an erotic nature that resembles what adults experience. And, when listened to closely, children not only express in words these feelings, but do so also in their play, in evidence in their behavior of their fantasy activities, and in their attitudes toward others, themselves, and parts of their bodies.

Having been studied now for nearly 100 years, mental life psychodynamic theorists hold that from early childhood on, we all become aware of the important part sexual experience and thoughts play in our lives. This becomes even clearer during the period from three to six years, and in Unit 3 we shall talk about the first major phase of organized sexual experiencing. During adolescence, which is the second major phase of sexual experiencing and organization, sexual thoughts and feelings become a central and frequently highly burdensome preoccupation. And, of course, in adult life, sex plays a major part in our lives. Psychodynamic (especially psychoanalytic) mental health scientists during this century have extensively studied, documented and detailed in writings, the fact that sexual life begins much earlier that had long been assumed --except by an earlier isolated writer or philosopher (such as Diderot) here and there.

Nearly 100 years ago, Sigmund Freud, the great mental life pioneer and founder of psychoanalysis, found from his work with people suffering from neurotic problems that our sexual life plays a large role in our mental life and health. Far from needing to be hidden and never talked about, sexuality, he believed, needed to be understood and recognized for the part it plays and the problems it can create in our 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.

It is remarkable that so important a part of our lives, so important a sector of human

experiencing as sexual feelings, thoughts, and activities are perceived by many parents as bad, to be feared, prohibited, and perhaps most problematic is that these too often cannot be talked about in the family. It is remarkable, given that sexuality is the vehicle for the preservation of the species, in the large picture of existence, one of the most important functions we fulfill.

But there are good reasons why we humans have become so fearful of, have so often maligned, and so often are unreasonable about so important a sector of our lives. For thousands of years to the present, cultures and religions have put much effort into guiding and governing people in the exercise of their sexuality and sexual lives. Poor controls over sexuality have led to the most dire of consequences. For example, without considering them in order of importance, first there are serious, even life threatening diseases that are transmitted only through intimate genital contact. Secondly, premature sexual activity in young teenagers can and does lead to pregnancies, some even as early as ten years of age. These can be of drastic emotional consequence to the young teenage mother, to her family, and especially to her baby (we shall discuss this further in the Units on the three to six years era and in the one on adolescence). And third, in our culture and probably in others as well, extramarital sexual activity has the remarkable ability to undermine and often totally destroy a love relationship, lead to emotional disengagement from full commitment in a marriage, be disruptive of intimacy, affection, and destroy trust. It often reduces love relationships to marriages of convenience. Fourth, in more instances that we like to think, sexual activity breaches cultural and religious morals and beliefs, and can cause life-long enormous emotional problems as occurs in incest. This problem which is often severely damaging to children who are so victimized, has recently been found to be much more pervasive than had been realized.

In the face of these consequences, why do humans bring these problems on themselves by sexual irresponsible behaviors? First, what force in them propels humans to sexual activity? Psychoanalysts speak of what propels sexual activity as the sexual drive, biologists speak of this as sexual instincts. Whether we think of these as sexual instincts or a sexual drive, these constitute a powerful force; and as we said, it must be so in order to preserve the species against the many factors that impede species survival. This is so across animal and plant life.

The sexual drive, as we prefer to think of it, is powerful in humans; sexual instincts are powerful in animals. But in animals other than humans, these instincts are activated or governed by limited but well organized built-in mechanisms. For instance, from what we know to date, male sexual activity in all but human animals tends to be released or activated only by female scents (pheromones) and behaviors. These are themselves activated in the female by a readiness and receptivity to impregnation and reproduction, which are determined by biological (hormonal) cyclicity and seasonal factors. In humans, by contrast, mental emotional factors seem to play a governing part in their sexual lives. Although biological (hormonal) cyclical activity plays its large part, equally major and operative in human sexual activity are mental and emotional factors. In Unit 3 we will elaborate on this as we discuss extensively the emergence of (genital) sexuality in the child, during their three to six years period, and the very large emotional and psychological developments this brings about. For now, we will limit our introduction to

this major aspect of development to a brief overview of psychological sexual development or, as psychoanalysts speak of it, psychosexual developmental theory.

Clinical evidence and treatment led Sigmund Freud to propose nearly 100 years ago that problems arising in the child's sexual development were at the basis of mental illness he identified as neurosis (which is a major category of emotional disorders). Initially he treated them like other physicians did then (late 1800's), as neurological problems. But closer study led Freud to conclude that these particular problems arose not from nervous system malfunctioning as was then thought, but from emotional conflicts in their childhood sexual development of which the patient is unaware. In order to help us know, he studied his patients problems closely and developed a theory of how sexuality probably unfolds in humans.

This is Freud's psychosexual theory. Sexual development, and with it sexual identity formation, unfolds through a universally found sequence of phases or time periods during which the following modes of sexual experiencing co-determine the child's progressively changing emotional life. The first, extending from birth to about 18 months of age, is the <u>oral</u> <u>phase</u>. Karl Abraham, another pioneer psychoanalyst, proposed that there are two component subphases during the oral phase. The first of these is the <u>receptive oral subphase</u> which extends from birth to about six months of age. As the name suggests, oral receptivity, the acceptance of feedings through the mouth, predominates in the waking life activity of infants. As we describe in Unit 1, the beginnings not only of feeding but also of taking in the environment by means of very early explorations is done much of the time not only by the eyes, ears and hands but also by using the mouth as a means of learning about the environment. As we emphasized in Unit 1, even during the latter part of the first year of life when much exploratory activity begins, as all parents know, infants tend to put everything that they touch into their mouths in order to explore, to learn about them. Parents often make the mistake of thinking that this is to eat what they put into their mouths. Rather, it is in the service of finding out what the thing is like, to explore and learn about it.

The second part of the oral phase was entitled (by Abraham) the <u>sadistic oral phase</u> which extends from about six months of age or so through 18 months of age. The reason Abraham labeled this second part as the sadistic oral phase, is that psychoanalytic theory at the time was especially aware of those aspects of human functioning which they identify as the instinctual drives. Very briefly, the instinctual drives consist of the <u>sexual drive</u> which has everything to do with psychosexual theory, and the <u>aggressive drive</u> which we will talk about in Section 2.24, below. "Sadistic" deriving then from psychoanalytic thoughts about aggression, was used by Abraham to describe the new additional behavior often engendered from about six months of age on by the emergence of teeth. Every mother who breast feeds her baby knows what Abraham was talking about, given that the eruption of teeth by creating pain in the infant's gums often leads to biting; infant observation suggests that this biting is not intended initially to be hurtful but rather is the product of the infant's efforts to reduce the pain the infant experiences due to the teeth pushing through the gums to emerge.

A second major phase of psychosexual development is the anal phase. Again, Abraham suggested two component subphases for this phase. The first extends from

about 18 months of age to about two or so years of age, which Abraham labeled the expulsive anal subphase. The second component phase Abraham entitled the retentive anal subphase which extends from 24 or so months of age into the middle of the third year. As with all efforts to give an idea of the duration of time these developmental phases take, as with those descriptive of the separation-individuation process (Section 2.22), dates given are not intended to be specific for every child; each child has his or her own developmental timetables, but rather these are suggestive of timeframes for normal development in general.

The next psychosexual phase which we will touch on in this chapter but will detail in Unit 3 is the phallic-oedipal phase, or as we prefer to call it, the first (or infantile) genital phase, a major organizer of human psychological experience and development which extends from two and one-half to six years of age.

The fourth phase of psychosexual development is the latency phase which extends during the early elementary school years, from about six to nine-ten years of age. This, Freud proposed, is followed by adolescence which is the first phase of true adult-form sexuality. Much more recently, some psychoanalysts (e.g. Dr. Marjorie Harley) have proposed a pre-adolescence phase extending from nine to 12 years, which they suggest bridges the latency phase and the critical longer developmental phase we know as adolescence. Adolescence extends from about 12 years to the late teens, and some psychoanalysts have in the last 20 years proposed may extend to 21 or 22 years. This then is followed by adulthood and the generative years of reproduction.

The student may be puzzled as to why Freud and psychoanalysts since him have included the oral and anal phases all children experience as part of the sexual development. Here are some of the reasons. His studies of the emotional symptoms he encountered in most of his neurotic patients drew Freud's attention to the fact that oral phase activity as well as anal activity play a large part not only in patients with sexual problems known as perversions but also in the life of the normal young child. All parents know that children sometimes need to suck and that sucking is not always associated with the need for food. This is especially evident in the soothing and comforting children experience by the use of a pacifier or their own thumbs. Similarly, in the course of toilet training some children make clear the pleasure they derive from holding in both urine and feces and the pleasure they experience in discharging these at will. That is to say, early life is experienced by children especially through the workings of their young bodies and that 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 for defecation (bowel movement) when the bowel is emptied of its contents. 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 Freud pointed out are first "body-experiences", and Piaget said that the young child's experiences are first perceived and organized cognitively (intelligence-wise) by sensorimotor processing, namely, by functioning of their sense organs in combination with motoric locomotion and manipulations, explorations of their bodies and the environment.

This Unit, spanning the second and third years, cuts across the late part of the oral phase, the anal phase and the beginning of the first (infantile) genital phase). Lets talk about each in turn.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.3 THE BEGINNING OF SEXUAL (REPRODUCTIVE) LIFE

2.2311 HUMAN DEVELOPMENT: Sexual (Reproductive) Life

The Late Part of the Oral Phase:

The twelve-month-old is well into the latter part of the oral phase. The teeth generally now are no longer a prime source of pain for the child but rather make for a well developed body apparatus by which the child can now chew foods which brings with it a substantial change in food intake. The emergence of teeth has been going on since the middle of the first year and the child is beginning to establish new feeding patterns.

At the same time, by now the teeth have become a source of distress to many caregivers. Biting seems a natural means for exploring things and for discharging feelings of distress and of hostility. By twelve months of age some young children have already bitten their mothers in the process of nursing and have also used their teeth when provoked too painfully by another child's behavior toward the self.

Exploration by means of putting things into the mouth continues well into the second year of life although increasing small hand movements coordination, which makes for greater control over manipulation of things will gradually take over as the dominant means of exploration from about the middle of the second year of life on.

Most troublesome in some children will be the task of weaning from bottle or breast feeding. 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, however, that most children now (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. Why it is more difficult for some children than others is not always clear. Whether it is a persisting inborn preference for that mode of self-comforting experience by some children, whether it is that some infants feel that they have not been comforted enough by their primary caregivers, whether they need longer periods of self-comforting to satisfy sufficiently their need for it, whether some children are experiencing more stress than others, any of these or all of them make some children more resistive than others to weaning from the bottle, breast or pacifier.

Johnny continued to use his pacifier until he was two and one-half years old. He seemed quite well nurtured and given to by his mother and we had learned that his father was very attentive and loving with him too. He did seem a bit shy, needed some encouragement to stand up for himself, to be assertive enough. We felt that he just seemed to be a "more sensitive" child, with some degree of inborn shyness (which is due

to a greater sensitivity to feelings than average) which make many daily events feel more stressful to him. The pacifier seemed to be a quick and easy source of re-enforcement. Because of the degree of autonomy they can exert on them, children are more likely to hold on to the bottle or pacifier as sources of comforting than the breast.

As we mentioned in Section 2.2211, some children select the bottle as a special source of self-comforting and during the second year will especially need to retain the night bottle due to the heightened stress created in young children by separation from the family 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 so that separation no longer creates intense anxiety. 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 the early part of the third year while in others, like Johnny, it will remain necessary for self-comforting for a longer period of time.

The emotional quality of mother-child interactions, including especially that of feeding, is an important contributor to how the child will feel about him or her self and in his or her relationships to others. Also, the more emotionally satisfying the parent-child relationship, the more comfortable and nurturing the feeding experience. And indeed, Johnny's feeding experiences were clearly quite good. Where the parent-child relationship (especially the mother-child relationship) is difficult, feeding may, on the other hand, not be a satisfying emotional experience, or, to the contrary, it may become a source of emotional satisfaction that will substitute for the insufficient emotional gratification coming from the relationship with the mother. It varies, of course. Richie, whose relationship with his troubled and very burdened young mother was painfully difficult, full of feelings of rejection and hostility, had poor feeding experiences; and he did not gain emotional satisfaction from eating. We believe this had more to do with his "failure to thrive", that his failure to gain weight as expected for his age and to grow, than that he was being starved. He was not starved (for food). On the other hand, Vicki who was depressed, was not physically abused as Richie had been, but her relationship with her depressed mother was poor due especially to mother's own depression and also being over-burdened. But she gained a fair amount of weight, in fact, got chubbier than she had been prior to nine months and than she would be later. It was not clear that she substituted food for emotional gratification. It was clear that she was not as active as the children around her and therefore was not burning as many calories as the average child, but it may also be that she was eating more than her body needed. In other words, she may have substituted to a degree, eating gratification for the emotional gratification she could not then get. Some support for this assumption may be taken from the fact that in late adolescence when she ran into some difficulty she did become somewhat overweight.

Infants, as Vicki did, may eat more food than they need for good health and growth as a result of their effort to comfort themselves emotionally by the good feeling that comes from eating. The feeding experience itself may become overly valued and may lead to overeating which will in turn lead to overweight. The heightened dependence on food (and later possibility on smoking, alcohol and even drugs) when eating becomes a substitute channel of self-soothing to make up for insufficient

"emotional feeding" (nurture) in the relationship with mother (and father), may become a more secure and reliable way of feeling cared for than emotional interaction with the parents. This selectively seeking emotional gratification by means of over-eating can become patterned from the first into the second year of life when it may further stabilize.

Again, in the normally well cared for one to three year old child, there is much pleasure in sucking on the breast, bottle or thumb and it is plausible to infer that sucking and feeding brings with them pleasure which is inherently of a sensual, an erotic type. This, according to some development theorists, is why the mouth is a vehicle for erotic gratification and participates in eventual adult sexual activity.

The Anal Phase:

In terms of the child's emerging sexual life, the functions of eliminating urine and bowel contents occupy a significant part of a child's emotional experiencing during the period from about 18 months of age to about two and one-half or three, in some cases even later. These also preoccupy the parents. For obvious hygienic and social reasons, as well as for emotional reasons, toilet training is an important development that preoccupies children and parents alike during this developmental period. At times young children who are not toilet trained are not accepted into preschool programs.

As all parents know, and children know too, there are emotional consequences to toilet training; these are of much importance for the child. Wanting to do what those we most value and admire, namely our parents, do and want us to do, is characteristic of every child. Except in the most traumatizing of conditions where children become enraged and despairing, to want to go to the bathroom like an older sibling does, like mother or father do, becomes a goal for every two year old child. Learning to control the discharge of bladder and bowel contents is experienced by the child as a remarkable achievement. And it is! This is reflected in the way parents react to the child's efforts, to the child's failures as well as successes. Not only is it a source of pleasure to develop such control, to please the parents the child admires and wishes to be admired by, but it also brings with it the feeling and experience that the child can learn to do things the child could not do before, that the efforts the child makes can bring success.

The child's complying with the wishes of the parents in toilet training, sometimes even against his or her own wishes and against resistance to complying with the wishes of the parent in toilet training, sometimes even against his or her own wishes and against resistance to complying with demands made upon the self, brings with it the ability for effective internal controls, controls over one's own at times troublesome wishes and inclinations (an issue we shall discuss further in Section 2.251). This compliance also brings a sense of doing the right thing, doing what is expected of me, doing what Mommy and Daddy want me to do. There is furthermore for the child the experience of being able to accept limitations, to accept rules and regulations, to accept compliance with social standards. The fact that this acceptance is made by the child in response to demands made by his or her own parents makes for a growing capability to accept instruction, guidance from those in our world who attempt to protect us and to help us grow into responsible people.

These are some of the reasons why the process of toilet training is one that makes a significant contribution to the emotional and psychological development of the child. As we shall elaborate in the section on child rearing, it bears mentioning here as the famous psychoanalyst Ann Freud said "If you want your child to be quickly toilet trained, give your child to your neighbor for one day and task of toilet training will be achieved." However, she pointed out, that toilet training will occur without the enormous benefits to the child which come from the child's achieving that toilet training when this demand is by the child's own beloved parents. Given that achieving toilet training to please the parents is rewarded by the parent's approval, that giving up one's own wishes to do just what one wants to do, here to resist toilet training, in order to comply with the demands made by the parents, these and other elements in toilet training make for the fact that when the parents toilet train the child, the contribution to the child's psychological growth is much greater and more advantageous to the child then when someone to whom the child is not attached makes the demands that go with toilet training.

It would stand to reason that, if the child's ability to control bladder and bowel sphincters (muscles) (see Section 2.131) 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 to comply with parent's demands. And, indeed, successful toilet training is commonly achieved when undertaken at about two to two and one-half years of age. We find that 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 is done in some cultures, even during the end of the first year of life. It is well to emphasize, however, that the benefits we talked about before will not accompany toilet training that is achieved during the end of the first year or the beginning of the second year of life because the development of the self and of the child's will is not yet sufficient for the child to feel he or she is developing internal controls or a sense of duty and responsibility. We must bear in mind that learning to control one's bladder and bowel is a learning experience as are learning to swing a bat, a racket, and to study (math, music, etc.). Which means then, that the more comfortable this learning experience, the more likely it is to encourage a child to learn in other areas of development as well.

Let us elaborate a bit on a central aspect of the problems toilet training may create for both parent and child. It is important to recognize that one of the major obstacles to toilet training is that it occurs at a time in a child's life when the development of self as an individual is at an important stage in its progress. Bear in mind that 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 we described under the Rapprochement Subphase and On The Way to Object Constancy (Section 2.2211). 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. This is also the time when the sense of feeling power, of feeling self-confirming moments when the child says "No!", gives further evidence of the child's consolidating sense of becoming an entity, a self-contained

individual. We want to emphasize, that moments of feeling oneself, of having a sense of experiences residing within "me", have occurred earlier, but from the middle of the second through the third year of life the sense of self achieves a new level of organization, integrity, and cohesiveness that bring with it the child's perceiving the beginnings of a sense of self. The child can now say "Mine, mine" which thing belongs to "Me" as the child feels the "I" of the 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, such as, to give up contents of one's own body, be it urine or a bowel movement, that parents 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 self, as a statement that the small newly burgeoning self does not have rights, or the freedom to do just what he or she wishes. Compliance to demands is necessary for approval by those the young child values, those whose admiration, whose approval the young toddler wants most. This means the giving up of one's own wishes, the giving up on one's own body contents that may, at times, be experienced as giving up a part of oneself. As we all know, it is difficult to not do something we want to do; and it is equally difficult to do things we do not want to do.

A further word is needed here. Young children do not experience the contents of their bowels as foul smelling, as dirty, as things to be gotten rid of. Close observation of very young children shows that they are not disgusted by the smell of feces; in fact, some of them find feces an interesting source of painting materials and will experiment with their feces as paint on the walls around them. It is especially by virtue of the reasonable disgust and annoyed reaction of their parents, that young children begin to experience disgust at the smell of their own feces. It is, in fact, because young children perceive the parents' intolerance (hygienically reasonable) for the feces that, when some hurt and angry children want to attack their parents, as in the course of battles of wills, as a means of expressing rage towards parents they experience as excessively frustrating or punitive, that young children may resist toilet training and may even smear their feces on walls. Some ill-treated children will use this pathway to express their rage toward parents. This is very much akin to what makes protesters of one cause or another smear graffiti on walls of buildings and in bathrooms. A child who is well cared for, who may experiment with coloring the walls with his or her feces will quickly react to the parents' disapproval of this activity by stopping it.

Let us return to the question of how the one to three year old child experiences parents' demands, and the internal struggle these often create for the child. The demand to learn to control bladder and bowel may be experienced by the child as a demand that the child give up not only possessions from within her or his body and also wishes to discharge the contents of both at will, it will then mean giving up some sense of one's own authority, some freedom of self expression, and we find in the clinical situation often brings with it a feeling of "I have to give up what is mine", "I can't do what I want", "I have to do what she (mother) wants", "What I want to do doesn't count", "I don't count", etc. All of these suggest that the child often seems to experience the parent's demand as

an imposition on the self, even depreciation of the self. Clearly, of course, this is not the parents' intention, quite the contrary. But many children at least at time do experience the demand for learning to control the discharge of bladder and bowel contents as a surrender of the self, as a feeling that the wishes of the parents count more than the wishes of the child. This is why toilet training is often experienced by the child as a restrictive measure and thereby leads to battles of wills.

Side by side with this imposition on the sense of self toilet training brings about, other issues arise from quite another side of toilet training experience. The preoccupation with toileting is believed to be due also to the seemingly increased awareness that the sensation brought about by both the passage of urine through the urethra and the passage of feces through the anal sphincter are pleasurable. Relief from a full bladder, a full bowel is experienced by humans as pleasurable because it is relieving of unpleasurable feelings and it may even be pain relieving. But it also carries with it a degree of sensual erotic sensation. Add to this fact, that diaper changing which has been occurring since birth brings with it cleansing of the toddler's sensitive genital regions as well as the anal sector of the body, manipulations which the child experiences as pleasurable, these manipulations now more than earlier heighten the erotic feelings attached to toilet training. In fact, some young toddlers experience diaper cleansing as erotically gratifying to such a degree that they may wish to delay toilet training because it brings with it at least in part a cessation of the parents cleansing the toddler's "bottom". Some normal and healthy children experience the cleansing of their bottom without right pleasure and may say as one little girl did, "Oh that feels so good Mommy, do it again."

Let us emphasize that genital sensations are evident in children from the first year of life on. As every mother knows, even a two day old infant boy on diapering may have an erection. Such reactions are physiological in nature, and we infer must bring genital sensation with them even from the first days of life on. Studies have shown that from the early days of life, during feeding, infant girls produces secretions within their vaginas which, equally we infer, must bring with them some sensations of an erotic kind. In other words, then erotic experiencing associated with the cleansing of the genitals and the anal region begin to be experienced from virtually birth on; and 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.

Where parent-child relationships are not sufficiently gratifying to the child, the child will find sources of gratification to try to make up for these important basic emotional deprivations. Since the activities involved diaper changing and toilet training bring with them pleasurable sensations, seeking pleasure from bladder and anal activities may be heightened to try to make up for insufficient gratification in the relationship to the parents just as food can become a substitute for love from one's mother and father. To a large degree, gratification from genital sensations and from anal sensations accompany erotic life in normal human beings, but these may become enlarged, may even become prime sources of gratification where relationships to the parents are not gratifying enough.

For all the above reasons, then, the battle of wills, the sacrificing of a degree of a sense of self, the erotic experiencing associated with diaper and toilet training, the gains to the child's psychological development that come from accepting external demands,

complying with these, deriving pleasure from pleasing parents, all make the experience of toilet training quite an important one. It is well to point out, that we could also emphasize the opposite of successful toilet training. Namely, the persisting problems surrounding toilet activity that may arise from problematic toilet training, from excessive demands being made on a child who must reject these demands in order to maintain a threatened sense of self, the desperate smearing of feces a child may engage in to express intolerable and forbidden rage toward parents who are in some way painfully hurting the child, all of these too make the toilet training experience and important one for the 18 month to three year old child. It does so as well for his or her parents.

In the section on Child Rearing, we shall address some of the awful consequences that have been found associated with difficulty in toilet training. For now, let us say that much is known by parents about the care that needs to be exercised in toilet training children. We believe that this is why the children we have been using for our examples in this material did not run into toilet training problems. In our program, the parents we worked with had already heard on radio or television and read in magazines about toilet training. None started toilet training before two years of age. None of the children was forced to sit on a potty until he or she produced a BM None was hit or insulted because he or she could not comply with early and unsuccessful efforts to toilet train.

But we have seen in our offices children who were brought to us because they suffered from repeated prolonged constipation or from smearing their BM's on walls or floors. If these behaviors continue for more than a few weeks, professional help is needed and parents are well advised to get this help.

Two more words on this subject. Toilet training for urine usually is slower than for BM's. For instance, bed wetting may continue in many normal children, boys especially (we do not know why) even up to four years of age. Some go on even beyond four; where it goes on more than once in a while beyond six years, professional consultation is generally indicated and is usually very helpful.

Lastly, children who are slower in their development, like many Down's Syndrome and cerebral palsy children, for example, will be delayed in their ability to be toilet trained and will need more time to achieve it. Much more patience, understanding, and sympathy is required in rearing such children in order to make them feel loved and valued.

