SEX WITHOUT SHAME

Encouraging the Child's Healthy Sexual Development

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TO MY SEXY CHILDREN:

MIMI, MARA, EVE, WENDY, MOSES, SARA, STEVE

KRISTI, RICK, JILL, DONNA, DAVE, AND PAM

WHO TAUGHT ME MOST OF WHAT I KNOW

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PART I

UNDERSTANDING THE CHILD'S SEXUALITY

1

SENSUOUS CHILDREN?

A cantaloupe sky signals the nearness of dawn as the two bare bodies again stretch upon the satin comforter. He nuzzles her skin, breathes her racy scent, and quickly rouses. He inhales deeply, presses urgently against her, and unwittingly pinches her nipple in the process. Flinching slightly, she rubs his nose and whispers softly. He fixes his eyes on her, and kneads one delectable tidbit with his fingers as he relishes the other with his lips. She pushes firmly on his nates as he forces his hips against hers. An ancient rhythm oscillates and ebbs. Gradually his grip relaxes and he drifts toward a deep, refreshing slumber. She tenderly disentangles her hair from beneath his body. Then she covers him with the comforter, and carries him to his crib.

The infant is a sensuous being who is capable of experiencing a crescendo of pleasure with each feeding. Triggered by odor, exquisitely responsive to touch, greedy and aggressive, the infant searches desperately, claims his prize, and melts into languid slumber. Boundaries dissolve in oceanic oneness. Why is cupid always portrayed as an infant? To be in love is to reexperience infancy. The infant owns his mother totally, and cares not for any other. If she denies him, he is instantly enraged. He is encapsulated by his neediness—for

touch, for scent, for food, for warmth. His whole body is a sexual organ. Many years ago Freud remarked, "Can anyone who has seen an infant sinking back satiated from the breast with a smile escape the thought that this represents the forerunner of later, specifically sexual, satisfaction?"

The famous sex researcher William Masters was first an obstetrician. He relieved the monotony of delivery after delivery by devising a game that he played with the newborn boys. He described the contest succinctly: "Can I get the cord cut before the kid has an erection?" He won only half the time. Innumerable baby boys were born with fully erect organs. He also noted that all girl babies lubricated vaginally in the first four to six hours of life. Infants were born ready and fully equipped. During sleep, spontaneous erections or vaginal lubrications occur every eighty to, ninety minutes throughout the entire life span. (Masters, 1975)* Throughout life, sleeping sexual function remains far more reliable. While awake, our conscious anxieties take their toll.

Masturbation culminating in climax may occur as early as the first month of life. The baby girl is the most enthusiastic and proficient. With unmistakable intent, she crosses her thighs rigidly. With a glassy stare she grunts, rubs, and flushes for a few seconds or minutes. If interrupted, she screams with annoyance. Movements cease abruptly and are followed by relaxation and deep sleep. This sequence occurs many times during the day, but only occasionally at night. The baby boy proceeds with distinct penis throbs and thrusts accompanied by convulsive contractions of the torso. After climax his erection (without ejaculation) quickly subsides and he appears calm and peaceful. Kinsey reports that one boy of eleven months had ten climaxes in an hour and that another of the same age had fourteen in thirty-eight minutes.

Infants intrigued by erotic sensations are neither emotionally ill nor stunted in development. Harry Bakwin, pedi-

* Full references appear in the Bibliography, which begins on p. 231.

atrician, presents the following case of a daughter of a physician:

> At about seven months of age she took a great fancy to dolls. She would press her body against a large rag doll to which she was very attached and make rhythmic movements. The movements at first took place only in the evening at bedtime. At one year of age she and the doll became inseparable. She carried this doll about with her all day and from time to time would throw the doll on the floor, lie down on top of it, and rhythmically press her body against it, "as in the sexual act," according to her parents. Attempts to distract her during these episodes caused screaming. She would cling to the doll until she felt satisfied. The parents thought that she "completed an orgasm in her own way." By about fifteen months of age the episodes had decreased in frequency and were of shorter duration and by seventeen months the masturbation took place only at bedtime. When heard from at four and one half years, she was to all appearances a normal child. Her mother described her as alert, bright, and vivacious…at present she is a medical student.

