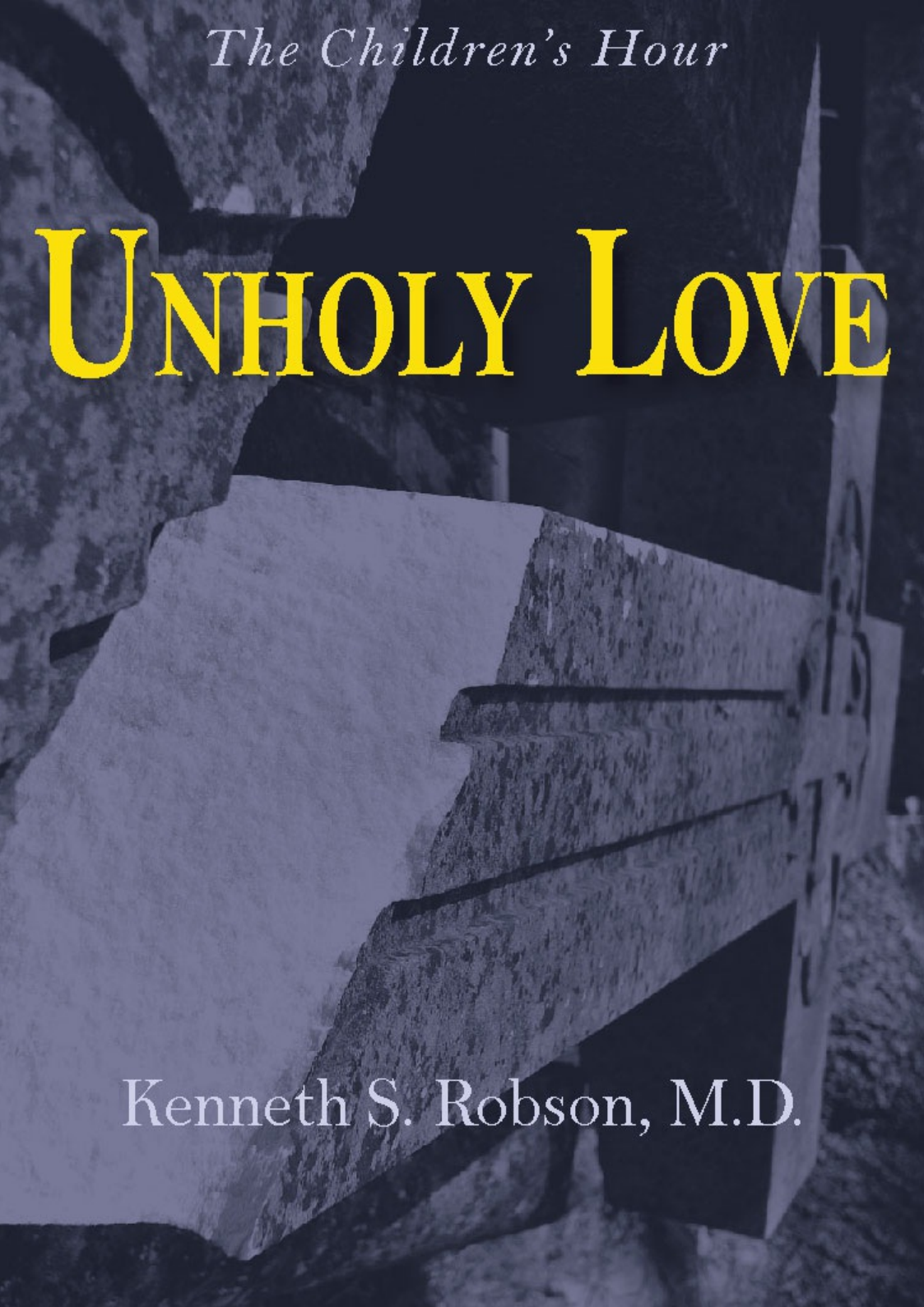
The Children's Hour

UNHOLY LOVE



Kenneth S. Robson, M.D.

