The Boy Who Was Raised as a Dog

And Other Stories from a Child Psychiatrist's Notebook

What Traumatized Children Can Teach Us About Loss, Love, and Healing

BRUCE D. PERRY, M.D., PH.D.

MAIA SZALAVITZ

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whether it was with family who still believed in the Davidian ways or with loved ones who rejected Koresh entirely. In fact, the research on the most effective treatments to help child trauma victims might be accurately summed up this way: what works best is anything that increases the quality and number of relationships in the child’s life.

I also saw how bringing disparate groups together—even those with conflicting missions—could often be effective. Dozens of state, federal and local agencies had worked together to care for these children. The power of proximity—spending time side-by-side—had pulled us all to compromise in our efforts to help these children. Relationships matter: the currency for systemic change was trust, and trust comes through forming healthy working relationships. People, not programs, change people. The cooperation, respect and collaboration we experienced gave us hope that we could make a difference, even though the raids themselves had ended in such catastrophe. The seeds of a new way of working with traumatized children were sown in the ashes of Waco.

**Chapter 4**

Skin Hunger

_Like everyone else, doctors enjoy being recognized for their achievements. One sure way of attaining medical fame is to discover a new disease or to solve a particularly daunting medical puzzle. And the physicians at one Texas hospital where I consulted saw the little girl in room 723E as such a challenge. At four years old Laura weighed just twenty-six pounds, despite having been fed a high-calorie diet via a tube inserted through her nose for weeks. The stack of her medical files that confronted me at the nurses’ station was about four feet high, taller than the shrunken little girl herself. Laura’s story, like that of the children of Waco, helped us learn more about how children respond to early experience. It illustrates how the mind and body cannot be treated separately, reveals what infants and young children need for healthy brain development and demonstrates how neglecting those needs can have a profound impact on every aspect of a child’s growth._

Laura’s files contained literally thousands of pages of documents, detailing visits with endocrinologists, gastroenterologists, nutritionists and other medical specialists. There were endless lab reports of blood work, chromosome tests, hormone levels, biopsies. The documents included results from even more invasive tests, which had used scopes inserted into her throat to examine her stomach, and scopes inserted rectally to examine her bowels. There were dozens of reports from consulting
physicians. The poor girl had even had an exploratory laparoscopy, in which doctors inserted a tube into her abdomen to scrutinize her internal organs; a snippet of her small intestine had been clipped off and sent to the National Institutes of Health for analysis.

Finally, after being on the special gastrointestinal research unit for a month, a social worker pressured Laura’s physicians to get a psychiatry consult. Just as the gastroenterology fellows thought they’d discovered a case of “intestinal epilepsy” when they first saw Laura years before, the shrinks, too, had a novel theory about Laura’s case. The psychologist who came for the initial consultation specialized in eating disorders, and he believed he was seeing the first documented instance of “infantile anorexia.” Fascinated and excited, he discussed the case with his mental health colleagues. Ultimately, he requested a consultation from me because I had more experience with academic publishing and he was sure that this would be a reportable case. He told me that the child had to be purging secretly, or perhaps getting up at night to exercise furiously. Otherwise, how could she be fed so many calories but still not grow? He wanted my insight on this disturbing new problem, seen for the first time in a young child.

I was curious. I had never heard of infantile anorexia. I went to the hospital planning to start the consult like I always do, by reviewing the chart to learn as much about the child’s history as possible. But when I discovered the four-year, twenty-previous-admission, six-specialty-clinic, four-foot-tall pile of documents, I just scanned the admission intake report and went in to introduce myself to the patient and her mother.

In the girl’s hospital room I found a distressing scene. Laura’s twenty-two-year-old mom, Virginia*, was watching television, seated about five feet away from her child. Mother and daughter were not interacting. Tiny, emaciated Laura was sitting quietly, her eyes big, staring at a plate of food. She also had a feeding tube, which pumped nutrients into her stomach. I would later learn that Virginia had been discouraged from interacting with Laura during mealtimes by the eating disorders psychologist. This was supposed to stop Laura—the alleged cunning, infantile

anorectic—from manipulating her mother around food and meals. The theory then was that people with anorexia enjoy the attention they get when they don’t eat, and use it to control other family members; denying them this “reward” was supposed to aid recovery. But all I could see here was a despondent, skinny little girl and a disengaged mother.