Thirty-six percent of year-old infants are reported by their mothers to play with their genitals. (Newson, 1968) Between two and three years, many more youngsters masturbate, and pleasuring is already commoner in boys than girls. Nursery school children show an avid interest in each other's genitals and initiate erotic experiments. Half of all middle-class preschoolers indulge in sex play or masturbation. (Sears, 1957) Games such as "Mommy and Daddy" or "Doctor" are common by age four. (Newson, 1968) By age five most children have asked questions about sex, and know that boys have a penis but girls do not. (Kreitler, 1966). From the age of three, little girls recognize themselves as certainly female, and little boys recognize themselves as certainly male. (Rutter, 1971) (Money, 1961)

Between three and six, children raised in traditional homes gather about themselves the accouterments of the male or female role. Little girls play house, enjoy dolls, and

draw figures with rounded contours. Boys choose active toys and construct drawings with points, angles, and moving objects. Girls are now much less sexually active than boys.

A curious modification arises at about the time when children enter school. Sexual activity declines, so that at age seven only ten percent of boys masturbate, indicating that most of those who did masturbate have relinquished sexual pleasure. Only five percent are engaged in sex play with girls. (Ramsey, 1943) This sudden repression of sexuality is the beginning of a period called "latency." There are no hormonal or growth changes which account for this rapid shift. In cultures such as the Arandas of Central Australia, children continue to masturbate and show avid interest in sex throughout maturation. (Roheim, 1974) In some segments of our own culture, such as certain communes and slums, eroticism continues to increase. The answer, of course, rests in our method of child rearing.

Another sign of underlying discomfort is the predominance of aggressive fantasies about sex. A glimpse of coitus or sounds from the parents' room at night are construed as "Daddy is beating Mommy." A five-year-old who sees his parents kissing passionately says loudly, "Don't do that, it isn't nice!" One half of the five-year-olds assume that mother's abdomen must be cut open in order to remove the baby. (Kreitler, 1966) About a third of children five and over believe that girls first have a penis but then lose it somehow; it shrinks or is cut off. One third, more boys than girls, have castration fantasies. (Conn, 1947) In the five-and-up age group it is extremely unusual for a boy to say something nice about his penis. When asked, "What is your penis like, good, bad or...?" little boys try to cover themselves, act perplexed, or make a statement such as "not very nice." Little girls of five are unfamiliar with the term "clitoris" and are more than likely to state that the "vagina" is dirty.

Although rare at age three, by age five there are already distortions and conflicts of the sex drive. A few children com-

pulsively but joylessly masturbate in ways that invite discovery and parental displeasure. Others request enemas and suppositories for the sensations they impart. Some little boys seek out and oblige older homosexuals, without seeming to derive any pleasure from the contact. Sprouting eroticism is easily damaged and difficult to restore.

Once past this most difficult age, normal children begin to expand their erotic horizons once more, in ways calculated to avoid discovery. Children over seven are well aware of adult attitudes about sex. They devise elaborate strategies to present themselves as innocent. Foreplay and orgasms are achieved in cellars, haylofts, and attics. Those who have temporarily abstained from masturbation often begin again. The accumulative incidence of masturbation in boys rises from ten percent at age seven to eighty percent at age thirteen. Heterosexual play rises from less than five percent at age five, to a third at age eight, and two thirds at age thirteen. (Ramsey, 1943)

A steadily increasing minority of boys are engaged in coitus. Orgasms without ejaculation do occur. There is no rest necessary following orgasm, so that serial climaxes crop up in quick succession. Girls, who begin life with a greater erotic response, continue to lag far behind, although their trend is similar.

In early puberty the divergence between the sexes becomes even more striking. The adolescent boy has his eroticism imposed by nature. There is an enormous rise in the erotogenic hormone, testosterone, which can produce intense sexual interest when administered to either sex. Nocturnal orgasms occur without encouragement or permission. The penis rubs against clothing and immediately responds to the sight or thought of an amenable maiden. The boy has fewer constraints and may be subtly encouraged by his father and openly urged by schoolmates. Older brothers may provide instruction. In contrast, the girl experiences a rise in the female hormones, estrogen and progesterone. These contrib-

ute little to her eroticism, and may even detract from it. She may still be unaware of her clitoris, which is tucked away beneath several fleshy folds and unromantically named "down there." Confusion and anxiety may accompany the onset of menses, the presence of blood, and often some discomfort. She is never to appreciate the raw, unsolicited gratification of a wet dream. She is beset by cultural remonstrances, ignorance, shame, and the fear of gossip. Most importantly, she has a past marked by deficiencies in erotic pleasure.

