



Webwords 35

Wednesday's child

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Beautiful Val was uncontainable when she brought 4-year-old Timothy to his Wednesday speech appointment several weeks ago. Interrupting constantly with peals of appreciative laughter – in response to her own witticisms and asides – she disrupted the session to the point that persisting was futile.

“Oh God, I’m terrible, terrible, terribly terrible” she chortled unrepentantly, flicking her perfectly coiffed hair with impeccable, fluttering French Tips. “I promise to be good next time. Best behaviour.” Even in this loud, agitated, witty state there was something brittle about her. A needy, vulnerable fragility.

She switched topic unexpectedly, exploding into song to the tune of “I’m getting married in the morning”, “I’ll make a motza minta money, when I buy those fresh food people shares; pull out the stopper, let’s have a whopper! But get me to the Broker on time!” The melody changed to a familiar supermarket refrain. “Oh! Woolworths the fresh food people, get me to the Broker on time.” She stopped. “Would Woolies be one ell or two? Two would be a jumper, wouldn’t it? Warm woollies from Woolies. My English dad always talked about his woollies. Winter woollies. Tepidus vestio; valde tepidus ornatus – he was a Classics scholar, you know! Latin, Greek, Hebrew, not Yiddish. Anyway, with those shares I’ll be a rich wo-MAN.” New tune. It took me back to 1976, *Fiddler on the Roof*, and my unforgettable first encounter, as a speech-language pathologist, with a family in which the mother had a **mental illness**¹. I remembered her name, and the child’s, and the father’s. Alison and Lindsay, and Ben aged 3. And there was a baby.

“If I were a rich man, Ya ha deedle deedle, bubba bubba deedle deedle dum. All day long I’d biddy biddy bum. If I were a wealthy man. I wouldn’t have to work hard. Ya ha deedle deedle, bubba bubba deedle deedle dum. If I were a biddy biddy rich, Yidle-diddle-didle-didle man.”

Timothy looked at me imploringly with a face that said, “Make her stop!”

“Do you know what the midwife said to my dad when I was born? She told him I was strong and healthy, and he said, ‘then she shall be called Valerie’.”

“Is that what Valerie means?”

“Well, yes, in Latin, but obviously, OBVIOUSLY, it’s a joke, a nonsense ...” shrieked Val. “A paradox, a contradiction, an absurd and illogical inconsistency, a cruel and ironic joke ... a mad misnomer ... oh God, you know ... with my mental health issues ... you know, *iss – youse* ... are youse having *iss – youse*?”

She continued talking and singing incessantly, ideas and neologisms flying, as worried, over-responsible little Timothy propelled her out the door. I wondered about his mental health, **now**² and in the **future**³.

A state of well-being

Mental health is defined in the section of the **WHO website**⁴ devoted to such matters as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively

and fruitfully, and is able to make a contribution to her or his community. Elsewhere on the web, in dictionaries and encyclopaedias it is described as a state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.

Full of woe

The following week saw a different Val, medicated to the hilt. Still beautiful, with that indefinable frailty, the French Tips had been gnawed to nothing, the hairdo was awry and she drooped into the room – a picture of defeat. Timothy, hair lank and knotted, clothes grubby and breath sour, followed her closely: casting sad, apprehensive eyes around the room, slumping into a chair, bearing his unpredictable world on his shoulders. Wednesday’s mother; Wednesday’s child. “Mine Nan bring me d-nuther day. Mine Nanny Sylvia. Mummy go hos-pul get better again. Mummy come back.” He hugged himself-for reassurance. “Yes,” she said expressionlessly to herself, self-absorbed, without looking at him or at me. “I’ll be back.”

Toggling between windows

Timothy and his grandmother arrived bright and early the following week, both bandbox fresh, enjoying each other’s company. Sylvia and I were probably both thinking that this was the fifth time we had met and that each time was because Val was having treatment. The first time had been when Timothy presented initially as a non-verbal 2-year-old. Sylvia explained that Val would be bringing him to therapy in due course, but not for a while because she had **postpartum depression**⁵ and wasn’t up to it. Surprisingly, in rapid succession over just eighteen months, Val’s psychiatric diagnosis had been changed to **chronic depression**⁶ and then, soon after her husband left and filed for divorce, **bipolar disorder**⁷. She was in and out of hospital repeatedly, and, as she put it, “Toggling between windows”. When I asked what she meant she responded that life, frankly, for her was either at a distance, through a window on the world clouded by mood stabilising medications and deep malaise, or up close and extreme. The view from this second, exciting window was intensified by manic mood swings and (usually) a refusal to medicate.

Maternal depression

The incidence of depression in all women is reported to be between 10% and 12%. This figure skyrockets to at least 25% for low-income women. Exposure to maternal depressive symptoms, whether during the prenatal period, postpartum period, or chronically, has been found to increase children’s risk for later cognitive and language difficulties (Sohr-Preston & Scaramella, 2006). Indeed, depression is a significant problem among both mothers and fathers of young children. Intriguingly it has a more marked impact on the father’s reading to his child than on the mother’s and, subsequently, the child’s language development (Paulson, Keefe & Leiferman, 2009).