The Emergence of the First (Infantile) Genital Phase

The first (infantile) genital phase is a development of enormous consequences to the child's emotional development. It brings with it a substantial conflict which every child experiences, a conflict that in turn leads to enormously important salutary developments in the child. The first genital phase extends from about two and one-half years of age through six years. We will therefore wait until our discussion of Unit 3 to detail the nature of this conflict, what brings it about, and what, in terms of salutary developments, this conflict itself brings about in the child. Because the emergence of this phase occurs during the third year of life we will here say a few things about it.

As we stated in the introduction to this Section, we have long learned now 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 begins, many parents recognize ample evidence of sexual activity long before puberty. We have already commented above that erotic sensations in the child's genitals can be inferred from their genital activities, such as erections in little boys, from the first days of life on and indeed, psychoanalytic child development theorists make exactly that assumption, namely, that a child's sexual life begins at birth. As we have already indicated during the first 18 months, however, erotic experiencing is most attached with the activities of the mouth and only occasionally does there seem to be evidence of genital arousal and sensations. Similarly, from about 18 months of age through about three years the predominant erotic feelings and experiencing are attached to activities of the urinary bladder sphincter and the anus as we detailed above. From the middle of the second year of life on many children show evidence of heightened sexual activity. This time, the heightened sexual activity is much more complex and pertains to the following three inter-related areas of experience:

(1) To the genitals themselves;

(2) To the child's emotional interest in babies; and

(3) To the child's heightened erotic love interest in one of his or her parents and a developing feeling of competition and rivalry with the other parent.

A note on each at this time; the issue will be addressed more extensively in Unit 3.

We must first, however, emphasize that by the term "The First Genital Phase", we are speaking of, early childhood sexual life. Important distinctions exist between what can we speak of as <u>infantile</u> sexual life and <u>adult</u> sexual life. The major distinctions between them begin with the fact that the two and one-half to six-year-old child is incapable of the biological fruition of his or her sexual fantasies and sexual functioning. By contrast, adult sexual life that begins with puberty brings with it the capability for fulfilling all of these. For instance, as everyone knows, reproduction is not feasible until puberty. Also, it is highly doubtful that young children are capable of achieving sexual orgasm, again a capability generally achievable only from puberty on. From another vantage point, infantile sexual life contains much that is fantasy-based and fantasy-experienced, whereas, it is generally not actualized, is little put into effect. This will become particularly clear when we discuss the nature of the young child's sexual experiencing in more detail in Unit 3. By contrast, with puberty the actualization of these fantasies is feasible, which creates its own problems as we will discuss in the chapter on Adolescence. We must 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 development. Again, points and examples will be detailed and discussed in Unit 3. For the present, a note on the three clusters of behavior one sees which are evidence of the beginnings of sexual life.

(1) With regard to the genitals themselves, one finds a heightened interest in the child's own genitals and those of others, a greater or lesser degree of preoccupation with these, as evidenced in an increase in the child's touching his or her own genitals, asking questions about the child's own genitals and those of others, the expression of pleasure at

the touching of the child's genitals, which we consider "infantile masturbation". It is not uncommon 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 genitals. Given the normal pleasurable sensations associated with touching their genitals, some children persist in this activity, in infantile masturbation, which tends to create some discomfort in and for the parents.

Many a child will begin to express anxiety when his or her genitals are touched by someone else. One two and three-quarter year old boy, with acute anxiety on his face stepped back as his mother attempted to close the zipper of his pants. It was clear that he experienced fear at what might happen to his penis when the zipper was pulled up. When they were four, Johnny and Doug expressed and gave evidence of such anxiety (see Unit 3, Section 3.2311). Many a young girl, two and one-half, to two three-quarters years of age may ask her mother when she will get her penis. Both Suzy and Diane did so when they were three and one-half and four and one-half (See Unit 3, Section 3.2311). A little girl may ask when she will get her penis, given that when she looks at her genitals, because they are in large part contained inside her body which she cannot see or yet imagine, she will wonder if she will get a genital equally visible to the eye as is the little boy's. Many a little boy may ask why Suzy does not have a penis. It is also important to note that children will from time to time begin to express anxiety in association with these questions. This will be further discussed in Unit 3.

(2) Since the inherent biological function of sexuality is the reproduction of the species, it makes sense to wonder whether or not young children show interest in babies. When do they show interest in babies, what does it look like, and what do scientists say about it? Scientific observation of young children as well, as clinical work with young children by psychoanalytic mental health professionals inform us that, yes, young children from about two years of age on show a notable interest in babies. The toy industry and many parents know this as well as evidenced in the large baby doll industry. A number of factors contribute to this.

As mental health researchers who have studied this issue in the long term, twice weekly, observation of young children, each child over a period of several years, we have reported the following.

During the first year of life, attention to other infants is occasionally seen in nine to twelve month olds. This interest consists most commonly of touching the infant with some excitement and often with resulting alarm. Interestingly, touching the infant's eyes and grasping the infant's hair (and then not being able to relax the grasp reflex) are most common and are what causes the alarm.

During the second year and early into the third year, the approach to an infant changes significantly. The 18 to 30 month old no longer just pokes at the infant's eyes or grasps its hair. For instance, 18 month old Diane seemed troubled by a six month old baby's fussing when his mother was out of sight (his mother had gone to the bathroom for several minutes). Diane conveyed this to her mother and mother came to the fussing baby where Diane followed her. On her knees like her mother, Diane and bent toward the baby like mother, Diane did this: she watched her mother pick up the six month old's rattle and try to calm him by rattling it gently in front of his face. It did not calm the

baby. Diane's mother put down the rattle and talked soothingly to him. As mother did so, Diane picked up the rattle and gently shook it near the baby's face. This still did not calm the baby. Diane's mother patted the six-month-old gently on the head; Diane put the rattle down and she too then gently patted the baby on the head. Diane and mother looked at each other while patting him, a lovely mirroring smile on both their faces. Similarly, we have seen one and two year-olds spank dolls, and in one way or another maltreat them.

Observing behaviors as these in a number of children has led us to propose that now during the 14 to 30 months period, a different attitude and approach occurs. The child, both boys and girls, seem to do to babies what is done to them, they identify with the way their own parents treat them.

Then, from about 27 to 30 months of age on, a dramatic change in approach to babies occurs. We have proposed that this is a new 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, as happened with Diane, will become attached to a particular infant, will say that a particular infant is "My baby" and some, as Jennifer did, will verbalize the wish to have a baby of their own. This type of behavior is less frequently seen in boys, as we saw briefly in Bernie, and makes for one of the significant distinctions between boys and girls. We shall discuss this further in Unit 3, Section 3.2311.

(3) From around two year 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 with no selectivity, 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. In Unit 3 we will emphasize why sexual feelings become attached to the child's own parents in preference to others. Suffice to say for now that from the middle of the third year of life on, many a child will begin to be more selective in the parent who is chosen for such genital contact. Let emphasize that many parents are not aware that the child's rubbing his or her pubic area against the parent's knee or while riding on the parent's foot is sexually pleasurable to the child, for reasons we will also discuss in Unit 3. Many a child now will begin to be selective in these activities. A boy will be found to rub his pubic area against his mother's knee, mother being uncomfortable but not altogether perceiving why. A little girl will select her father for similar activities.

Many a parent also knows that around this time when parents greet, embrace, they may suddenly find the child between them pushing them apart. Or, when mother enters the house, as father proceeds to greet her he finds that he is beaten to it by his son who wants to get a hug from mother first. Some children will outright express indignation when mother and father embrace, some may verbalize their feelings clearly. For instance, when Diane was three and one-half years of age according to her father, she "sashayed up to me, fluttered her eyelashes and said `Will you take me dancing and to the movies?'". When he was just four years old Johnny inquired from his mother whether Daddy was coming home for dinner. To mother's reply that he was, he said: "Oh, does he

have to!". Because these behaviors contribute toward the development of a large conflict within the child, many a parent, having dealt with this conflict when she or he was a child by means we will describe in Unit 3, may find it difficult to recognize the contents and the meaning of the child's behaviors we have just described.

These sexual developments, as well as developments that pertain to aggression which we shall describe in Section 2.24 below, bring with them changes in physical posturing and physical behaviors which begin to make for distinctions between boys and girls, which makes for visual differences in behavior that we may consider to be "boyish" and "girlish". As illustrated in the quote from the father, above, his daughter, Diane, sashayed up to him and fluttered her eyelashes. This little girl also later wanted father to buy her a "wedding" dress when he bought mother a dress. Some little boys between two and three years of age begin to posture like apes, begin to play games clearly suggestive of "King of the Mountain", begin to be heavier on their feet, to be rammier in their behaviors, etc. More about all of this in Unit 3.

2.2312 CHILD REARING: How to Handle Sexual Behavior in Growth-Promoting Ways

The Late Part of the Oral Phase

As we discussed in Section 2.2122 on feeding, patterns of feeding change with entry into the second year and become established during the second and third years. Feeding is a major opportunity for parent-child interaction and is served most advantageously when feeding interaction between child and mother or father is positive. Most healthy children will eat the amount they need to satisfy their hunger and are invariably capable of letting the parent know when they have had enough. It is so, however, that during the second and third years, greater sensitivity to tastes (and smell) develops and most children prefer to eat some things over others. It is well for parents to encourage good balanced diet feeding patterns. It is however, important to not force feed, nor to punish a young child for not eating foods that make the child nauseous, but 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.

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. Again, we caution parents against feeling that their one year old will not understand such a prohibition; that is blatantly not so.

It is also well for parents to bear in mind that during the second year of life the mouth can continue to be an instrument for exploring and that the child's putting some thing in his or her mouth is not necessarily indicative of a child's wish to eat it. Clearly,

items that are small, that could be sucked into the lungs such as beads, peanuts, small toys, etc., should be prohibited just for this reason; an explanation to that effect is very helpful.

The process of weaning, commonly carried out during the second year of life by most parents, 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 (one with a lid and mouth-shaped spout) from near the end of the first year, well before the child is to be weaned from the breast or bottle. Many less than one year olds can become quite adept at using such a cup for water or juice. In weaning, the strategy of telling a crying say 18 month old child that all his or her bottles are gone and there are no more bottles in the drugstores is poor strategy. One day the child will discover that there are many bottles in drugstores and the trust in the mother the child has developed will be undermined by this finding. Deceiving children can be much too costly in terms of trust. Much better to be direct, face the child's displeasure, and try to help the child cope with it.

It is well for parents to bear in mind that where the bottle becomes a comforter, it will be much more difficult for the child to give it up; this is particularly so with regard to the "night bottle". As we described in Section 2.2212, the comforter can be a remarkable source of help to the child's tolerating stranger and separation anxiety during the second year of life and it may be wise for the parent to allow the child to determine when the night bottle will be given up. The same can be said, of course, for thumb sucking and the use of pacifiers which serve the same purpose. And, 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.

As we noted before, Johnny used a pacifier into his third year. Father, who absolutely adored Johnny, did not like Johnny's continuing to use a pacifier. Because we had clarified to mother that it probably made Johnny feel more self-reliant and comfortable, she would remind father of this and would tell him, in front of Johnny, that it is not true that "only babies" use pacifiers as he had said recently. She did this because, in part, she herself wished he did not need it, but our explaining its usefulness to Johnny, its enhancing his sense of self, autonomy and self-reliance, made her especially attentive to father's as well as her own feelings about it. As nearly always happens, Johnny's pacifier just vanished when he was two and one-half. We wonder if what really upsets parents about their children's need for a pacifier, or thumb, or teddy bear, is their sensing the young child's feelings of insecurity and need for reassurance, in short, the child's feelings of vulnerability; this probably is a major factor in most parents' unease about their children's using comforters. There probably are other reasons as well; for instance, dentists often tell parents that thumb-sucking is likely to cause a poor alignment of the child's teeth. It may be so for some children. But we believe it is less costly to pay for orthodontal care (braces) during the child's early teens, if needed, then to impede the development of greater inner emotional security and self-reliance to which the comforter (thumb, pacifier, night bottle) contribute.

It is well for parents to recognize that a substantial degree of sucking, be it thumb sucking, or even the use of a night bottle during the third year, may have more to do with

the child's soothing himself or herself in reaction to erotic needs, rather than to tiredness or other distress. It is a fact of life, that all children experience a certain degree of erotic feeling and gratification associated with the mouth that becomes part of normal erotic life. For instance, kissing, it is well to remember is an oral activity and is a major step in the development of an erotic attachment in human relationships. Oral erotism tends to create no remarkable problems for children and requires very little action on the part of the parent to contain it within normal bounds. One area where oral erotism may become heightened is in association with the child's need for larger than expectable amounts of food which commonly, although not always, results from the child's excessive frustrations experienced by insufficient holding, insufficient nurturing, during the first years of life. During the second half of the second year, particularly during the Rapprochement Subphase, needs for comforting, for being held and nurtured, where excessively frustrated may lead to substitutive intake of foods which can become exaggerated. This exaggerated intake of food may also secondarily serve some erotic oral gratification which may then become patterned and part of the person's way of coping with stress.

The Anal Phase:

Toilet training is more or less challenging for all parents. In November 1993, a major American newspaper[6] carried the front page, headline report from which a few sentences follow:

"L.M. was only 23 months old when he died after a beating . . . in July . . . . M.L. was 3 when [he was found in June] in the basement [of his home], battered, naked, dehydrated and suffering from a broken leg. S.S. was 2 when he died of massive head injuries received during a beating . . . in September 1991 . . . . And . . . R.T., still bears the scars from being dunked, at the age of 2, into a tub so hot that it seared off her skin. . . . All four tragedies, prosecutors contend, had something in common: The violence was triggered by a toilet-training accident."

"Getting children out of diapers is one of the most frustrating and time-consuming hurdles that all parents face. But for some, it is so frustrating that researchers now are linking toilet-training accidents with many of the most serious -- sometimes deadly -- cases of child abuse." (p.1).

When, how, by what means to toilet train concerns all parents. Knowing when children are capable of controlling their sphincters should be a key factor in scheduling toilet training. As we have detailed before (Section 2.131), 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.

First, one of the most important things to bear in mind in the course of toilet training is that it may be experienced by the child as a prohibition against, as an imposition on the child's emerging sense of self. The child may feel he or she has to do something the child

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[6] The Philadelphia Inquirer, November 9, 1993. Front page, Feature Story by Martha Woodall, Inquirer staff Writer.

does not want to do, to yield to a demand for giving up one's just stabilizing sense of autonomy and individuality for the sake of complying with the parents' wishes. Assuming such an explanation to be valid will engender more sympathy in the parent as the parent encounters the child's resistance to toilet train. To be told you have to do something you do not want to do when one is feeling shaky about one's sense of self creates a problem for all of us. It is nowhere more difficult than it is for the young child who experiences it as a threat to his or her emerging sense of self. It is well for the parent to bear in mind, not only that this sense of self is a magnificent development needed for healthy adaptation, but that every child who achieves individuality fully-enough will cope better with the demands of everyday life.

We want to emphasize that toilet training is 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 capability of controlling one's sphincters which brings with it a sense of accomplishment, and in turn heightens the sense of self, autonomy and competence.

It is also well for the parent to recognize that in this at times difficult process of toilet training, the parent is trying to help the child learn to accept certain do's and don'ts, to accept the necessity for complying with demands whose intentions are in the child's best interest, to begin to accept rules and regulations, an essential for life in society. Given these understandings, an approach to toilet training can be made which rather than undermine, will enhance the child's emerging sense of self, autonomy, cohesiveness from within, competence, and self esteem. It is well to bear in mind that toddlers value pleasing their parents, getting their parents approval much more than gifts of candy, toys and privileges.

Toilet Training:

In beginning the toilet training of the two-year-old child it is advantageous to wait for clues from the child that he or she wishes to go to the bathroom in the "potty" rather than the diapers. It is best to proceed being able to tell the child that the child himself or herself as well as the parents want the child to learn to use the "potty". Parents should not hesitate to make reasonable demands for age-appropriate growth-promoting compliance from the young child. 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 self and individuality. "I know it is your body and your BM (whatever name the family gives to it), so you tell me when you think you need to make a BM; OK?" Or, "I know you want to be a big girl or boy, so please tell me when you have to make a BM (or whatever the family calls it) so I can help you". Some gentle pressure is at times helpful: "Look, you will feel better when you can use the potty; so you tell me when you have to make a BM!" Two-year-old children can so be trained in a matter of days or several weeks.

Where there is more resistance, it is well to try but 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 oppositional behavior, of battles of wills between child and parents.

Just a word about each. We shall simplify what may happen in the child in order to help parents consider useful possibilities. Professional consultation is suggested where parents are at a loss to know what to do; grandparents and neighbors can often be helpful, but they may equally often not be.

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 vehement refusal with seeming to be afraid of sitting on the potty is evidence of anxiety. A two year old who shows little distress at the suggestion that he or she try to sit on the potty, complies and is not able to have a BM after a few minutes -- but easily has a BM in his or her diapers 15 minutes later -- may just not yet be ready. Expecting a two year old to sit on the potty for 15 minutes or more will not promote toilet training. The child is more likely to experience it as tedious, 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 BM is a good way to start. Expect for those children who show facial expressions of worry or fear about using the potty, insufficient readiness versus anxiety needs time to prove itself. That is, the child who is able to use the potty in June but did not succeed in May, may just not have achieved sufficient voluntary control of his or her anal sphincter then and was insufficiently ready. The normally developing child who at 32 to 36 months and beyond is still not able to use the potty may have an anxiety based problem doing so. Here professional help may spare parents and child significant continuing difficulty. Raging at the child, or shaming the child brings potential difficulties for the child, the parents and their relationships. Success in toilet training achieved by shaming, raging and physical beatings may defeat all the potential gains reasonably experienced toilet training brings; these 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 pride, (5) a better organized sense of "do's and don'ts", (6) an increasing feeling of competence, and (7) a consolidation of feelings of love, respect, and valuing in the child toward the parents.

For the child who has been strong-willed and had much difficulty cooperating with parents, or the child who has been hyperactive virtually from birth on, or at least from the end of the first year on, toilet training must be recognized by the parents to be a task replete with challenges, sensitivities, risks and opportunities for both the child and themselves. For the strong-willed child who is highly driven from within and has experienced limit setting to lead to many battles of wills with mom or dad, toilet training may become an experience and interaction which may significantly improve the child's development and relationships or it may worsen these. Here the balance of sensing, respecting, and allowing the child's feelings of autonomy and developing sense of self on the one hand, and gently and judiciously but firmly ("tough love" style) setting limits with much encouragement and duly complimenting success, can be enormously fruitful. Parents need to guard most against being pushed by their hostility -- which is what drove the serious child abuse reported in The Philadelphia Inquirer article to which we referred above -- in the way they deal with their children, and especially with children like these. That a parent experiences much frustration with such a child is unavoidable; if parents do

not guard against the hostility such a difficult and frustrating child produces in them, this hostility may pervade their actions and create greater problems than before. Toilet training a child who is strongly oppositional 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 that is not governed by excessive hostility, shaming, and harmful treatment of the child. Parents with such children are wise to get professional help if difficulty persists, before some derailment of the child's emotional development occurs.

Dealing with problems in toilet training which continue into the next period of development as well as bed wetting (which can be considered a problem only when it persists into the three to six years of age period, will be taken up in Unit 3 (Section 3.2312).

Many parents become alarmed at a toddler's expression of pleasure when in the process of diapering, bathing, or in toilet training, mother or father by cleansing the child's "bottom" brings with it some sensation of pleasure. Normal children derive pleasure from their bottoms being cleansed or wiped when it is done in a gentle fashion. It is not the expression of some perverse experiencing, as one mother worriedly asked us. It startled the mother whose child said to her "Oh, do it again Mommy, it feels so good". This child was able to express something that many a normally child feels and is part and parcel of the toddler's emerging erotic feelings. Of course, we recommended that mothers and fathers not "do it again"; that they make cleansing of the "bottom" a routine activity that is necessary for the child's proper care. It is highly advisable to consciously make it not an erotic activity. Responding to the two year old with "It's time to get dressed now; you'll learn more about that when you're older." will do very well. Reacting with shock, calling the child "Nasty", brings with it the child's feelings that there is something wrong with or bad about normal bodily feelings or even with him or her. This may set the stage for a child's feelings that erotic feelings are dirty, bad and that nice people do not have such feelings. The consequence of this can be serious for later sexual life.

<u>The Emergence of the first (Infantile) Genital Phase:</u>

We want to emphasize again the distinctions that we made earlier between infantile sexual life and adult sexual life. We want to emphasize here 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 sexual 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. It is important that parents recognize that normal sexual life begins early in childhood and not just at puberty.

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. We shall talk more about this in Section 2.2531. For now it is enough to say that there is a biological inclination to identify more with the parent of the same sex. Four year old Johnny would

pretend he was the father. When he was two years old he would put on his father's cap and tell mother he was Daddy. In this the child begins to feel like his father; a girl will often do the same. But there is more specific sexual behavior we believe, as clinicians, parents will be well served to know, as will their children. With this in mind, let us consider the three types of more specific behavioral evidence which allows us to infer the child's experiencing an infantile sexual life.

The child's interest in genitals, his or her own and those of others 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 child may simply ask of a father for instance, "Can I touch your penis?" or "Mommy, where is your penis?". These are questions normal two and one-half and three year old children ask. They ask these because of a sincere interest they have 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. For instance, nearly three year old boys may worry that their penis may fall off. After all, if a boy's sister does not have a penis, maybe something can happen that will make him not have a penis. Little boys have such worrisome fantasies. We shall address this more extensively in Unit 3. For now, let us say that four and one-half year old Doug, for instance, found it hard to believe that little girls do not have a penis. Already, when she was nearly 32 months old, Diane had asked her mother when she would get her penis. Her mother was initially very surprised at this; even though she had heard about this, she did not believe it. She accepted our telling her that this is a normal reaction and, following our suggestion, Mother and Father took turns to tell her that little girls are made very special, as are boys, but in this boys and girls are different. Girls have very special parts inside their bodies that make them girls, parts that boys do not have; these parts, include a vagina and a uterus, and more, that make it possible for her to have a baby when she is a grown woman like Mommy. This was only the beginning of such concerns for Diane. Suzy, at three and one-half also began to express such concern. In Section 3.2312 we discuss handling this complicated issue constructively in greater detail.

A related phenomenon occurred with three and one-half year old Bernie who like his mother, wanted to have a baby in his abdomen. We discuss this also in Section 3.2312. For now it is perhaps enough to say that it is well for parents to take their children's questions seriously, to listen to them with respect. Little 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.

Probably one of the more difficult things for parents to know how to handle in growth-promoting ways are the child's beginning to "touch" his or her own genitals which most commonly occurs during periods of quietness, such as when the child is sitting in front of a television. The factor that makes parents uncomfortable is their recognition that the child is deriving pleasure from this manipulation. This is "infantile masturbation". It is a normal activity, arising out of the emerging differentiation of the central nervous system, and is a normal part of the child's emerging sexual life. A good way of dealing with masturbation is to tell the child that this is a private activity he or she

can engage in when in her or his room, it is not for public display, it is not the type of activity to engage in when people are gathered in the living room, etc. More on this in Unit 3 when it is more prominent an issue for parents. Again, recognize that "infantile masturbation" is normal, that it is best to be respectfully and responsibly gentle about trying to guide the child in when and where to touch their genitals, and to let the child know she or he will understand these feelings and know what to do about them much better as the child gets older.

It is also well for parents to know that when a two and one-half year old little girl says "I want my baby", like Diane and Jennifer did, the child means just that. The child does not mean that she wants mother to have another baby, 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, a baby she made. We will talk about this further in Unit 3, Section 3.2312. For now, suffice it to say that a child's interest in babies, this is especially so with girls, as it was with Diane, during the third year of life becomes a very genuine preoccupation. Parents might set themselves up the non-intrusive experiment of just looking for the differences between the way the children reacted to babies when they are in the second year of life as compared to when they are in the third year of life. Some children's expressions of feelings pertaining to this issue will be very clear. On average, boys react less dramatically than girls. Let us also add, that those children (girls especially) who do not express an awesome wish for a baby are not abnormal. This interest is likely to emerge to a greater or lesser degree later. Quite a number of girls do not show such interests; some boys may. More on this in Unit 3.

Most parents find it somewhat cute that while embracing they suddenly find their toddler between them pushing them apart. Mother may be puzzled by her four year old son saying "Oh, does he have to!" when mother tells him that father will be coming home for dinner. Or, it is more than cute when three and one-half year old Diane "sashays up to her father", flutters her eyelashes and asks him to take her dancing and to the movies. These are serious feelings. So is the child's statement that she is going to marry her father, or the boy, as Johnny and Doug said, says he is going to marry his mother. We will talk more about handling these feelings and declarations in growth-promoting ways in Unit 3.