Kinsey states:

> Fifty percent of the girls from the upper social levels manage to arrive at marriage before they have ever experienced sexual arousal to the point of complete climax. Many people are proud of this, and think it an ideal which the boy might very well follow. But the girl has achieved her so-called sublimation as a result of a long build-up of inhibitions. Against her record of no orgasms before marriage, the male she weds has a record of some thousand or fifteen hundred climaxes. One hardly needs to look further for the chief cause of sexual incompatibilities in marriage. One-half of all these previously unresponsive girls—that is one quarter to a third of all the women who marry—will fail to come to climax in intercourse after marriage.

In 1970, Masters and Johnson estimate that half of all marriages are sexually dysfunctional. Others, such as Waggoner (1974), feel that this is a conservative estimate. It is generally agreed that women are far more impaired than men, and that this is related to their lack of early sex experience. The overwhelming preponderance of orgasmic dysfunction in women is clearly related to their lack of early sex experience.

Although the young male commonly attains a climax efficiently, he is beset by other problems. He ruminates about the size of his penis, the persistence of his erection, or his ability to satisfy his mate. He experiences a pervasive sense of inad-

equacy which transforms the bed into an arena or, occasionally, a dunce stool. His anxiety precipitates premature ejaculation, retarded ejaculation, and impotence. His problems also emanate from childhood, especially from sexually blurred and unenthusiastic parenting. Fifty percent of all marriages are estimated to suffer from some form of sexual dysfunction. Sex clinics are manifesting an unprecedented expansion. Training programs for therapists are full, and couples who need treatment are placed on long waiting lists. Those who request aid are but a tiny fraction of those who could benefit. Some who request treatment cannot be helped.

How can we prevent this misery? The only possible prevention lies in the development of a positive, enthusiastic approach to children's sexuality. The roots of all dysfunctions extend back to early childhood, and even in the first year of their lives, we shape our children's capacity for pleasure. The sex drive is singularly vulnerable. It can be diverted, elaborated, constricted, or squelched. We need to understand and nourish the wellsprings of eroticism.

We have entered an exciting era of sexual enrichment. With Alex Comfort at bedside, we massage each other's feet, communicate fantasies, and abandon deodorants. Erotic art, once confined to San Francisco's North Beach, or Amsterdam's sex shops, is available at the comer newsstand. Yet we who frolic on the satin sheets of youth are strangely reticent with progeny.

Even the perception of the eager suckling infant is eclipsed by the need to deny erotic import. He is "cute," or "famished," but never passionate. Nursing is reduced to such aseptic components as calories and formulas. To nurse or not is a decision for or against an intensely erotic experience. Some mothers are rendered embarrassed and anxious by their own response. The nipple comes erect and hardens at the infant's eager approach. Seconds later the breast tingles as the milk spurts forcefully. The rhythmic tugging at the nipple elicits genital sensations. Some women experience

serial orgasms, and then drift into a refreshing slumber.

Fewer than twenty percent of mothers in the United States today nurse their infants. Many of those offer the breast as a duty, and soon abandon the effort. Very few are able simply and quietly to offer the teat and savor the sensations.

Those who choose not to nurse give reasons with which a good Victorian could have rationalized sexual abstinence. Breast-feeding is dirty, messy, embarrassing, and inconvenient. It can wreck mother's body, sag her appendages, derail her from productive efforts, sap her strength, and keep her from knowing how much milk her infant is getting. Nursing may make infants hard to wean because they like it too much. They may get too full, not receive their vitamins, or waste away. The central values are production, cleanliness, appearance, and the scientific method. Mutual pleasuring between mother and infant is conspicuously absent. In fact, the mother is thought to experience more pleasure if she doesn't nurse, for lactation will tie her down and make her less sexually attractive.

The woman who chooses to nurse in spite of these discomforts has at her command many strategies and appliances to ward off pleasure. She can allow her infant to suck only for specified periods through the porthole of her triply reinforced nursing bra. Though weary, she may sit upright, evacuating her teat at the infant's first sign of satiation. A relief bottle allows her to "rest." If still queasy at the infant's raw excitement, the uncontrolled squirting of the milk, and the moistened underwear, she soon begins to prefer the sterile bottle.

