The Children's Hour

Of Human Bondage

Kenneth S. Robson, M.D.

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A Life in Child Psychiatry

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Only Connect.

- E.M. Forster

My days as an intern in pediatrics were long, my nights longer, and sleep either brief or absent. Especially after midnight the semi-darkness and silence pervading the usually frantic, well-lit hospital wards granted me temporary repose in an atmosphere of dim, fluorescent aloneness. Warmth at these times was welcome, reassuring. In the early morning hours of one such night, passing a crib on the toddler unit, I was assailed by the beseeching arms and Rossetti-like visage of a blonde, wide-eyed, two-year-old girl. Her insistent hugs seemed personal. But by the light of day she was a tiny, indiscriminate siren, promiscuously luring all who passed into her embrace, but soon moving on to the next comer with no deeper contact than a politician campaigning for office. Infection had brought her to the hospital, but her more serious, debilitating illness was a grave and permanent deficiency disease: the incapacity to attach to another, spawned in the early months of life by the psychological absence of her depressed and overwhelmed mother.

As with the Greylag Geese of Konrad Lorenz, there is a critical time period for human infants to connect to their caregivers. When this time passes without the process of attachment running its expectable course, impairments in trust, friendship and empathy result. Children suffering such "detachment" are everywhere and nowhere, unable to live well, love well, die well, or be alone. Relationships remain exploitive and need-fulfilling, serving an empty master whose internal attic contains few or no recorded images of being loved. As adults, these unfortunates fill their worlds with noise to quell the silence and emptiness within. They lack the capacity to be alone since they cannot soothe themselves with internal resources.

Karl, a superficially charming twenty-seven-year-old actor, an Alan Ladd look-alike, lived in constant dread of nights spent alone. He sought the physical company of any partner, male or female, who would sleep with him. These anonymous bed warmers were callously discarded the next morning after assuaging Karl's terror of aloneness for yet another night. After two or three sessions of psychotherapy, which he had sought in desperation at the time of his mother's death, he became aware

that his hit-and-run mode of existence had been present since his earliest years. With my support (though it could have been anyone's) his acute pain diminished. At this point, however, he had no stomach for reflecting on the fleeting nature of his contacts as a problem; relief of immediate pain was enough. Since he remained fearful of genuine, enduring closeness, he jettisoned me, with predictable indifference, as another encumbrance to whatever he could garner in life. For Karl there were no connections. He was an adult version of the toddler whose crib I was unable to pass.

Since most children successfully form attachments during the first years of life, it is not the absence of connection but the rupture of these ties that composes the more common paradigm of loss, grief and mourning in childhood. The many symptoms and behaviors that children present, which are formally classified as illness, are often better understood and worked with by focusing on the centrality of loss or anticipated loss, for child, parent or both, rather than describing the more dramatic and less painful elements of the clinical profile. Separation and loss are signals; symptoms are noise. Grief sustained in childhood is remarkably intense when compared to its adult counterpart, both for the child and those around her. The child's tenuous defense mechanisms coupled with the unstable nature of the developing self account for the flood of emotion that loss or death in childhood unleashes. The thin lattices of being, like newly forming ice on a pond, come easily asunder. Denial of such pain in the observing adult is preferable to sinking into the frigid, salty waters of despair. It is no different with the elderly whom we often do not listen to, or if we do, whose painful, unedited truths we disregard.

When Beth's grief finally surfaced, I struggled to listen. Beth and her father adored each other. From birth through her first two years, their days began with the myriad rhymes, rituals and games loving parents invent and reinvent. A favorite involved her father wiggling her big toes while singing new ditties to his giggling, enraptured audience. Beth did not forget. On a business trip from Hartford to Washington, his car vaulted the guard rail. He died instantly. Like all two-year-olds, she had no cognitive tools, other than fantasy, with which to comprehend the incomprehensible or its aftermath. In childhood the death of a parent spawns two losses, the absent dead and the remaining but grief-stricken parent—another death, though in life. On the day of her father's death, and for many days thereafter, Beth's mother wept ceaselessly, overcome by her own pain, unable to respond to her daughter. Beth repeatedly mounted the living room couch, watching through the front window, waiting on her accustomed perch for her father's return. Increasingly puzzled and furious, Beth soiled the living room floor, a last straw to

which her mother responded with understandable rage. Previously an impeccably clean youngster, Beth now soiled several times a day, bringing her to my care one year after her father's death.

