Chapter 15
A Broken Child – A Diseased Woman

Anna Luise Kirkengen

We are such stuff
as life is made of –
and our lived body
tells its tale.

15.1 Cecily Cramer

Now in her mid-forties, Cecily Cramer[1] is a well-educated, married mother of three children under 17-years of age. My initial contact with her came at the suggestion of her therapists, psychologist Aina, and psychomotor physiotherapist Sanne, both of whom are highly experienced, trauma-oriented professionals.

In our correspondence prior to our first meeting, Cecily authorised me to access the medical records from both of her recent university hospital psychiatric ward admissions, as well as the notes from her out-patient clinical care following the second of these. Cecily also gave me her consent to read the notes from her sessions with Aina and Sanne. Lastly, she allowed me to see the detailed results of an x-ray examination that the university hospital's radiology department had carried out, requisitioned by the hospital's oncology department.

As Cecily and I discussed this documentation in depth during our conversations, I became convinced that her complex sickness history would remain incomprehensible, both to those treating her and to Cecily herself, were her painful life history not taken into account. In fact, her current symptoms could *only* be decoded once their trajectory had been traced back to when they first emerged: at that point, they

[1] Cecily Cramer (pseudonym) has contributed to the present form of her history and consented to its publication.

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were the sole survival strategies available to her. They did aid her, initially, in her struggle to protect herself. Over time, however, her continuing to rely on those same strategies became a dangerous habit, one that depleted her vitality and literally put her life in jeopardy.

When Cecily recognised the pattern and its impact, she realised that she both wanted to, and could, seek help to break free of it. Her 4-year cooperation with Aina and Sanne enabled her to do just that, and, in the process, regain her self-respect, increase her confidence, improve her health, and help her find the strength to go on, both with her personal life and with her profession.

15.2 Crisis Onset

At 20 years of age, Cecily was diagnosed with a rare, aggressive cancer requiring intensive treatment, including surgery, medication and follow-up. After some years, she was pronounced free of cancer. She married, worked full-time as a specialist nurse, took part in competitive sports, and gave birth, each time with complications, to three healthy children who all developed well. Then, her cancer recurred. Again she went through a difficult course of treatment, and again was declared cancer-free. Toward the end of the long sick leave that followed her treatment, the new leader of her department at work, whom she had never met, began urging her to return to her demanding position, full-time. Cecily feared she would lose her job if she refused. Although she did not feel ready, particularly with three small children at home, Cecily "obeyed" and went back to work. She even agreed to work shifts during Christmas.

By January, she was feeling suicidal. She felt overwhelmed by hopelessness, suffered from frequent nightmares, anxiety, insomnia and an inability to concentrate. Desperate and scared, she was admitted to the psychiatric ward.

15.3 Two In-Patient Psychiatric Hospital Ward Admissions

Records from her first admission read as follows:
Woman with known depression, admitted by her GP due to increasing depressive symptoms. Allergic to penicillin and a possible adverse reaction to another drug. Predispositions: alcoholic father, cousin with personality disorder.

No one, however, asked Cecily: How were you affected by your father's alcoholism? How would you describe your parents? How did they treat you? What do you know about your cousin's condition?

Records:
Somatic: surgery and treatment for kidney cancer, 21-years old.

No one, however, asked her: How did that serious disease, and the long-term treatment for it, affect you and your life, especially considering how young you were?

Records:
Patient denies having a substance abuse problem.

No one, however, asked her: Have you ever been abused or maltreated?

Records:
Psychological: Prior depression 2 years ago treated pharmaceutically; considerable side effects from the first meds. Second meds, ineffective.

No one, however, asked her: What would you say is the main reason you feel hopeless and down?

Records:
Patient felt she needed to return to full-time work shortly after treatment for recurring cancer because she was afraid of being fired.

No one, however, asked her: Did you feel pressured, or forced, as if someone had control over you? If so, might that have reminded you of something that happened to you earlier?