The Children's Hour:

A Life in Child Psychiatry

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Unholy Love

Her parthenogenetic birth from. Adam's body makes Eve his daughter so that the Judeo-Christian tradition rests on a primal father-daughter incest motif.

- Naomi Goodman

Tess loathed her husband's body: his long muscular torso, hirsute back, and, especially, his genitals. A hug or caress from him set her on edge, filled her with apprehension and disgust at the prospect of sexual intimacies. In her fifth year of marriage, she was the mother of three young children. After the birth of her first child, intercourse became painful then repugnant. Over time she began to avoid all physical contact with her husband who, though a gentle, somewhat passive man, was increasingly puzzled and hurt. A tall, buxom woman, Tess was flirtatious, quietly seductive in her public persona. She longed for extra-marital affairs, "sex without complications." Privately, she showed occasional flashes of self-deprecating humor but more often was grimly intense. While referred initially for her chronic depression, she soon revealed how fully her attitudes toward sex with her spouse preoccupied her, leading to serious reflection on divorce. To abhor sex with him was, increasingly, to abhor the totality of his presence in her life.

As Tess explored with me the history of her sexuality, the dynamics of her family of origin became more transparent. Her mother was a brittle, self-centered woman with limited capacity for warmth, while the father, handsome and ebullient, was open and spontaneous with his loving, possessive feelings for his daughter. It was he who had provided the swaddling embraces that Tess craved. At twelve Tess was lectured by her father on the dangers of dating, of naive trust in what was the sexually exploitive intent of most males. Standing sternly over her, crowding her, he began to fondle her buttocks. She was frozen, stunned. The details of this scene were scorched into her memory: her father's sweaty smell, his breathing, his flushed ruddy face, the feel of his hands on her flesh, the heat of it all. His fondling continued through Tess's early adolescent years. Her only means of preserving the closeness to him now was to paint over this inexplicable violation with psychological whiteout, eliminate it from conscious awareness. Like most abscesses, it remained encapsulated until her marital sex life began. Then, fragment by fragment, it drained, surfaced and reassembled itself in consciousness. Her now unedited memory, like a pornographic film strip, became the focus of her attention during foreplay and

penetration with her husband, fusing so that memory and partner, father and husband, past and present became one, filling Tess with repulsion and dread. So powerful was this perception that during their infrequent sexual encounters, Tess began to silently repeat to herself a mantra: "You're not my father, you're not my father."

In therapy we struggled to make sense of her father's startling behavior. Tess's rage flowered and spread, like poison gas, to all men except her sons, whom she idealized and physically "loved to death." Try as I might to separate her past paternal relationship from her marriage, boundaries would not rise. The time warp of memory had petrified. She tired of such painstaking work. Her depression deepened, she seriously considered suicide but opted for a grave but less lethal option: initiating divorce proceedings. She abruptly withdrew from her therapy against my advice. Her husband had become the repository of all that was bad and, leaving him, she again preserved her present relationship with her supportive father whom she chose not to confront with his prior behavior. Tess moved to the deep South, taking with her the burden of her frightened, twelve-year-old self, very much alive within, but not well. She remarried, though I do not know the course of her new life. I do know that Freud was correct in asserting that character is destiny and that Tess's future remained bound to her past.

The erotic and sexual aspects of children's lives are obscured in the shadows of society's anxiety and denial; incestuous relations are especially alarming. From Freud to Sophocles, such impulses have been seen as the stuff of high drama and psychic torment but rarely as natural, necessary, useful partners to self and gender-development. While sexuality is central in human affairs, there is a tendency to view the erotic life of children prior to puberty as either absent or as harmless play, and puberty as a biological stranger, a sudden, ill-fitting visitation without past or future, arriving uninvited from parts unknown. The idea that there is a complex, continuous evolution to the sexual life of children, beginning with birth itself, is seen as an aberrant belief of cranks and perverts. But if comfort with one's physical self, sensuality, sexual arousal and safe, modulated, loving closeness are not learned as unified parts of a whole in infancy and childhood, they invariably remain isolated from one another thereafter. Such is the reason that in adult life the comfortable union of intimate relatedness and sexuality is all too often not accomplished. These are two crucial competencies more often evolving as independent, unrelated, parallel developmental trajectories that go their separate ways. The psychological chasm between intimacy and sexuality, evident in Tess, is present in myriad failed relationships and contributes

significantly to human loneliness, estrangement and difficulty sustaining long-term connections with a partner.