The brain is an historical organ. It stores our personal narrative. Our life experiences shape who we become by creating our brain’s catalog of template memories, which guide our behavior, sometimes in ways we can consciously recognize, more often via processes beyond our awareness. A crucial element in figuring out any brain-related clinical problem, therefore, is getting an accurate history of the patient’s experiences. Since much of the brain develops early in life, the way we are parented has a dramatic influence on brain development. And so, since we tend to care for our children the way we were cared for ourselves during our own childhoods, a good “brain” history of a child begins with a history of the caregiver’s childhood and early experience. To understand Laura I would need to know about her family, which in her case consisted of her mom.

I started by asking Virginia innocuous, basic questions. Almost immediately I began to suspect that the source of Laura’s problems lay in her young, well-intentioned, but inexperienced mother’s past.

“Where are you from?” I asked her.

“I guess, Austin,” she said.

“Where are your parents from?”

“I don’t know.”

Within minutes I discovered that Virginia was a child of the foster care system. Abandoned at birth by a drug-addicted mother, father unknown, Virginia had grown up at a time when it was common for the child welfare system to move infants and toddlers to a new foster home every six months, the rationale was that this way they wouldn’t become too attached to any particular caregiver. Now, of course, we know that an infant’s early attachment to a small number of consistent caregivers is critical to emotional health and even to physical development. But at
that time this knowledge hadn’t even begun to penetrate the child welfare bureaucracy.

More than in any other species, human young are born vulnerable and dependent. Pregnancy and early childhood are tremendous energy drains on the mother and, indirectly, on the larger family group. But despite the severe pain of childbirth, the numerous discomforts of pregnancy and breast-feeding, and the loud, continuous demands of a newborn, human mothers overwhelmingly tend to devote themselves to comforting, feeding and protecting their young. Indeed, most do so happily; we find it pathological when one does not.

To a Martian—or even to many nonparents—this behavior might seem like a mystery. What could prompt parents to give up sleep, sex, friends, personal time and virtually every other pleasure in life to meet the demands of a small, often irritatingly noisy, incontinent, needy being? The secret is that caring for children is, in many ways, indescribably pleasurable. Our brains reward us for interacting with our children, especially infants: their scent, the cooing sounds they make when they are calm, their smooth skin and especially, their faces are designed to fill us with joy. What we call “cuteness” is actually an evolutionary adaptation that helps ensure that parents will care for their children, that babies will get their needs met, and parents will take on this seemingly thankless task with pleasure.

So during our development, in the ordinary course of things we will receive attentive, attuned and loving care. When we are cold, hungry, thirsty, frightened or distressed in any way, our cries will bring the comforting caregivers who meet our needs and dissolve our distress in their loving attention. With this loving care two major neural networks are stimulated simultaneously in our developing brains. The first is the complex set of sensory perceptions associated with human relational interactions: the caregiver’s face, smile, voice, touch and scent. The second is stimulation of the neural networks mediating “pleasure.” This “reward system” can be activated in a number of ways, one of which is the relief of distress. Quenching thirst, satisfying hunger, calming anxiety—all result in a sense of pleasure and comfort. And as we have discussed earlier, when two patterns of neural activity occur simultaneously with sufficient repetition, an association is made between the two patterns.

In the case of responsive parenting, pleasure and human interactions become inextricably woven together. This interconnection, the association of pleasure with human interaction, is the important neurobiological “glue” that bonds and creates healthy relationships. Consequently, the most powerful rewards we can receive are the attention, approval and affection of people we love and respect. Similarly, the most powerful pain we experience is the loss of that attention, approval and affection—the most obvious example being, of course, the death of a loved one. This is why even our greatest intellectual, athletic or professional triumphs seem empty if we have no one with whom to share them.