We want to point out that parents may find these behaviors difficult to deal with because, in large part, we normally retain within ourselves some residual conflict from the time when we were children, when we as normal-enough children had great difficulty dealing with these feelings and wishes ourselves. This will become clearer when we discuss this major development issue in Unit 3.

2.2 EMOTIONAL BEHAVIORAL DEVELOPMENT

2.24 THE DEVELOPMENT OF AGGRESSION (Nondestructive Aggression and Hostility)

<u>Introduction</u>

As we said in Unit 1 (Section 1.331), aggression becomes a vital, complex, and multicolored inner psychological force which motivates several kinds of behaviors including adaptive and creative as well as non-hostile and hostile destructive activity in humans. We have found that parents are much helped in optimizing the development of the various forms of aggression in their children when they have an explanatory model of it that can help them understand what aggression is, and what promotes its development into constructive as well as hostile destructive inner forces.

As with other major sectors of our selves that make up our personalities like the evolving sense of self, the ability to form love and social relationships, the ability to solve problems and learn, and the capacity for healthy sexuality, the first six years of life are critical years for the development of aggression and its patterning into personality. During the first year of life, the growth-promoting as compared to growth-disturbing development of those inborn dispositions (temperament) that underlie how children experience and express their aggression is largely determined by the <u>positive-enough quality of experience</u> children have (see Unit 1, Sections 1.331 and 1.332). This is so especially with regard to the child's (1) being warmly and sufficiently cared for, nurtured, fed, kept comfortable enough and in good health, and (2) being responded to emotionally in a sufficiently positive way, in the mainly daily interactions they have with their primary caregivers (especially mother and father), and in being valued for themselves as child persons.

During the second and third years, the development of both constructive and hostile destructive trends of aggression is especially determined by the quality of the child's relationship experiences which pertain to the emergence of autonomy, of the sense of self, and of separation and individuation (see Section 2.2211). During the period from 2Ø to 6 years, these trends are most determined by the experiencing of the child's dramatic emergent sexual life, which we discuss in Unit 3.

As we detailed in Unit 1 (Section 1.331), with entry into the second year, the various forms of aggression can be seen in the child's behaviors as beginning to become organized into modes and patterns of expression typical for each child. <u>Hostile destructiveness</u>, which is produced by experiences of <u>excessive unpleasure</u> (emotional or physical pain) as evidenced in reactions of rage, by the end of the first year has acquired direction, as if it seeks a target. It is usually directed at someone or something, and carries with it the intent (the wish) to cause pain or harm, or even to rid oneself of, or destroy someone or something. The spectrum of hostile destructiveness, the form of aggression reactive to unpleasure, goes from modest feelings of anger to, when it becomes <u>excessive</u>, fury, rage and tantrums.

During the second year, "hate" becomes part of this spectrum of hostile destructiveness as the 18 month old child now develops the capability for an enduring heightened negative valuation with feelings of wanting to harm or destroy someone or something. As we shall detail below, during the second and third years, feelings of hate can be mitigated or intensified depending on experience in the course of the basic conflict of autonomy (evidenced in "battles of wills") and of the Rapprochement Conflict of Separation-Individuation (see Section 2.2211). How the child experiences these normal developmental conflicts and how his or her parents react to and deal with the child's behaviors as the child navigates through these demanding conflicts, these are the major determiners of the patterning of hostile destructiveness the child's inborn givens allow. Of course, life stressors -- which invariably bring with them heightened unpleasure and therewith the potential generation of hostile destructiveness --, like illness in the child or parent, loss of job and income, accidents, parental hostility and estrangement, etc., each contributes importantly to this patterning as well, primarily by heightening the burden of hostility in both child and parents.

During the second year, nondestructive aggression -- the aggression that fuels assertiveness, getting to our goals, and mastering our self and the universe in which we live -- also undergoes further development, organization, and stabilization as the sense of self, of one's autonomy and of individuation begin to develop. Nondestructive aggression further develops as the sense of self, autonomy and individuation achieve a further degree of cohesiveness during the third year. A well-patterned ability to be appropriately assertive is crucial to the integrity of the sense of self, self confidence, autonomy and adaptation. We shall detail below how "battles of wills" and passage through the Rapprochement Conflict impact on the development and patterning of both hostile destructiveness and nondestructive aggression.

There is little need here to elaborate further that non-hostile destructiveness, best exemplified in destroying (biting and chewing) associated with eating, is essential for survival and is not, of itself, a source of problem in child rearing. Where problems in feeding arise these have nothing to do with non-hostile destructiveness. Like biting, these problems are more likely to occur in reactions of excessive unpleasure. A child's biting for example, as in reaction to another child grabbing an 18-month-old's toy for the third time, is hostile destructiveness, not non-hostile destructive aggression.

Pleasurable hostility best evident in teasing and taunting, as we discussed in Unit 1, Section 1.291, is a critical variant of hostile destructiveness in which an experience of excessive unpleasure which generates hostility is dealt with by becoming converted into a pleasurable experience of inflicting pain or harm on another person or thing (see Section 1.2531). The accumulations within oneself of hostile destructiveness eventually brings with it pleasure in the discharge of hostile destructiveness. Bear in mind that most early years' excessive unpleasure experiencing occurs, whether directly caused by parents or not, in the context of primary relationships, and that the hostile destructiveness these generate is attached and directed to those the child needs, values, and (eventually) loves most. Because the needed and valued parents become its principal target, the direct expression of this hostile destructiveness is barred by the child and then, by displacement, most commonly discharged against other persons than the primary ones (see Section

2.2531). During the second and third years of the sufficiently well cared-for child's life, the hostile destructiveness generated in conflicts of autonomy and rapprochement produce the largest load of hostile destructiveness generated by experience. Of course where infants are neglected or abused as Richie was, the load of hostile destructiveness generated will far outweigh that produced by the normal developmental conflicts of autonomy and rapprochement. Also, in well cared-for children, the accumulation of hostility in them may also receive a large contribution from peer related experiences.

2.24 THE DEVELOPMENT OF AGGRESSION

2.241 HUMAN DEVELOPMENT: Aggression

The active aspect of oneself, the self as "doer" has at its center what can be usefully identified as "the thrust to autonomy." Some psychoanalytic mental health researchers-clinicians propose that the thrust to autonomy is compelled, is fueled or driven by nondestructive aggression. During the second and third years of life the thrust to autonomy is well activated and remarkably exercised. It becomes age-appropriately patterned, entered into personality, and determines the beginning of the child's feeling competent, self-reliant, and the conviction that "I can do".

The Autonomy Conflict and Aggression:

During the second and third years, the thrust of nondestructive aggression which compels the child into activity only gradually begins to be controlled by the child. That is, the child is as much a victim of the inner-drivenness of this nondestructiveness aggression, as she or he is so to say made into an active agent by it. This is best illustrated in one of the most common problems that emerges for the child under the influence of this magnificent in-the-service-of-adaptation nondestructive aggression. Pushed by this inner-drivenness, many times the 12 to 24-month-old child finds himself or herself compelled to explore something which arouses in the duly responsible caregiving environment alarm and then prohibition. Let us take the simplest example first, then illustrations with more detail. A vigorously active 20-month-old child seems compelled, as if pushed from within, to pull out the plug of an activated air-conditioner from its electrical outlet. Because it is a dangerous thing to do, the caring mother rushes to prohibit this action by the child. Rather than appreciating the protective act of the caregiver, the child reacts with protest, opposition and with resistance, which leads to a battle of wills between mother and her 20-month-old child. Of course, as we saw in 11 month old Jennifer, these battles of wills have already been going on from the end of the first year of life (see Unit 1, Section 1.262). It is clear that as the battle of wills between child and parent persists, anger is activated in both child and parent, and as it continues, hostility is usually generated in both.

In Section 2.2211 we described the exhausting battle of wills that developed between 13 month old Diane and her mother. Bernie, Jennifer and Suzy too had hefty battles of wills with their mothers. As with these children, with Diane, we emphasized that the battle of wills described was produced by the fact that Diane's Mom insisted that Diane not take the toy cart our of our observation room because she felt the toys in it should be available to the other children as well as to Diane. But Diane's wish to take the toy cart into the hall was driven by forces within Diane over which Diane had not yet developed sufficient control. This is at the heart of the problem: the child is driven by healthy, normal forces, nondestructive aggression and narcissism, over which the child has not yet

developed inner control. We said that what creates the excessive unpleasure in the child is that because the child is driven by the inner pressure to explore, when that exploration is interfered with (prohibited), the child experiences the interference as more or less unpleasurable. We described how Diane became furious with her much valued mother because she experienced Mother's repeated and insistent prohibition as highly unpleasurable.

We said that another key factor operates here, what we call narcissism. Narcissism is an inner sense of self-valuing. All children are born with a natural substantial dose of self-valuing, and a substantial dose of this is needed for healthy development and a good-enough sense of well-being. The combination of the thwarting of the child's healthy narcissism and nondestructive aggression by a beloved parent's prohibition is what causes the "battles of wills" to occur. The more the unpleasure experienced, the more the hostility toward that parent will be generated. It is important to bear in mind that the 16 to 18 month old child cannot yet say: "Aggression, slow down here!". To be able to do that, the child will need to develop internal controls which will make it possible for her or him to indeed guide his or her activities and thereby learn to avoid that which is harmful to the self and that which will generate anger and hostility in the child toward those the child values most (see Section 2.2521, below). We also emphasize that, when parents do not understand what causes their child to more or less stubbornly resist the mother's prohibition, most parents take it as a personal insult, which then triggers anger and sometimes even rage and violence as we described in Section 2.2312 regarding the serious child abuse sometimes reported associated with toilet training.

It is in the set of this type of experience, namely the child's inner thrust to do what he or she seems compelled to do, that the child's experience of saying "No" emerges. As we detailed in Section 2.2211, the experience of the "No!" is usually unpleasant to the caregiver but it is of enormous importance to the structuring of the 18 month old child's sense of self, of assertiveness, self-confidence, and self-cohesiveness. This "No" is the verbal expression of experiencing the healthy narcissism and nondestructive aggression which are at the core of the child's developing autonomy and individuality.

The "No" and the battle of wills to which it may lead, are critical determiners of the development of aggression in the self. If the child feels so threatened that she or he cannot say "No" to the people she or he values, the child's nondestructive aggression is likely to become inhibited, hostile feelings to become more intense, and the inner sense of emerging autonomy and self will then be thwarted. If the 18 month old says "No" too strongly, too frequently, is too unyielding to the demands made by the parents, here too difficulty with aggression is likely to ensue. Too much oppositional feeling (stubbornness, inflexibility -- due to a variety of reasons) in the child will create too frequent and too intense battles of wills which will generate more and more hostility and too much ambivalence in both child and parent. Therefore, a position somewhere between insufficient assertiveness and too persistent and unyielding assertiveness on the part of the child is needed to facilitate the child's developing a healthy balance of solid nondestructive aggression and only moderate levels of hostility and hate.

In summary then when driven from within to explore something that can be harmful to the child, or be destructive to something the parent values, or be offensive to another

child or another human being, the caregiving environment is confronted with the need to set limits which the one to three year old child is likely to experience as onerous and will generate anger and even hostility. It is important to emphasize that the normal child may not be able to accept reasonable limits in a reasonable way -- neither readily, nor calmly -- and is likely to experience hostile destructiveness toward the parents he or she value. We will return to this important and difficult conflict below when we speak of ambivalence.

The Rapprochement Conflict and Aggression:

Another major developmental process becomes a source of experiencing aggression in the 18 to 24-month-old child. This is the experiencing created by the separation-individuation process which at this time engenders in the child the basic conflict of the Rapprochement Subphase (see Section 2.2211). The Rapprochement Subphase conflict, which consists of the wish to separate and become an individual, be an entity, on the one hand, side by side with the wish to remain "one with mother," brings with it much anxiety given that these two wishes are in opposition to each other. Anxiety brings with it unpleasure. The higher the experience of anxiety, the higher the degree of unpleasure; the more the unpleasure reaches a level experienced by the child as excessive, the more it will create hostility in the relationship in which this conflict is experienced, namely in the relationship to the mother. This important developmental conflict, therefore, unavoidably also brings with it hostility even in the best of circumstances.

In Section 2.241, we described how between 18 and 20 months of age, Jennifer experienced an acute amount of anxiety, pain and anger in interaction with her mother as she behaviorally went through a clearly inferable Rapprochement conflict. Her feelings of unpleasure (distress) and anger arose within herself and in her relationship with her much valued, now beginning to be loved mother. In this then, experiencing hostile feelings toward the mother she loved, Jennifer experienced a burden of ambivalence which gradually decreased as she seemed to cope and come to terms with the internal conflicted wishes she experienced. As she became more comfortable with her feelings of separateness from mother, her overt anger toward her mother stopped.

This temporary increase in mild hostile feelings in Jennifer were linked by us to her Rapprochement conflict because of her clearly identifiable behavior. There are of course other sources of unpleasure in children during this second half of year two and given that their experiencing of the Rapprochement conflict may not be as clearly evident as it was in Jennifer, it may not be possible to identify increases in hostile feelings to be due from this developmental conflict. For instance, we felt that Suzy who had long been irritable and difficult to calm seemed to occasionally experience more separation anxiety during this period, at times with hostile feelings expressed in her behavior as well. Interestingly, because of all the efforts her mother and father continued to make in comforting her and helping her cope better, we believe that the challenge of separating and individuating helped Suzy organize herself better, and all in all, she now showed less anger and hostility than during the end of year one. We shall talk about how parents helped Suzy achieve this in Section 2.242.

It was more difficult to discern whether the developmental task of the rapprochement subphase was clearly and fully experienced by Vicki or Richie during the second half of year two. 18 to 24-month-old Vicki was coming out of her depression but continued to be quite subdued and we saw little overt angry or hostile behavior, and we could not ascertain whether or not she experienced Rapprochement-based anxiety and pain. Richie on the other hand, seemed so deeply hurt and enraged, had outbursts of rage we shall describe below, but here too it was not possible for us to ascertain that these were contributed to by anxiety or pain due specifically to the task of the rapprochement subphase.

Not only does the Rapprochement Subphase conflict bring its own source of hostility toward the mother, it also brings hostility toward the father. Dr. Mahler and other development experts have proposed that this is especially due to the child's experiencing Father as the person who is pulling the 1 1/2 year-old child out of the oneness with mother, the person who, side by side with blaming mother also becomes blamed for this process when the child experiences the anxiety it produces.

In addition, some of the spin-off activity from the Rapprochement conflict, such as the hoarding of toys, the grabbing of things that belong to others under the influence of feeling that "It's mine", also bring with them experiences of hostility both from the vantage point of feeling that what is "mine" has been taken by another person as well as by the struggle that ensues from a child's wanting to take from another child what belongs to the latter.

In sum then, healthy nondestructive aggression in combination with healthy narcissism compels the child into autonomous activity that may run into conflict with the parents (caregivers) and create battles of wills, which then generate anger and hostility toward them. Secondly, the Rapprochement Subphase with its Rapprochement Conflict, also generates hostility toward those the child values most, namely mother and father.

Aggression and Ambivalence:

Given then that mother and father are most valued by the child, are most endowed by the child with positive feelings which, as we said in Section 2.2131, from 18 months of age on we begin to identify as "love" feelings, and that these persons also now are the individuals who are generating hostility in the child, which from about 18 months on can become "hate", the child will now experience feelings of ambivalence which endure, which persist. Whereas earlier the ambivalence experienced by the well-enough cared for child from the end of the first year of life on tended to be experienced in small doses and for short durations, from about 18 months of age on such inner feelings of hating the person the child loves have endurance and become a harsh psychological, emotional burden for the young child. Ambivalence, hating, wanting to destroy someone we love, creates a powerful internal conflict which the child may have great difficulty dealing with, which may bring with it the very beginnings of guilt feelings. We shall address in Section 2.242 how parents can be helpful in coping with these feelings of ambivalence and of guilt (see also Section 2.2612). In addition, by virtue of the fact that the hate now beginning to be felt toward the loved mother is unbearable and creates enormous

anxiety in the 1 1/2 year old, the child will defend himself or herself psychologically against feeling the hate experienced toward the mother (see Section 2.231). Also, a large part of the hate experienced toward the mother may become converted into pleasurable destructiveness which is often displaced on others in the form of teasing, taunting, as well as outright expressions of hostility and hate. For these and other reasons, children need parental help in learning how to mediate constructively the hostility generated in the child. We shall talk about this in Section 2.242. For now, we emphasize that, when excessively unpleasurable experiences generate hostility toward the mother and father to whom the child is attached and loves, this will produce anxiety which, in turn, will be experienced as unpleasurable and may again generate more hostility. Thus, there is a self-perpetuating system in the generation of hostility which can create havoc in the young child.

Furthermore, the child will need help in coping with the hostility generated with him or her because that hostility will interfere with the experience of nondestructive aggression in the following manner. As we said, experiences of excessive hostility toward the mother and the father we love not only leads to enormous anxiety, but also to guilt, to fantasies of being evil, unlovable, to-be-rejected, subject to being abandoned at any moment, all of which creating unbearable anxiety in the child which then will lead the child to develop defenses in order to not experience such pain (see Section 2.2532). One of the most common defenses employed by the very young child in the face of excessive hostility is the inhibition of aggression. One of the major problems with the use of inhibition of aggression is that it is not selective. That is to say, the young child cannot inhibit only hostility, only hostile destructive aggression; all aggression seems to be subject to the inhibition. Therefore, healthy nondestructive aggression becomes inhibited as well. One often sees this in a child who is unable to stand up for himself or herself in the face of insults, teasing, the taking of things which belong to him by other children. Or, in the child who is too passive, who never says "No!". One can sense that a child who is using inhibition too vigorously against all aggression will not be able to motivate himself or herself to action, to undertaking projects, etc. The detrimental effects of this inhibition can best be seen not only in the lack of motivation such child exhibits, but also in the fact that learning may be impeded by the inhibition of nondestructive aggression. Therefore, in order to be reasonably self-assertive and to learn optimally, children need their parents' help in coping with their experiences of hostility toward mother and father. We will address this below.

Rage Reactions and Temper Tantrums:

We said in Unit 1, Section 1.291 and elsewhere in the text that how children experience unpleasure varies widely from child to child, and within the same child from day to day and even from hour to hour. A child who is tired or hungry or ill is more likely to experience unpleasure events more quickly and sharply than when that child is well rested, fed and feeling well. A child who has a low threshold for irritability due to inborn factors that make him or her a quick reactor to pain (unpleasure) and frustration is likely to react more quickly and intensely than a child who is calmer and can wait more

easily. We have seen how quick-reactor and more easily irritated Suzy would have rage reactions quite frequently for several months after her birth and from time to time even during her second year. By contrast we did not see rage reactions in Jennifer or Johnny for instance.

Very important is the fact that children who experience much pain, physical and/or emotional, in the way they are cared for, are more likely to accumulate increased loads of hostility within them. Children like Richie, who was not an overly hostile infant at 6 months of age but became so after several (4 to 8) months of emotional neglect and physical abuse, may have such loads of hostility accumulated in them that the least little hurt or frustration can set them into a rage. Children are complex organisms from very early on in life. Not all children who suffer much develop such quick and intense reactivity to pain (unpleasure). Many factors account for such differences including the child's inborn dispositions (like Suzy), intensity and frequency of hurts and neglect, the meaning to the child of the experience that hurts, and efforts made by the caregivers at care-giving and to repair hurts. All of these we felt played a part in the fact that Vicki, who also suffered much pain due to her mother's feeling overburdened, depressed, but who was not hit or beaten by mother or father, experienced a childhood depression but was not raging and had no tantrums. We felt and saw that Vicki was attached to her depressed mother, had more been emotionally deprived than abused, and that we picked the problem up quite early (from about 9 months of age on) and psychotherapeutic treatment was instituted soon thereafter, all of which may have accounted for Vicki's not becoming an enraged child.

We should add though that some quite well put together one year olds who live in quite good-enough home situations may at times during years two and three have an occasional rage reaction or tantrum.

We want to briefly review here what we said in greater detail about rage reactions and temper tantrums in Unit 1, Section 1.291. Rages and tantrums in children are caused by experiences of excessive unpleasure that reach levels the child experiences as unbearable. We consider a rage reaction to be a single episode of an outburst of excessive hostile destructiveness; a temper tantrum consists of a series of rage reactions, usually appearing and sounding like one rage reaction after another, increasing in intensity, reaching a peak of intensity, leveling of and then getting weaker and weaker till it stops, seemingly with the child exhausted. We saw rage reactions in Suzy and Richie during the second year but not tantrums; we no longer saw rage reactions in Suzy during the third year and we cannot say whether they continued in Richie into the third year, although we would expect they did, because he was not returned to our Program after the summer vacation.

We said in Unit 1, Section 1.291 that rage reactions and temper tantrums have structure. A rage reaction usually starts at the point of intolerability of panic (more often emotional pain than physical pain), increases in intensity, and wanes more or less quickly depending on varying factors. Rage reactions sometimes start explosively, especially when the child (or adult) tries to contain the mounting feelings of hostility and/or hate and reaches the point when he or she no longer can do so. Also, a rage reaction tends to stop fairly abruptly when that which caused the rage to begin with is stopped. Usually,

however, a rage reaction has a bell-shaped curve, with a climbing limb, a peak, and a descending limb (see diagram in Section 1.291).

A temper tantrum is a series of such rage reactions (episodes) with pauses between rage episodes. Like each rage reaction, the entire tantrum series usually has a bell-shaped curve, starting with lesser intense rage episodes, followed by more intense ones, and gradually fading with exhaustion. It is not uncommon though for a tantrum to start explosively -- where the child has tried to contain the explosion of rage feelings -- and gradually decrease in intensity, or even stop fairly quickly when that which caused the tantrum is stopped.

We believe, from observing tantrums and rage reactions closely that they differ in other important ways as well. Usually during rage reactions the 1 to 3 year old child seems to be aware of what is going on around him or her as he or she rages. In temper tantrums, the 1 to 3 year old is in touch with what is going inside and outside of himself or herself as the tantrum begins, and then again as each rage reaction of the tantrum slackens (during the descending limb of each rage episode). However, once into the climbing limb and the peak of each rage episode of the tantrum, the young child seems not in touch with what is going on outside the self. We say the child has then lost touch with reality and is not likely to hear what is then said to him or her nor recognize the parents efforts to help. This is important to know in order to handle a child’s having a tantrum in a growth-promoting way, which we shall discuss in Section 2.242.

We repeat that except when associated with some forms of brain disorder such as seizures or high temperatures, rage reactions and temper tantrums are always caused by some excessively unpleasurable (painful) experience that has become unbearable to the child. Rages and tantrums do not occur spontaneously (except in seizure disorders).

We saw that Suzy's battles of wills with her mother, father, and even Mrs. Sander by 26 months had become less intense. Hand in hand with this then, her reactions of hostility seemed less intense as well. We now got the impression that their relationships had so stable a level of love in them, that Suzy's battles of wills with mother (they had all along been less heated between Suzy and her father and Mrs. Sander) seemed to now be an occasion, indeed an opportunity for Suzy to practice having better control over her hostile reactions toward mother (as well as father and Mrs. Sander who really "adored" Suzy). The benefits of this were multiple for both Suzy and her mother: Suzy seemed to better recognize and respond to mother's efforts to help her, the love between them seemed felt by both even during these battles, the hostility level was less and thus less fear-inducing in both. In addition, mother felt more self assured and good about her parenting, about which we shall say more in Section 2.242.

Nonetheless, handling her own hostility toward the mother she loved was not "fun and games" for Suzy; nor for mother and father. It was less of a problem for Mrs. Sander not only because she had more experience dealing with children than Suzy's mother and father, but also because she was not getting the same intensity of conflict and, therefore, of hostility as did Suzy's mother and father. She was not as loved or as hated by Suzy because of the lesser emotional investment Mrs. Sander and Suzy quite naturally made in each other. Nor was it easy for mother. In fact mother was stung when 30 month old Suzy clearly and distinctly, in a moment of quite intense feelings of hostility said to her:

"I hate you!" We described in Section 2.2l32 how mother reacted and will do so further in Section 2.242. What is to be recognized here is that putting feelings of hostility and hate into words as Suzy now did indicated a level of organization, control, and functioning much further developed over how she dealt with these troubling feelings before. Putting troublesome feelings into words is a very important achievement (see Section 2.2521).