At three Beth was a plucky, impudent gamin with long blonde hair, finely chiseled features, and piercing green eyes whose gaze, quite independent of her prevailing mood, remained mischievous. While she wore an air of jaunty, self-assured insouciance, many years later she shared with me the terror and despair with which her inner, private world had been furnished. Still, she was acutely observant. In the waiting room, prior to my first visit with her, Beth spilled a bag of marbles she had in tow, a piece of home and comfort. Cleverly, I wisecracked that there was no better place to lose one's marbles. Twenty-five years later, she remembered. In transit to my office she took my hand easily. Like most tiny children, she looked downward, at her shoes or mine. She would also recall that view. Her chatter, head cocked, was full of the malapropisms of the young; it tinkled and charmed.

The child psychiatrist must recognize and respect boundaries. Children in need like Beth are especially vulnerable. She became very important to me and I to her. Devotion, concern and deep affection, in effect love, are indispensable elements for a psychotherapist. Neutrality, as described in the texts, is foreign to me. In my field the relationship is the central component of therapeutic success. However, a profession that deals in broken hearts requires its members to be alert to indulgence of their own needs, exploitation of those of their patients, or both.

Beth's fecal soiling was an anomalous symptom. The smell of feces or flatus is a universal icon of disgust. In childhood, anal matters are the basis of humor and embarrassment intense enough to deny one's own responsibilities for flatus and its smells. No normal child relishes being literally stinky or, derivatively, a stinker. But encopretic children, predominantly boys, seem oblivious to these powerful social conventions, willing to offend in any setting or circumstance without apparent awareness of the consequences; they are willing to sit in school, for example, with a mess in their pants until the teacher can no longer tolerate the smell. To further complicate matters, physical symptoms such as soiling that lodge in bodily sites, out of mind, are literally unspeakable. They cannot be translated into feelings or relationship problems; their somatic code cannot be broken, so they resist discussion in psychotherapy. Encopresis is notoriously insulated from language. Children will neither acknowledge nor converse about the obvious, the Emperor's new but soiled clothes.

Beth and I connected quickly. In the initial weeks of meeting with her there were no words or play that seemed related to her father. And while no direct information about her soiling surfaced, she focused attention on a Play-Doh factory that had the capacity to squeeze out long, messy cylinders of paste, a labor she industriously repeated until it became ritualized as the opening scene of every session. Beth also enjoyed finger painting, excitedly creating broad, thick swatches in black or brown but remaining stubbornly reluctant to identify the subject of her art when I was unwise enough to pursue its provenance. I assumed that these aspects of Beth's play related to her soiling and that she had been furious about her father's disappearance which her mother, wrapped in her own sorrow, had never explained. Did her now habitual messing signal an angry reproach toward her mother, who had not only taken her father away but neglected Beth since his disappearance? Did such profound distress on mother's part mean Beth had done something terribly bad, terribly wrong? I looked for answers to these questions in Beth's pictures, play and fantasies.

If these translations of her soiling were accurate, a straightforward, maternal apology was overdue. It was tendered, opening up a barrage of equally overdue questions on Beth's part: Where was daddy? Why didn't he come home? Wouldn't he come back if they called him? Didn't he like them anymore?

Or was he, like mother, angry that she had pooped on the floor, so angry that he was staying away to punish her? She knew that her mother had stepped into feces lying in her path and had seen the rageful result. For three-year-olds, chance and the uncertainty principle do not exist. Randomness is not credible: all events occur in a deterministic world within which the egocentric child is cause, the *deus ex machina*. As her mother and I answered these questions, Beth's soiling slowed, became intermittent and, after some weeks, stopped altogether, although tantrums seemed more frequent. In the office her fascination with Play-Doh and finger paint waned. But, cleaning up this aspect of her act did not bring her father home. Certainty that he would never willingly abandon her led to new hypotheses to account for his absence.