If you are one of the majority of infants born to a loving home, a consistent, nurturing caregiver—say a mother or father—will be present and repeatedly meet your needs. Time and again, one or both parents will come when you cry and soothe you when you are hungry, cold, or scared. As your brain develops these loving caregivers provide the template that you use for human relationships. Attachment, then, is a memory template for human-to-human bonds. This template serves as your primary “world view” on human relationships. It is profoundly influenced by whether you experience kind, attuned parenting or whether you receive inconsistent, frequently disrupted, abusive, or neglectful “care.”

As noted earlier, the brain develops in a use-dependent manner. Neural systems that are used become more dominant, those that are not grow less so. As a child grows, many systems of the brain require stimulation if they are to develop. Furthermore, this use-dependent development must occur at specific times in order for these systems to function at their best. If this “sensitive period” is missed, some systems may never be able to reach their full potential. In some cases the neglect-related deficit may be permanent. For example, if one of a kitten’s eyes is kept closed during the first few weeks of its life, it will be blind in that eye, even though the eye is completely normal. The visual circuitry of the
brain requires normal experience of sight in order to wire itself; lacking visual stimuli, the neurons in the closed eye fail to make crucial connections and the opportunity for sight and depth perception is lost. Similarly, if a child is not exposed to language during his early life, he may never be able to speak or understand speech normally. If a child doesn’t become fluent in a second language before puberty, he will almost always speak any new language he does learn with an accent.

While we don’t know whether there is a fixed “sensitive period” for the development of normal attachment the way there appears to be for language and sight, research does suggest that experiences like Virginia’s, in which children are not allowed the chance to develop permanent relationships with one or two primary caregivers during their first three years of life have lasting effects on people’s ability to relate normally and affectionately to each other. Children who don’t get consistent, physical affection or the chance to build loving bonds simply don’t receive the patterned, repetitive stimulation necessary to properly build the systems in the brain that connect reward, pleasure and human-to-human interactions. This is what had happened to Virginia. As a result of transient and fragmented caregiving during childhood she just didn’t get the same degree of reward—pleasure, if you will—from holding, smelling and interacting with her baby that most mothers would.

At the age of five Virginia had finally settled into what would be her most permanent childhood home. Her foster parents were loving, highly moral, Christian people, and good parents. They taught her manners. They taught her to “do unto others.” They provided a basic, humane, script for normal behavior. They taught her that stealing was wrong, so she didn’t take things from others without permission. They taught her that drugs were bad for you, so she didn’t use drugs. They taught her to work hard and go to school, so she did that, too. They wanted to adopt her and she wanted to be adopted by them, but the state never terminated the parental rights of her biological parents and there was occasional talk by her caseworkers of the potential for reuniting her with her biological mother, so the adoption never went through. Unfortunately, this meant that when she turned eighteen, the state was no longer legally “responsible” for Virginia. As a result she had to leave her foster home and the foster parents were told to have no further contact with her. Their future as foster parents for other children was linked to their compliance with the wishes of the caseworkers. Because of yet another inhumane child welfare policy—one aimed at reducing the system’s legal liabilities, not protecting children—Virginia lost the only parents she’d ever really known.

By then she had graduated high school. She was placed in a halfway house for children “aging out” of foster care in a low-income community. Cut off from her loved ones, with no clear-cut rules to follow and seeking affection, Virginia rapidly became pregnant. The father of her child left her, but she wanted a baby to love and she wanted to do the right thing, as her foster parents had taught her. She sought prenatal care and was quickly enrolled in a good program for high-risk mothers. Unfortunately, as soon as the baby was born, she no longer qualified for that program because she wasn’t pregnant anymore. After she gave birth, she was on her own.