As we shall see, the skin-to-skin contact between mother and infant constitutes the basic erotic experience. These sensations also contribute to the most fundamental form of intimacy—body intimacy.

My mother was young and liberated in the 1920s. She attended college, and studied as the only female in the

department of anthropology of the graduate school at Harvard. She traveled to Europe, smoked, and drank. She had several affairs before she married my father. My father had been raised in a strict, prohibitionist family, where on Sunday children were permitted only to read the Bible. He was entranced by my liberated mother. Both my mother and father allowed me to see them naked and to join that bare expanse of skin beneath the covers on a Sunday morning. Recalling such earthy license, I was astonished years later to hear that my mother often refused my father sex. Her record for rejection was three years while in her thirties.

When my mother bathed me, she reserved the genital area until last. She scrubbed it harshly, indicating that I had better learn to wipe myself clean with the toilet tissue. When old enough to bathe myself, I avoided washing or touching that tainted area. At age five I contracted a vaginal infection. My mother took me to a gynecologist without assessing the problem herself. The doctor gingerly examined me while my mother commented on the stench. He recommended sitz baths. Night after night I sat for a half hour in three inches of tepid water well laced with boric acid. I thought my foulness would contaminate the water and cause a rash. I felt dirtier after bathing than before. The infection cleared up faster than my fantasies.

By the time I entered medical school, I was married and had borne two children. I still avoided tub baths and scrubbed hastily in the shower. I had never masturbated, climaxed, nor viewed my sexual organs in the mirror. I might have waited for Alex Comfort with the other unfortunates of my overactive but undersexed generation, had it not been for freshman anatomy. My cadaver was a female. I ruminated upon my own naïveté as I dissected her shriveled organs through the acrid fumes of formaldehyde. With scientific fervor I promised to investigate not only my anatomy, but my sexual function as well. With Grant's *Atlas of Anatomy* propped at bedside, I began my task.

The years that followed were crowded by work and children, carefully reared according to Dr. Spock. Above all, I avoided my mother's mistakes with my own offspring and made no connection between genitals and dirt. I didn't think my children had sexual problems. Indeed, there was little or no ostensible erotic activity, for which I was mildly thankful. One little girl did develop a passionate interest in playing "horsey." She wrapped her legs about my body and ecstatically rubbed her pubis up and down. Too sophisticated to push her away, I calmly but firmly placed her aside and rose to cook dinner. I refused to play "horsey" again.

My oldest daughters are now in their twenties. Separately, each has confided concern about an incomplete erotic response. How could this be? Didn't I read the right books? Hadn't I avoided the pitfalls of my own childhood? Belatedly, I realized that I had never said anything nice about sex. I had averted my eyes, studied my replies, hushed my husband's moans of pleasure, and locked the bedroom door.

Three generations had repeated.

2

PARENTING PAPERBACKS

UNFORTUNATELY, sexual and other revolutions are a lot of work with rather prosaic returns. The most that our generation can accomplish is a gradual disengagement from the misconceptions of our time. Our past remains to permeate the present. One less-than-liberated woman asks her physician if it is true that homosexual children result from the rear-entry coital position. Another inquires if it's wrong for her sixty-five-year-old husband still to want sex. An adolescent boy asks his coach if there is any way to prevent the wet dreams that impair his athletic prowess.

Each generation advances intellectually, but lags emotionally. A medical student and his young wife are able to speak about sex with his mother, a just-liberated matron. The young couple tests the depth of the mother's newfound philosophy by discussing many intimate details. The mother doesn't even blush. She replies with a shady joke and a sex manual quotation of her own. Finally, the young wife describes the intricate manipulations necessary for her vagina to lubricate. She suddenly turns and asks her mother-in-law, "What does it take for you to get juiced up, Mom?" The mother blushes, stammers, and is unable to answer.

Attitudes toward childhood masturbation have aptly illustrated changes in our attitudes toward sex. Prior to the eighteenth century, masturbation was condemned solely on

moral grounds. Thereafter, the habit became inexorably wedded to physical disease. Masturbation was said to cause insanity, tuberculosis, syphilis, eventual impotence, or sterility, and deformed children. Those unable to control their urges sometimes committed suicide in despair. Any indulgence was the forerunner of fatal addiction.