Classical Greek tragedies take their story lines from universal, developmental fantasies of childhood, beautiful for the clinician to witness, though often ghastly. Beth had seen her mother's rages repeatedly, at her father, at her. These crazed eruptions were terrifying. To Beth, mother was dangerous. Beth wondered if she was unbearably envious of a daughter's loving intimacy with father. No longer her

husband's single love, had mother punished Beth, now a hated rival, by making certain that neither of them possessed him, magically destroying him? Such fantasized love triangles are the fabric of ancient myths such as that in which Clytemnestra murders Agamemnon, breaking Electra's heart. Much great art, of whatever medium, emerges from the creator's transformation of such real life dramas as separation, reunion, rivalry and loss. To Beth this patricidal script was real. Sadly, when fantasies and external reality mirror one another, the imagined takes on the quality of fact. Closeness to men became hazardous to Beth, proximate to lurking disaster and death. She played out these concerns with dollhouse figures in my office for some months. But such efforts were not sufficient to protect her from her past, her future or her imagination.

I worked with Beth for two years. What I assumed was the final phase of our therapy dealt with the persisting enigma of mortality. The understanding that death is permanent is rarely accomplished before the age of nine or ten. Beth, at age five, had neither attended her father's funeral nor visited his grave. She struggled to digest her father's death without success. It seemed that Easter, the season of death and transfiguration, would never come in her fourth year; winter was bitterly persistent. In the midst of preparing the eggs for the family hunt, Beth told her mother that she wanted her father to be in attendance. She dictated an invitation, asking her mother to share it with me:

> *Dear Dr. Robson,*
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> *I want to say that I love him. I want to say that I'm going to send an Easter card to him. Now I want to tell him that we're going to send another Easter card to him from my mommy. We're going to Washington and we'll see him in the spring. Can't go now because it's too cold and windy.*

Love,

Beth

Her signature was spread in bold letters across the page, the "h" lying, somewhat forlornly, on its side.

Some weeks later, without warning, in the midst of a session with me, Beth interrupted her play, stood transfixed, eyeing me from across the room, and uttered in a barely audible voice: "My daddy is in a box in the ground. He can't eat, he can't talk and he doesn't wake up." I nodded silently, flooded with her sadness and my own tears. I reminded Beth that neither her soiling nor love for her father had led to this

unhappy, still partially grasped reality.

Soon thereafter I stopped seeing Beth and her mother. It was a natural time for interruption, as the fog surrounding her loss was lifting. Four years later (she was now nine), I met Beth again. By chance she, her mother and I were attending the same holiday party. I was delighted to see them and to learn that Beth was apparently doing well. Her mother turned to Beth and asked, "Do you remember Dr. Robson?" Beth shyly turned to me and nodded no. Then, peering down at my shoes, her prevailing view of me at three, she surveyed me again from my soles to my head, nodded in the affirmative, and smiled. Shoes made the man.

Losses such as Beth sustained distort relationships and reality. Parting in certain situations can even be lethal. This is particularly true for the victims of asthma, "the illness of terror." For the afflicted child a serious attack simulates suffocation, or drowning. For the parent of such a child, the random onset and danger of attacks creates an attachment demanding more or less constant apprehension and scrutiny. Separation is one of several situational stressors that can precipitate symptoms, leaving parent and child perpetually in fear of parting. Psychotherapy in these circumstances revolves around strengthening the sense of mastery and competence in the child. Tod was a severe asthmatic. Afflicted since age four, he was ten when I was asked by his pediatrician to reduce his mother's anxiety. Medical control of his attacks was poor; he had entered the hospital on multiple occasions with his breathing seriously compromised. His parents had struggled to maintain a sense of normalcy in Tod's life and their own. I was struck by Tod's own efforts in that direction: he appeared a robust boy with a warm smile. He dressed like his peers. He loved Elvis.

But his moon face, a product of chronic use of corticosteroids, and barrel chest, resulting from increasing efforts to maintain normal breathing, gave notice of his illness. The goals of therapeutic efforts with Tod and his family were aimed at his gradually assuming more responsibility for anticipating attacks and administering medication before his wheezing reached dangerous levels. At night, in darkness and separated from his mother, he felt especially vulnerable. By morning he often ended up at the foot of his parents' bed in the sleeping bag kept there as an outpost of safety. While slow progress was evident, the acceleration of his disease led to a decision on his pediatrician's part to send Tod to a hospital in Arizona. There he was to remain, separated from his parents, for months or longer.