Records:
In addition, patient has started to see a psychologist, which has opened up old problems (among these are childhood incest) that the patient, as she puts it, "has trouble coming to grips with".

No one, however, tells her: Nobody ever experiences abuse without being deeply marked by it. No one asks her: What do know about how these early experiences of being abused have affected you and your life – and what do you remember about whoever abused you?

Records:
The patient reports that she has lost her appetite, doesn't sleep properly, doesn't want to get up in the morning, that her memory fails her, that she can't concentrate and suffers at night from anxiety and nightmares.

No one, however, suggests: Your ailments seem to be part of a pattern, perhaps connected to having been under too much stress for too long a time. No one inquires: Do you see any relationship between these problems and experiences from your childhood?

Records:
The patient says that she wants to commit suicide, sees it as her last way out, but hesitates out of concern for her husband and her three children.

No one, however, asks: Why can't you, or why don't you want to, go on with your life?

Records:
The patient confirms that she has had such periods of depression throughout her entire life.

No one, however, asks: Might your feelings of powerlessness and exhaustion have something to do with what was done to you when you were a child? Was there anyone who protected you?

Records:
The patient appears to be suffering, but there is no indication of hallucinations or psychosis. Conclusion: known depression, increasingly aggravated by workplace problems; suicidal ideation. Treatment plan: mood stabilising followed by further treatment.

Addition to the records made by Cecily's ward psychiatrist the following day:
She describes a personality structure characterised by not wanting to speak out or object. She has been eager to do her best, which has probably contributed to her load becoming heavier than necessary. She is sad, prone to weeping, feels hopeless and her thinking is chaotic. Her depressive symptoms range from moderate to high. Her personality does seem to predispose her to depression, although current external stressors have also contributed.

Here, she is assigned a diagnosis while, simultaneously, being defined as its origin – her predisposing "personality". No one seems to have been listening to her when she spoke of having an alcoholic father, or of a childhood marked by incest, as well as other problems – all of which she says she is struggling even to grasp. Psychiatry seems totally deaf to this alarming and highly relevant information.

Addition to the records made by the psychiatrist in charge of Cecily's case, one week later:
The short-term aim for treatment is for her to become calm and stabilised. The long-term aim for treatment is to discharge her in an improved condition.

Nothing in this plan would indicate any intention of seeking to understand the patient, or of offering to help her come to grips with her basic problems. The record does mention, though, that Cecily's medication is to be increased to eight psychoactive drugs.

Addition to the records made by the psychiatrist after 10 days of in-patient treatment:
The patient still shows depressive symptoms. She finds it difficult to participate in planned activities. Her thoughts are in turmoil, constantly circling around the past; in today's conversation ***we*** *try again to talk about it being natural to think of the past when depressed, so that it soon fills all the space. Therefore,* ***we*** *ought to try to concentrate on the actual here-and-now and work with the depressive elements, in addition to acquiring tools to think more positively.* [Emphasis added.]

The psychiatrist uses the plural: "…**we** try…**we** ought". This **we**, however, does not include the patient. By using this **we**, the physician nullifies the patient's stated need to come to grips with what disturbs her thoughts: her past. He shows no interest in this past, nor any intention to inquire into it. He has defined the problem as "here-and-now" with no relationship to "there-and-then".

Four weeks into Cecily's hospitalisation, she meets with psychologist Aina for the first time. Only now is she invited to recount memories of her traumatic childhood and of her inability to comprehend her own emotions. She tells Aina about her younger, multi-handicapped brother for whom she felt responsible because he was so vulnerable, describing herself as "defenceless". She shares that she does feel safe on the ward but misses her children. She admits that, even after 20 years of marriage, she still keeps secrets from her husband, and she reveals to Aina that she starved herself as a teenager because she wanted to die.

Cecily meets with Aina six times before being discharged. Aina summarises in her notes that Cecily has been traumatised, unseen, neglected, and under exceptionally high stress for a prolonged period. Nonetheless, she avoids making any demands on the people around her.