The child psychiatrist, if he or she can tolerate what is clearly in view, is witness to this developmental line of sexuality as it unfurls within the child and his family. Like other developmental phenomena, emerging sexuality is determined by genetic influences, temperament, parent-infant interaction and social mores. At one end of that curve lie emotional constriction and inhibition of eroticism; at the other extreme, one finds incest and/or sexual abuse. These polar opposites both lead to developmental impairments. Between these extremes, over a long continuum, one finds both the many varieties of healthy sexuality and the common but highly malignant sexual over-stimulation of children, perhaps less visible but more damaging to the developing child's capacities than incest or abuse. No engine, no developing ego, can run when persistently flooded. The common sources of such unmodulated, sensory overload include constitutional inability to "gate out" or filter incoming stimuli and/or family lifestyles that are intense, arousing and uninsulated. Such stimuli and lifestyles produce children who are like pianos without damping pedals. Parental empathy and accommodation to an infant's particular style and temperament are essential in fostering self-regulation and control, porcelain-coating the overheated wires of developing sexuality.

As noted above (see Chapter One) what Winnicott called "primary maternal [parental] preoccupation" with newborns is in fact being in love. He saw this state as essential for both parent and infant attachment and later life outcomes. He did not discuss the inseparable connection between the arousal of wishing to fuse and merge with the other and the sexual desire that is part of being in love at any age. The nuzzling, caressing, cuddling, cooing, biting, stroking and sucking between mothers and their infants reappear as the foreplay of adult sexual relatedness. A small sub-group of normal mothers come to orgasm when nursing. Only in our species is the breast both a source of nourishment and an organ of sexual arousal. If incestuous impulses were not powerful, the rigid societal taboos against them would not exist. I have wondered whether their presence, when appropriately governed, can be considered adaptive in our species, facilitating both durable attachment of parents to their young as well as successful melding of intimacy and sexuality in the developing infant and child. Incestuous desires become maladaptive at either end of the bell-shaped curve: when anxious, constricted adults recoil from physical contact with their young or, conversely, have or exercise insufficient control over those same

impulses, as with Tess's father. The curriculum for the coming together of intimacy and sexuality begins at birth. Its healthy completion depends upon the psychological integrity, capacity for restraint and respect for boundaries with which parents raise their young.

Winnicott also described two distinct modes of contact between parents and their offspring: the "orgiastic" style characterized by over-stimulation, lack of interpersonal boundaries and overwhelming excitement, in contrast to the empathic, balanced, low-intensity, and respectful "object-relatedness." A bell-shaped curve connecting these modes describes the spectrum of human parenting styles. I grew up in Illinois, a farm state where children of twelve or thirteen had to drive tractors. Recognizing the hazards of puberty and speed, it was customary to affix a wooden block appropriately called a "governor" under the gas pedal. All children, and many parents, need governors. Tess's father lacked one; Ben needed one.

Ben, the oldest of three children, was five when referred by a terrified pre-school director. This robust, handsome, reckless, ebullient boy ravaged the girls in his group by regularly grabbing them in the crotch. Angry, anxious parents let it be known that Ben was on the do-not-invite list and threatened to remove their children unless immediate action was taken. That action brought Ben to my attention. In my office he lost little time in demonstrating the problem. He was a whirling dervish whose actions spoke louder than words. He lay supine on the floor, mimicking copulatory thrusts. His drawings rendered crude figures with disproportionately large breasts and penises, and he related to me with intense, boundary-violating physicality. His parents were bright and devoted to Ben, and while consciously eager to calm his alarming firestorm they were at a loss to explain it. My questions regarding bathing and toileting practices, privacy, modesty and the physical stimulation involved in greetings and partings met with blank looks. Both parents assured me that Ben was not excited at home, a sign of their denial or the common disorder of parental blindness. Considering ADHD (Attention-deficit Hyperactivity Disorder) an aspect of his difficulty, I started him on Ritalin. His teachers reported some motor-slowing, but his wandering hands continued to be a problem.

