The Children's Hour

Fear and Trembling

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A Life in Child Psychiatry

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Terror in the house does roar."

- William Blake

In South Boston ("Southie" to natives) news travels fast. People know what their neighbors are up to and are fiercely loyal to their own. So when the bloody remains of Maggie McGarry's twelve-year-old twin girls were found behind their three-family house on the Monday after Easter, sorrow and alarm hit the streets and the headlines. Kira and Madeline had been raped and bludgeoned to death. There was only one witness, six-year-old Bernard, who was wakened by screams beneath his third-floor window. Peering down on the dimly lit end of his world, Bernard was able to identify, by his long, unruly hair, a sixteen-year-old high school dropout who had been making up to the twins without success. In a rage, he had taken by force what was otherwise denied him. Bernard's statement to the police was sufficiently detailed to charge, arrest, and incarcerate the assailant, whose DNA was present in fingernail scrapings from the girls.

Sui generis, childhood is a time of fear. Nightmares seem real; the storms of raw impulse are violent and often attributed to the outside world, thereby being disowned. *Grimm's Fairy Tales* are indeed grim, accurately reflecting the inner world of children that etches terror onto the ordinary. The benefits of downsizing dread, shrinking reality, are appreciated only later in life. Indeed, the adult world also finds great pleasure in scaring itself, if the success of horror films is indicative. All of this is the known and expected.

But for many children actual horror floods in, at times claiming their spirits, fixing memories and sometimes staining and warping their emerging characters. Certain catastrophes in certain children can forever change biology by creating and maintaining early warning systems, perpetual wariness, in a world that, long afterwards, remains ever hazardous and threatening —in which the demons of nightmares become real. Anna Freud, with her astute clinical eye, observed that children have a finite amount of substance from which to create the self. Children exposed to massive and/or repeated external danger construct an outer, protective "rind" at the expense of an inner world rich in fantasy, imagination and play. Internally such children become, much like Brink's trucks, rigid and constricted. They feel

empty. The "Battle Fatigue" of World Wars I and II and, more recently, Post-traumatic Stress are conditions to which children, too, are subject—in wars and natural disasters, on city streets, and sometimes within the frightening privacy of their homes and the bent, corroded circle of family.

I first met Bernard several weeks into the baseball season, and his Red Sox cap assured him choice seating in my office. A pale, slender, reticent boy with a quizzical half-smile, he willingly joined his mother and me. It has often struck me that tragedy frequently cannot be read in the faces of those it assails. The boring rituals of convention sometimes obscure horror and loss. Bernard's receptive manner did not reveal signs of the unnatural disaster that he and his family had just experienced. When a child has been confronted with terrifying danger, the initial therapeutic task is to recreate safety in one small space. That was my goal in the first several, unusually quiet sessions with him. He was drawn to a collection of plastic soldiers in the various poses of war. Play is the equivalent of speech in children. Play in healthy children is scripted by fantasy and imagination. In traumatized children play more often reflects events or experiences that actually happened. Moreover, one sees repetitive play sequences that seem to reflect unconscious efforts to master trauma through its reenactment. A three- year-old girl was referred to me years ago after the wagon she was riding in tumbled into the street in front of an oncoming car. Fear is infectious, and her mother's terror spread to the child, who was clingy, lost bowel control, and wakened at night in alarm. The cure came quickly: again and again she upended a tiny toy wagon in my office, to the accompaniment of the screeching brakes she simulated. Within two weeks her symptoms abated.

Bernard made a fort from Legos and placed one army inside the fort and another assault force outside. There was a lookout post with a window that received special care. A "recon" scout kept careful watch from that site. Bernard did not engage in direct discussion of his sisters' deaths for several weeks. The armies were his voice, the scout his personal narrator. The pyrotechnics and sound effects were chilling, and colleagues in adjacent offices wondered whether Armageddon had found its way to my office. Naturally, the strike force within the fort's four walls was regularly victorious. At times the enemy without took hostages, often two, who were tortured and manhandled by their interrogators. These play sequences closely resembled the murder of Bernard's sisters. I waited for my openings. Bernard permitted me to play the well-positioned scout. I commented on the dangers about, the soldiers' vulnerability, the terror of an ambush, the need for medics, and the burial of the war dead on both sides.

According to his mother, Bernard had abandoned friends. She herself was overwhelmed by sorrow, further straining Bernard's supports. I told my wife that I imagined bringing him home, adopting him. It was a fantasy, of course, my response to his needs. If I count the number of children waiting in line for my family's care over the years, it would put Mia Farrow and Angelina Jolie to shame. Gradually, over the weeks of summer and fall, Bernard began to draw pictures of his house and the crime scene. His words were spare, addressing his dread in watching his sisters die. He visited their grave once weekly with his mother and began to weep at the graveside. The newspapers covered the case and the forthcoming trial. Bernard's anxiety rose again, since he wondered if the murderer would come after him for being a *stoolie.* "What if he breaks out of jail? He knows my house, and our dog never barks at strangers. Or maybe he'll get a friend to take me out." It was hard to reassure him that his fears were groundless. For the rest of his life, I supposed, no fears would be groundless for Bernard.