But Virginia had no idea what to do with her baby after she left the hospital. Having had her own early attachments abruptly and brutally terminated, she didn’t have what some might call the “maternal instinct.” Cognitively, she knew what basic acts needed to be performed: feed Laura, dress her, bathe her. Emotionally, however, she was lost. No one had thought to specifically instruct her to provide the loving, physical interactions that infants need, and she didn’t feel compelled to do them on her own. Simply, Virginia got no pleasure from these things and she had not been taught that she should do them. Not pulled by her limbic, emotional systems and not pushed by her cognitive, information-carrying cortex, Virginia parented in an emotionally disconnected way. She didn’t spend much time holding her baby; she fed the little one propped up with a bottle, not nuzzled close to her bosom. She didn’t rock her, didn’t sing to her, didn’t coo or stare into her eyes or count her perfect tiny toes over and over or do any of the other silly but hugely
important things that people with ordinary childhoods instinctively do when caring for a baby. And without these physical and emotional signals that all mammals need to stimulate growth, Laura stopped gaining weight. Virginia did what she thought was the right thing, not because she felt it in her heart, but because her mind told her that’s what a mother “should” do. When she got frustrated, she either harshly disciplined the child or ignored her. She simply didn’t feel the contentment and joy from the positive caregiving interactions that normally help parents overcome the difficult emotional and physical challenges of child-rearing.

The term used to describe babies who are born normal and healthy but don’t grow, or even lose weight following this form of emotional neglect, is “failure to thrive.” Even back in the eighties, when Laura was an infant, “failure to thrive” was a well-known syndrome in abused and neglected children, especially those raised without enough individualized nurturing and attention. The condition has been documented for centuries, most commonly in orphanages and other institutions where there is not enough attention and care to go around. If not addressed early, it can be deadly. One study in the forties found that more than a third of children raised in an institution without receiving individual attention died by age two—an extraordinarily high death rate. The children who survive such emotional deprivation—like the recent Eastern European orphans, one of whom we’ll meet later—often have severe behavioral problems, hoard food, and may be overly affectionate with strangers while having difficulty maintaining relationships with those who should be closest to them.

When Virginia first sought medical attention for her baby eight weeks after she was born, Laura was correctly diagnosed with “failure to thrive” and was admitted to the hospital for nutritional stabilization. But the diagnosis wasn’t explained to Virginia. Upon being discharged she was only given nutritional advice, not advice on mothering. A social work consult had been suggested yet it was never ordered. The issue of neglect was ignored by the medical team in large part because many physicians find “psychological” or social aspects of medical problems less interest-

ing and less important than the primary “physiological” issues. Further, Virginia didn’t seem like a neglectful mother. After all, would an uncaring mother seek out early intervention for her newborn?

And so, Laura still didn’t grow. Several months later Virginia brought her back to the emergency room seeking help. Unaware of Virginia’s history of disrupted early attachment, the doctors who saw her child next thought Laura’s problems had to be related to her gastrointestinal system, not her brain. And so began Laura’s four-year medical odyssey of tests, procedures, special diets, surgeries, and tube feeding. Virginia still didn’t realize that her baby needed to be held, rocked, played with and physically nurtured.

Babies are born with the core elements of the stress response already intact and centered in the lower, most primitive parts of their developing brains. When the infant’s brain gets signals from inside the body—or from her external senses—that something is not right, these register as distress. This distress can be “hunger” if she needs calories, “thirst” if she is dehydrated, or “anxiety” if she perceives external threat. When this distress is relieved, the infant feels pleasure. This is because our stress-response neurobiology is interconnected with the “pleasure/reward” areas in the brain, and with other areas that represent pain, discomfort and anxiety. Experiences that decrease distress and enhance our survival tend to give us pleasure; experiences that increase our risk usually give us a sensation of distress.

Babies immediately find nursing, being held, touched, and rocked soothing and pleasurable. If they are parented lovingly, and someone consistently comes when they are stressed by hunger or fear, the joy and relief of being fed and soothed becomes associated with human contact. Thus, in normal childhood, as described above, nurturing human interactions become intimately and powerfully connected with pleasure. It is through the thousands of times we respond to our crying infant that we help create her healthy capacity to get pleasure from future human connection.