In our sessions I involved Ben in quiet games, attempting to cool his ardor. But he was already addicted to action. With miniature family figures he played out repeated scenes of lust, violence and frenzy that reflected the unquiet nature of his inner world. The images he drew continued to exhibit

sexual themes. After some months of what felt to me like fruitless effort, I was becoming discouraged. Then, as if it was an entirely new notion, Ben's mother, musing with me in the office, wondered whether her nuzzling and kissing him passionately on the stomach, a nightly bedtime ritual, bothered Ben at all. The belatedness of her revelation was not conscious withholding of important information. Rather, her bedtime ritual had become habit, caused no pain, and was deeply gratifying to mother and son. Further, to give it up would establish greater distance from Ben and foster his separation from her. With stakes this high, this painful, it is often the case that such observations as Ben's mother made never reach a point of open discussion, never come to light. But if they do, a new phase of treatment is often heralded. In Ben's case his parents were beginning to see that their over-stimulating behavior related to Ben's sexualizing activities. They worried, appropriately, about Ben's siblings and became more vigilant about the interactions of the children with one another.

The stalled therapeutic process began to move. Ben's father took notice of his wife's morning exercises conducted daily on the living room floor, in her nightgown, breasts and genitals exposed to Ben's excited, exploring gaze. She, in turn, caught sight of Ben's fascination with his father's penis which was visible when his skimpy, after-bath towel covered little of its intended target. Once these rituals, long out of parental awareness, were illuminated, other similar, sexually arousing practices poured forth into the light of day where they became subject to modulation. The orgiastic was moving toward ego-relatedness. These sexually provocative behaviors illustrate the extraordinary extent to which eroticism is imbedded in normal, everyday parenting. Ben quieted, his self-control began to organize and restrain the impulses that had flooded him; his mastery rewarded him, the praise of his teachers adding support to his progress. At age eighteen Ben was a gifted student who imagined a career as a trial lawyer. He was accepted for early admission to a prestigious college. The runaway energies of his early years had been harnessed.

There are those occasions when a brief therapeutic foray is sufficient to reset a family's thermostat of stimulation. Diana, a nine-year-old girl with blonde braids and pale skin, was the daughter of an accountant who himself had grown up in a physically constricted, oppressive home where physical contact was discouraged. Determined to spare his children this legacy, he shed his clothes. Nightly on returning home from work, he calmly conducted his family's life in the nude. I learned of this paternal practice from Diana who was referred to me because of her extreme anxiety, her hand-wringing worry.

In her picture of the family home she drew a scene at first unintelligible: a second floor room with what turned out to be a hole in the floor though which she and her brother listened to and watched parental intercourse on enough occasions to impress them. The sight of parental love-making and the sounds of orgasm are terrifying to children who confuse the scene and acoustics of passion with murder. A good carpenter and discussion of the values of paternal modesty reduced Diana's intolerable levels of arousal. The record for speedy interventions of this kind was set by a seasoned, Viennese teacher of mine. His anxious, agitated, eight-year-old patient achieved repose when the intercom between the parental bedroom and their child's was turned off at night, thereby eliminating alarming sounds and anxiety.

The reversible damage of overstimulation contrasts with the developmental malformations resulting from serious abuse. Martha, referred in the context of a criminal case against her stepfather, was also nine. But, unlike Diana, this slightly overweight girl with thick glasses was almost mute. She related with difficulty, turning and glancing away from me, speaking rarely and in a barely audible voice. Having lived with her mother and stepfather for the last two or three months, she had recently told her disbelieving mother of her stepfather's regular sexual approaches to her during her mother's absences from home, shopping or bowling with friends. The stepfather was immediately removed from the home, pending a full investigation of which my evaluation was a part.

