The Children's Hour

Rooted Sorrows

Kenneth S. Robson, M.D.

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A Life in Child Psychiatry

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What cannot be said will get wept.

- Sappho

Meryl was driving, her new baby on her lap; suddenly, out of control, the car careened wildly down a bleak, unlit, unfamiliar street. Running the curb, it smashed violently into the wall surrounding a more familiar house. At the moment of impact Meryl and the baby fused, became one, and were thrown to the sidewalk, lying supine, alone. No help came. In time, a newsman, expressionless, looked down on her, shot camera footage and, departing with neither greeting nor goodbye, left the still unattended Meryl in gray, shadowy silence. She wakened from her dream in hopelessness and despair, the same emotions that led her to seek consultation. I shivered at the creative elegance, the beauty of this dream that had come to light like an author's lost manuscript, revealing previously unknown chapters of a life. Meryl, a Rubenesque mother of two, had kept company with depression in her earliest memories. She could not recall a time when she'd been free of gloom. Since the birth of her last child, now five months old, her mood had darkened. She ruminated about suicide in the midst of a major post-partum depression. Her dream suggested to me that the birth of her second child had activated memories of despair from the time of her own birth. The robotic newsman might have been a stand-in for an unresponsive, depressed parent whose inability to provide care left Meryl depressed from infancy.

She approached her father, who confirmed a family secret: his wife had required a three-month psychiatric hospitalization after Meryl's arrival and was marginally functional for most of her daughter's first year. Anna Freud observed that infants in this situation "follow their mothers into depression," taking in the mood itself as milk, even if soured. All that is available to them as sustenance is their mother's despair. In later life this bad meal can present itself as chronic depression that is often untreatable. Though mother (deep within) is black and bleak, her child holds on to her for dear life: she is all of the known world. Meryl's dream was an accurate chronicle of her beginnings in the grip of her mother's melancholy. Unexpectedly, she responded well to anti-depressant medication. Within a month her mood lightened and she was better able to survive the rigors of new parenthood. She interrupted her treatment, relieved and grateful.

Historically, the initial descriptions of depression in child psychiatry were limited to the severe, maternal-deprivation syndromes of infancy, Marasmus and "failure to thrive," which lead infants to withdraw, refuse food, lose weight, stop growing, and often die. Meryl was fortunate: we have come a long way toward overcoming our Victorian legacy of childhood as a blissful time, a legacy that has provided added fuel for a skeptical public that doubts the possibility that young children can suffer depression. At the time of my training in the Sixties, the modest literature on childhood mood disorders was speculative and unconvincing. What presumably did not exist in our patients was neither looked for nor seen. I recall my disbelief at the suicide of a high school classmate, a tragic event for which I could find no frame of reference. Only in the last twenty-five years has clinical and biological research described and documented the relatively high prevalence of mood disorders in childhood and adolescence, their genetic and familial basis, and their response to psychotherapies and anti-depressants. Ten to fifteen percent of randomly surveyed elementary and middle school students have thought about suicide. It is particularly poignant to witness the pain of despair in the young where it feels, somehow, more out of place, more intense and desperate than in adults or the elderly. I am especially moved by such moods in children.

The onset of depression prior to puberty, unless it is clearly situational, unfortunately increases the likelihood of mood disorders in adolescence and adult life. Meryl's story was typical of this pattern. I feel some urgency to reverse depression in this early onset population, hoping to change a child's odds for the better. In this quest, a child's character is a potent force that can help overcome a discouraging prognosis.

I was asked to see Francie, then eight, on an inpatient basis. She had been admitted after seriously assaulting a third grade classmate whom she felt had insulted her. For the month prior to this assault she slept poorly, sometimes unable to fall asleep until three or four in the morning, pacing her house while banging kitchen pots together in a noisy, maddening, one-person parade. Her parents had recently divorced. There was a history of alcoholism, serious gambling and Bipolar Disorder in the family. While the diagnosis of manic depression in pre-pubertal children is rare, Francie had enough stigmata to suggest that disorder. By the time I saw her, she had terrorized the other children on the unit and, as a cyclone of activity, was beginning to wear on a usually patient staff.