Because both the brain’s relational and pleasure-mediating neural systems are linked with our stress-response systems, interactions with loved
ones are our major stress-modulating mechanism. At first babies must rely upon those around them not only to ease their hunger, but also to soothe the anxiety and fear that come from not being able to obtain food and otherwise care for themselves. From their caregivers they learn how to respond to these feelings and needs. If their parents feed them when they are hungry, calm them when they are frightened and are generally responsive to their emotional and physical needs, they ultimately build the baby's capacity to soothe and comfort themselves, a skill that serves them well later when they face life's ordinary ups and downs.

We've all seen toddlers look to Mom after scraping a knee: if she doesn't look worried, the child doesn't cry; but if baby sees a look of concern, the loud wailing begins. This is only the most obvious example of the complex dance that occurs between caregiver and child that teaches emotional self-regulation. Of course some children may be genetically more or less sensitive to stressors and stimulation, but genetic strengths or vulnerabilities are magnified or blunted in the context of the child's first relationships. For most of us, including adults, the mere presence of familiar people, the sound of a loved one's voice, or the sight of their figure approaching, can actually modulate the activity of the stress-response neural systems, shut off the flood of stress hormones and reduce our sense of distress. Just holding a loved one's hand is powerful stress-reducing medicine.

There is also a class of nerve cells in the brain known as “mirror” neurons, which respond in synchrony with the behavior of others. This capacity for mutual regulation provides another basis for attachment. For example, when a baby smiles, the mirror neurons in his mother's brain usually respond with a set of patterns that are almost identical to those that occur when Mom herself smiles. This mirroring ordinarily leads the mother to respond with a smile of her own. It's not hard to see how empathy and the capacity to respond to relationships would originate here as mother and child synchronize and reinforce each other, with both sets of mirror neurons reflecting back each other's joy and sense of connectedness.

However, if a baby's smiles are ignored, if she's left repeatedly to cry alone, if she's not fed, or fed roughly without tenderness or without being held, the positive associations between human contact and safety, predictability and pleasure may not develop. If, as happened in Virginia's case, she begins to bond with one person, but is abandoned as soon as she feels comfortable with her particular smell, rhythm and smile, and then abandoned again once she acclimates to a new caregiver, these associations may never gel. Not enough repetition occurs to clinch the connection; people are not interchangeable. The price of love is the agony of loss, from infancy onward. The attachment between a baby and his first primary caregivers is not trivial; the love a baby feels for his caregivers is every bit as profound as the deepest romantic connection. Indeed, it is the template memory of this primary attachment that will allow the baby to have healthy intimate relationships as an adult.

As a baby Virginia never really got the chance to learn that she was loved; as soon as she grew used to one caretaker, she was whisked off to another one. Without one or two consistent caregivers in her life she never experienced the particular relational repetitions a child needs to associate human contact with pleasure. She did not develop the basic neurobiological capacity to empathize with her own baby's need for physical love. However, because she did live in a stable, loving home when the higher, cognitive regions of her brain were most actively developing, she was able to learn what she “should” do as a parent. Still, she didn't have the emotional underpinnings that would make those nurturing behaviors feel natural.

So when Laura was born, Virginia knew that she should “love” her baby. But she didn't feel that love the way most people do, and so she failed to express it through physical contact.

For Laura, this lack of stimulation was devastating. Her body responded with a hormonal dysregulation that impeded normal growth, despite receiving more than adequate nutrition. The problem is similar to what in other mammals is called “runt syndrome.” In litters of rats and mice and even in puppies and kittens, without outside intervention
the smallest, weakest animal often dies in the few weeks following birth. The runt doesn’t have the strength to stimulate the mother’s nipple to produce adequate milk (in many species, each baby prefers and suckles exclusively from a particular nipple) or to elicit adequate grooming behaviors from the mother. The mother neglects the runt physically, not licking or grooming him as much as she does the others. This, in turn, further limits his growth. Without this grooming his own growth hormones turn off, so even if he does somehow get enough to eat, he still doesn’t grow properly. The mechanism, rather cruelly for the runt, directs resources to those animals best able to utilize them. Conserving her resources, the mother feeds the healthier animals preferentially, since they have the best chance of surviving and passing on her genes.