Addition to the records made by Cecily's psychiatrist the day before she is discharged:

The patient is very concerned about whether to talk with somebody about how she was earlier in life regarding all the stress she has been under. We discuss that it is certainly important that everything be dealt with, whenever she is ready. As things are now, however, we must take one thing at a time. Her depression needs to be the focus, and for her to feel calmer and not burden herself with too many stress factors.

The psychiatrist does admit that it would be important, eventually, to discuss the past, although he does not explain why. For him, the disorder itself, *depression*, represents a greater threat to the patient than does the *source* of the disorder. Thus, he separates the disorder from its origins, which he terms "stress factors", without having made any attempt to learn what those might be.

Upon discharge, Cecily is prescribed **seven psychoactive medications**. The physician recommends a prolonged sick leave before a gradual return to work. She is promised out-patient clinic follow-ups to begin immediately, but none is ever offered to her. Despite it being clear that Cecily is on extended sick leave, her employer continues to urge her, insistently, to come back to work.

Six weeks after being discharged, Cecily is readmitted to the same psychiatric ward, in even worse condition than at her first admission. Again, she states that she cannot bear entreaties, demands and threats from someone who has power over her. Again and again, she speaks of how terribly her boss has treated her, of how she has been abandoned by her employer and by the healthcare system that "forgot about" her after her recent discharge.

This time, Cecily meets psychologist Aina after only five days, but they manage to have just two meetings during Cecily's 18 days of hospitalisation. She is told to

continue taking four medications for depression, one for restlessness, two different analgesics to be taken as needed, one drug for nausea and one sleeping pill.

15.4 Follow-Up Care

Without explanation, Cecily is referred to the out-patient clinic for those with personality disorders for her follow-up care rather than, as had been planned earlier, the clinic for people suffering from mood disorders and depression. She is immediately offered an appointment with Aina, however, and from then on, the two meet and talk on a regular basis.

When asked how Cecily felt being on the ward, she responds:

> *The ward nurses and the team in charge of my treatment were told not to talk to me about my past but to keep the focus on my depression symptoms. I felt ignored. Wrong. Put in a box for depressed women. The conversations were only about what* ***they*** *thought was important and about giving me psychological education. Everything was about what I myself could do to overcome my need for isolation and loneliness. But this was exactly what I'd been trying to do on my own, before being admitted. The only advantage to being on the ward was that I didn't commit suicide. And I met Aina, and she had the courage and strength to object to "pre-packaged treatment" and take me under her wing.*

With Aina, Cecily begins to share information about her life that she had not shared before, including, after a few meetings, about her fear of her father. The details that psychologist Aina is enabled to glimpse about what Cecily had been subjected to as a child, convince her to suggest that they involve psychomotor physiotherapist Sanne in the treatment process. Cecily agrees. Sanne examines Cecily's body, her posture, musculature and her patterns of pain and tension. A dual therapeutic process then begins, with sessions twice a week. As often as possible, Cecily's meetings with the two therapists are scheduled to take place on the same day, sometimes with all three working together.

The issues and specific findings that are uncovered are nowhere to be found in Cecily's extensive records, neither within the somatic documentation – the voluminous files from oncology, surgery and radiology – nor in her psychiatric in-patient records.

Four months into this treatment regimen, Cecily attends her routine post-cancer check-up at the hospital's department of radiology. She confides some details about her childhood to the radiologist. This prompts him, at his own initiative and without any official requisition, to take x-rays of her entire body. What they reveal is horrifying: they document a literally broken child. There are x-ray images of 32 fractures – on Cecily's forearms, legs, hands, fingers, toes, face/jaw and thorax – the majority dating from ages 6 to 14. Only the seven fractures that had probably been sustained when Cecily was an adult, the results of sports injuries or a bicycle accident, bear traces of having been treated medically in any appropriate way. The broken child, however, had not received adequate help.

What then did Cecily gradually piece together about her childhood and adolescence?