Tentatively, haltingly at first, after many weeks we began to assemble the jagged fragments of Bernard's life. His dreams re-played the murders but woke him less often. I had the impression that this disaster was becoming encapsulated, like an abscess, but I knew better than to lance it now. There would be ample time for further drainage in the years to come. He began bringing in the sports page to discuss the prospects for the Sox. He sought the company of friends he had avoided for a time, and his schoolwork improved. The trial court awarded Bernard substantial monies for future psychotherapy.

When Bernard was referred to me I welcomed the opportunity to help him and his family recreate their shattered universe. I knew that I was revisiting a sad land unfortunately known to me since the death of my second son, Nicholas. Nicholas was riding his bike during a family vacation in France when he was hit by a car. He died several hours later. There were moments in the work with Bernard and his family, and with many other patients in similar straits, none of whom knew of my son's death, when my own sorrow and memories surfaced. Surely I was mastering my trauma as well as theirs. I knew of a child's bloody, broken body, of unspeakable horror, futile rage at the missing, the silence louder than the noise of life, and the empty, shadowy inner theater where, without audience and unknown to the outside world, a distracting documentary runs night and day. In such instances as Bernard's, I help and am helped; but I am very careful, as anyone in similar circumstances needs to be, to maintain the professional boundary that allows me, by virtue of my own experiences, to better serve my patients. They are not there to serve me. The use of my pain is respect for and remembrance of the dead. My *yahrzeit* for

Nicholas.

Maria, a plump, loud, unruly six-year-old with hair akimbo, was seen once during a hospital inpatient consultation. She was referred to the unit after threatening her infant brother with a kitchen knife. Brutal, impulsive violence was the lullaby of her early years: her mother was beaten regularly by a succession of drunken, explosive men whose tantrums Maria feared and hated. In hospital she only permitted female staff to touch or approach, watchfully avoiding the company of men. Her nights were full of agitation and, according to staff, she rarely slept, hyper-alert and startled by the slightest ambient sounds. I was asked to evaluate this state of eternal arousal, this internal, summer Lapland where night is day and sleep denied.

I could approach Maria only as she sat on the lap of a nurse she had befriended. She vocally protested my presence and assured me with blazing eyes that she would not talk, would not utter a word, and to demonstrate her determination pursed her lips into a hard, straight, bloodless line of grim defiance. In such situations I have learned to practice, in memory of Gary Cooper, a dialogue that is a monologue requiring no answers. Puzzled by my enthusiastic support of her silence, Maria occasionally glanced at me furtively. I began narrating the life of a child I knew who was always upset, a girl just her age who was always frightened by the loud noise of fights in her house.

Maria could not resist and asked if it was someone she knew. This *doppelganger,* I went on, was always scared and very angry that her mommy did not protect her from such chaos. Maria nodded. And, I added, many times she wanted to run away and find a mother who really loved her. Maria turned to her nurse and whispered, "I run away a lot," then sank farther into the soft, ample cushion of her caregiver's lap. I shared with Maria, avoiding her gaze, that this child needed to know that she was safe, that her mommy was safe, and that even six-year-olds can dial 911. With this apparently novel advice, Maria's eyelids began to droop. The police, I reminded her, were ready night and day, waiting to protect little girls and carry off noisy, dangerous men. And did she know any lady police ? They were just as strong as the men. Maria, barely nodding, fell into a peaceful sleep, her body's taut cables uncoiling for the first time. I hoped she was dreaming of a career in public safety; it is never too early to plant the seeds of a vocation, of competence and self-respect that may transform the open wounds of trauma into a viable future.

Post-traumatic Stress Disorder has become lucrative. Many lawsuits are considered or initiated with the intent to prove psychological damages resulting from calamities of one sort or another that a generation ago would have been taken as the luck of the draw: auto accidents, predatory teachers and circumcisions that go awry. In children especially, the prediction of future damages becomes relevant but murky. Hippocrates was not a fortune-teller. And Nature not infrequently confounds clinicians as well as meteorologists, welcome proof that mankind controls less than it thinks. Child and adolescent psychiatrists are often asked to become experts in such cases. Humility, integrity, thoroughness and a sense of humor are paramount to practitioners who enter these lists. Fondness for chess and detective work are also helpful.

Particularly fascinating to me are the children who do not develop symptoms when exposed to the same events as their afflicted peers. This hopeful puzzle, for it speaks to resilience, is especially evident in evaluating groups of children in identical circumstances. A school board rightfully besieged by worried and irate parents asked me to interview ten female adolescents molested by a troubled janitor four years earlier. Five of these young women, despite vivid memories of clear abuse, were spirited teens, free of post-traumatic stigmata, and eager to share with me their academic, social or athletic success. Others were plagued by agonizing shyness, shame about their bodies, nightmares recalling the experience and intrusive, disturbing "flashbacks." Two had neither memories nor detectable *sequelae* and were optimistic about the future. The melodramatic, extravagant claims of one girl were simply not credible. These varied outcomes are characteristic of responses to major stressors and underscore the importance of protective factors in determining whether any one child will succumb to trauma.