She welcomed me with contempt: "You bald, ugly, stupid little man." I could not resist smiling at this scornful greeting, launching Francie into a tirade of further derisive commentary on my dress, my big nose and my credentials. Had she been an adult, her words would not have entertained me, but coming out of a child's mouth they seemed incongruous and harmless. In fact, I admired her spunk and her pride, and saw that her eyes were warmer than her words. I liked her, admired her, respected her candor and continued to do so through the years of our work together. She was bright, pretty, enormously stubborn, and like most bipolar children, she was intensely, perpetually irritable. "I could kill you," she warned me, "I could kill myself." This was my first glance at the hopelessness and futility that would plague Francie as she sank, through the years, into prolonged periods of suicidal gloom. Her parents seemed to trust me, and I agreed to take her on as a patient. In some way I was hopeful about this child.

Bipolar children require a delicate balance of medications that are potentially toxic and dangerous. Mood stabilizers such as lithium, Depakote or the newer agents must be employed to level the turmoil of mania, insulate the bare wires of the mind. Anti-depressants raise the bar on despair but can provoke mania; the side effect of weight gain is especially troublesome to girls, who impulsively stop their medication if their bodies begin to change. As bipolar children grow in size and age, a previously stable regimen loses its effectiveness and new combinations must be tried. Adolescence does not thrive on sickness or its cure. Non-compliance with medication is the rule, the consequences of which in Bipolar Disorder are always serious. Francie and her mother, with whom she lived, were remarkably tolerant of my pharmaceutical juggling, though my patient could not resist a complimentary "You don't know what you're doing Dr. R; I may need an expert."

Through elementary and middle school, and then into high school, Francie struggled to keep her agitated, overly busy mind on learning while trying to enter a social world that was put off by her blunt, hurtful rudeness and chronic, defensive disdain. Her only friends, at times, were her guidance counselors. She was determined to join but didn't know the steps of the dance. I often felt that my office was kind of a refueling stop, a place for her to renew her determination. We had become good friends. She became calmer, less feisty and increasingly respectful. In despair, on one occasion, Francie asked, "What really is wrong with me?" She knew, of course, that she had been called bipolar but had been too scared to explore the meaning of that word. I drew a bell-shaped curve on paper to illustrate the universality of all traits and behaviors and reviewed with her the population curve of bipolar traits. We

talked of racing thoughts, mood instability and irritability. We discussed the balancing actions of the mood stabilizers and anti-depressants. Francie asked to keep the sketch. I added, "You are not bipolar, you are not this illness: you are yourself and always will be. The bipolar condition, like a birthmark, is part of you but is not who you are, what matters to you, or how you choose to live your life. If you had diabetes it would not be you either." She understood what I wanted her to grasp, and she knew that I meant it. She smiled.

When Francie reached her junior year in high school, she underwent a change that I did not, do not understand. At the age when bipolar conditions often become more severe, her moods became more even, her irritability diminished, and her deep depressions virtually disappeared. She had previously worn her hair long, often covering her face. Now she had it cut as to reveal her natural beauty. The lines of her face became sharp, well defined; the crystallization of self within was evident without. On her own initiative, without leads or connections, this socially clumsy young woman found an excellent job. Francie was courageous; she did not complain about her illness and resisted shame after her multiple hospitalizations. She was tough enough, sufficiently self-respecting, not to allow herself, or others, to identify her as different or "crazy." And while she was at times eccentric, old beyond her years, she had developed antibodies to adversity through overcoming it. There are heroes on a small scale. Francie qualified.

The almost imperceptible physical signs in Francie that heralded change are reliable clues in all assessments of patients. In addition to skin turgor and color, posture, gait, dress, hygiene, tone of voice, brightness of gaze, and eye contact are especially informative. Progress in therapy is more accurately measured by these silent, external signals than by the noise of words. In most instances the body, unlike the tongue, seems incapable of deception. The eyes have it. And in depression the body frequently becomes the repository of woes that are of the spirit, not the flesh. The milder end of this spectrum is hypochondriasis; the more severe depressions may present themselves as somatic delusions, convictions that the body is rotting, organs shrinking, teeth falling out, fatal illness developing.

Sandra was orphaned at eight when her parents were killed in a highway accident. After this tragedy she was raised by her maternal grandmother. At age fourteen Sandra's grandmother developed stomach pains that were diagnosed as a gastric malignancy. She died a pain-filled death six months later.