In a dull monotone, Martha blandly described lurid details of his quiet but intimidating insistence that she undress, spread her legs and let him play "Push" with her, inserting his erect penis into her vagina. Afterwards he cleaned his semen from her genital area in the adjacent bathroom with towels whose colors and patterns Martha could describe in detail. Though her step-father, whom she had been fond of, was charged and imprisoned, Martha was certain of and terror-stricken at the prospect of his return. Once she was positive she had sighted him at the mall when shopping with her mother and, in terror, insisted on fleeing the scene. While I could recommend therapy for this child, there are many insults to body and mind that clinical work cannot repair. The capacity to live a reasonable life after such trauma does, however, occur and raises fascinating questions relating to resilience and protective factors in the life outcomes of children. It is to a certain extent because of such resilience that in the world at large, most sexual abuse goes unnoticed, unreported or ignored. Take, for example, Raymond's mother, who brought her son to me, concerned with his academic failure and social ostracism. His loud, strident voice and clumsy, asynchronous gait suggested the random chaos and lack of psychic glue with which

some genetically disordered children seem hastily and carelessly assembled by Nature. I saw Raymond only three times. He was eager to avoid all physicians and their products, refusing to return to my office after his third visit.

His mother, who was devoted and competent, came alone in a last session. She had wanted to share with me that Raymond, unbeknownst to him, was conceived in an incestuous relationship between her father, Raymond's grandfather, and herself. Raymond only knew his grandfather as "dad." Her prolonged liaison with her father, free of coercion and enjoyed by both, commenced at age eleven, ending at nineteen. She insisted that the sexual aspect of their relationship stop when she decided to marry a faithful suitor, a decision she consummated when Raymond was two. Both she and her new husband, whose sexual relationship with one another was satisfactory, continued to relate to her father. Raymond, of course, welcomed his grandfather's visits. His mother, who had never sought counseling, described her atypical family ties in a matter-of-fact manner. She somehow accepted her unnatural fate without overt rage or visible shame and had not experienced depression. She felt, in retrospect, exploited but not harmed and was especially proud of her determined emancipation. Raymond's mother was not, in any fundamental way, a troubled woman. There are others like her in this world, some broken, many silently resilient. Raymond was more damaged than his mother, in part by the doubling of recessive genes that contributed to his academic and social impairments.

If we were to imagine Tess's father, Martha's stepfather or Raymond's grandfather in prison, we would see the utter contempt in which those who prey sexually on children are held by their fellow criminals. In the penal code of offenders, pedophilia falls outside the bounds of the acceptable, including rape and murder, markedly decreasing the survival rate of incarcerated child-molesters. Society is more uncertain about the standing of child sexual predators whose numbers are growing and whose age is dropping. Like child murderers, do we diminish the seriousness of their crimes by virtue of their age or prosecute them as adults, fully responsible for their offenses? The genesis of predatory sexuality in pre-pubertal children is complex and entangled with the developmental needs of experimentation and exploration in the service of mastering the bio-psycho-social elements of sexuality. What in the recent past were considered normal "growing pains" now are classified as felonies and prosecuted as such in the very young.

Jack, at fourteen, involved a seven-year-old neighbor in multiple episodes of sexual play including her fellating and masturbating him while he digitally penetrated her vagina. After six or seven episodes, she revealed the details to her mother. I was asked by Jack's attorney to evaluate his status. Jack was a slight, slender youth whose nonchalance, given his circumstances, was striking. While he readily described the interactions with his victim in lurid detail, he expressed no remorse for his actions and had not apologized to the victim or her family. He angered easily, and when wronged by others comfortably entertained homicidal fantasies toward his perceived wrongdoers. I informed Jack, his family and his attorney that he had a serious problem, that it would persist into the future, that he was a risk to others, and that indefinite probation and highly structured treatment were essential to his safekeeping. If self-control is not mastered by four or five years of age, the capacity to delay an impulse remains problematic, often throughout life.

Layton was nine and had already acquired a significant dossier of sexual predation on a younger brother, two neighbor girls and a male peer; he frequently asked classmates if they wanted to have sex with him. This invitation involved his carnal knowledge of fellatio, anal and vaginal intercourse, all of which he had attempted or performed, enjoyed and continued to desire. Layton was big for his age, pale, and made only superficial connections with me during our three meetings. His behavior was ingratiating but unconvincing, making the real Layton, if one existed, hard to find. Flooded well before puberty with sexual desires, he seemed a marginally civilized, amoral boy who had demonstrated to all that he was unsafe in any setting. Like Jack, the history provided by his parents gave me minimal data to unravel the sources of his precocious, indiscriminate, dangerous lust. I urged the school and Layton's family to request state assistance in placing him in a therapeutic, residential program where the danger he posed could be better contained and more intensively explored.