All of this development played a large role in the fact that 30 month old Suzy's rage reactions were now quite more tame, of shorter duration and quite less frequent. She would show intense feelings of hostility, would tense up her body in exasperation, get red in the face, get hold of a toy or item of clothes and throw it on the floor, sputter sounds that now organized into "I hate you", start to cry and (needing comforting and reassurance, and perhaps Mom's help to control herself), she wrapped her arms around Mother's legs. After a moment's delay, Mother, now collapsed into a chair, picked her up and comforted her.

It was not this pretty with Richie. About one month after we first saw him, l5 month old Richie's efforts were unstable, shifting quickly. At moments he appeared deeply depressed; at others, he smiled. He beamed when 2 year old Suzy engaged him in play by rolling a ball to him which he then rolled back to her. When Suzy playfully hid the ball between her legs (to make it "disappear"), he appeared confused, suddenly unbearably frustrated, cried and banged his head on the floor, to the pained dismay of Suzy. One of the mothers intervened to calm him. Some minutes later he went into a rage reaction, tensing his body, then flailing his arms and legs and he collapsed from the sitting position onto the floor, crying in a rage, all because he could not take a toy another child had just been playing with.

One week later we saw Richie put toys down in a striking manner: he smashed them on the floor or into the toy cart or out of it which elicited his great-aunt (and the group Instructor) to physically stop him (verbalizing the need for him to contain his angry feelings). We felt that the rage he felt had "invaded" his exploratory motor (movement) activity; it became too harsh and destructive. We learned from his great-aunt that he now wakened during the night screaming, that he then could be comforted by her within a few minutes, which suggested that he was having frightening dreams, nightmares. 3 months later, at l8 months he was now walking, wobbly but without support. Better coordinated, he was still throwing toys too harshly, suddenly and dangerously at times so that he needed to be contained (we shall detail in Sections 2.242 how this was done). When he was just under 2l months of age he had made large strides in development. Now his hostile destructive feelings were in much better control; there was no throwing of toys and no signs of his up-to-now explosive reactivity. His occasionally folding his hands on his chest so as to prevent them from grabbing or reaching for things he should not touch, and his at times shaking his head "No" at such moments, suggest this better control (also see Section 2.2611). At this time, Richie was having as many as 3 nightmares per night according to his great-aunt.

Here is another illustration from our observational research. Although David was just 2 months more than 3 years (38 months), when the event we shall describe occurred, we can use it here because this type of behavior had been going on from very early on.

From birth on David had a low threshold for irritability (what seemed like little things to others produced irritability in him) and was a quick reactor. Even with the mother's good efforts to care for him, he was difficult to care for because he was so easily irritated and frequently distressed, and so were his parents. As a result, there were many episodes of hostility between them which troubled mother a great deal. Fortunately, these were well out-balanced by the parents' loving their baby and, in turn, David was well attached to them and loved them.

Here is a narrative of David having what could have been a much more troublesome tantrum than it was. We shall here also draw attention to what the mother did in handling it; we coached the mother at certain moments and shall explain in Section 2.242 the reasoning for what we suggested to her.

Typically for him, 38 month old David seemed on edge when his mother rolled him and his 11 month old sister in a stroller into our observational setting. He squirmed, vocalizing bursts of effort and complaint, conveying intolerance for being restrained. Alert to his state, as soon as she could, his mother pulled him with care out of the stroller, trying to calm him by acknowledging his eagerness to get out, while he helped her efforts with his own strained and eruptive movements to get out.

Phew! He could now move where he wanted. He darted to the fruit on the table; smiling, he signaled to his mother it was there. He went to the toys. During this time his mother had gotten to his sister, a much calmer and easier child, and helped her out of the stroller. Ten minutes had passed when David brought an apple to his mother; it was not clear if he wanted her permission to eat it or simply to inform her that he was doing so. Mother did not want him to have it because he had earlier complained of stomach pain, and she told him, she feared it might upset his stomach more.

He erupted! Virtually at once, his face looked intensely pained and in rage, with crying and blustering sounds, he dropped to the floor kicking and flailing at his mother who had just taken the apple from him. Mother looked pale and embarrassed as she tried with our guidance to tell him sympathetically why she had prohibited the apple for now. His kicking and flailing made her pull away slightly, but as he calmed a bit, she came closer and continued her efforts to explain and calm him further. Within thirty seconds he let her hold him, and she, now seated in a soft chair, continued her efforts. Both child and mother looked pale, drained, and intensely in pain.

About one minute into the calming phase as another child picked up the wooden car with which he had been playing, David erupted again though not as harshly. As he ragefully complained and demanded the return of the toy, he picked up a block and threw it toward and nearly hit, not the child who was playing with the car, but another mother, a person totally uninvolved in the event. Further frustrated by the second child's resistance in returning the toy, in quick sequence David grabbed his sister's bottle and threw it at her, picked up another block, threw it at the Parenting Group Instructor, and nearly fell off the chair doing so. He looked at the Parenting Instructor more anxious than raging as the Instructor told him he was sorry David was feeling so bad but that he didn't want David to throw things at him nor to fall off the chair. The Instructor told him he wished David could talk to his Mommy or to the Instructor about the things that were making him so upset. Simultaneously, his mother was gently telling him not to hit his sister and

that Dr. Parens (the Instructor) had not done anything to him, and that he could not throw things at people. With his mother's help, the second child returned the car to David, and David became calm as his mother continued to talk to him. Both, still, looked exhausted and pained.

As he recovered gradually, David began to annoy his sister by taking the toy with which she was playing, smiling provocatively at his mother as he did so. The teasing intensified into taunting; mother now became angry with him. Just when he was on the verge of going too far, David abruptly changed his activity, asked his mother to play with him at identifying the letters of the alphabet. Mother seemed relieved and readily complied. David and his mother continued to look emotionally drained, and David seemed vulnerable to a reoccurring eruption of rage by his lowered threshold of irritability, resulting from the traumatic state produced by the tantrum. More on this in Section 2.242.

2.242 CHILD REARING: How to Handle the Child's Aggression Constructively

How to Optimize a Child's Nondestructive Aggression:

We should note that it is important for parents to help secure their child's ability to be sufficiently assertive, motivated to learn and cope, and to protect his or her own rights and property. The model of aggression we use holds that nondestructive aggression in healthy amounts is needed to secure these abilities. Most children are born with a sufficient built-in amount of nondestructive aggression. Some children, especially shy children -- which is an inborn type of temperament -- need to be supported and encouraged to stand up for themselves. From the latter part of the first year of life, Johnny was a bit timid. At 11 months, when 11 month old Jennifer pulled the pacifier from his mouth several times, he seemed not able to mobilize his self-protective nondestructive aggression to stop her, and when he became upset, we did not see any evidence of hostile feelings activating him to defend his rights and property.

We talked to the mothers in our parenting research group that while as we shall detail below, it is important to help our children handle their hostile destructive feelings appropriately, it is also important to help them develop a sufficient ability to put their normal nondestructive aggression to good adaptive use. We need to help our children be self-protective to reasonable degrees. We need to help them be reasonably self-assertive, be motivated to explore, learn and reach for their goals, and more. We also need to recognize that hostility (hostile destructiveness) is sometimes needed to protect ourselves, those we love, our rights and property.

We suggested to Johnny's parents (mother was there) that they carefully, without too much pressure and absolutely without humiliation, encourage him to not let Jennifer pull his pacifier, that it belongs to him not to her, and that if that was what he wanted, he

could have it in his mouth! Slowly, gently, mother could tell him that it's OK for him to not let some other child take his things or push him. Speaking of the fact that we sometimes need hostile feelings to protect ourselves and those we love, led to "But, I don't want my child to become violent, I don't want him (or her) to hit, bite, or grab things from other kids." We believe this: all families need to decide their philosophy about this question. We suggest that parents tell their children as the need arises that although it is not usually OK to be the first one to hit another kid, that it is OK to hit back when hit by another child first. Although it will not apply during the 1 to 3 year period, there is an exception, when indeed one's child should be permitted to hit first. That is when a bigger child bullies your child and will not stop when told by your child to leave him alone. Experience teaches us that "the best way to stop a bully is by a good punch in the belly." Many "bullies" who commonly are children who have been abused at home, tend not to stop bullying until this happens.

Setting Limits Constructively:

"Why doesn't he listen to me"? "I have told him not to do this five times!" "She is so stubborn; nothing I do works!" These and other expressions of frustration, anger, despair are common among parents of children in the second and third years of life. In our work with parents we have found it helpful to point out that the inner-pressure which drives a child to explore the universe around him or her is so large that the child cannot easily stop the activity that is compelled by that inner-pressure. The inner-pressure, of course, is that of nondestructive aggression in combination with healthy narcissism which thrusts autonomy, the self into action. It is just this inner pressure that made Diane want to push the toy cart into the hall; and just this that caused the big problem that occurred with her mother who did not want her to do so. All parents want their children to feel motivated, to learn, to do things that are growth-promoting and that achieve results, to be "doers". Yet, the inner thrust for autonomy which makes self motivated achievement possible is also that inner push to activity which causes the frustration, anger and difficulty felt by parents referred to at the start of this paragraph. If it indeed leads the child to feel motivated and be a "doer", parents will want to know how to deal with this inner pressure in growth-promoting ways. And, furthermore, given that this inner force leads to the battles of wills which we described in Section 2.241 (as well as in Unit 1, Section 1.262), and that these battles of wills by generating hostility increase ambivalence (hating those we love), with all the problems ambivalence brings, it is important for parents to set limits in a constructive way.

First, parents should know that children are as much the victim of their inner forces and pressures as are the parents. Knowing that the child has not yet developed internal controls over this more or less powerful inner drive will facilitate the parents understanding of the problems encountered in setting limits. This is one of the major reasons (the other is the child's healthy narcissism, that which leads to child to want to do what the child wishes) that setting limits is never achieved in one effort, that it is required again and again, and that developing internal control takes time. Knowing these facts will lead to less frustration in the parent, less disappointment, and less hostility toward

the child. Of course children vary in the degree to which they accept limits and this is significantly determined by (1) the level of aggression with which they are born, and (2) the degree to which they are malleable, which has much to do with the degree to which children themselves can bring about internal control over their aggression.

Most important, the way children are treated by their parents in limit-setting is also a significant contributor to the way limits are accepted by the child. Limits which are set in a way that is respecting of the child, attempts to understand the child in action, are sensitive to a child's feelings, are set to protect the child and not to make the parent feel that she or he is the boss, all will make limit-setting easier for the child and more acceptable.

How limits are set also contributes to its success or failure. When parents set limits they should do so with respectful firmness, with the expectation that the child will sooner or later accept the limit, and will comply with the parent's demand. It bears repeating, loving firmness is an essential part of setting limits. We have at times heard mothers become intimidated by the child's not complying after several "requests" that a child, say, take off his coat soon after coming into our research setting. At this point a mother may plead: "Oh please Honey, take your coat off for Mommy." This usually is no more effective than what mother had done so far. We have also seen some fathers be much too quick to yell or threaten a child after 2 refusals to comply with father's telling a child to take off his coat. One method is too slow, weak and ineffectual; the other is too rapid, frightening and authoritarian. Neither gives the child the feeling that the limit is truly in the child's best interest.

We propose that limit setting have a pattern. We find that 5 steps to go from starting setting a limit to punishment to provide good spacing of demands for compliance.

Step 1 is a clear, simply stated demand that the child do something <u>and the reason why</u>. "Johnny, don't take Doug's truck. It belongs to him (or he's playing with it now). It's not nice to take things from other people (unless it belongs to Johnny)."

Of course, the situation in question will determine how the parent takes this first step. If it is that 22 month old Johnny is trying to grab 30 month old Doug's truck (or as did 11 month old Jennifer who grabbed 11 month old Johnny's pacifier from his mouth), if Johnny does not comply, step 2 should come fairly quickly. If it is a matter of telling Johnny to take off his coat, step 2 can be delayed by a few seconds (10-15). If it is a dangerous situation such as 18-month-old Bernie's beginning to pull the plug of an activated air conditioner, the first step is a firm and somewhat loud (Bernie! Don't touch that plug; it's dangerous." With a less compliant child, this step 1 will need to be accompanied with the parent quickly going to the child as the demand is stated firmly and even forcefully.

Where step 2 is needed, it should be said more firmly and a bit louder: "Johnny, stop that. I told you it's Doug's turn to play with the truck. I wouldn't let him do that to you and you can't do it to him." If Johnny still does not comply, step 3 is needed fairly quickly, say in 2 to 5 seconds. Step 3 should be more firm than step 2, louder, with a tone of warning. A few words are very helpful: "Johnny, you're looking for trouble." or "You're asking me to do it for you? Come on, let go!"

If step 3 does not get compliance, Step 4 requires the parent to get up, go to Johnny,

and now not necessarily more loudly, but with more seriousness, perhaps even a bit of severity: "Look, I don't know what is going on today with you, but you must let go. If you don't you will be punished." If that does not work, step 5 consists, in this instance, of the parent taking hold of Johnny's hand, using the least force necessary to loosen his hand from the truck, and telling him that Mom or Dad is very disappointed in him for this, and he will not be able to watch his favorite TV program today.

Circumstances (the situation) will determine how quickly to progress through the 5 steps. So will the child. With a shy child, the progression should move more slowly, more gently; with a hyperactive or non-compliant child, more quickly and more firmly.

Note that Step 5, is accompanied with a punishment. Punishment occurs when limit setting fails. Where limit setting works, that is, where compliance occurs before Step 5, no punishment is required. It is important to avoid punishment whenever possible. However, it is important to set limits when they are needed, and to punish when the limit fails.

We say again, limit-setting is the parent's acting in the child's behalf where the child is too immature to know something cannot be done (for a good reason) or is risking causing harm to himself or another, or valued thing; punishment is the withdrawal of a privilege or the inflicting of pain for failure to comply with parental dictates. Punishment is a difficult task and usually puts the parent-child relationship most at odds and full of negative (hostile) feelings.

Where punishment is needed, the withdrawal of privilege is more advantageous than physical pain. This is so at all ages. It is usually unwarranted and unnecessary to inflict physical pain in one to three year olds. Children want to be loved and respected and where they are they usually respond well to well structured limits and, where these fail, to the withdrawal of privilege.

Privileges should be withdrawn at a reasonable rate. Mother told 27 month old Johnny he would not be able to watch Sesame Street today. That was enough. It would have been unwise to withdraw that privilege for one week. Too harsh a punishment elicits too large a load of resentment and hate. It is less likely to do so where the child feels the punishment is reasonable.

There should be strict rules about parents hitting children. This is especially so with young children. For parents who for one reason or another truly believe they must spank or hit their child to get reasonable compliance, we would propose the following:

Only one swat with the parents' open hand, on the one to three-year-old's clothed "bottom". It is completely unnecessary to strike a child on the bare "bottom". It can cause more emotional problems than parents realize, according to mental health professionals. Only very moderate force should be used. The aim should be to make a point, not to inflict intense pain. Shaking a child is dangerous; we now know that it can cause brain injury. Yanking a child by the arm can pull the arm out of the shoulder. Hitting a child with a fist or some instrument (be it a belt, a paddle, a stick, etc.) is much too harsh and children know it! The result is more likely to be resentment, hate, and loss of respect than to get constructive compliance that holds.

Let us return to setting limits constructively. When setting limits, parents should be clear. And they should clearly state the reason why the limit is set. A limit that is set

with "Because I said so!" or "Because I'm your father!" is sure to be resented more than one with a reasonable explanation such as "Because it will spoil your appetite." or "Because you will be too tired in the morning!" For instance, Diane's mother told her she did not want Diane to take the toy cart into the hall because it should stay in the meeting room so that the other children would have access to the toys in it. Diane's mother did not use these words but she made this point clearly to Diane. We also encouraged Richie's great-aunt to tell Richie that he could not throw the toys as he did because he might hurt someone doing so and also, he might break the toy or something it hit. Similarly, we suggested to David's mother that she tell him the reason she would "not let him eat the apple now is that it might upset his tummy more", and to remind him that he said his tummy hurt this morning. The limit is set usually because the child is doing something that may be harmful to him or herself, may be harmful to something the parent values, or hurtful to someone else, or may not be acceptable socially. Limits that are set for reasons other than these, should be questioned by the parent.

We have seen what a difficult experience it became for Diane and her mother, when mother simply did not want Diane to push the toy car into the hall. Setting limits is a serious issue for all parents and children. And we have seen it to be a difficult undertaking for all parents, across all cultures and socioeconomic groups with whom we have worked. As we said in relation to toilet training, where the limit setting that comes with toilet training fails, it often frustrates and angers parents, in some cases of such severity as to lead to child abuse and even the killing of a child.

Given that setting limits, an effort to protect and act in the child's behalf, invariably leads to battles of wills in most children, and given that these battles of wills generate hostility in both child and parent, it would make sense that one should set limits only when they are needed. And, they should not be set without a good reason; reasonableness ought to govern the setting of limits. For instance, if a parent in annoyance automatically tells a child he or she cannot do something the child is doing which in fact is not undesirable, the parent then recognizing that the limit was set more as an expression of annoyance with or anger toward the child, the parent can revise that limit. The parent's changing his or her mind about a limit can be done with a simple statement, "I've changed my mind, it's OK for you to do that now." and this admission of changing one's mind often turns out to be most growth-promoting. Children never ridicule their parents when they change their minds. A parent has a right to make a mistake; the important thing is to recognize it, verbalize it, and try to undo it. Children always appreciate and respect parents' apologizing for mistakes they make.

Some of these issues are taken up more extensively in our book entitled *Aggression in Our Children: Coping With It Constructively*[7]. In that book, we discuss in some detail an important event that often occurs in limit setting. It is, that when parents are setting limits, it is a serious mistake for them to at such times refuse a child's appeal to be comforted or held. We want to briefly explain this here. When a mother (or father) sets limits the child often reacts to the limit setting with increasing anger and hostility toward the mother. Because the child is feeling hostility toward the parent the child loves which

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[7] *Aggression in Our Children: Coping With It Constructively,* by H. Parens, with E. Scattergood, W. Singletary, A. Duff. Northvale, NJ: J. Aronson Press, 1987.

causes the child much anxiety, the child commonly will feel the need for comforting. This is especially so with children under 5 years. We believe that when the child asks for comforting during limit setting and battles of wills, it is usually because of the anxiety created in the child by the ambivalence she or he feels. Many parents then misinterpret the child's appeal to be comforted as an effort to "butter up" the parent, to try to get the parent to yield to the child's wishes. Of course, the normal child wishes the parent to yield to his or her wishes; we all want what we want when we want it! However, this is not usually what motivates a child to ask for comforting in the midst of a battle of wills. Rather, it is the child's hostility, which causes anxiety, and then leads to the need for reassurance of the parent's continuing love. The fact is that when a parent refuses to comfort the child in the heat of a battle of wills, the parent is experienced by the child as hurtful, hostile, rejecting, a witch or monster, and this experience further heightens the child's experience of hostility toward the mother or father which then further heightens the anxiety felt by the child. This then tends to foster further rejection of the parents' demand by the child and may increase the resistance to the limit imposed by the parent. Often when children yield to the parent's limit-setting after comforting is refused it is more a giving up than it is an internalized acceptance and recognition of the merit of the limit. The child stops the behavior that is undesirable by giving up rather than by seeing reasonableness in the limit set, rather than by an acceptance that is growth-promoting. Giving up is not growth-promoting. Furthermore, when we are told something we do not want to hear, and are angry with the "bad" limit-setter, it is likely to "go in one ear and out the other". This, of course, goes against accepting the limit.

By contrast, when a mother accepts a child's plea for comforting in the heat of a battle of wills, which happened quite regularly with Suzy, the child experiences the mother, the prohibitor, the limit-setter, as a caring person, a positively responsive loving person. We saw this clearly in Suzy and her mother especially, though it also was so with father. It was in large part due to Suzy's having learned that she could count on her parents' trying to comfort her when needed, that she progressively responded more easily to limit-setting, and that she grew as well as she did, became better and better organized as a self, and formed so good a relationship with each of her parents.

The battle of wills triggered by Diane's mother prohibiting 13 month old Diane's taking the toy cart out of the meeting room set up a very painful situation for Diane and her Mom. In this instance, Diane did not plead for comforting. Diane's Mother just very naturally, seeing her loved little girl so awfully troubled, offered to comfort her. As we described, she even wisely offered to again after Diane, still too angry with Mom, was ready or able to accept it, as if she was not yet able to be calmed and comforted. Diane's mother "offered", she did not force comforting, though she did force Diane to not take out the toy cart by picking her up and holding her against her will.

Diane's mother could not have handled it better, we believe. She had set the limit clearly. She told Diane to not take the cart out because the other children might want some of the toys in it. When Diane virtually exploded in a rage reaction, including briefly, in one flurry, hitting and kicking her mother and herself, Mother was startled and upset but automatically tried to make Diane feel less upset. We encouraged mother to hold to her limit setting because it was reasonable and to work it out with Diane, and to

continue to try to calm her. As mother calmed her, she did so mostly by the way she held her, not by talking, except to say "Oh my", "Oh my goodness" a couple times.

Recall that mother seemed clearly puzzled by Diane's getting upset when mother bent down (Diane sitting on her lap) to pick up a toy to offer to Diane. We encouraged Mother now to let Diane have a say, so to speak, of what she now would want Mother to do. We too were a bit surprised (and learned an important lesson) when Diane, sitting pulled away from Mother's torso at the edge of mother's knees, just wanted Mother to not move. We inferred from her facial expression and body posture and movements, that Diane was struggling within herself with being furious with the Mommy she was so securely attached to. We told Mommy this and recommended that she just let Diane show her what she needed moment by moment. Mother was superbly tuned into her baby's state of internal conflict. As Diane calmed some, Mother felt it and again tried to bring Diane close to her to comfort her better. At one point Diane yielded, seeming now ready to accept her good Mother's offer to make her feel better. Mother had stayed with her limit setting which, even though it was painful for both and mother and child, ended on a safer but quite positive feeling of "being together". We suggested to Mother that on the way home, and perhaps again later, that Mother talk to Diane about what happened. That she could start by saying that she was sorry to have caused Diane such hurt feelings. But, to tell her, she did so because Diane needs to know there are things she can do and things she cannot do, just like it is for Mommy and Daddy and everybody. That the reason Mommy didn't want Diane to take the toy cart out was so that the other children could have the toys to play with too.

Again, even though Diane did not ask Mother for comforting, Mother did well to offer it. When a young child is in intense pain, we mental health professionals have come to see that it is highly desirable for the child to be able to seek help. We are concerned about children who feel that one should not expect or hope to get help when it is really needed. Of course, in due time a child should be able to do things on his or her own. But one should also be able to ask for help when help is needed. Medical nurses have long known that TLC (tender loving care) is among the best medicine we have. When a child is embattled with the parent to whom she or he is attached (and loves), the child experiences pain. The child is then wise to ask for help. The child, feeling the parent's efforts to make her or him feel better, becomes more inclined to hear and take in what that loving person says, more likely to experience what she says as being reasonable and in the child's best interest. While holding the child who is being comforted, the mother or father can then gently and sympathetically repeat the prohibition, and also repeat the reason why. It sounds like much work, and it is. But under these conditions the child is more likely to experience limit-setting as being really in her or his best interest even when the child protests.

In the midst of limit-setting, it is helpful for the parent to bear in mind what is at stake here. Among other things, it is the child's magnificent thrust to autonomy (to be a "doer") which at this given moment makes him or her do something the parent is prohibiting; it is the built-in budding power in the child which is acting in the service of securing in the child a good sense of self, of self-esteem, and eventual self-confidence. In line with this, the "No!" which the parent experiences often as so annoying, so angering

even, is really the representative of the child's healthy assertiveness, integrity, and sense of self. It was visibly relieving to Suzy's mother when we told her that 18 month-old Suzy's "No" stood for her emerging sense of autonomy, her sense of more and more becoming a self. Yes, it was annoying, but it was said more to protect her feeling of being a person than to be annoying to mother. It was not some form of obnoxious mean-hearted behavior. When it was reasonable we suggested that Suzy's "No" be accepted. "No, she doesn't want her sweater taken off", or "No, she doesn't want another cracker". But the other hand, when Suzy's "No" was not reasonable, Mother needed to let her know. "Look Suzy, I know you don't want to have your coat put on you, but its too cold outside and Mom's gonna put it on you and then put hers on too". And then she needed to follow through even when Suzy resisted. "Heh, come on Kid, your coat has to go on! I don't want my Sweet Suzy to catch a cold!" The handling of the child's assertive "No!", if too harsh, may lead to either an excessive thwarting of this healthy assertiveness, much needed for the sense of autonomy, or it may heighten and hostilify the assertiveness (which is nondestructive aggression) into negativism (which is loaded with hostile destructiveness), and makes "opposition" a painful interaction between child and mother. This may then become a patterned reaction on the part of the child and become part of the child-parent relationship.