Two months after this loss, Sandra was hospitalized in a state of disorganization. A gaunt, homely girl with facial acne, she was almost mute. She refused food, already looking wasted and ill. She sat doubled over, clutching her stomach, grimacing and moaning as if in pain. I sat with her, and while she made eye contact, she did not speak. I carried on a monologue: "You miss your grandmother (her groaning intensifies). It is so sad to lose her, you must feel all alone (she doubles over). You're worried that you have stomach cancer (she meets my eyes) but the doctor says you're fine. You're trying to keep your grandmother inside (load groan), you want to be with her." Our meetings for a time were iterations of each other, my commentary interrupted periodically by the vivid body English of Sandra's responses. Freud's classic paper, "Mourning and Melancholia," described Sandra's dynamics: to deal with the loss of a loved one, the bereaved incorporates that person, symptoms and all, taking them in wholesale, living and dead symbolically fusing, with the specific symptoms from which the loved one died most prominent in the somatic display.

Sandra began lingering, wraith-like, by my office door, a beseeching look crossing her face whenever I came into view. Shortly she began wailing, almost keening, in a plaintive whine, "Dr. Robson, help me, please help me." As her verbal output increased, her somatic behavior diminished. She moved out of her body, back to her mind when the unbearable pain of this death began to be more tolerable. She wept in paroxysms of grief interspersed with fury at all of the loved ones who had abandoned her, now appearing clinically depressed but vocal, organized and able to eat again. I wondered how she could live, what sustained her in the face of her ill-fated life. I experienced her stark, overwhelming grief and wept with her. Finally, she was discharged to the home of a relative in another city. Some of life's injuries are too severe to heal, leaving the patient crippled or deformed. Within, Sandra's landscape had become as barren and charred as Dresden after the bombing; her stomach's aching ceased, but I'm certain she continued to live in pain.

To an adolescent, time is boundless; when one hurts it seems the pain will never stop. In such circumstances suicide becomes a cure, a drastic, irreversible analgesic. For the child psychiatrist the risk of self-destruction is ever-present; it hovers over every clinical situation where depression is prominent and requires diligent monitoring, though it is an option one would rather forget. Suicides in adults usually involve lengthy planning and careful implementation; in adolescence impulsive acts are more the rule. Available pills, car keys, or a gun, when the family is out of the home at a time of anguish, are

sufficient to bring on sudden, unexpected death. Darren was different.

In adolescent suicides, one often finds a prior history of depression. Darren began drinking at twelve. He liked the taste of alcohol, and by sixteen, when I had brief contact with him, was an alcoholic. His father, absent in Darren's life since infancy, was also alcohol-addicted and prone to major depressive episodes. Alcohol and depression are genetic and familial companions living in the same dangerous biological dwelling. Darren's grades had been declining precipitously following a break-up with a girlfriend with whom he had been closely but stormily involved for the preceding two years. On the day prior to his hospitalization, Darren began drinking, alone, in the afternoon. Out of liquor, he drove to the nearest package store, where he was well known, purchased a fifth of cheap whiskey and, in the darkness of evening, began to drink it behind the store. He consumed the entire bottle, lost consciousness, and was virtually invisible to all who passed. The local police, who frequented this store, happened by chance to pull in far enough to see Darren's prostrate body some twelve hours later. He remained in coma after his hospitalization, near death from alcohol poisoning. When he was sufficiently recovered to talk, I was asked to evaluate the risk of suicide and recommend a plan of treatment.

This six-foot-plus, two-hundred-pounder looked older than his years; he resembled a college-age defensive lineman. His voice was slow, deep and monotonic, his eyes dull, his emotional expression flat and muted, his thinking labored. As with many males, Darren's conscious wish to die was shared with no one and his suicidal act was deliberately carried out in isolation, increasing the likelihood of death and minimizing the possibility of rescue. A girl of that age would probably have shared her despair with someone and would, in all likelihood, have located herself where she would be found. The social skills and impulses of girls decrease the danger of their suicide attempts, though they make many more than males.

Like the lost man unwilling to ask for directions, Darren surrounded himself with lethal silence. He resented his salvation, convinced that the gray, painless obscurity of death was a right taken unjustly from him. He was clear, matter of fact with me regarding his continuing intention to end life; there were no qualifiers. I always ask depressed children and teens the color of their mood. Black is a poor sign, the hue of hopelessness and Darren's selection. I also ask what a child loves and is good at, convinced that competence at even one thing can strengthen if not save a life. Darren answered: "Nothing, I'm good at

nothing, not even dying." When the risk is high I feel scared. I was scared in Darren's case and, against his will, committed him to ongoing inpatient care. But the wish to die, when unambiguous, is a determined ambition not to be thwarted. Darren's compass pointed in only one grim direction. There were no forks in the road ahead.