Anticipating the dread of this decision, I saw both Tod and his parents more often as the departure date approached. He was to travel to Tucson with a nurse but no family members. He managed a wan smile the day prior to his departure. I was called that evening by the Emergency Room near Tod's home. Tod had arrived there *in status asthmaticus*—a state of uninterrupted asthmatic attacks. Tod was carried into the hospital and died several hours later. "Parting," Emily Dickinson wrote, "is all we know of heaven and all we need of Hell." Tod's funeral, which I attended, seemed dream-like and muted, cast in the pastels of a Fellini film. I shared in the family's sorrow.

His parents, with whom I had established a close relationship, asked to meet with me shortly after his death. Grieving, guilty and angry, they wondered what they or anyone involved in Tod's care could have or should have done. Already they were discussing having another child, a course of action I strongly discouraged, knowing that children who replace a dead sibling fare poorly in many instances, both they and their parents haunted by the ghost of an unknown, larger-than-life, idealized presence with whom they cannot complete and are sometimes confused. Some five years later Tod's parents sought me out again. They had a new son, now four, who was born, almost to the day, on the second anniversary of Tod's death. He had just developed early symptoms of asthma. Driven by the unbearable loss of their son, this second chapter of a sad book reconfirmed my professional impotence in the face of a fated or ill-fated drama. This visit from his parents also highlighted an unfortunate pattern of human behavior: the powerful tendency to repeat or reinvent past traumas. Freud called this "the repetition compulsion."

Beth's life went forward. Her mother remarried a decent man who reached out to his new step-daughter. But, convinced of the dangers of that closeness by her father's death, she resisted her own longings, staying at arm's length from him as she entered puberty and adolescence. The bad cards of fortune are not always random: her step-father died from acute leukemia. Later I met Beth, now twenty, in a hospital parking lot. She was pregnant and married. Our contact was fleeting. Then, at the age of thirty she asked to meet with me. Now a tall, slender woman dressed in black, her eyes were instantly recognizable, as if the three-year-old I'd known so well lingered, unchanged by time, living within an adult's body like the smallest figure in a Russian doll. Her seeking me out was a kind of homecoming for both of us. She was in deep distress, desperate and suicidal. A well-meaning therapist, after hearing her life story, had insisted that she visit, for the first time, her father's grave to "begin healing." This misguided effort unleashed a torrent of memories and dreams in Beth: bodies rising from the earth as in

Revelations, unresolved feelings and memories flooding her days and nights. Mistrust of closeness to men continued to plague her despite her husband's apparent reliability. She had borne two children but they, it seemed, mothered her. My thrill at seeing Beth after so many years was tempered by the depth of the psychological scars she bore, and by my recognition that my work with her had not diminished the power of more malignant strains in her life. A favorite nostrum of one of my old teachers, an auto mechanic before he entered medical school, was "We don't make 'em, we just service 'em." A candid reminder of my profession's limitations.

I was able to facilitate Beth's resumption of therapy and support her accepting the care she sought but feared. Her life had been difficult. Her many wounds remained open and raw. She took the presence of her pain as a reminder that she should look backwards, exhume her father and her memories of her earliest years. This mission had already proven hazardous to Beth, and I warned her that it might be safer and more helpful to quiet the troubled waters of her present life before seeking to calm the stormy seas of her past. Some days after Beth's visit I received a package: a bag of marbles and a note that read: "I haven't lost them yet." Beth lives in me just as I live in her. Her marbles and her note, now framed, sit on my office desk, a precious connection linking present to past with timeless, bittersweet memories and a shared sorrow in both our hearts.

If one views the practice of child and adolescent psychiatry as a musical composition, it would read "theme and variations." The central needs of human life are few: to be healthy, to be loved, to be competent at some form of endeavor, to be able to laugh and to play. The variations on these themes comprise the beauty of the field, each presentation the same but different, the differences highlighting the elegant nuances and overtones that ultimately draw one back to the center. Monet painted one haystack many times and Cezanne one Mt. Sainte-Victoire. In my field, attachment, separation and loss are played as the opening bars by the French horn and are repeated by the strings in a coda's closing notes.