Classically, depressed mothers are seen as “under-stimulating”, being less involved than well mothers, or inconsistently nurturing with their children (Field, 1992). They have been found to: initiate parent-child interactions less frequently than non-depressed mothers and not get as much pleasure from them; talk less to their infants; have reduced awareness of and responsiveness to their infants’ cues; rarely, if ever, use child directed speech (“parentese”); be slow to respond to their children’s overtures for verbal or physical interaction; make overly critical comments and criticise more frequently; show difficulty in fostering their children’s speech and language development; experience trouble asserting authority and setting limits that would help the child learn to regulate his or her behaviour; and find it hard to provide appropriate stimulation.

By contrast, some depressed mothers interact excessively, over-stimulating their infants and causing them to turn away. Whether under- or over stimulating, these mothers are not responding optimally to their infants’ cues or providing a suitable level of feedback to help their children learn to adjust their behaviour. Additionally, there is evidence to show that the children of depressed mothers mirror their mothers’ negative moods and are overly sensitive to them (Goodman & Gotlib, 2002). Some mothers envelop their children in an inappropriate closeness and over-identification with their own moods. Children who are preoccupied with and invested in the reactions of their mothers, fathers or other caregivers may not learn to seek out comfort or accept consolation or reassurance when they need it. As a result, their own activity and ability to express emotion may not develop adequately.

Another story

Of course it is impossible to predict how the story of Val and Timothy will unfold, but hopefully it will not be as tragic as the 1976 story of Alison, Lindsay, Ben and the baby. When Alison brought Ben for a speech assessment, the 3-week-old baby, there in a corner in a carry cot, had not been named. I was concerned when Alison told me dully that she had not had the energy to talk to Lindsay properly about a name for “it”, and the perfunctory, disinterested way she dealt with the tiny infant’s survival needs. She told me she would be all right when the baby blues had passed, as they had done months after Ben’s birth. But this was more than the blues; it was more like postpartum depression. She was off her food, wasn’t sleeping, was irritable with intense angry outbursts, and overwhelmingly tired. As the weeks passed she told me that she was not bonding with “it” (Jessica) and that she was having troubling fantasies about harming herself and the baby. At the time I shared rooms with a psychiatrist, and a meeting with him for Alison and Lindsay was quickly organised. Once on medication she seemed better, but still something was **not quite right**⁸. Towards the end of Ben’s therapy block Lindsay rang to cancel his last three appointments, explaining that they had had “a family calamity”. I left the door open, not daring to guess what the calamity was. When Ben resumed his intervention there was no Alison and no baby. She had smothered the infant and taken an overdose.

Good advice: just simply ask

Debriefing was hard. The psychiatrist said I had done the best one could do by facilitating the referral, and I told him I knew he had done all he humanly could. It was unsatisfactory and sad. His advice to me at the time has been integrated into practice over several decades. “Ask,” he said. “When you take a history, ask each mum, or dad, or other primary caregiver who accompanies new clients, as a matter of routine, about his or her state of mind. Don’t try to look for tell-tale signs or red flags in a history. Just simply ask.”

This good advice is to be had everywhere in the Internet era on a wide range of websites. It can be found in the US Preventive Services Task Force (2009) recommendations for the routine screening of adults for depression, where health professionals are advised to ask two basic questions that may lead to appropriate referrals:

1. “Over the past two weeks, have you felt down, depressed or hopeless?” and
2. “Over the past two weeks, have you felt little interest or pleasure in doing things?”

If an adult client answers “yes” to either or both questions they should be referred, according to the task force, to an appropriately qualified professional in the mental health field to be guided through an in-depth questionnaire to rule depression in or out.

The panel did not make a comparable recommendation for (or against) routine screening of children (7 to 11 years) and adolescents (12 to 18 years) for depression, citing a **lack of evidence**⁹ about the reliability and efficacy of such tests in youngsters.

Speech-language pathologists working with young children should know that a loss of interest in play is a red flag that a child of 3 to 6 years of age is depressed, and that two other major warning signs are sadness and irritability (Luby et al., 2003).

References

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- US Preventive Services Task Force (2009). Screening and treatment for major depressive disorder in children and adolescents: US preventive services task force recommendation statement. *Pediatrics*, 123, 1223–1228.

Links

1. <http://www.sane.org/>
2. <http://www.connectforkids.org/node/3003>
3. <http://au.reachout.com/>
4. http://www.who.int/mental_health/en/
5. <http://www.mayoclinic.com/health/postpartum-depression/DS00546>
6. <http://au.reachout.com/find/articles/depression-types-causes-and-symptoms?gclid=CJD6vlnx5ZsCFZMwpAodpHK36g>
7. <http://www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml>
8. http://www.sane.org/information/factsheets/something_is_not_quite_right.html
9. <http://www.ahrq.gov/clinic/uspstf09/depression/chdepr.htm>

Webwords 35 is at <http://speech-language-therapy.com/webwords35.htm> with live links to featured and additional resources. Clients’ names in this column are pseudonyms.