Unlike the sexual arousal and desire in Jack and Layton, childhood eroticism appears in many forms wherein sexuality is secondary to other impulses or needs. The natural exploration of genitals at two or three in toddlers elicits intense sensual pleasure and, when prolonged, relieves depression and anxiety, both of which are biologically suppressed by sexual arousal. The self-soothing, medicinal role of masturbation in the young, particularly in neglected or depressed children, is often stigmatized as sexual abuse; but onanism is Natures antidepressant. Similarly, although the homoerotic experimentation of puberty raises flags of alarm, it most often represents efforts to integrate biological sexuality into the self

and not molestation. Time, good training and a detailed family and developmental history taken by experienced clinicians are essential tools in separating actual danger from harmless, maturational necessity. They are phenotypes, not genotypes. That is, they look alike but serve altogether different ends. It is also impossible to separate childhood sexuality from the surrounding family process: issues such as interpersonal boundaries, intensity, guiding values, and history of loss may explain what assumes the disguise of excessive sexuality.

Jean was twenty-four when she sought treatment for her depression. A quiet, attractive, seductive young woman, she displayed striking inner impoverishment and emptiness. Such subjective states reliably reflect deprivation of parental care in the first three years of life. Her adolescence had been filled with an endless parade of sexual partners, none of whom seemed emotionally important. Pregnant at twenty, she entered a brief, unhappy marriage that ended shortly after the birth of her now three-year-old daughter. Jean used this charming toddler to overcome her own shyness, much in the same way that the magnetic attraction of puppies generates contact and conversation with strangers. Small talk was otherwise impossible for her. While her family had been intact, a busy father, whose mind was usually elsewhere, and an overwhelmed, irritable mother left Jean and her older brother suffering emotional poverty in the midst of material plenty. Her brother became her main source of company and solace in childhood. Their mutual sexual play began in the years before puberty and was comforting and distracting to both. In adolescence, Jean and her brother became sexual partners, experimenting regularly with oral, anal and genital practices. And while sexual desire was pleasant, for Jean her brother's familiar, soothing physical warmth was primary. His penis in her vagina helped fill her inner vacuum. Her pregnancy was experienced in a similar way as a "fullness" that brought her well-being. But birth was a loss for which she compensated with an endless series of transient sexual contacts that served as analgesics, narcotics, and anti-depressants. During intercourse with these serial, anonymous partners, she fantasized the man's erect penis, as it entered her, as a tiny homunculus of herself. In this way her partner ceased to exist: she related only to herself, repeatedly driven to use the language of sexuality to deal with non-sexual issues of abandonment and neglect that continued to echo in the barren reaches within. Psychotherapy, comforting when present, could not reverse the persistence of her early deprivations. These scars remained, while her therapy ended with my moving out of state to direct the division of Child and Adolescent Psychiatry at the Institute of Living.

Behaviors common to one culture often fare badly or fail when transplanted to another. Nudity, for example, in our country elicits prurient interest while in Northern Europe (and probably most of the world) naked adolescents and adults seem almost clothed. Attitude and custom are powerful garments. So it is with the varieties of sexual practices common to different peoples. But in every land children are intimately involved in sexuality from early in life. There is no single right way to rear our young, sexually or otherwise, and the long term connections between different parenting techniques and life outcomes for our children remain matters of debate. Given this state of our knowledge, or ignorance, it is perhaps wise not to cast the first stone. Dean Rusk, the former Secretary of State, recalling Duhrer's engraving of an all but naked Adam and Eve, warned a war-mongering cabinet "not to lift the fig leaf if you are not prepared to deal with what lies underneath." In child psychiatry one needs to be at ease lifting the fig leaf and dealing with the powerful forces of sexuality that lie beneath.