Yes, it is difficult to set limits well and not too harshly, to limit-set reasonably, only when needed, and in as positive a manner as possible. It complicates the task even more for parents that too much hesitancy in setting limits, too soft an approach in limit-setting usually does not work well. The parent has to convey the demand, the expectation of compliance. Benevolent firmness, reasonable demandingness should not be equated with hostility on the part of the parent or caregiver.

In addition to the battles of wills creating a major problem for children and parents during the child's second and third years of life, there is of course also the heightening of hostility created in the child by the Rapprochement Subphase conflict (see Sections 2.2211, 2.2212, and 2.241). We saw the bewildering experience l 1/2 year old Jennifer went though when she could not make up her mind: to go with the other children and play, or to stay close to mother, next her on the couch; to separate and further individuate, or to stay emotionally one with mother. She could not yet experience with comfort the ability to be "separate and apart from", and at other times feel "together with" her mother. This created anxiety in her and, as it became more intense, caused more and more unpleasure in her and generated hostility toward her (now) loved mother. Mother was just quite bewildered too by her daughter's seemingly irrational inability make up her mind. Jennifer had all along been quite a decisive kid. Mother was becoming annoyed with her. We were a bit surprised too until we felt we could identify what l9 month-old Jennifer might well be experiencing. When we explained to mother, as usual with the child right there, and explained in words we felt Jennifer could understand, that Jennifer was beginning to realize that she and Mom are 2 separate people, that she and mother are not one although they love each other a lot, and that being separate from Mom caused her a lot of worry. On the one hand she wanted to be herself, an individual who could go and play with her friends, but she also wanted to stay very close to and be one with Mother. She had not yet learned that she could be "together with" and "separate from" Mother.

When Mother said she saw what we were saying and could now understand why her usually pretty assertive child was clinging and afraid to go play with the others, Mother stopped feeling annoyed with Jennifer's behavior. When Jennifer now fussed with her and even tugged at her or pushed her somewhat angrily, Mother was able to not be upset and tell her "That's OK, Jennifer; you just work on it. You'll be OK. I'll stay right here, if you wanna go and play." We are certain that this kind of reaction on her mother's part helped Jennifer tame the hostile feelings her anxiety was producing. This mother could both support her daughter's efforts at growing psychologically as well as tame the hostile feelings she was experiencing. Both factors reduced the anxiety this normal developmental conflict causes.

Handling Hostility and Hate Constructively: Reducing Ambivalence:

We pointed out in Section 2.241, that the hostility generated in the one year old child (and from then on) by the unavoidable limit-setting required to care for the child well leads to ambivalence which, in turn, creates anxiety. We saw how 13 month old Diane, after her rage outburst at her mother, seemed to become immobilized, sitting at the edge of her mother's knees. We inferred that she was struggling with internal feelings that were in conflict with one another: she was enraged with the mother she already valued so much. Diane's mother did a number of helpful things during this difficult 1/2 hour event. One of the most important things is that she tolerated her one-year-old's feelings without rejecting her. She did not like Diane's being mad with her and hitting her. But she seemed to understand that Diane had good reason to be mad at her. She did not allow Diane to keep hitting her, nor though, did she scold her for hitting her. Had Diane continued we would have suggested that mother tell her not to hit mother. She knew that she meant a great deal to her 13 month-old daughter and that these positive valuing feelings (not yet love) far outweighed Diane's now very hostile feelings. Foremost by her holding Diane on her lap, Diane's Mom helped Diane struggle with and contain the rage she felt toward Mom. With this, her feelings of rage subsided, so then did her anxiety, and Diane could then collapse into her mother's body and being comforted could heal the hurt she felt.

Feeling intense hostility toward one's parents creates much difficulty for all children (and adults too). It creates anxiety because from l8 months or so of age on hating the mother we love is experienced as very threatening, as tantamount to wanting to destroy the loved parent and thereby being abandoned by that mother or father. Experiencing too much pain (physical or emotional) generates hostility in children and then children do feel and wish to destroy. These feelings and wishes become particularly difficult when from about 18 months of age on, sometimes even earlier, children are capable of the enduring feelings of hate which bring with them wishing to destroy someone they value and love. All children are capable of violent feelings and wishes, of wishing to hurt, to tear apart, of wishing to destroy those they also love. It is an error to assume that normal children do not experience hate or the occasional wish to destroy. Given that battles of wills and the rapprochement conflict both generate hostility in even well cared for children and heighten whatever hostile destructiveness may already have developed from

painful experiences of the first 18 months of life, how can parents best help their children deal constructively with these intolerable feelings?

First, it is important to recognize that normal, healthy, well cared for children, in the face of unavoidable second year conflicts detailed above, will experience hateful feelings toward their parents. Parents should not despair by this fact. First of all these feelings are unavoidable even in the best of circumstances.

Second, these difficult feelings of hating someone we love, in good caregiving hands, becomes the initiator of enormously important developments which serve adaptation and socialization in the child. To hate someone we love compels us from within ourselves to modulate and control this hate. We believed that 18 month old Jane's sleep problem, due we assumed from the fear she expressed on suddenly waking during the night, was in fact an effort to cope with feeling hate toward the mother she loved. We explained to the mothers, including Jane's, that bad dreams are usually caused by children (and adults) trying to cope with feelings of hostility and hate they feel which then become part of their dream life (see Section 2.2531). In fact, with Jane, we told mother that perhaps Jane was very angry with her Mommy (due to autonomy conflicts and perhaps more) and that Mommy ought to look for times when she feels Jane is angry with her and let Jane know it is OK to sometimes be angry with her, that it does not mean Mommy will stop loving her. We were very pleased when mother reported to us at the next visit that Jane's sleep problem stopped that same evening of the day we said this to mother, with Jane present. There are better ways for the child to deal with hostile feelings than by having bad dreams and a sleep problem!

The child learns to deal with hate by a number of strategies including mitigating the hate. This is done by a process proposed by some mental health clinicians which we will describe in Section 2.2521, a process assumed to neutralize, that is, to convert and channel hostility and hate into nondestructive aggression. This process of neutralization frees the child from maladaptive inhibitions of aggression, helps the child in developing empathy (the capacity to perceive what someone else feels), in the channeling of aggression into creative activity, and more. The child's earliest experience of hate, therefore, should not lead to despair in parents, but rather to a course of action that can be growth promoting. It may be that some of these salutary developments would not occur were the child not confronted with the need to tame, within himself or herself, feelings of hate toward those the young child needs, values and loves.

First then is to accept that children feel hate toward their mothers and fathers, that in fact mothers and fathers become the first persons toward whom the child experiences hate. Were it not so, the crucial development of the adaptive function of converting hate stated above would not occur. Often finds this kind of phenomenon. In the heat of a battle of wills, 2 year old Suzy raged at mother "I hate you!". Stunned, mother was speechless and collapsed into a chair. We explained to Suzy's mother that although those words hurt, it helped Suzy organize the difficult feelings she was experiencing toward the mother she loved and would give both of them an opportunity to learn how to deal with them constructively. We asked Suzy's mother if she remembers times when Suzy showed her and also told her that she loves her mother. We told Suzy's Mom that from what we could see, the feelings of hate Suzy now said she felt for her mother were

outweighed by her clearly evident feelings of love. Suzy loved her mother far more than she hated her. Furthermore, we said, the hate Suzy feels, she felt then, during the time when she expressed these feelings. Although hate endures, it will not endure long when a child also has enduring feelings of love that she experiences more frequently, as was the case with Suzy.

We told Suzy's mother and the mothers in our parenting group that at such moments we have heard other mothers unwisely say, "I know you don't mean that." This is undesirable because, (1) it is what the child then feels. The mother's statement is jarring to the child; the child is feeling hate, like the child said. As we learn from patients in psychotherapy, the child often thinks: "I am not supposed to feel hate", "Hate is bad; I am bad". Or, the child may feel "There is something terribly wrong with me because I am feeling what I am not supposed to be feeling", etc. This may lead the child to deny (lie to himself or herself) feelings the child has and then not deal with them constructively. Problems of handling one's own feelings may then follow. Also, a mother's "I know you don't mean that" (2) Robs the mother of the opportunity to help her child deal with just such difficult feelings in a constructive way. It bewilders the child when the mother says this; it is not helpful, even though it may lead the child to suppress or falsify the feelings the child experiences and just verbalized.

By contrast, a mother's tolerance of that statement can open opportunities for her to help her child. For instance, we suggested to Suzy's mother, it is far better to say "I'm not surprised that you feel that way. I've felt that way too sometimes. But you know, I'm so glad that even though you hate me now I also know that most of the time you love me a great deal." A statement of this kind can be enormously reassuring to the child while staying with the facts, and giving the child hope that the hate will not overtake the stabilizing love feelings the child has toward mother and father.

The fact is that verbalizations of hostile feelings such as "I hate you" are far more adaptive than hostility expressed by means of the child hitting, biting or throwing something at mother. Motor (physical) attacks are, in general, more difficult to repair than are verbal attacks. Given that a child's attacking his or her mother or father, at any age, eventually brings with it feelings of guilt, it is desirable for parents to encourage the verbalization of feelings and to prohibit their children from hitting them, biting them, or insulting them (usually verbally), etc. The verbalization of feelings without insulting leads much more easily to constructive problem solving than are hitting and insulting. It is important to emphasize that "I hate you", "I am mad at you" are not insults; they hurt, but that are not depreciating statements. They are expressions of hurting but normal feeling. Cursing words are insulting.

Helping the child mediate the expression of hostile feelings gives the parent a magnificent opportunity to help the child. Setting limits on the expression of hostility is guiding. "No, you can't hit me; but you can tell me that you're mad with me" can be enormously helpful. "No, you can't grab what belongs to Johnny; if you want it, ask him for it. If he doesn't want to give it to you, you'll have to wait your turn or, here, play with this". Firm, loving, guiding prohibitions with suggestions of an alternative are enormously helpful to children. They may not like them, but they help.

Parents know and first time parents soon learn that helping the one to three year old

child cope with hostility is not an easy task of parenting. Suzy's parents knew this. So did Diane's. Also, setting limits is not an easy task of parenting. Both require work, some over a long stretch of time, but both are enormously important for the child. As we discussed in Section 2.241, one of the major reasons children need parents' help in coping constructively with the hate they feel toward these parents is that ambivalence creates enormous anxiety as well as guilt in children, has much to do with the degree of ambivalence the child feels toward himself or herself and eventually others in general, and has much to do with the child's sense of well-being (see Section 2.261 where we talk about hate causing guilt). In addition, it may maladaptively inhibit nondestructive aggression, thwarting autonomy, assertiveness, the burgeoning sense of self, and of learning.

Dealing Constructively with Rage and Temper Tantrums:

A special major area where children need caregivers' help is in their experiencing temper tantrums. Temper tantrums which in some children may begin during the first year, tend to be common during the second year and the third years of life. We repeat that temper tantrums are enormously difficult for both child and parent, indeed are experienced as traumatic by both child and parent. They reveal the experience by the child of enormous loads of hostility and a large sense of feeling helpless. This topic is discussed extensively in our book *Aggression in Our Children: Coping With It Constructively*. Here are a few words about handling them constructively.

It is so that rage reactions and temper tantrums are an expression of high levels of rage and hostility experienced by the child which create a most unpleasant burden for both child and parents. But it is important to recognize that they occur when the child experiences an utter feeling of helplessness in the face of what he or she experiences as a very painful situation. This is so whether or not to the parent feels the cause for the tantrum appears to be a very mild condition; if there is a tantrum, there usually is a feeling of helplessness in the face of much pain. Because they are traumatic, if possible, temper tantrums ought to be avoided. However, this is not so under conditions of "blackmail". When a child threatens to have a temper tantrum if he or she does not get her way about something, this should be talked about with the child openly and directly. This is "infantile blackmail" and is not an acceptable way to negotiate getting one's way. Much caution is required to sort out whether the tantrum is the product of actual helplessness in the face of excessive pain, as was the case with Richie and with David, or whether it is the product of the child's wanting what he or she wants when he or she wants it, what we can speak of as narcissistic orneriness. Children have to be helped to learn they cannot always have what they want. It is not easy to give up on what one wants. But we all must tolerate this. We shall talk about Richie and David in a moment. Let us consider a 20 month old who, you feel quite sure has been having rage reactions and even tantrums when he cannot have what he wants. The goal is to get the child to learn that rage and tantrums are not an acceptable way of negotiating getting what one wants from people, especially not from people one loves.

First say to the child, acknowledge, that it is difficult to give up on wanting

something we want badly. It pays to be sympathetic. It succeeds better than to convey to the child that he is foolish, or greedy, or unreasonable to want what he wants.

Second, tell him he cannot have what he wants and tell him why. For instance: "We can't afford it" is often a most reasonable thing to say when it truly is so. Or, "It belongs to Johnny; you can't take something that belongs to somebody else." Whatever your reason, tell the child and tell only the truth. If you have no reason, you should not be saying the child cannot have what he is asking for.

Third, tell him "It's OK to be angry with Mom (or Dad), but it is not ok to have a fit! Try to tell me what you feel; don't just scream and kick!"

Fourth, tell your 20 month-old "I am sorry that you feel so badly about not getting what you want, I know what that feels like too. But you are not to have fits, or kick and scream, to try to get me to give you what you want. It won't make me give it to you. Now, try to control yourself better."

Some parents believe a 20 month-old would not understand what the parent is saying. No so. Do use language you feel your 20 month old is accustomed to hear around the house, but do not assume he will not understand the types of sentences and phrases we suggested. Do bear in mind that if the 20 month-old is in the throes of having a tantrum, he may not hear all you say, as we shall clarify now. If he is having a single rage reaction, the same principles can be applied as with a tantrum series of rage episodes.

In Section 2.241, we said that in order to handle them constructively, it is helpful for parents to know that temper tantrums have structure (pattern) and specific features. Overall a temper tantrum mounts gradually, achieves a peak and wanes gradually. If allowed to run its full course, it wanes by exhaustion. Sometimes temper tantrums differ from this pattern, such as they may burst out suddenly; but commonly a tantrum contains one major waxing and waning curve. Superimposed on this major curve are outbursts or episodes of tantrum each with a waxing and waning curve (it is usually the first outburst that may appear suddenly) which has features critical to the handling of a tantrum. As we said, each episode of the tantrum can be understood as having a <u>climbing</u> limb, reaches a <u>peak</u>, and then wanes during a <u>descending</u> limb.

During the climbing limb of this tantrum episode, the child becomes progressively overtaken by increasingly all-consuming feelings of rage which make him or her progressively unable to perceive or register (understand) clearly events that occur outside of the self. Therefore, efforts on the part of the parent (or other caregiver) to communicate with the child, to try to comfort or calm the child during the climbing limb of the tantrum episode, are likely to not be experienced by the child and will therefore fail. Usually during the climbing limb of the tantrum episode, the child will express rage, may flail, kick, and it is well for the parent (caregiver) to simply try to prevent the child from hurting himself or herself or the parent, or things around and to wait until the climbing limb reaches its peak.

Then, during the peak of this tantrum wave, the parent will hear a subsiding, a lessening intensity in the tone of the rage and recognize that the child may be more accessible to what the parent says. At this time and during the descending limb of the wave is when the parent can intervene actively with the child. Here empathic (feeling

what the child may feel) calming and comforting with words such as "Get a hold of yourself, Honey" can be very helpful. Calming, comforting efforts when made during the descending limb of the tantrum episode also can be heard and registered by the child and will gradually be effective.

The child may not accept the parent's first efforts at comforting, but these should nonetheless be offered as sympathetically and caringly as possible. Parents (caregivers) who try to calm and comfort during the climbing limb of the tantrum episode will become discouraged by the child's non-responsiveness. Here it is not simply that the child is rejecting the parent's efforts. This may be so at the beginning of the climbing limb, but once it has gathered momentum, it is because the child is not able to perceive or respond to the parent's efforts. The child's rejection of a parent's efforts to calm and comfort during the descending limb will tend to be directed toward the parent but will make the parent feel that a communication is established, and with caring persistence the parent's efforts will eventually bear fruit. Even though the child may refuse the parent's efforts to calm and comfort during the descending limb, the child will have registered the parent's efforts and these will eventually impact on the child; in other words, the parent's efforts make an impact even when the child refuses the effort. In time, when the balance of love and need for comforting outweigh the transient hate and rage and the child feels, the child will accept the parent's efforts to calm.

We noted in Section 2.241 that 15 month-old painfully abused and traumatized Richie would have sudden outbursts of rage, where his whole body seemed to just suddenly uncoil; when 2 1/2 year-old Suzy playfully hid the ball. Richie suddenly cried, his body uncoiled from sitting on the floor, and he banged his head on the floor. Alarmed, Mrs. V. rushed to pick him up and gently explained that Suzy was only playing, that she had the ball. Very dismayed Suzy showed it as he looked down at her. Mrs. V. continued to calm him and his outburst subsided. Then a little later, his body teased suddenly arms and legs flailing as he collapsed from the sitting position, crying ragefully because he could not take another child's toy. For reasons not clear to us, again before great-aunt could get to him, her friend Mrs. V. did. She knelt on the floor near him and patting him gently she tried to calm him. Soon his flailing stopped. She continued to pat him say "Boy, you're having a hard day today. But you can't have what Doug is playing with. Here, let's get you something else" as she drew the toy cart to her to select out a toy for him. Having already found Mrs. V. to be someone who seemed to treat him caringly, Richly was quite responsive to her and calmed down. Because we wanted the great-aunt to learn from the good way Mrs. V. had responded to Richie's rage outburst we commented on how well Richie responded to her, how sensitive and sympathetic her effort was and how constructive it seemed to be. Mrs. V., we emphasized, had not gotten angry with him for "falling out" (having a fit) and conveyed that she recognized how awfully upset he felt.

When Richie began to throw toys around or harshly on the floor, his great-aunt got hold of his hands and told him that he was bad. We suggested that he absolutely needed to be stopped as great-aunt did but that he needed help to contain his angry feelings, that this would take time, to tell him to do so, and preferably without conveying to him that he was bad. It is what he did that was "bad", not he. To call him bad would only hurt him

and activate more hostile feelings. Sympathizing with is pain would help both of them better, as she demands that he control himself better. Understanding that excessive pain, over many months, was responsible for both his excessive hostility and his inability to handle these feelings seemed to make sense to the caregivers and helped guide their attitude toward him (and the other children).

Thirty-eight month old David's tantrum had quite a different origin and context. He too erupted rather suddenly. But it was clear from his tension when he entered the program area that his frustration tolerance was low this morning. His mother, though, just could not have prevented his outburst, even knowing that he was already tense and irritable. He had been able to tolerate being in the stroller on entry to our program area even though he would have preferred to be on his own two feet. She was right to avoid being struck by his flailing and kicking. And we suggested to David that he try to get a hold of himself even though we thought he might not even be hearing what mother and we said then. We felt mother was also right to not let him eat an apple since he had complained of a stomachache earlier. With our suggestion she told him she didn't want him to eat it just for this reason. She knew her son well, knew it would be difficult for him and she followed our example of telling him its hard to not be able to eat an apple when one would like to. As he calmed some, mother came close to him and said these things to him too. Soon he accepted her offer to hold him as she continued her efforts.

When he erupted the second time, less harshly than the first, he lashed out some. In quick sequence he threw a block at one mother, grabbed his sister's bottle and threw it at her, threw a block at the Instructor and nearly fell off the chair in which he was standing next to mother. We encouraged mother to verbalized as we did. We wished David would talk about being upset rather than throw things. Mother told him he was not to throw things at people and that besides, that mother, his sister and Dr. Parens had not done anything to him. Mother continued to calm him.

When he soon after began to tease his sister, his mother became angry and told him to stop. We pointed out that David was taking his anger out on his sister, that he was "displacing it from directing it against his mother with whom he truly was angry." Mother said this much to him, in her own words. We felt that her efforts worked when we saw David, on the verge of going further in provoking his sister and mother, asked mother instead, to play a game with him. Very wisely, rather than saying, "No, you've been bad!" she agreed and David quieted down. By her considerate handling of his troublesome rage, mother was probably felt by David to be someone who can help him to better contain and gradually decrease the intense rage he felt.

During the descending limb of a tantrum, and especially after the entire tantrum has come under control, are good times for the parent to caringly repeat the admonition which may have triggered the temper tantrum, be it the parent's prohibition in limit-setting, or if this is not what produced the temper tantrum, the parent may try to learn from the child what is upsetting him or her and talk with the child about the experience. Again we emphasize that during parental efforts to calm and comfort a child is a good time to repeat the setting of the limit because it is more likely to be heard by the child at this time than under conditions when a parent is scolding or rejecting a child.

In closing this section we want to reiterate that the parents efforts at helping the child

cope with hostility within the child, be it expressed directly in acts of hostility, or be it expressed in a pleasurable expression of hostility, namely in teasing and taunting (as we shall describe below), or be it in the form of a tantrum, the parents efforts will bear fruit. It will help the child cope with feelings of hostility toward the parent that are unbearable to the child. As we shall detail in Section 2.2531, hate toward one's parents creates much anxiety in children and leads to their developing defense mechanisms to cope with both the anxiety and the hate. Some of these defenses activate good ways to cope. Others can create large problems for the child, including the inhibition and therewith the blocking of aggression which is needed for healthy adaptation, learning, and the development of a sense of self and of identity.

On Handling a Young Child's Teasing and Taunting:

During a home visit to an l8 month old boy and his mother, we observed a remarkable episode of teasing. We have seen many lesser moments of teasing during the second year of life but this one will serve us well. 18 month old Jacky had a 19 month-old friend over for a while and Jacky's pregnant mother was caring for the two of them. Following them from a distance, we noted that Jacky's 19 month old little friend had pulled out a small plastic bathtub from under Jacky's crib. For reasons not clear to us, this upset Jacky and he pushed the tub back under the crib. No sooner had Jacky done so, that his little friend, an impish smile on his face, pulled the tub out again as he looked provocatively at Jacky. Jacky whimpered and with some anger pushed the tub back under his crib. Again, his little guest, impishly smiling, looking at Jacky, pulled the tub out. Jacky now angry, pushed him and shoved the tub back under the crib. Jacky's mother had followed us and saw what was going on. She asked the often-encountered concern "He's not my child, should I scold him for doing this to Jacky?" We suggested to mother that since the child was her guest, she had the responsibility of protecting her little visitor against doing things harmful to himself or others. She also needed to secure her Jacky's well-being. Therefore, we suggested, she should deal with it according to her philosophy of child rearing. "When in Rome, do as the Romans do" goes the saying. Mother could demand that her little guest do as she would have her son Jacky do. We chimed in too: "Heh, Michael, that is not a nice thing to do to your friend Jacky. How would you feel if he teased you?" Michael was a bit taken aback. "Look Michael, we wouldn't let Jacky tease you, and you are not allowed to tease Jacky; understood?"

We did not know why Michael did this to Jacky. And we are uncertain as to why Michael's action upset Jacky so. For now what matters is that children should not be encouraged to and should not be allowed to tease others. Teasing need not be an awful thing to do. But it must be recognized for what it is: it is always hostile, more or less. And it often is due to the displacement of hostile destructive feelings onto someone other than the person who instigated the hostility in the child in the first place.

We should add here, that parents teasing a child is an act of hostility. It can sometimes feel playful to the parent; it seldom does to the child. There are far better ways to be playful with a child. We recommend that parents not tease their children because it invariably hurts and humiliates the child.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.25 THE CHILD'S ABILITIES TO ADAPT -- PART II (See 2.21, PART I)

Introduction:

From birth on, infants feel. They already have all kinds of feelings, good feelings and painful feelings. From mid-first year on, it is clear that they also have thoughts, wishes and fears (see Unit 1). The 1 to 3 year-old child has feelings, thoughts, wishes and fears. Some of these are highly pleasurable. Some of the 1 year old child's feelings, wishes and fears can bring with them intense discomfort including anxiety, depression, shame, the beginnings of guilt, and more. When the discomfort is too intense, the child does all he or she can by appealing to the environment to somehow attenuate these feelings and wishes, or by protecting himself or herself against experiencing them by a variety of adaptive maneuvers including the development of internal controls, and psychic mechanisms of defense (which we speak of simply as "defenses"). The child is not born with these controls and defenses in place; they develop in response to the need for them.