Infants diagnosed with “failure to thrive,” are often found to have reduced levels of growth hormone, which explains Laura’s inability to gain weight. Without the physical stimulation needed to release these hormones, Laura’s body treated her food as waste. She didn’t need to purge or exercise to avoid gaining weight: the lack of physical stimulation had programmed her body to do so. Without love, children literally don’t grow. Laura wasn’t anorexic; like the scrawny runt in a litter of puppies, she just wasn’t receiving the physical nurturing her body needed to know that she was “wanted,” and that it was safe to grow.

WHEN I’D FIRST ARRIVED in Houston, I’d gotten to know a foster mother who often brought children to our clinic. A warm, welcoming person who didn’t stand on ceremony and always spoke her mind, Mama P.* seemed to know intuitively what the maltreated and often traumatized children she took in needed.

As I considered how to help Virginia help Laura, I thought back on what I’d learned from Mama P. The first time I met her I was relatively new to Texas. I had set up a teaching clinic where we had a dozen or more psychiatrists, psychologists, pediatric and psychiatry residents, medical students and other staff and trainees. This was a teaching clinic designed, in part, to allow trainees to observe senior clinicians and “experts” doing clinical work. I was introduced to Mama P. during the feedback part of an initial evaluation visit for one of her foster children.

Mama P. was a large, powerful woman. She moved with confidence and strength. She wore a large brightly colored muumuu and had a scarf around her neck. She’d come for a consultation about Robert, a seven-year-old child she was fostering. Three years before our visit, this boy had been removed from his mother’s custody. Robert’s mom was a prostitute who’d been addicted to cocaine and alcohol for her son’s whole life. She had neglected and beaten him; the boy had also seen her beaten by customers and pimps and had himself been terrorized and abused by her partners.

Since being removed from his home Robert had been in six foster homes and in three shelters. He had been hospitalized for out-of-control behaviors three times. He had been given a dozen diagnoses including attention deficit hyperactivity disorder (ADHD), oppositional deficit disorder (ODD), bipolar disorder, schizoaffective disorder and various learning disorders. He was often a loving and affectionate child, but he had episodic “rages” and aggression that scared peers, teachers and foster parents enough for them to reject him and have him removed from whatever setting he was in after he went on one of his rampages. Mama P. had brought him to us because once again, his inattentiveness and aggression had gotten him into trouble at school and the school had demanded that something be done. He reminded me of many of the boys I had worked with in Chicago at the residential treatment center.

As I began talking I tried to engage Mama and make her feel comfortable. I knew that people can “hear” and process information much more effectively if they feel calm. I wanted her to feel safe and respected. Thinking back now, I must have seemed very patronizing to her. I was too confident; I thought I knew what was going on with her foster child and the implicit message was, “I understand this child, and you don’t.” She looked at me defiantly, her face unsmiling, her arms folded. I went
into long-winded and very likely unintelligible explanation of the biology of the stress response and how it could account for the boy’s aggression and hyper-vigilance symptoms. I had not yet learned how to clearly explain the impact of trauma on a child.

“So what can you do to help my baby?” she asked. Her language struck me: why was she calling this seven-year-old child a baby? I wasn’t sure what to make of it.

I suggested clonidine, the medication I’d used with Sandy and the boys at the center. She interrupted quietly but firmly, “You will not use drugs on my baby.”

I tried to explain that we were quite conservative with medications, but she wouldn’t hear it. “No doctor is going to drug up my baby,” she said. At this point the child psychiatry fellow, Robert’s primary clinician, who was sitting next to me, started to fidget. This was awkward. Mr. Bigshot Vice-Chairman and Chief of Psychiatry was making an ass of himself. I was alienating this mother and getting nowhere. I again tried to explain the biology of the stress response system, but she cut me off.

“Explain what you just told me to the school,” she said pointedly. “My baby does not need drugs. He needs people to be loving and kind to him. That school and all those teachers don’t understand him.”