For many suicidal teens, Darren's Ahab-like single-mindedness is absent. The act is more impulsive, and while it may succeed, at times by mistake, life is still valued. I have become, however, increasingly concerned that suicide is an ever more acceptable choice to the young adult at this time in history. And the value of life, sometimes taken for a pair of Air Jordans, has steadily declined. The erosion of family structure, the dilution of values by which to live, media exposure, and the ready availability of weapons contribute to the adolescent suicide rate. But the tragedy of a wasted young life, whether compromised by untreated mood disorders or ended by death, lies not in the hands of chance. It is avoidable. There are ample hammer blows of misfortune that one cannot easily sidestep. But to willingly step into their path squanders opportunity. It mocks life. The birds I most love, the Red-tail Hawk and Great Blue Heron, do not mock and never squander. My Dachshund, Isabella, cannot be dissuaded from love or life or joy. I bring her to my office.

Nowhere has the beauty and elegance of the mind been more apparent to me than in the unfolding of mourning in a depressed sixteen-year-old girl whose estranged, troubled father had killed her mother and himself while Alyssa was at school. She was referred to me by her principal. Alyssa was a short, muscular young woman with a boyish build and a boyish look topped with short-cut red hair. Her initial response included, much to her chagrin, sudden fantasies of killing friends with whom she might be chatting in the hall between classes. These violent shorts were, she said, altogether out of character for her, and frightening. Her thoughts at bedtime scattered in all directions and her sleep was troubled by terrifying dreams. She assured me that her parents' death was "not a problem." When the pot is about to boil over, you do not turn up the heat. I prescribed a low dose of a major tranquilizer, and the frequency and intensity of Alyssa's horror films diminished. I suggested to her that they were "decoys," distracting her from her sorrow and pain.

Shortly these terrifying images were replaced by the sound of a woman's voice weeping uncontrollably. This experience occurred at random times and initially was as frightening as the earlier

fantasies. “Alyssa,” I asked, “whose voice, whose pain do you think that is?” “Nobody I know,” she answered. I suggested that her mind was playing kindly tricks, keeping her grief at arm’s length, waiting for a stronger, better time to mourn with her own voice, her own tears. “Will that come out of the blue ?” she asked. Knowing that it might, I gave her my cell phone number and made certain that she felt comfortable calling me at any time of night or day. Two weeks later Alyssa reported that she rarely heard the sorrowful voice but now was having “weird” dreams. In one that was particularly distressing, her younger sister was sitting on her lap, sobbing and wanting to be held and hugged. “You’re passing the buck,” I joked. “Your sister has her own therapist and her needs are being met.” Alyssa was very bright and, psychologically speaking, a quick study. “I get it, I get it,” she exclaimed, “it’s a switcheroo.” “Yep,” I answered, “and you’re about ready to call a spade a spade.”

She was, and in time the tragedy of her life became bearable through her own tears, her own sorrow, her own undisguised pain. Her mind’s kindly choreographer was expert in timing and design, never asking more of her charge than she could bear. Such is the artistry of the unconscious drama coach we carry within.

My training in child psychiatry was woefully impoverished in biological approaches to diagnosis and treatment. Of course, few of the array of currently available medications and the research studies to test their efficacy had made their appearance. My practice over the last twenty years has involved many patients needing pharmacotherapy in addition to counseling. While biology is not my native tongue, the advent of medications that address the conditions that I regularly encounter has brought me closer to my identity as a physician. Unlike some of my colleagues, I find a particular sense of competence in properly medicating children and adolescents. The results are sometimes dramatic and gratifying. Archaic Greek won’t buy you breakfast in modern Athens.

Depression is a universal experience. The parent who says to a child in pain, “Buck up, you don’t have it so bad” needs a short course in remembering. For the child with a blackly depressive mood, more tools than time’s passage are required: psychotherapy, medication and a panoramic lens that widens one’s view of the world. My favorite metaphor with children who have abandoned all hope is the inevitable batting slump that topflight major league hitters suffer, usually more than once in the course of a season. They avoid despair by focusing on what they can correct before coming to the plate again,

increasing the chances of better luck next time. Will doesn't always produce a way, but it helps when hell waits around one's corner.