We have described that children experience wishes which create conflict within them such as wishes to separate and individuate side by side with wishes to stay one with mother during the rapprochement conflict, or by having feelings of hostility or hate that lead to the child's experiencing the threatening wishes to harm, to attack, to destroy those the child values, including the self, or, they may have wishes to take things that belong to someone else. In Unit 3 we will detail other wishes the child experiences as unacceptable and which lead to enormous feelings of anxiety, guilt, and more. Although the adaptive developments of internal controls and defenses have already begun during the first year, these developments are sharply accelerated during the second and third years. In this Section we shall talk first about the child's degree of self-reliance and dependence on others, then of the development of internal controls, then the development of mechanisms of defense, and we shall then speak separately about one of the most common development protecting defenses, regression.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.25 THE CHILD'S ABILITIES TO ADAPT -- PART II

2.2511 HUMAN DEVELOPMENT: Dependence Versus Self-Reliance

The developmental line of dependence goes "from dependence to self- reliance". As we said in Unit 1, the issue of dependence can be understood and examined from two vantage points: (1) dependence on whom?; and (2) dependence for what?

With regard to the first, dependence "on whom", the one to three year old infant is, of course, dependent fully on his or her mother and father. Non-parental caregivers, in home or in daycare, act in essence as substitutes for or as extensions of the parental caregivers.

Coming to soon learn the character of the dispositions and the distribution of labor of their respective mothers and their fathers in the home, especially from year one to three, young children come to depend on each parent for specific functions. For example, children commonly tend to depend more on their mothers for nurturing, for distress or pain reduction and comforting, as well as for feeding and diaper changing, etc., than they do on their fathers. In a similar way, one and two year olds, will already begin to turn to their fathers for moving a heavy item or fixing a broken toy, or for rough housing, etc. Of course, each set of parents (where there are two) distribute these parenting functions as they choose, in varying combinations and balances. Children learn quite early the specific dispositions and preferences of their respective parents and assign specific functions to them. This includes specific functions of dependence on them; that is, you turn to Mom for this, to Dad for that, to either for same.

With regard to dependence "for what", we find the twelve month old well advanced from when he or she was a newborn. Whereas the newborn was dependent for virtually all physical care needs, for feeding, cleanliness, etc., the 12 month old has advanced in his or her capability to put food into his or her own mouth, but needs for it to be bought, prepared and dished out. The one to three year-old, explorer of her or his new world, is capable of remarkable degrees of activity and discovery, but nonetheless is strongly dependent still for the gratification of his physical needs. In addition to the basic needs for care, for instance, because the 14 month old can walk and explore, the young child needs an environment that is made safe for her or him by responsible caring parents. Furthermore the 18 month-old in spite of his or her protests is in strong need of limit-setting in the face of dangerous enterprises such as when Bernie was about to grab the electrical plug of an activated air conditioner. Similarly the 18 month-old can manage to get herself or himself quite dirty but is in need of assistance to get himself or herself cleaned up. Of course, the one year old needs to be diapered; that of course will change during the third year when many a two and a half year old is able to manage his or her disposal of urine and bowel movements in the potty with some help from mother or

father. Help in cleaning is still necessary but the major functions of discharging these into a toilet can very well be in the hands of many a two-and-a-half to three year old child.

The one to three-year-old child is enormously dependent on those around him or her, for help in developing skills for adaptation. The years from one to three are magnificent years for the parents' becoming their child's first teachers. From teaching the child to walk late during the first year or early during the second year, and somewhat later to naming parts of the body, and still later to speak, to begin to eat with utensils, to learn colors, in some to begin to learn letters, etc, all make for a developmental period rich in the parents' establishing themselves to their child as principal helpers and first teachers. Parents also, most importantly, are needed for learning problem solving methods, as Johnny's mother needed to help him better stand up for himself, and adaptation to society as Diane's mother did when Diane decided to take off with the toy cart.

But the child's dependence on others for the gratification of certain emotional needs remains, as indeed these remain with us forever. Namely, we need the love especially of those with whom we have primary relationships (see Sections 2.2211 and 2.2212), and we need to love those primary others. This need does not wane although it changes in character from infancy through adulthood. The 18 month old dramatically experiences the need to be loved. The new experience (see Section 2.2131, on the Development of Affects) of which the l8 month old child is now becoming capable, the newly developed ability for feelings of love, make for a heightened experiencing of this need. The imbuing of the child's attachment to mother, father, siblings with such love feelings forges more deeply their relationship. The need for expressions of love by the parents and, in turn, by the child toward them, become amply evident during the second and third years and make disapproval by the parents very painful. Their disapproval, as we said of shaming (which is the withdrawal of approval), if too intense and too frequent will be highly detrimental to the development of emotional well-being.

Keep in mind that as powerful as these dependency needs ("for what") are, the physical care needs, adaptive developmental needs, and needs for emotional closeness and love, that the thrust to self-reliance is also amply evident during the second and third years of life. This thrust to autonomy and self development is evident in the need to do things oneself, in the one year old's wanting to stand on her or his own two feet, in reacting to the inner pressure to explore everything. These needs to do things oneself, to feel one's emerging autonomy and sense of self, are in balance with the needs, for nurture and for love and closeness. Both sets of needs those that promote self-reliance and those that need to be gratified by others, require an optimal balance of being gratified and at times benevolently frustrated.

2.2152 CHILD REARING: Optimizing Dependence and Self-Reliance

Parents must know that children depend on them for most of their physical care needs, for the development of adaptive skills and especially for love, affection, respect,

and being given a sense of being valued. Dr. Margaret Ribble many years ago (1943) spoke of the fact that one of the major problems she encountered in her work with parents of very young children is their intolerance for the child's dependence on them. Our observational experience leads us to believe that one reason parents fear their children's dependence is due to the erroneous fear that their children will not want to grow up and be self-reliant. They fail to recognize the enormous thrust to autonomy, to self-reliance, to becoming an individual which is amply evident in children during the second and third years of life and thereafter. In fact, the thrust to autonomy becomes dramatically evident in children from the second half of the first year of life on, and even earlier in some children.

Again, it is important for parents to bear the following in mind. First, (1) a child's self-reliance grows out of sufficient gratification of the child's dependence needs; that is to say, the more the child's dependency needs are gratified reasonably, age appropriately, and sufficiently, the more will that child become self-reliant. We saw how much more self-reliant Jennifer, Diane, Bernie, and Johnny were than painfully frustrated and neglected Richie at the beginning of year two. (2) Again, as we saw in the well-cared for children the dependency needs of the one to three year old are handsomely balanced out by powerful needs for autonomous activity, a large inner pressure to do things oneself, all of which contribute to and arise from a basic inner sense and need to be oneself, to be an individual. We suggest to parents that the one to three year old child, like the child before and the child after, will not ask to be held without feeling the need for it. If the child is not loved, if his dependency needs are frustrated, these needs will actually became more intense and remain longer. In fact they will increase and press for expression, up to the point where, in hopelessness, as we saw in Vicki and in Richie, the child may give up. And if a child gives up on the need to know he/she is lovable, is love-worthy, the more will that child be harmed, continue to be needy, and be hampered in becoming an individual who is amply self-reliant. Vicki became painfully depressed we believed because her depressed mother could not be sufficiently emotionally available to her, could not sufficiently gratify her needs for emotional contact and nurture. Depressed as she became, her neglect was much less than was Richie's whose entire development and survival were in jeopardy.

2.25 THE CHILD'S ABILITIES TO ADAPT -- PART II

2.2511 HUMAN DEVELOPMENT: Developing Internal Controls

All young children become afraid when they experience intense negative feelings, especially toward their parents. Intense feelings of hostility, hate, and rage, cause fears of losing parental approval and love, fears of being destroyed by them, or of being abandoned by them, and, perhaps even more anxiety producing, they fear they may destroy their parents, and that they may destroy themselves. They then fear losing control over their hostile destructive feelings and wishes. Close observation of them reveals that 14 month-olds, 16 month-olds, 20 month-olds, are at times startled, frightened and even shocked by their sudden lashing out against mother, or a younger sibling, or having pushed a cup of coffee or a lamp too hard and they come crashing down.

To be sure 1 to 3 year-olds fear many things. Some fear loud and sudden noises. All children around 1 year, somewhat before and into the second year fear separations to a greater or lesser degree, and also fear strangers. Many fear being in complete darkness and need a night light. And more.

We also know that young children will experience fear when Mother or Father experience fear. For instance some researchers have shown that presented with the same situation such as the activation of a toy robot or on seeing a unknown dog, the child will become frightened; if the mother is not, the child may then also become not frightened. A number of good experiments have shown what researchers have called "social referencing" which means that the child will automatically check with a caregiver to decide whether or not to be afraid of something. The "contagion of affects" (that we tend to feel what we see others feel) and "empathy" (the ability to perceive what someone else feels) play a role in "social referencing". We think that social referencing is highly adaptive, in general, because it guides young children in learning what is safe and what is not, what reaction and behavior is desirable and what is not. In Unit 3 we shall describe how 3 to 6 year old children come to fear some of the sexual feelings, wishes and fantasies they have as well as fear that their bodies will be harmed in one way or another.

Young children have many fears. And we can see that some fears come from outside themselves and some come from within the child. For instance those that come from outside include fear of a dog, or of a loud noise, or of Mom's anger, etc. Those that come from within the child include fear of one's own hate and rage, and after 2 1/2 years or so also fear of one's sexual feelings, and the wishes and fantasies both hostile destructive and sexual feelings generate. Of course the child needs to cope with both external and internal sources of fear. A major way the child has to cope with those feelings, wishes and fantasies he or she has is to develop internal controls over them. The child is not born with these in place. They must be developed. Let us look at this more closely.

With progressive developments in better evaluating reality (seeing and feeling the way things factually are), increasing understanding of causality (if I push a ball it will roll

and it rolls because I pushed it), awareness of their intention (I want to do this or that, I will do this or that, etc.) in thoughts and actions, from 18 months of age on children begin to know when they cause something to break, when it was accidental or when it was intended. And, when they have broken something valued, they fear disapproval, scolding and punishment. This brings with it fear and anxiety (a feeling of helplessness in the face of what the child experiences as a threat as of losing mother or father, or losing her or his love, etc.). The fear and anxiety is what may lead the child to deny he or she actually did it (see Section 2.2531).

More threatening is this: a 20 month-old child increasingly derives great pleasure from doing things autonomously (on his or her own), feels increasingly competent in her or his actions, for instance like when l8 month old Bernie approached the plug of an activated air conditioner and was about to pull it out, when his dear mother suddenly reacted with alarm and prohibition. It did not with Bernie, but as we saw with l3 month old Diane, let us assume that a battle of wills ensues between them, and now many a normal and well-endowed child feeling enraged with "My bad, mean Mother", experiences a surge of wishing to bite, hit and maybe even to tear her hair out or cut her in pieces! Then, suddenly a feeling of terror sweeps over the child. In the face of such feeling of terror, the child experiences the need to control this monstrous surge to bite and destroy his or her mother. Lest you doubt that an 18 or 20 month-old can feel so violent, consider our awfully traumatized Richie, whose rage in throwing toys caused alarm to all those around. And consider also that even good parents can feel so upset and so provoked by the child they truly love, that they sometimes are overtaken by wanting "to beat the day lights out of the kid" -- which more troubled parents do as we said at the beginning of Section 2.2312, the Anal phase and Toilet Training.

The better the relationship with mother, the firmer and more secure will this child's own determination be to control himself in the face of such a surge of hostile destructive feelings and thoughts. In a child where the relationship to mother is already heavily burdened with past disappointments, deprivations of nurture, love and respect, perhaps even emotional and physical abuse, and much hostile destructive feeling is already attached to mother, the surge of wishes to hurt and destroy her will be strongly reinforced by the hostile feelings already there and will be much more difficult to control. In such circumstances, harsher and more global efforts will be required by this 20 month old to achieve internal self-control. Excessive maneuvers may then be required by this second child to prevent himself or herself from acting on this surge of hostile destructive feelings and wishes.

During the second and third years, dealing with hostile destructive feelings toward mother and father are the feelings that most invoke in the child the need for internal controls. Whether these feelings of hostile destructiveness arise from "battles of wills" as we saw in 13 month old Diane, or from a heightened Rapprochement Conflict as we saw in 19 month old Jennifer (Sections 2.2211 and 2.2212), or from prior feelings of rejection or deprivation of basic emotional needs as we saw in Vicki, or from being physically abused by the parents as happened to Richie, large efforts will be exerted by the child to control from within the discharge of these hostile destructive feelings. This is what immobilized 13 month old Diane sitting at the edge of mother's knees. The poorer the

relationship to mother or father, the greater the task of developing internal controls, and especially as we saw in Richie, the more burdened all aspects of the child's development. In Suzy, the greater burden of developing internal controls came not from problems in the parent-child relationship but more from her troubled ability to integrate and organize the feelings of irritability and hostile destructiveness she experienced due to the immaturity of her nervous system (and perhaps other brain malfunction) at birth.

Given that the inner pressure a child experiences is often more powerful than the child himself or herself during the second and third years of life, help from the parents is needed by every child.

2.2522 CHILD REARING: Optimizing the Development of Internal Controls

Here as in all other aspects of the child's development, the more respecting, thoughtful, considerate and loving the relationship of parents to child, the more will the child's emotional development be facilitated. Let us emphasize that we do not mean by this that parents are the only contributors to the relationship that develops between child and parents. The child brings to the relationship her or his inborn givens, his or her modes of adapting, including his or her own temperament, reactivity to experience, difficulty to organize experience, degrees of irritability (whether due to brain immaturity, to allergies, food sensitivities, skin sensitivities, etc.). What we want to emphasize here is that whatever the child's inborn givens, dispositions and temperament, it is in the hands of the parents to optimize as best they can the relationship they have with their child. We all know that some children are much more difficult to form a strongly positive relationship with and to rear than others. We emphasize that however difficult or easy a child may be to rear, the parents' efforts to optimize the relationship to their particular child will pay off, will eventually bear fruit and promise much more to be growth-promoting. Here is, we believe, the major reason why making efforts to optimize the mother-child and the father-child relationship, facilitates the development of internal controls in the child.

Whatever inborn dispositions, temperament, strengths and vulnerabilities the child brings into the relationship with his or her parents, feeling loved, respected, treated with considerateness (as by the "Golden Rule": Do unto others as you would have them do unto you) will tend to motivate <u>within the child</u> the need to control his or her feelings of hostility and hate, his or her wish to destroy the loved parent. Suzy's parents worked hard to help Suzy develop internal controls. Her irritability and difficulty in organizing her experiences and her reactions, made the burden difficult. We told her parents, as we saw how her mother repeatedly tried to not only frustrate her as little as needed, but also to get Suzy to pull herself together, that their efforts would and in fact were paying off. Mother's telling 20 month old Suzy "Get hold of yourself!" seemed very much taken in by Suzy. By the end of her 3rd year, Mother introduced the idea of "counting up to 5" (Suzy was not yet easily counting then) to help Suzy delay her reacting with anger and hostility. Most important here is that the parent who is loved, all things considered, will

have much greater influence on the child's own need to protect the valued parent against the child's own destructive feelings and wishes. This influence is far greater and more effective than yelling, scolding, punishing, and physical threat or abuse. Her is why.

The child who is not treated by his or her parent(s) with consideration, respect, and love, will feel hurt by the parent(s). The more the young child is hurt (physically or emotionally), the more will hostility and hate be generated in the child toward that parent. The more the hostility and hate outweighs feelings of love and being treated caringly, the less will the child be able to develop internal controls over the volume of hostility and hate the child feels. Furthermore, the parent's influence on the child's need to protect the parent against the child's own destructive feelings (which the parent himself or herself caused to be generated in the child) will be far less than where love, consideration, and respect dominate. The 12 to 36 month old child is small. Her or his feelings can be enormous. The greatest help the child can get in developing internal controls comes from the positive quality of the parent-child relationship.

We saw in Richie, how during his second year of life, his ability to control his reactions of rage and infantile violence was very limited. The example of Richie tells us that in fact where the load of rage and hostility is high (due to a long history of experiences of high levels of emotional and physical pain), it will be virtually impossible for the one year to control the feeling and expression of rage. 14 month old, 16 month old Richie would erupt in a rage reaction. It was especially Mrs. V.'s comforting and thoughtful limit setting that helped him contain these outbursts from continuing into tantrums.

We cannot overemphasize the great burden it is for the 1 to 3 year old child (and later as well until mid-adolescence) to control his or her own feelings of hostility, hate, and rage experienced toward and at the hands of his or her own mother and father. This is so even for well cared for children. It is that much greater for the neglected and/or abused child, because his or her load of accumulating hostile destructive feelings is much greater. We wondered (we could not ascertain though) if Richie had had these outbursts of rage since he was taken from his troubled young mother at the age of 9 1/2 months. When we first saw him at 14 months, he appeared depressed and seemed very inhibited in his movements and expressions (see Section 2.2531 as to what causes such inhibitions). We often see, in depressed children (and adults), that it is when they begin the process of recovery from painful illness that they experience outbursts of intense hostility, hate and rage.

To help the child achieve good internal controls, external (caregiving) controls are invariably needed. Approaches which respect the child as a budding person and include trying to understand what the child is experiencing, what the child is trying to do, and why, are much more likely to help the child's development of internal control than those that disregard the child's feelings and motivations. Also given that the major normal parent child interactional arena where the 1 to 3 year old child experiences hostility toward his or her parents tends to be in the area of limit-setting, setting limits well, constructively, is a priority issue for parents' helping their children develop internal controls (see Sections 2.241 and 2.242 where setting limits is detailed).

It is also well to bear in mind that children tend to model their behaviors on their

parents behaviors. Because parents are emotionally so important to their children, children identify with them, they become like the people they value most in many aspects of their behaviors (see Section 2.2211). Therefore, how parents behave in their self-control is critical also to how the child will behave in his or her self-control. We all know only too well that children model their parents behaviors more than they adhere to how their parents wish they would behave. In part, this is due to a defense mechanism we call "identification with the aggressor" which we will discuss in Section 2.2521, below.

The development of internal controls is importantly facilitated when children are helped to learn constructive ways of expressing feelings that cause them distress or pain, since these, if sufficiently intense and prolonged generate hostility in the child. It is valuable to talk even with 1 to 3 year old children about what is causing their anxiety, their fear, what is causing their hurt, their disappointments, their fear of rejection and shame. We emphasize again, that parents should talk to their infants even before the infant has learned to speak (see Section 2.2142). The reasons are that (1) children understand words well before they can speak; (2) children can communicate with their caregivers well before they can talk, by expression of feelings and by gestures and movements; (3) a parent who speaks to a child is herself or himself expressing feelings which the child registers and "understands" whether it is that mother is pleased or angry, approve or disapproves, can handle it or cannot, is sympathetic or ridicules, etc. And most important, it lets the child know that this magnificent vehicle for expressing feelings, putting them into words, is available to the child. Sigmund Freud said something like "The person who first threw an invective at his enemy rather than a spear was the starter of civilization." It is also said, although unfortunately not always true, that so long as adversaries are talking at the negotiation table, there will not be war. And so too, it was far better that 30 month old Suzy shocked her mother by shouting "I hate you" than for her to put those feelings into some physical action against her mother, herself, or something mother valued (see Section 2.242 on How to Handle Such Expressions). Related to this, it is enormously useful to help children learn how to express feelings of hostility in acceptable ways, given that these feelings particularly create enormous difficulties for children with regard to the question of developing internal controls (see Section 2.2421). Again, talking to a child about the feelings of hostility experienced is enormously helpful. Talking about such feelings includes allowing these feelings to be recognized, to be experienced by the child, to not be avoided by the parent. In addition to talking about these feelings, guidance is needed in taming the discharge of hostility through hitting, biting, spitting, and in some verbal two year olds' using foul, insulting language. How this is done is important. "Come on, Johnny, get a hold of yourself!" is far superior to telling Johnny that he is evil (see Section 2.242). The latter heightens feelings of hostile destructiveness since this is experienced by the child as insulting and shaming (see Section 2.242, Limit-Setting).

2.25 THE CHILD'S ABILITIES TO ADAPT -- PART II

2.2531 HUMAN DEVELOPMENT: Mechanisms of Defense

Side by side with the beginning development of internal controls, a development that takes years, the child also uses other coping measures to deal self-protectively with the distressing experiences he or she has. These measures (defense mechanisms) are set up by all children in the course of normal development and these will become typical for each child and make a major contribution to the development of each child's personality. Indeed, the development of our personality receives essential contributions from first, our inborn reactivities, tendencies, and temperament, and second, from those defenses we set up in the face of internal feelings of distress, anxiety, rage, etc. that are experienced as too difficult to deal with directly. This is so especially for those troublesome feelings that arise in relationships, especially from those wishes we have which create conflict within us and of which we ourselves disapprove.

Defense mechanisms are always used for the purpose of self-protection, of coping. We set them up automatically, without thinking "Now, I'll deny, or, I'll avoid, etc." We do this generally without being aware we are doing it. In fact, we often set these up because we ourselves cannot tolerate feeling extreme feelings or what we experience as undesirable or conflict producing feelings or thoughts or wishes. We do not want to know we feel or think these, in order to not suffer. Therefore, mechanisms of psychic defenses in and of themselves are adaptive when we first set them up; in and of themselves they are helpful. However, we pay a price for using some of them. This is what is problematic about those that cause problems. The price is varied.

Most important is that when defense mechanisms work well, we do not consciously know what we feel or think or wish and, therefore, especially in the case of problematic defenses, we usually do not take action to resolve, or undo, or handle these feelings, thoughts, or wishes more constructively so as to satisfactorily deal with the feelings and thoughts and not require the trouble producing defenses.

Secondly, these defense mechanisms can make us blind to dangers to ourselves and/or to others. For example, a twelve year-old who denies the dangers of using crack-cocaine, like an ostrich they say, will not see the possible coming danger and hurt himself or herself seriously. So too will the young adolescent who denies that unprotected sex may have serious, even life threatening effects, including a highly premature pregnancy or a venereal disease. Also, for example, when we deny we are enraged with or hate our mothers and/or fathers, in order to express this denied hate we may displace it onto a neighbor, or project it onto someone else (and disown having these feelings), thereby hurting innocent others. More on this below.

Thirdly, defense mechanisms unavoidably make us distort reality to a greater or lesser degree. Having studied infants with their mothers for many years, we have found that the most challenging feelings children have to deal with in the first three years of life are intense feelings of anxiety, fear, and the hostile destructive feelings, those of rage and

hate. The most troublesome wishes for them are wishes to destroy the caregivers to whom they feel attached. Being attached to them means the young child feels he or she "needs" them -- as indeed the child does. Thus we have come to think that feeling hostility, hate, and rage toward those to whom the child is attached creates intense anxiety and fear in the 1 to 3 year old -- the fear of losing control over one's rage and hate, and that one will destroy those highly valued, needed, and more or less loved persons, one's own mother and father. Bear in mind that the less than 3 year old child, when overtaken by feelings of hate or rage "feels" he could destroy; he or she does not then feel "I am small and couldn't hurt a fly!" Quite the contrary. Not then recognizing his or her very limited actual physical strength, the young child exaggerates his or her power to equal the intensity of the hate and rage he or she feels.

Understanding this, we can better understand why a variety of defense mechanisms are used by the child to cope with hostile destructive feelings toward those to whom the child is attached. This is most the case when children (of all ages) feel hate toward their mothers (especially), and toward their fathers (if they are attached to them). Here are some of the major defense mechanisms 1 to 3 year-olds (and older) use.

Denial is, as the word implies, to react to feelings the 1 to 3 year old experiences as intolerable by means of self-deception, a form of lying to oneself, to believe that what is known to have occurred did not occur. It is to deny a piece of knowledge. Being frightened by feelings of rage toward mother, a child may need to deny that rage all together; "I am not angry with Mommy, I love her". What causes the rage then will not get dealt with.

Projection is a mechanism where that which the child experiences is externalized, it is turned outward of oneself and is ascribed to someone else or something else. The feeling is; "I am not angry with Mommy, it's Mommy who is angry with me".

It is well to bear in mind that defense mechanisms are enormously useful at the time that they are employed. However, they are disadvantageous in resolving feelings, and in solving the actual conflict or problem the young child is experiencing.

Inhibition is a common mechanism used particularly in the face of wishes the child experiences as dangerous and/or transgressive. This may pertain to sexual feelings and, particularly during the second and third years of life, to feelings of hostility and assertiveness. This is particularly so where assertiveness is linked with transgression such as wanting to take what belongs to someone else. Inhibition means that the feelings or wishes experienced are stopped from being experienced and/or expressed. Young children, use inhibition especially in the face of hostile feelings toward mother and father, and where the load of hostile destructiveness is high will tend to use inhibition in a global way, in an exaggerated way. This frequently leads to the inhibition not only of hostile destructiveness but of nondestructive aggression as well. Inhibition which can serve the child in a moment when the child might feel explosive, becomes costly when it disallows the working through, talking about and the resolving and reducing of the feelings of hostility the child is experiencing.