“OK. We can talk to the school.” I retreated.

And then I surrendered. “Mama P., how do you help him?” I asked, curious about why she didn’t have the problems with his “rages” that had gotten him expelled from prior foster homes and schools.

“I just hold him and rock him. I just love him. At night when he wakes up scared and wanders the house, I just put him in bed next to me, rub his back and sing a little and he falls asleep.” The fellow was now stealing looks at me, clearly concerned: seven-year-olds should not sleep in bed with their caregivers. But I was intrigued and continued to listen.

“What seems to calm him down when he gets upset during the day?” I asked.

“Same thing. I just put everything down and hold him and rock in the chair. Doesn’t take too long, poor thing.”

As she said this I recalled a recurring pattern in Robert’s records. In every one of them, including the latest referral from the school, angry staff reported frustration with the boy’s noncompliance and immature “baby-like” behaviors, and complained about his neediness and clinginess. I asked Mama P., “So when he acts like that, don’t you ever get frustrated and angry?”

“Do you get angry with a baby when a baby fusses?” she asked. “No. That is what babies do. Babies do the best they can and we always forgive them if they mess, if they cry, if they spit up on us.”

“And Robert is your baby?”

“They are all my babies. It’s just that Robert has been a baby for seven years.”

We ended the session and made another appointment for a week later. I promised to call the school. Mama P. looked at me as I walked with Robert down the clinic hall. I joked that Robert needed to come back to teach us more. At that, she finally smiled.

Over the years Mama P. continued to bring her foster children to our clinic. And we continued to learn from her. Mama P. discovered, long before we did, that many young victims of abuse and neglect need physical stimulation, like being rocked and gently held, comfort seemingly appropriate to far younger children. She knew that you don’t interact with these children based on their age, but based on what they need, what they may have missed during “sensitive periods” of development. Almost all of the children sent to her had a tremendous need to be held and touched. Whenever my staff saw her in the waiting room holding and rocking these children, they expressed concern that she was infantilizing them.

But I came to understand why her overwhelmingly affectionate, physically nurturing style, which I’d initially worried might be stifling for older children, was often just what the doctor should order. These children had never received the repeated, patterned physical nurturing needed to develop a well-regulated and responsive stress response system. They had never learned that they were loved and safe; they didn’t have the internal security needed to safely explore the world
and grow without fear. They were starving for touch—and Mama P. gave it to them.

NOW, AS I SAT with Laura and her mother, I knew that they both could benefit, not only from Mama P's wisdom about childrearing, but also from her own incredibly maternal and affectionate nature. I went back to the nurse's station, dug out her phone number, and called. I asked her if she'd be willing to have a mother and her child move in with her, so that Virginia could learn how to raise Laura. She immediately agreed. Fortunately, both families were involved in a privately funded program that allowed us to pay for this kind of care, which the foster care system is usually too inflexible to permit.

Now, I had to convince Virginia—and my colleagues. When I returned to the room where she was waiting, Virginia seemed anxious. My psychiatry colleague had given her one of the papers I had written that focused on our clinical work with abused children. Virginia assumed that I had deemed her an incompetent parent. Before I could even speak, she said, “If it will help make my baby better, please take her.” Virginia did love her baby—so much that she was willing to let her go if that's what it took for her to recover.

I explained what I wanted to do instead, that I wanted her to live with Mama P. She, too, assented right away, saying she would do anything to help Laura.

My pediatric colleagues, however, were still extremely concerned about Laura's nutritional needs. She was so underweight that they were afraid that she would not take in enough calories without medical support. After all, she was currently being fed through a tube. I told the other doctors that we would strictly monitor her diet to be sure she was getting enough calories, and it turned out to be a good thing that we did. We could then document her remarkable progress. For the first month with Mama P., Laura consumed the exact same number of calories she had in the prior month in the hospital, during which her weight had barely been maintained at twenty-six pounds. In Mama P’s nurturing environment, however, Laura gained ten pounds in one month, growing from twenty-six to thirty-six pounds! Her weight increased by 35 percent on the same number of calories that had previously not been enough to prevent weight loss, because she was now receiving the physical nurturing her brain needed to release the appropriate hormones required for growth.