There are some children who, finding themselves in sudden, terrifying or even life-threatening circumstances, show few if any overt signs of trouble until months or years later when a hidden memory rises to consciousness, often prodded by a sight, sound or setting linked to the original trauma. Willie, a thirteen-year-old little league ace, was an outstanding student, good friend and seemingly solid boy. Everyone praised him. He loved animals and at age nine had played with a neighbor's dog in his backyard. Without warning the dog had turned on Willie, attacking him viciously, lacerating his face and dragging him to the ground. Only a passing motorists rescue efforts freed Willie, who then went by ambulance to the hospital. Several surgeries were required to repair the damage. Willie's life did not change much thereafter; his supportive and unflappable parents helped their son through this crisis

with their steady ways. Four years later Willie happened on a dog resembling the attacker in a similar setting and became acutely depressed. Flashbacks of the original incident flooded his mind and the isolated phrase "I will die" floated in and out of his awareness, always accompanied by terror and despair. He recalled that this grim prediction had silently possessed him as he rode to the hospital after the dog's attack. Psychotherapy was strongly recommended to bring peace to this thoughtful, sensitive, fundamentally healthy boy.

Bill Sack, a colleague and good friend, has studied the adjustment of adolescent Cambodian immigrants to this country over the past twenty years. All of these youths witnessed carnage, torture, the killing of friends and family, and the destruction of their homes. They left their country to enter a new, strange land without the benefits of a familiar language, familiar landscape, or friends. Like the survivors of other Holocausts, their memories are shards of pain that tear, continuously and without warning, through the fabric of the ordinary, prompted by a sight, a sound, a smell, a taste. Without the ordinary we can neither assemble nor reassemble our lives. But many of these youths move forward, becoming successful students, entrepreneurs, professionals and even politicians. Their minds remain beleaguered by flashbacks of horror that run simultaneously and in parallel with hopefulness, will and the mastery of new tasks. Those who not only survive but prevail over the horror of their earlier lives have in common the reliable presence, through the turmoil, of one loving, devoted adult: a necessary and sufficient condition to live tolerably in the presence of pain while addressing the needs of present and future. One loving adult helps the eye stay focused not on what was but on what is or is yet to come.

While trauma may atrophy, loosen its grip on the mind, with and sometimes without therapeutic help, there are situations in childhood where that grip tightens and expands. In these cases it becomes difficult for the clinician to differentiate the flashbacks of post-traumatic stress from the hallucinations of psychosis. I have wondered, in fact, whether in some situations the discontinuous, episodic flashbacks of trauma become increasingly fixed and, when finally immobile, come to rest in the form of madness. I once interviewed a twelve-year-old girl, Abbey, in a diagnostic seminar. A flushed, sweaty, pallid youngster, she appeared terrified of unidentified dangers, entering the interviewing room as a camera, scanning every face, every object of furniture and every door before seating herself near me.

As I learned about Abbey's life, she alleged that an older brother had repeatedly raped her over

several years. As she haltingly recounted this horror, she glanced in all directions, groaning and wringing her hands; her eyes finally lighted upon a cabinet of dark wood at which she stared intently with mounting dread. "There he is, there he is again, oh no, no, no." Calming after some minutes, Abbey was able to describe the image of her brother's face glaring at her, menacing her, on the cabinet door in much the same manner that the face of Jacob Marley appeared to Scrooge on the knocker of his front entrance. These apparitions were more or less constant for Abbey, pursuing her in any place at any time. Her dread and dysfunction were of such proportions as to bring her daily life to a halt. In effect, she was psychotic without the fully expressed stigmata of psychosis. Just as a recurrent, obsessional thought, such as a hypochondriacal concern, can merge into the delusional, becoming fact rather than fancy, so it was with Abbey's visions of her brother. What then is mental illness? Whence does it come, inside out or outside in? Is it possible to observe the birth and life of madness in the laboratory of trauma—to see outer events enter the mind and brain, not just as memories but as larger, more malignant presences that metastasize to all corners of being? These questions, like the work that prompts them, display a terrible beauty.

The admonition of Sophocles, "Count no man fortunate until the day he dies," seems wisely to acknowledge the inevitability of misfortune throughout the course of life. That every man comes, sooner or later, face to face with horror is all too true. Most such events go unreported and, sometimes, unnoticed. But when these confrontations take place in childhood their volume is louder, the space they occupy larger, and their insinuation into the developing self more profound. Whether affected by single events, or years of exposure as in wars or urban ghetto life, the course of an afflicted child's life veers and recovers, or falls off the track of development. Child psychiatrists can sometimes provide a road map, without shortcuts, toward the resumption of travel in the right direction. I have come to see that the presence or persistence of post-traumatic symptoms need not outweigh the healthy capacity to live. One can live, even well, with horror if it is managed, contained or kept at bay. Health matters, illness sometimes does not. We can walk on one leg, see with one eye, write with one hand despite the fates. The soul, not the body, needs symmetry.