There are many times, however, when inhibiting the expression of hostility or rage can be very helpful. This mechanism, like the others, can stop the child's action at a given moment, and therewith, give the developing internal controls a chance to take over.

For example, nearly 3 year old Suzy's "counting to five" before she blew up helped her then not blow up. We saw the troublesome effect of poor abused Richie's not being able, at first, to inhibit his explosive throwing and smashing of toys.

Displacement is a mechanism that is frequently employed during the second and third years of life particularly to handle large loads of hostility (see Section 2.241). Displacement, which the child uses to protect himself or herself against the fear of destroying a highly valued person like mother or father, allows for a seeming reduction of hostile feelings toward them. Bear in mind that these feelings, however, are not truly reduced. The major problem with displacement is that the hostile destructive feelings are "displaced" onto innocent others. In the long run these then can be costly given that they are likely to lead to scape-goating and prejudice (where someone is hated who had nothing to do with what caused the original feelings of hostility). We know from what we see in communities throughout the world, how, when displacement leads to prejudice, it then can become a very trouble-making defense.

Turning destructive feelings against the self is another troublesome defense a 1 to 3 year old may set up to protect against the dread of losing control over feelings of hate and rage toward mother or father. Some infants who have high levels of hate and rage may hurt themselves often, seemingly "by accident", may bite their hands or arms when furious or throw themselves on the ground as if not caring if they break a bone or bruise themselves. These behaviors are not just due to the loss of control by the child, but also include the displacement, if you will, of wishing to destroy onto the self rather than onto another person.

Splitting of internal representations is a complex and important defense mechanism which is used by one and two year old (and older) children to protect against excessive feelings of hostility toward valued persons. Psychoanalytic theorists propose that what we experience is registered within the mind in ways and forms that make these experiences retrievable through memory. This registration of experience in the mind leads to our developing more and more stable "mental representations" which play a key part in human experiencing and in who we become. That is, the ways we experience ourselves and those others who are of primary importance to us, are registered in the mind in some form of mental representations, images or schemas of ourselves and others "in action" and with feelings, in the kinds of events and moments we have together. A basic assumption of this theorizing is that early in emotional-psychological development, children tend to separate into two networks of internal (mental) representational schemas what is experienced as good, as gratifying, on the one hand, from what is experienced as bad and hurtful, on the other. The theory proposes that we have images of ourselves as good and as bad and images of others as good and as bad.

Mental health professionals hold that in order to experience ourselves and others in normal and healthy relations, an integration of these good and bad representations of ourselves and others is necessary. Otherwise, the self is at other times experienced as all bad, and at times experienced as magnificent, as all good. Similarly, others will at times be experienced as all bad or at other times as all good, with no flaws, no faults, no weaknesses. Experiencing oneself as all good will unavoidably many times prove not to be true and then be even intensely disappointing; or experiencing oneself as all bad is

highly detrimental to oneself, to one's self esteem. Similarly, needing to experience another as flawless, all good, will often be painfully disappointing and lead to giving up on the relationship to this other; and, of course, expecting others to be all bad, evil, makes one enraged with them and mistrusting of them. So that when these sets of mental representations, good and bad, are not integrated, when representations of self and other are either one or the other and not a reasonable balance of some good and some bad, this leads to distortions of both self and others which are detrimental to adaptation and to relationships. Therefore, maintaining or stabilizing in mental representations a splitting of good and bad self and others -- self and other always go together -- should be prevented.

The 1 to 3 year-old child will develop a splitting of good and bad self and other mental representations in the face of intense feelings of hating someone they value and love. In other words then, ambivalence (hating someone we love) is a key determiner of the defense mechanism of splitting. In the face of intense feelings of hating (wanting to destroy) the mother 20 month old Suzy loves, she had to cope with the fear that the intense hate she now experienced toward her "bad mother" could bring about the destruction of the mother she experienced as good, and as a result of this, splitting the mother representations into bad mother and good mother networks could have become employed. Fortunately, the way she (by verbalizing "I hate you") and mother dealt with it probably made it possible for Suzy to not need to split. Splitting, in short, is used to protect the mental representation of the good mother from being destroyed by what the child experiences as the bad self or the bad mother. Or, Similarly it is used to protect the good self from being destroyed by what the child perceives as the bad self and the bad mother. Again then, although splitting may be relieving for the moment, in the long run it becomes highly detrimental because it intensifies the hostile destructive feelings the child experiences toward self and others since these are not "amalgamated" or "alloyed" with the split-off love feelings.

It is important to know that, as mental health professionals tell us, that feelings of love are the most powerful modifiers of feelings of hate. Sigmund Freud spoke of it almost as though, like in a chemical solution, the mixture of hate with love, sharply lessens the feelings of hate. Therefore, not only should parents, as Suzy's parents did, help their child not split mental representations, but it is also important to know that good love relationships protects the child against becoming someone who excessively hates, wants (needs) to destroy and be violent.

Identification is a mechanism 1 to 3 year old children begin to use for a number of self protective purposes, some highly positive and beneficial, others problematic. Identification is beneficial when it is based on wanting to be like those persons the child loves and admires, especially mother and father. This is how children become the children of their specific parents, adopting their points of view, their ideals, their goals, their religious beliefs, their family values, etc. In addition to identification arising out of admiration and even idealization, identification also occurs when the child fears losing someone the child loves, or in the face of actually losing such a person. In fact, throughout life, the process of mourning the death of someone we love includes identifying with that person, our taking on some of that person's characteristics, modes of

behavior, etc.

But identification can also take negative forms. For instance, when a child is frightened of a parent who is subject to outbursts of rage, attack and destructiveness, the child may be so terrified of that parent that coping mechanisms will be activated to make the experience tolerable. It is possible, that when 14 month old Richie suddenly exploded when frustrated by Suzy's play with him, and in his many subsequent outbursts, that partly this explosive behavior may have been activated by identification with his troubled abusive mother. This we call "identification with the aggressor", which means to act like, become like that raging parent who now is feared. What is then achieved is this, as Anna Freud described: if a child is afraid of ghosts, one way to not be afraid of ghosts is to pretend to be a ghost too. If one is afraid of a parent who behaves like an ogre, becoming an ogre oneself, becoming the attacker rather than the victim lessens the fear the child experiences. In this way, a child too may have fits of rage, outbursts of anger like the feared parent. Again, although this defense allays momentary mortifying fear, the child is not serving himself or herself well by adopting these kinds of behaviors. This defense mechanism, when it stabilizes in the individual, is a major contributor to abused children becoming abusing individuals and eventually abusing parents.

One more note on identification in 1 to 3 year olds. Both boys and girls identify with both their mother and their fathers during the first 3 years of life and beyond. Thus we saw 18 month old Diane behave toward the fussing baby just like her mother did, first by shaking the baby's rattle, and then by patting him. Similarly we have seen young children pat mother on the shoulder when mother is upset. Boys identify with their mothers' (and fathers') nurturing, caregiving, home-making, etc., as do girls. Girls identify with their fathers' family functioning, be it being protective, the one who fixes tables, windows, etc., as well as do boys. Of course the child's own inborn dispositions will influence which functions and behaviors the child identifies with. Biology too will play its large role. Thus when, during the third year, the child's gender formation begins to be a large developmental task, identification with the parent of the same sex tends to increase. We shall address this in Unit 3 (Section 3.2311).

Reaction formation is a defense mechanism whereby what is experienced, felt or thought, is turned into its opposite. Most commonly, when overloaded with hostility and wishing to be hurtful, the child may experience this as unacceptable. These feelings may then become converted into just the opposite, wishing to be nice, to protect others from harm. "I'm not mad at Jennifer, I love her!", her 3 1/2 year old brother Mike once raged at his mother about his little sister. Reaction formations, like identification, may be enormously advantageous to the child. It is often used due to anxiety. But it is also used due to the child's own love-based disapproval of wanting to hurt one's little sister or beloved mother or father. It can help to actually diminish the feelings of the hate. But at times they may also be disadvantageous in that this defense does not allow a resolution of the underlying feelings of hostility. This is so especially when used with denial that is absolute, where the young child is not at all aware of being enraged. All in all though, reaction formations often bring with them highly desirable personality features, such as the wish to protect and care for rather than harm and destroy, the wish to build rather than tear down and damage. If this defense mechanism does not bring with it too much

inhibition or suppression of self expression, too much denial of self experiencing, it may be a very constructive and productive defense mechanism.

Neutralization (or mitigation) of hostile destructiveness is a mechanism of defense which is enormously advantageous to the child and like the other defenses described is especially activated during the second and third years of life. By neutralization or the mitigation of hostile destructiveness we mean a gradual process of working through feelings of hostility into feelings of aggression that are freed from hostility. That is, to convert hostile destructiveness into nondestructive (non-hostile) aggression. Exactly how this occurs is uncertain, but psychoanalysts agree that loving, valuing primary caregivers is essential for this process to be activated. We assume, and there is clinical evidence for it, that in the operation of such a mechanism, inner hostile destructive feelings become modified (probably by love feelings) and are converted into a source of aggression that can be used for constructive purposes. Clinical psychoanalysts have placed much store in this defensive maneuver as a basic method of reducing inner feelings of hostility which is then accompanied by a freeing up of what they say are inner "psychic energies" that can serve constructive ends and adaptation.

Sublimation, like neutralization (mitigation), is a defense mechanism that truly changes the quality and the aims of the feelings and wishes into "sublime" forms. Therefore, sublimation deserves to be in a class by itself. Sublimation is the complex defense of dealing with feelings, wishes (fantasies), and internal pressures which create inner mental-emotional stress or conflict within the child, by means of the creative process into creative methods of action be it learning, drawing, dancing, activity in sports, etc. During the second and third years of life one sees the beginnings of sublimation, for example, as 10 month old Jennifer did (really quite early in life), in children attempting to make a game of a battle with mother (see Section 1.262 in Unit 1). Although parents may at times experience a child's making a game of a battle of wills as a way of trying to win the parent over, or to change the parent's mind about a limit that is being set, the fact is that making a game of a battle of wills is a method the child comes upon of trying to turn a threatening and frightening situation into one free from hostile feelings, one instead of fun and pleasure. Making a game (that works) of a conflict, of a battle of wills, takes something of the creative process to achieve. It is a conversion of a conflict situation into a play situation, of actively (though unconsciously) reducing feelings of hostility and hate and heightening love feelings, and requires creativity on the part of the child. Of course, love feelings have to be there for the child to do this. These beginnings of sublimation during the second and third years gives way to a remarkable expansion of sublimation capacity during the three to six year period which we shall discuss in Unit 3.

Empathy and Altruism are also not just or not purely defense mechanisms. They are ways of coping (especially with feelings) that not only do not cause the child difficulty but are, in fact, emotionally and socially valuable. For now, we shall say a word about them here because they do seem to belong in a special class of "coping mechanisms" along with sublimation, a class of very positive, constructive, and creative coping mechanisms. 20 month old Jane showed a surprising degree of both empathy and altruism in an unexpected moment. But first let us remind the reader that by empathy we

mean the ability to feel, to perceive what another person is experiencing (feeling), and altruism is the willingness to give up something one has or wants for the well-being of another person. We had occasion to be in the elevator on the way to our meeting space for the child-parent program when Jane and her very pregnant mother (7 months) came into the elevator as well. Jane seemed in a fine mood and started to show signs of wishing she could push the elevator buttons. Excited, she looked up at her mother who appeared drained and overburdened (but neither sad nor upset). Mother, seemingly preoccupied in thought did not notice Jane's activity. On looking up at her mother, 20 month old Jane, who customarily was well inclined and able to let her mother know when she wanted something, suddenly changed her mind. Her face softened, she dropped her raised arm, and she just looked at her mother, sympathetically. She made no request to be picked up by her to push the button. It was we felt, as though Jane had felt "She looks so tired, how can I ask her to pick me up!" And she gave up the wish. We felt, it was out of concern for her mother, out of altruism. She had been able to empathize with her mother's feelings and decided not to make a demand of her now. We thought: "What a lucky child-mother pair!"

Regression, another major defensive operation used by one to three year old children warrants special attention. We will discuss regression in the next section.

2.2532 CHILD REARING: Optimizing the Use of Mechanisms of Defense

There was a time when people assumed that if individuals develop defense mechanisms they are mentally ill. It is important for parents to realize this is not so. As we just said, all children experience feelings and wishes, are propelled by powerful inner forces (evident in their feelings and wishes) which create enormous anxiety and inner mental conflicts in children. Because these are too difficult for the young (and older) child to tolerate, all children need to protect themselves against feeling such anxiety and conflict in order to adapt comfortably enough to the demands of everyday life. The idea many people have that early childhood is an easy time of life is totally wrong. Children have to use all of their resources to adapt to life and most particularly to cope with their own inner stirrings, feelings, and pressures. We do not mean by this that children are constantly bombarded by wishes that create havoc within them. Quite the contrary, well cared for, physiologically untroubled (average normal) young children do experience many moments of calm, quietness, internal comfort, pleasure, loving, feeling loved, etc. Children are not constantly worried about their feelings, wishes or their internal pressures. This is particularly so for those who are well cared for, who feel respected and loved, have long enough periods of pleasure and satisfaction. What we want to do away with is the notion still entertained by many parents that childhood is like being in a paradise, like having no problems at all, like having no worries anxieties, or fears. Not true!

As with all other aspects of early development, parents can be enormously helpful to their children in helping them cope as constructively with the stresses the child

experiences. Bear in mind that moderate stress enhances development and the capability to adapt, and in tolerable doses, moderate stress is growth-promoting. With this in mind, if parents can identify the play of some of the defenses we described in the above section, they will be able to first, understand better, more correctly what their children are experiencing. Secondly, they will therefore be able to deal better with some of their children's behaviors which arise from these defenses. Third, they will be better able to help their children cope with inner pressures the child experiences as overly taxing. Here are a few examples.

Angry with mother because mother just told 18 month old Jennifer that Jennifer is not to take the ball 18 month old Johnny is playing with (reminiscent of her pulling Johnny's pacifier from his mouth 7 months earlier), 18 month old Jennifer goes to 16 month old Vicki and pulls her hair. Recognizing that Jennifer was displacing the anger she was feeling toward mother for having prohibited her from taking the ball from Johnny, Mother had a clear idea as to what she should do. It was far more helpful for Mother to say "Look, don't take out on Vicki being mad at me; talk to me about it", than to say: "You're being a nasty, bad girl." So too, 3 year old David's mother was very helpful to all concerned when she told him not to take his anger out on his younger brother, or on Dr. Parens, nor on himself too at the end of his temper tantrum (see Section 2.242).

We recommend that parents exercise their imagination in what might be activating their child's behaviors; but we want parents to be aware that they may be too intrusive in making assumptions about what makes a child do something. Caution is needed; too much intrusiveness into a child's private thoughts can be detrimental. However, in moderate doses, parents pointing to a child's behavior as being caused by something which is very clear, as in these instances, that Jennifer was really angry with her mother and was taking it out on Vicki; that David was angry with mother and not to take it out on his brother or Dr. Parens or even himself, this can be very helpful. Having seen 18 month old Doug tease his "friend" by pulling out the baby tub from under the crib, reminding him (we thought) that his mother is having a (new) baby, it was very useful for the child's mother to tell Doug, nicely but firmly, that he is not allowed to tease her son, period, no matter what it is Doug was angry about -- unless her son had made him angry (which he had not while we observed them). What we are talking about now will become clearer in the next Unit when we address issues that are more sensitive and require more respect for the privacy of the children's feelings, wishes and fantasies.

Many a time after a child has done something which the child assumes will displease mother, for example spilling mother's coffee, the intolerance of anticipating mother's expected disapproval for what the child did can cause the child to feel the need to and blatantly deny that he did what everyone saw him do. "I didn't do that!", 2 1/2 year old Johnny said when exactly that had happened. What is causing him to deny what he did is his anticipation of the terrible pain of mother's disapproval, of mother's scolding. Mother's demand that he be more careful, that she doesn't want him to get hurt because she loves him, because sometimes coffee is hot and also because she has enough to do without having to clean up such a mess, etc., allayed his anxiety and he no longer felt the need to deny.

We want to emphasize again that whereas defense mechanisms are used by the child because the child cannot bear the inner stress (anxiety, conflict) associated with particular wishes the child has, and that these defenses are therefore useful for the moment, that some of these defenses may not be useful in the long run whereas others are highly desirable and can be very productive. Among the ones that are not useful and which when they are seen to occur need the parent's attention, are inhibition, denial, displacement, turning hostility against oneself, some reaction formations, identification with the aggressor, and at times splitting and projection. For example, a child who overly uses inhibition as a defense may not be able to stand up for his rights to the truck he is playing with when 2 year old Sam grabs it from him. Rather than holding on and telling Sam that it's not Sam's turn to play with it, he yields, looks deflated, and registers no complaint. Because he is unable to reasonably assert himself, he loses his turn to play with the valued truck.

18 month old Jennifer's mother was not as helpful as she could be when she told her daughter "You're being a nasty, bad girl!" We all knew each other quite well by now and the mothers (and children, as well as most of the fathers we occasionally saw) trusted the parenting group Instructors, so that it was by now easy to point out to the mother's that Jennifer was displacing the anger she felt toward Mother for Mother's limit-setting (not letting her take the ball l8 month old Johnny was playing with), onto by-stander Vicki. And Mother, following our explanation and discussion said to Jennifer "You heard what Dr. Parens said, don't take it out on Vickie when you're mad at me, talk to me about it" (even thought Jennifer's language development was just beginning). We often told the parents that it is useful to tell a child "Talk to me about it" even when a less than 2 year old does not yet talk well or even not at all.

3 year old David's mother was really on target when she told David "Don't try to upset your brother, he didn't do anything to you" and then, "Don't take your anger out on Dr. Parens, he's not the one who made you angry." And, equally important, when we pointed out that David's nearly falling off the chair may have been more due to turning his anger against himself than to just losing his balance, she thoughtfully added "And, I don't want you to take it out on yourself, either, you're not allowed to be mean to yourself either."

It is more difficult to deal with the child's projection of his or her feelings of hostility onto others which then makes the child feel these others feel hostile toward the child. It is important to bear in mind that feeling hostility, hate, or rage (all due to various forms of hostile destructive aggression) toward the mother and father the 2 year old loves produces an acute conflict within the child and with it, much immediate anxiety. We did not see much evidence of projection in the children we are talking about here, even in Richie or Vicki, we believe, because they were increasingly really well cared for. Diane's brother Jack showed what we felt was due to projection in a surprising incident when he was barely 3 years old. He was a very active, fast moving boy, curious and busy. In this instance, he reached to touch or pull the plug of a lamp plugged into an electrical outlet. Alarmed, his mother rushed to him, took hold of his hand and with some alarm told him not do that. In a split second Jack's other arm was up over his head, as if shielding it from being clobbered by his mother. Mother was shocked and embarrassed. She told us

that she just could not believe his reaction. She had never beaten him, never even slapped him. He acted "as if I beat him all the time." We were getting to know this mother then and indeed we believed her, and told her so. (Getting to know her even better over a period of more than 4 years, confirmed that this mother did not slap, or strike her children; nor did the father). We told Jack's mother that of course children who are often slapped or struck physically would react like this. But some children might react like this who are not beaten by their parents. What we call projection can do this too. Startled, upset, and very angry with mother for her alarmed limit setting, it is possible that Jack immediately defended against feeling enraged with mother by externalizing these threatening feelings of rage and ascribing them to his mother, which led to his expecting that she would clobber him! Jack's mother was very upset. We encouraged her to talk to Jack about what happened, about her just not wanting him to get hurt, that electrical outlets are dangerous and he is not to touch them until he is quite older like 6 or 7, that what he did scared her, and that she's sorry she scared him. This mechanism of defense, projection, is more commonly seen later, especially from 5 years of age on, even in well cared for children. For example, a 6 year old who feels threatened by her own feelings of hate toward her mother who set limits with her yesterday, may feel that the children who are playing and laughing are laughing at her and hate her! It is well for parents to wonder then what could be causing the child to be inhibited, to project, to deny, to displace hostility, etc.

One of the most useful tasks a parent can undertake is to create the habit for interaction with her or her child where talking about worrisome things, where the expression of feelings whatever they may be, is made possible. This does not mean that a child needs to be permitted full expression of wishes and feelings that are troublesome, such as pulling mother's hair, scratching mother's face, hitting mother, father, or other children. It is rather to allow that feelings of anger are permissible, that they are feelings we all have at times, that a child is not bad for having seemingly intense needs or wishes or hostile destructive feelings and wishes, to make these something we can talk about, in order to learn how to deal with them, to handle them in constructive ways. It will pay both child and parent in the long run if parents realize that it is important to spend time talking about upsetting experiences, frightening experiences, what causes anger, what causes temper tantrums, etc. Talking about things that are difficult for children to handle leads children to feel that they can turn to their parents in time of need, when they cannot solve a problem themselves.

It is important for parents to realize that children 14 months of age can be talked to, can be talked with, that young children soon come to recognize when feelings can be talked about, when attempts to solve problems can be talked about with parents. The reverse is true as well, children are quick to learn when parents find certain feelings intolerable, when parents cannot take time to talk about things that worry their children, and children may then not turn to their parents with feelings of hurt, distress, or problems when in need of help. Most people are rightly aware that children who are permitted to and are encouraged to talk to their parents have an enormous advantage over children who do not.

Furthermore, we have learned that parents who talk to their children when they are

young, are parents who can feel secure that their children will talk to them when they are teenagers. Some parents seem to feel that young children cannot be talked to or with, that only school-age children can be talked with. Some even wait until their children are adolescents and try to establish a talking relationship with them then. Invariably these efforts can help, but they commonly tend to not be as successful as in instances where parents have talked to their children since they were very young, even less than one year old. Children in the second and third year of life are very easy to talk with. Furthermore, children at that age are for the most part very eager to talk to their parents, and there is no better time to begin the work of developing an open channel of verbal and emotional communications between parent and child than from the very beginning. During the second and third years, the verbal dialogue becomes especially important. The major reason that children find greater facility in talking to their parents when they are one and two years of age is that the next phase of development, from 3 years to six, is a period when children begin to experience things they need to keep private from their parents, internal wishes that create enormous problems for them as we shall detail in Unit 3. From 3 to 6 years is the period when talking to their parents about their feelings and wishes is made more difficult for children by their normal inner stirrings. Therefore, as we emphasize again and again, there is no better time to begin to talk to one's children than in the first, second and third years of life.

2.25 THE CHILD'S ABILITIES TO ADAPT -- PART II

2.2541 HUMAN DEVELOPMENT: Regression

By regression mental health developmentalists mean to return to an earlier state or level of development. Mostly it is caused by anxiety. Remember that anxiety is created in the child by feeling helpless in the face of a stress or danger, be it due to a new challenge of development or excessive pain with which the child feels unable to cope. This may lead the child to retreat or regress, to a more mastered period of development or to a better mastered mode of adaptation and functioning.

Normal development consists of a series of new challenges for the child, challenges in motor functioning as for example in learning to walk, or in dealing with internal pressures such as the wish to individuate before the child is ready to tolerate feelings of separateness, or whether it is in learning how to deal with feelings of rage toward the mother the 1 to 3 year old child values deeply; challenges like these constitute normal development. Some of these create fears, stress, and anxiety. Let's be quick to add that such challenges of course also bring pleasure, excitement, eagerness to meet them, elicit enormous efforts on the part of the child, and bring marvelous feelings of success and mastery.

We want to emphasize that development truly consists of the child's going from one phase of a particular line of development to another, each phase having its particular task of development as Erik Erikson said, each requiring adaptation to that task, and mastery

of it. It normally happens that no sooner is one phase of development and its internal task sufficiently mastered that the next phase of development is right there challenging the child again.

Not uncommonly, in the process of adapting well to a new task of development, the child takes three steps forward and one back. It is important that parents not be troubled when the child takes that one step back, when the child regresses. Commonly such steps back are taken to regroup, to re-stabilize, and usually are transient, temporary, as well as expectable. Once the child feels reinvigorated, a new effort will be made to undertake the new challenge.