By observing Mama P. and by receiving the physical affection Mama showered on everyone around her, Virginia began to learn what Laura needed and how to provide it for her. Before Mama P., meals had been robotic or filled with conflict: the constantly changing dietary instructions and advice given by various doctors and hospitals who were trying to help just added to the confused hollow experience of eating for Laura. Also, because of Virginia's lack of understanding of her child's needs, she'd swing from being affectionate to being tough and punitive to simply ignoring her daughter. Without the rewards that nurturing normally provides both mother and child, Virginia had been especially prone to frustration. Parenting is difficult. Without the neurobiological capacity to feel the joys of parenting, irritations and annoyances loom especially large.

Mama P's sense of humor, her warmth and her hugs allowed Virginia to get some of the mothering she'd missed. And by watching how Mama P. responded to her other children and to Laura, Virginia began to pick up on Laura's cues. Now she could better read when Laura was hungry, when she wanted to play, when she needed a nap. The four-year-old had seemed stuck in the defiant stage of the “terrible twos,” but now she began to mature, both emotionally and physically. As Laura grew, the tension between mother and daughter during mealtimes ended. Virginia relaxed and was able to discipline with more patience and consistency.

Virginia and Laura lived with Mama P. for about a year. Afterwards, the two women remained tight friends, and Virginia moved into Mama's neighborhood so that she could remain in close touch. Laura became a bright little girl, similar to her mother in that she tended to be emotionally distant, but with a powerful moral compass; they both had strong
positive values. When Virginia had a second child, she knew how to care for him appropriately, right from the start, and he suffered no growth problems. Virginia went on to college and both of her children are doing well in school. They have friends, an invested church community and, of course, Mama P. just down the street.

Both Laura and Virginia still bear scars from their early childhoods, however. If you were to secretly observe either mother or daughter, you might find her facial expression vacant, or even sad. Once she became aware of your presence, she would put on her social persona and respond appropriately to you, but if you paid close attention to your “gut” you would sense something awkward or unnatural in your interactions. Both can mimic many of the normal social interactive cues, but neither feels naturally pulled to be social, to spontaneously smile or to express warm nurturing physical behaviors such as a hug.

Though we all “perform” for others to some extent, the mask slips easily for those who have suffered early neglect. On a “higher” more cognitive level both mother and daughter are very good people. They have learned to use moral rules and a strong belief system to tame their fears and desires. But in the relational and social communication systems of their brain, the source of emotional connections to others, there are shadows of the disrupted nurturing of their early childhoods. The nature and timing of our developmental experiences shape us. Like people who learn a foreign language late in life, Virginia and Laura will never speak the language of love without an accent.

Chapter 5

The Coldest Heart

Entering a maximum-security prison is always daunting: after the extensive identity check at the gate, you have to hand over your keys, wallet, phone and anything else that could possibly be stolen or used as a weapon. Everything that identifies you, except your clothing, is confiscated. One of the first locked doors you pass through is marked by a sign saying, in effect, that if you are taken hostage past this point, you’re on your own. The policy is ostensibly to prevent visitors from pretending to be held captive by prisoners and enabling their escape, but it also immediately instills an unsettling feeling. There are at least three or four double sets of thick metal doors, with many layers of human and electronic security between them, which slam solidly behind you before you can meet with the kind of prisoner I had been brought in to examine. Leon, at age sixteen, had sadistically murdered two teenage girls, and then raped their dead bodies.

Virginia and Laura demonstrated one way that neglect in early childhood can disrupt the development of the areas in the brain that control empathy and the ability to engage in healthy relationships—a loss that often leaves people awkward, lonely and socially inept. Emotional deprivation in the first years of life, however, can also predispose people to malice or misanthropy. In the mother’s and the daughter’s cases, fortunately, despite their underdeveloped capacity for empathy, both became highly moral people; their early childhood experiences had left them