Treatment was so drastic as to seem macabre. One physician recommended that the clitoris be "freely excised either by scissors or knife—I always prefer the scissors." The nerves leading to the penis were cut, an operation which produced permanent impotence. This was a small price to pay for freedom from debilitating disease. (Baker, 1866) In fact, one disease was created in order to explain nocturnal emissions or "wet dreams." This disease, "spermatorrhea," connoted intrinsic evil and was a penalty for early, heavy masturbation. (Schwartz, 1973)

In 1854, Charles Drysdale presented the following ominous account of this condition:

> The victim wakes suddenly from a stupor, just as the discharge is pouring out, which he will try in vain to check; or perhaps he does not wake till it is over, and then, as a lethargic consciousness, which of itself tells him what has taken place, slowly awakens, he puts down his hand and sickens with despair, as he perceives the fatal drain, and thinks on the gloomy morrow which will follow. ... The patient may, after years of suffering, sink into the lowest stage of weakness, and die…the disease has in many cases progressed to insanity, and idiocy…

Gerhart Schwartz describes the profusion of mechanical devices to correct spermatorrhea which flooded an eager market. Most were spike-lined rings, to be placed about the penis at bedtime. Uncomfortable, but not unbearable without an erection, they produced excruciating pain when the penis distended. This immediately awakened the unfortunate wretch, who was then told to take a cold bath in order to relieve his excitation. Electric shocks and tight bandages

were also employed. In 1908, Miss Perkins, a nurse who worked in a sanitarium, wrote about the most secure and complete device to prevent masturbation. She called it "Sexual Armour":

> It is a deplorable but well-known fact that one of the most common causes of insanity, imbecility and feeble-mindedness, especially in youth, is due to masturbation or self-abuse. This is about equally true of both sexes. Physicians, nurses and attendants associated with insane asylums have long found this habit the most difficult of all bad practices to eradicate, because of the incessant attention required of them in respect to the subjects in their care. … Therefore, with persons who have carried on such disastrous practices until serious ailments of the mind have resulted, there has been but little hope of cure. …
>
> My profession has made me very familiar with this subject and the many melancholy human tragedies of this character which have transpired before my own eyes have impressed upon me the great necessity of a device which will aid those concerned in the treatment of such cases, and the cure from this disastrous practice, and which will at the same time give the person under treatment all necessary personal liberty.

Her contraption consisted of a steel and leather jacket which enveloped the entire lower torso. Perforations allowed urine to escape. A hinged trap-door, bolted and padlocked in back, was opened by a second individual in order to allow for defecation. Other such devices were sold accompanied by handcuffs for additional protection.

About the turn of the century, a Michigan physician described his patient, a girl of seven:

> She had been taught the habit by vicious children, at a country house from which she was adopted in the summer of 1895. I learned from the foster mother that on the advice of physicians she had given her worm remedies, they thinking that, perhaps, the irritation was due to the migration of pinworms. The parts had been kept thoroughly cleansed; she had been made to sleep

> in sheep-skin pants and jackets made into one garment with her hands tied to a collar about her neck; her feet were tied to the foot-board and by a strap about her waist she was fastened to the head-board so that she couldn't slide down in bed and use her heels; she had been reasoned with, scolded, and whipped, and in spite of it all she managed to keep up the habit.

This benevolent physician snipped and cleansed the tissue, thinking that the problem was due to irritation from infection. The first night after the operation, she tore off the dressings, opened up the wound with her fingers, and bled profusely. (Schwartz, 1973)

Although we often think of the United States as more advanced than its conservative European counterparts, concern with masturbation declined more slowly here. After World War I, supply houses still carried sexual restraints in their catalogues. Medical textbooks continued to mention mechanical devices, but noted their relative ineffectiveness in other than small children. As late as the 1970s a well-known textbook in urology mentioned several unfavorable conditions caused by self-manipulation.

Dr. Martha Wolfenstein has traced changes in attitude toward masturbation through her analysis of the publications of the United States Children's Bureau. Through the years these pamphlets have presented the accepted standards of child rearing. (Wolfenstein, 1953)

Between 1914 and 1921, the danger of children's sexuality was painfully evident. If not promptly and rigorously squelched, both thumb-sucking and masturbation would permanently damage the child. The prescribed treatment was to bind the hands and feet, the body spread-eagled on the bed, so that the child could not suck his thumb, touch the genitals, or even rub thighs together. Total eradication of any self-pleasuring was the goal of responsible parents.

In 1929, the focus of severity shifted to early rigorous bowel training, and exact feeding schedules. For the first

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