Some regressions are activated by feelings that create conflict within the child. For example, a 3 year old Jack when experiencing pleasure in autonomy and individuation, encountered mother's disapproval of his exploring an electrical outlet, he probably experienced a surge of wishes to hurt and destroy mother, then most likely was swept by a feeling of terror at the thought of being rid of this "bad and mean mother", in reaction to which he seemed to retreat from wishing to be autonomous, separate and individuating in favor of being inhibited, staying one with mother, an infant incapable of such "vile" and troublesome autonomous acts and intentions. Under these conditions, the thrust and wish to be autonomous may be blamed and experienced as bad, threatening. Although Jack's reaction was of short duration, the child may, then, retreat from such autonomous wishes and from efforts at individuating. As we said in Section 2.2521, the more positive the relationship to the mother or father, the easier the handling of these feelings and the less the regressive reaction. By contrast, if a relationship with mother or father is especially difficult, the regression may be harsher, last longer, and in serious enough circumstances professional help may be needed.

There are regressions during the second and third years of life which are normal and expectable. Some may be of such duration and of such intensity that they may impede normal development. One of the most common normal regression during the latter part of the second year of life is that produced by the rapprochement conflict, as we saw in 19 month old Jennifer (see Section 2.2211). Remember that made anxious by the wish to be separate and individuated from mother, because she was not yet emotionally, psychologically ready to feel securely attached while also separate, she clung to her mother. But then, pushed from within to the separate and an individual on her own, she pushed her mother away, quite upset. Not secure enough when feeling separate at this time, she would revert or regress to clinging. This regression was needed, helped her cope; and then she could try again to separate and try to individuate. This regression did not stop or even slow down her good development.

But there are regressions that do slow down and even stop development, some for quite some time. Such more serious regressions may result from notable inborn intolerance of anxiety, or in a child who was born with difficulty in organizing experience, or these may occur in severely hampered relationships where hostile destructiveness is generated to very large degrees, or these may occur in young children who suffer from withdrawal of attachment to them on the part of a deeply depressed mother; there are many possibilities. Of course, such conditions can even create an arrest in development for which professional intervention is needed.

2.2542 CHILD REARING: Handling Regression Constructively

Parents tend to become distressed by their children's regressions. Even though 30 month old Jack's mother was very upset by his fear that mother was about to clobber him, and it embarrassed and worried her, she also then became upset that Jack seemed less adventuresome and explore less for several days after this incident. She was worried then that the intensity of her and Jack's reactions would now have crushed his good sense of autonomy, of being a doer. We explained to Mother the value to Jack's learning of her terrible fear that he could, because of his not knowing the dangers that come with the great usefulness of electricity, hurt himself very seriously. Now though, we were certain that talking with her 3 year old about what made her react as she did, that he must be careful and take good care of himself and not do things that can hurt him or someone else, that Jack would revert from his inhibitions and probable regression, and regain his strong thrust of autonomy, and be his usual exploring self.

Parents react differently to different regressions, according to their own past experiences and remaining intolerance and vulnerabilities; some regressions cause them less distress than others. For instance, a mother may experience her two-year-old's loss of toilet training less troublesome than the child's renewed clinging. Given that regressions often are an effort on the part of the child to regain a position of mastery when the child is feeling anxious, that these reactions are temporary, as if the child were trying to catch his or her breath to take on another stretch of the mountain, it is well for parents to take heart when these occur. It was highly desirable that, once she understood what was probably going on in 19 month old Diane, mother could easily tolerate both Diane's clinging and the confusion her conflicted behavior caused in Mother. Where comforting is asked for by the child, it is always desirable to be available for that comforting as well as for supporting the child's efforts. Encouraging a child to try to regain the functioning the child recently lost can be helpful.

However, parents have to feel their way with their child in terms of pushing them toward progress, supporting the child's efforts without pushing too hard. Children will give signals to their parents as to how hard a push they can tolerate. Forcing children to do something the child refuses to do because of a feeling of helplessness in the face of it, is generally not advisable. Smaller steps of progress may allow for better coping and the stabilization of progress. Most important here is the parent's effort to read the child's reaction; if the child is experiencing too much anxiety, too large a feeling of helplessness is evident, pushing may slow rather than advance progress.

While we encourage parents to not despair in the face of regressions in their children, given that these are unavoidable in normal development, at the same time we encourage parents to not fear seeking consultation in the face of regressions in their children which worry them unduly, or last too long for comfort. Sometimes a professional consultation can be enormously clarifying and no more than that may be needed. At other times consultation will reveal that more help is needed, that some new strategies of parenting

may be required which can be facilitated by guidance from a child development professional. In the face of some of the severe regressions that do occur, professional intervention may save parents and children much distress and pain. Furthermore, it is important for parents to know that more severe regressions may not resolve themselves, and that specific interventional strategies are needed to undo such degree of regression, to undo the arrest in development that may follow from them, and put development on a better course.

2.2 EMOTIONAL AND BEHAVIORAL DEVELOPMENT

2.26 THE BEGINNINGS OF CONSCIENCE FORMATION

2.2611 HUMAN DEVELOPMENT: Beginnings of Conscience Formation

The child's conscience begins to be formed from the end of the first year of life on. This begins with the child's gradually, step by step, internalizing into his or her mind the "dos" and 'don'ts" that are a part of everyday life with mother, father, and other important caregivers. Internalization of parental dictates (the "do's" and "don'ts") gains momentum during the second year of life. This is especially associated with the normally required limit setting. Indeed, the child's progressive accepting of limits set by mother and father leads to the earliest establishment of conscience formation in the one year old child.

Side by side with the internalization of parental dictates, contributions to how to behave, what to do and not to do, also comes from identifications (wanting to be like, behave like) the one to three year old child makes with mother and father. The first identifications grow out of the experience of oneness with mother during the first two years of life. The second source of identifications occurs in association with the growing our of that oneness (Symbiosis Mahler called it), the differentiating out of that symbiosis during the Rapprochement Subphase and the subphase On the Way to Self and Object Constancy (see Section 2.2211). In association with identifying with the mother that grows out of giving up the experience of oneness with her, parallel identifications occur with the father, the "knight in shining armor" who helps draw the child out of the oneness with mother. Not uncommonly, a 20 month old child may put on father's hat, pick up his brief case, and pretend to go to work.

Another major contributor to the beginning development of conscience is made by the toilet training undertaken most commonly among us during the third year of life. Toilet training makes demands on the child to comply with expected behaviors that are standard in the child's environment, and the giving up of some of the child's own wishes and preferences for what to do and when to do it. This process too occurs step by step and brings with it the internalization of parental wishes, demands, rules of conduct, and goals for the child. Because toilet training brings with it discipline about and pertaining to the earliest bodily experiences the child has, toilet training makes an important contribution to internalizing, to accepting the demand for standards of behavior set up in the child's environment.

A fourth major contributor to conscience formation comes from the experience of hating, wanting to hurt, to destroy the loved parent. The loved parent has to responsibly, when needed, make demands, set limits, in one way or another deprive the child of what the child wants, and thereby generates in the child hostility toward that parent. Feeling rage, wishing to destroy someone we love, is the principal producer of guilt. Feeling guilt, as we understand it, is the hallmark of having a conscience reaction; feeling guilt

means that a substantial internal structuring of conscience has occurred, however young the child may be. Such feelings seem particularly associated with the ability to feel love and hate, namely from about 18 months of age on. Although the degree of guilt, its intensity and its quality are not yet what these will become during the 3 to 6 years period, such feelings may already be strong and make their contribution to the beginning of conscience during the second and third years.

Here again, the quality of the child's relationships importantly influences the quality of the beginnings of conscience that develop. The greater the feelings of love, respect, and the efforts to understand the child, the greater the chances that a responsible and reasonable conscience will begin to be formed, and the better the child's self-esteem. Or, the greater the feelings of hostility and hate mutually felt between child and parents, the lesser the respect and consideration in interactions, the greater the ambivalence (the mix of love and hate feelings) in the child, the harsher the conscience that it being formed, the harsher the earliest self-recriminations, the harsher the hate toward self, and the lower the self-esteem.

In Richie, it seemed to us from the outset that at 14 months of age he had great difficulty controlling the reactions of rage he experienced. Even the benign, playful hiding of the ball by Suzy caused him to explode. He had developed a hypersensitivity to even the least painful experiences -- all due to the large load of hostile destructiveness already accumulated in him, so that the slightest pain now could be the spark that would set off the explosion of hostile destructive feelings in him. Hand in hand with this, he had not developed the ability to cope with such feelings within himself. We also thought that Richie at this time had not yet been able to internalize benevolent parental dictates like "Don't take the toy another child is playing with, unless it belongs to you." Nor, we assumed, did he know to not lash our when upset and angry.

As he became less depressed, more trusting that some people, like his great-aunt and Mrs. V, really wanted to give him good care, we saw gradually the development of internal controls over his tendency to have rage outbursts. These progressed slowly. With this, we assumed that he was also internalizing the idea that it is not acceptable to just lash out at others and things when hurt and enraged. As his attachments became warmer, friendlier, he seemed better able to not just lash out.

Here is what we mean. At 14 months and 25 days of age, Richie seemed to spontaneously harshly throw toys, causing alarm in those around him. He was depressed and looked at people with mistrust and vigilance. At 15 months and 1 day, when Suzy played with him, he suddenly exploded when she hid the ball, and he cried and falling, banged his head rather hard on the carpeted floor. He accepted Mrs. V's calming and comforting. Soon after, he flew into a rage when he was not allowed to take a toy from another child.

At 15 months and 8 days, he seemed less morose, smile at some people. He became more active, moving about and exploring more. Though he explored more, he threw toys into the toy cart harshly, smashing. Though harsh, his smashing was more directed (into the toy cart) and did not frighten people. He now began to have nightmares. These commonly occur in children (and adults) who when awake are trying hard to control the expression of hate and rage they feel. At 18 months and 7 days, he looked depressed but

did smile at people. He threw things suddenly, again too harshly, threateningly, in a wide circle. He was quickly restricted and scolded a bit harshly by his great-aunt. Although still suspicious of them, he interacted with peers more easily.

At 19 months and 15 days, there is more smiling feeling that depression. He still has bursts of suddenly, harshly throwing toys. At 19 months and 23 days, harsh outbursts of throwing toys continues, but none are thrown at people. He then, of course, continues to be reprimanded which he seems to accept without protest. He has never lashed out at a child younger than himself. Now he interacts warmly with Mrs. V and several other children and mothers.

At 20 months and 23 days, a large stride in development seems to have taken place. He seems not depressed, his smiling feeling seems more stable. He has quite better control over his hostile feelings; no throwing today, no explosions. Now he holds his hand on his chest from time to time, as if to prevent them from grabbing or reaching for something he thinks he should not touch. He also at times then shakes his head "No." He continues to have bad dreams, even 3 per night, that make him cry out.

It is these progressive changes that led us to believe that the development of internal controls and the internalization of "dos" and "don'ts" were occurring gradually. These progressed hand in hand with the improvement in his relationships and his trust that others would not hurt him, rather that they would be good to him.

2.2612 CHILD REARING: Optimizing the Beginnings of Conscience Formation

Given that conscience formation means the development of an internal code of standards for behavior, the development of conscience is essential for adaptation. In fact, without a conscience humans do not accept rules of social conduct that make life together possible. On the other hand, if a conscience becomes too harsh, imposes too many restrictions, prohibitions, and produces too much guilt, here too adaptation becomes difficult. Excessive loads of guilt, too hateful an attitude toward oneself, too rigid restrictions imposed on oneself, will impede healthy emotional development and adaptation. Therefore, parents have the task along with the child, of securing the development of a reasonable conscience, one that is neither too weak nor too rigid, too unconcerned not too punitive, neither too lax in expectations nor too demanding.

It is important for parents to know (as many do) that children are not always the best judge of what is a reasonable reaction to a transgression. And it is best that they react reasonably to the child's own insufficient compliance with demands made by the parents. Children sometimes can be too soft in their reaction to their own transgressions against another child, or, quite the contrary, they can be too harsh. Having taken a toy from another child, a 20 month old may feel fully justified in doing so; another child may feel that he or she had done a very terrible thing when scolded for it. Important here is that the reaction of the primary caregivers, mother and father especially, will profoundly influence the child's own reaction to her or his own behavior. If mother or father is too

harsh, the child is inclined to internalize that reaction into his or her budding conscience. If the parent is too lax, that attitude is most likely to be internalized. We have learned that the caregiver's reaction will be much more meaningful when the caregiver is mother or father, the object of a "primary relationship." Although children may respond readily to non-parental caregivers' prohibitions or reactions of disapproval, these will not carry the same weight and will not be taken into the conscience as readily as when it is the parent who reacts in this fashion. The key factor is the degree to which the person who prohibits or disapproves is emotionally valued by the child.

The fact is, that the child's reactions to limit setting, to toilet training, to experiencing rage or hate toward the caregiver, are much more contributing to the internalization of dictates and of the caregiver's reactions, when these come from the persons the one to three year old values and loves most. In fact, we emphasize that the painstaking efforts required by setting limits, by toilet training, etc. bring with them greater psychological development when these are done by those to whom the child is most attached.

All the children we are talking about in this Unit except Richie were showing evidence of conscience formation activity of a normal degree. This was somewhat more difficult to ascertain with Vicki because her depression brought with it the toning down (inhibition) of hostile and hate feelings she probably experienced toward her mother to whom she was deeply though painfully attached.

We saw the struggle 13 month old Diane experienced with her mother and inferred from her behavior that an important internal conflict occurred. This internal conflict, of feeling rage and intense hostility toward the mother she emotionally valued so much, truly immobilized her for about 20 minutes on her mother's lap, and seemed to be "worked on" by her for a number of days. Part of this work in her mind (psyche) included coming to terms with what her mother demanded of her, that Diane comply with the dictate: "You are not to take out the toy cart (because the other children have rights to it too)." Mother was saying a great deal to her daughter with this: you have to learn that other people have rights too; you can't expect to always be able to do what you want; you have to learn to tolerate reasonable frustrations and disappointments; some things are permissible and some things are not; and more. Mother's being sufficiently emotionally available to Diane, her patience, her thoughtful efforts to make her child accept this disappointment, her tender efforts to comfort her, all facilitated Diane's efforts to deal with her rage toward her dear Mother and to internalize the rule of conduct her mother wanted her to learn. We saw similar good efforts in 19 month old Jennifer's mother when she tried to help Jennifer deal with her internal conflict over wanting to separate and individuate from mother one the one hand, but due to the anxiety this caused Jennifer, she also wanted to "stay one with Mother."

And we also saw this quality of effort in 38 month old David's mother as she struggled with her own feelings of anger toward her son while at the same time she stayed emotionally available to him and tried to help him caringly to regain control over his rage feelings toward her. It was especially important that Mother be reasonably patient, stay emotionally available to him, and help him as quickly as possible and reasonably as possible to tone down and diminish his rage for the following reason. It is not just the words of the mother's dictates that the child internalizes into what will

become part of the child's conscience. It is the entire experience, or scene, as the child perceives it to be, with all the feelings the child has; this is what becomes internalized into the child's conscience. Thus, the more benign the emotional quality of these experiences, the more benign the feelings that become part of the "do's" and "don'ts", of the conscience. The more hostile and hateful the feelings of these experiences, the more hostile the feelings that enter into the formation of the conscience.

We need a conscience to live acceptably, responsibly in Society. A healthy conscience guides us, even protects us against doing things we should not, such as do violence to others and to ourselves. Too harsh a conscience may make us too critical not only of ourselves abut also of others, may make us depressed and feel "evil", make us feel unlovable, interfere with our working well and reaching the reasonable attainment of our goals; it may even lead to suicide.

Children who are not sufficiently well attached to at least one caregiver, be it mother, father, or someone else, may not develop a conscience at all, or minimally. Such children will then not be governed by a moral code of behavior and will not be motivated to comply with demands, rules, and laws of School and Society. From these come most of our criminals. The same holds for children who are excessively hurt during these early years, who then develop insufficient feelings of love for others associated with large loads of hate toward others and, as a result, develop a conscience that condones, make directing hate feelings toward others feel reasonable and deserved. In this way, children who are abused by those they are naturally prepared to love, their own parents are likely to develop a conscience that condones hating and destroying others.

2.26 THE BEGINNINGS OF CONSCIENCE FORMATION

2.2621 HUMAN DEVELOPMENT: Development of Self Image and Self Esteem

How the child feels about herself or himself develops gradually. It depends on a number of factors including the child's general internal comfort, the normal enough functioning of her or his physiology, thresholds of irritability, capability to organize experience, all these factors arising from the child's inborn givens, in combination with the experiences (especially in the family relationships) the child has from the beginning of life. Where relationships between child and parents are good enough, the average-normal child's physical and emotional needs will most likely be sufficiently met as a result of which the child will experience an inner feeling of being well cared for and of comfort. Out of such inner feeling of sufficient gratification and comfort grows a feeling of a self that is comfortable, that feels sufficiently at ease, and sufficiently valued.

Feelings as these have already made their important contribution to the child's emotional state during the first year of life. Some sense of self during the first year, which then includes a sense of being worthy of care and nurture, makes an important contribution to the child's ability and wish to relate well to others from the end of the first year of life on.

During the second and third years, these feelings of self develop further, organize and begin to coalesce into an inner sense of oneself, visible in the child's expectation of comfort when comfort is needed, of care when care is needed, of a sense of "me" and "mine" which many a child verbalizes during the latter part of the second year. This sense of self now becomes not only cohesive but much more complex. That is to say, we assume an enriching evolving of the child's self image as the child individuates out of the oneness with mother, takes the first steps to psychologically-emotionally separate from mother and father during the Rapprochement Subphase and that Toward Self and Object Constancy (See Section 2,2211).

In addition, arising out of the child's identifications which we discussed in Sections 2.2211 and 2.531, a complex mental image of the self begins to take shape components of which are modeled on the way the child experiences the parents, namely, as magnificent, powerful, loving, angry, demanding, hostile, depreciating, raging, etc. This often highly valued image of the self from the second and third years on begins to hold up goals for the child's self development, goals of conduct and of achievement. These can be pro-social or antisocial in character. Children who are reared by mean and raging parents may end up feeling like Iago, in Shakespeare's Othello, who cries out "I believe in a cruel God who made me in his own image."

All in all, how the child values her or himself, feels about her or himself, has three major contributors that become organized into one's self esteem from the second and third years of life on.

The first has to do with the self valuing some mental health theorists identify as

primary narcissism, a sense of inner value they assume every child is born with. The degree to which this normal and needed primary narcissism is reasonably intact is a major contributor to the basic sense of self-value. The degree to which this feeling of self-valuing stabilizes in the child, is directly reflective of the way the child is valued and treated by his or her parents. This also determines the development of basic trust during the first year of life (see Unit 1, Section 1.311).

The second source that makes a large contribution toward the quality of the child's self esteem is very closely tied to the first one. It is the quality of the relationships we have with our primary caregivers, in the young child of course primarily mother and father. As we have emphasized throughout this text, the better the quality of these relationships, the more reasonably positively life is experienced by the child, the more positively the different aspects of personality develop, and so too, the better the self esteem. Being valued and loved by those we value and love brings with it a remarkable state of well-being; this condition is essential throughout life, of course, but especially so for the child during the second and third years when the basic core of self esteem, the basic self image, and the basic ideal self image begins to organize in the child's mind (psyche).

The third major contributor to self esteem arises from the quality of the developing sense of autonomy, of competence, of effectiveness which the child begins to develop during the second and third years of life. The degree to which the child can feel a sense of "I" (mostly verbalized by children this age as "me" or "mine") is substantially established in the one and two year old by the child's own bodily and behavioral functioning, by the feeling of being able to do things oneself, of having an effect on the environment, on persons and things. The pleasure one sees a child experience when she or he achieves a new skill, when he or she does something the child has not done before, such as the pleasure and pride that accompany taking one's first steps or setting plastic donuts on a peg in proper sequence, these convey a sense of inner valuing that comes from the feeling of successful autonomy, of feeling: "I can do . . . ."

By contrast, experiences of failure bring with them a unique feeling of distress. To not succeed in trying to achieve a new skill or in trying to do something, leads to a feeling of failure, of feeling: "I can't do this . . . ." This in turn leads to feeling shame, one of the most painful of feelings. This awful feeling which brings with it the feeling of not being good enough, not lovable, begins to be experienced by children during the second year. From about 18 months on, children can feel shame, which directly erodes self-esteem. In human relationships too, feeling undervalued, not appreciated enough, leads to a child's feeling shame, feeling not good enough. Children experience enormous pain when they feel they are "not good enough." This, of course, is also what they feel when they are shamed by those they value.

The sense of self esteem then, a major contributor to the sense of self and the self image the child develops, gains sharply in development during the second and third years, and is highly determining of how the child will experience life and will develop.

2.2622 CHILD REARING: Optimizing the Developing Self Image and Self Esteem

The development of the idealized self image, the image the child constructs for himself or herself as the best he or she can be, and the sense of self esteem are intimately bound up with the development of one's sense of self and the character of the child's relationships to his or her parents. Of course, relationships to other people matter too; but from the very beginning of life we are all most governed by the quality of the relationships we have with those we value most. Following on the three major contributors to the development of self-esteem we outlined in Section 2.2621 above, we want to say the following.

First, parents knowing that the child needs to feel valued and needs protection of her or his primary narcissism will guide many parents, especially those who fear that genuinely felt positive responsiveness and shows of affection may spoil or in some way infantilize the young child. Some parents fear that being affectionate with the child will bind the child to them too strongly, make the child too dependent and interfere with the development of healthy self reliance and individuality. Showing affection neither spoils the child, nor interferes with healthy development; quite the contrary, it is needed for growth.

Second, the child's self experiencing during those highly formative life events like limit-setting, autonomy, ambivalence, separation-individuation, and others, during the second and third years occur most in the context of the relationships with the parents. A now well-known piece of advice given to parents follows from this that influences self esteem. It is that during the second and third years and later as well, feeling approved of as a person by the parents even when the child's behavior is disapproved of is highly reassuring of the parents' continuing love; furthermore, it will make the child better able to accept the disapproval of the behavior and facilitate the child's not repeating it. This significantly helps secure the second source of self-esteem, namely, feeling loved by those we love, even in the context of troublesome parent- child interactions. Unfortunately parents only too often tell the child, the child is bad, or evil, when they want to modify the child's behavior.

Third, given that positive self esteem follows on success in efforts at autonomy, at being competent and effective, it is highly useful for the parents to support their child's efforts to do things well, to do them by themselves, and to duly compliment a child's success. It does not work to the child's advantage when a parent compliments the child for just anything and everything; it may in fact devaluate the parents' approval. When earned, approval should be verbalized.

Thus, the quality of the parent-child relationships, again, turn up to be a major factor in the child's developing self esteem. But it is well to emphasize that when we speak of optimizing a parent-child relationship, we do not mean that children and parents should never be angry with each other, that one should avoid ever being angry or that one should hide feeling angry with one another. Hostility and hate in love relationships is unavoidable. What we do mean is that when parents, in addition to loving and valuing

their children also bring to their parenting a feeling of respect for the child, even the one to three year old, the hostile feelings will not destroy all the good in the relationship. This is even more secured when, in addition, parents treat their child the way they would like to be treated were they the child then, and make efforts at understanding what the child is experiencing (empathy); all these are the ingredients that make for a good parent-child relationship. In fact, as we discussed extensively in Section 2.242, parents should not suppress feelings of anger, hostility, or even hate at the time that these are experienced. But it is important that they be expressed with caution and reasonably. Then, crucial is that efforts to repair, to make up, again in reasonable ways, contribute enormously not only to optimizing the parent-child relationship but in helping their children learn how to deal with their own unavoidable feelings of anger, hostility and hate toward the parents they love and respect. Children very commonly really appreciate parents' making efforts to repair hurt they may have caused their child; regrettably, this does not apply to instances where the parents have too severely traumatized their children be it by excessive physical abuse, by harsh and repeated emotional abuse, by sexual abuse, or by severe neglect.

In summary then, respecting the child in addition to loving the child, secures a healthy residual of the inborn narcissism we all need for good self-esteem. Supporting, making possible the child's efforts at autonomy, at developing a feeling of competence, baby proofing the house to make it safe for the child to explore and learn, all contribute to sustaining good self esteem. And then, expressing feelings of valuing, appreciating the child, feelings of affection (verbal and physical), all contribute as well. And lastly, shaming a child in order to get compliance from him or her can be a very costly way of achieving it. Yes the child may then comply. But the hate of the parent will be intensified bringing with it the need to find ways of discharging that hate and of being destructive, bringing with it mistrust of the parent and later others, and lowering self esteem, each of these being very capable of causing no end of problems for the child and the parents.