My alcoholic father was unemployed. So my mother held down two jobs and was out of the house from early morning to late at night, every day, all week. My father stayed home, drinking – and playing cards with his brother and some friends a few times a week. I used to clean up when they'd finished so my mother wouldn't come home to a mess. I also took care of my very handicapped younger brother. Every morning before I went to school I'd get him into his wheelchair and to the bus stop, where they picked him up and drove him to the institution where he stayed all day.

Afternoons were the worst, when the men were around our kitchen table. That's when I was physically maltreated and sexually abused by all of those more-or-less drunk, repulsive men. They cursed me and beat me. They strong-armed me and pushed and threatened and raped me, vaginally, anally, orally. I was locked in the cellar or tied to a narrow shelf. My brother and I were often starving because my father and his friends ate whatever was in the refrigerator. I had no money to buy food because my father spent whatever was in the house on liquor. I was bullied at school because my clothes were old and worn out. I never brought a proper lunch to school, my hygiene was poor, and I was never taken to a doctor. I couldn't always prevent my brother from being beaten and maltreated as well. I learned to hide my pain, even when these men broke my bones raping or beating me. The worst of them was my uncle. My father never molested me sexually, but in all other ways.

15.5 Reflections

15.5.1 Recently Acquired Knowledge

The medical context is changing. The history of Cecily Cramer's life and illnesses represents a case-in-point of knowledge that has not simply been accumulating during the last three decades, but also converging, within a broad field of research domains. In 1998, the first findings of the *Adverse Childhood Experience Study* were published in the *American Journal of Preventive Medicine* (Felitti et al. 1998). These documented that childhood hardships, differentiated into ten types, were shown to correlate to adult sickness, in a dose-response relationship; that is, the more hardships experienced during childhood, the higher the risk of becoming ill in later years (Felitti and Anda 2010).

Since then, many similarly designed studies have supported these findings, worldwide. There is now no doubt *that* childhood adversities resembling Cecily's in type and duration are harmful to a person's current and future health and well-being (Shonkoff et al. 2009). The wide spectrum of detrimental effects reaches into every specialty within somatic and psychiatric medicine, as well as impacting the social sectors charged with tackling alcohol and drug abuse, the law enforcement sector, the family welfare agencies that confront divorces, broken homes, partner violence, occupational issues, disabilities. In other words: the economic consequences of child maltreatment and abuse impact a wide range of societal systems and their budgets, constituting a burden that would be heavy for any society to bear (Knudsen et al. 2006).

Once the fact *that* childhood adversity is related to adulthood sickness had been documented, the question then arose as to *how*. How are experiences of strain transformed into pathophysiological processes? An interdisciplinary field of research currently termed *neuroscience* has been developing steadily, step-by-step. It has helped provide a foundation for hypothesising models that might explain the inherent logic of how those processes occur. The neuro-endocrinologists at Rockefeller University, New York, have made a huge contribution: they developed the now widely accepted concept of *allostasis*, a term meaning, "stability through change" (McEwen 1998). The concept of allostasis aids in exploring the flexibility of human physiology, how it may adapt to extreme challenges and maintain viability during long-term strain and hardship. Deriving from allostasis is the concept of *allostatic overload*, referring to what happens when stressful conditions must be endured over excessively long periods of time, with all the energy-providing systems in the body paying the price. When allostatic overload has exhausted the body's flexibility and adaptability, the most central, systemic regulators may break down (Danese and McEwen 2012). Such a "multisystem-dysregulation" is characteristic of complex sickness, although that is still conceptualised and termed "multi-morbidity" (Wiley et al. 2016; Tomasdottir et al. 2015).

The long-term, overwhelming strain of allostatic overload has been shown to take a toll on the immune system and on the hormonal and central nervous systems as well. This means that the regulation of glucose, lipids, minerals, blood pressure, heartbeat, muscular tension, rest, sleep, respiration and digestion are all adversely affected. These systemic disturbances, or overloads, contribute to an array of serious and chronic conditions, such as cardiovascular, respiratory, and liver diseases, as well as type 2 diabetes. They also affect tumour development and the frequency of infections by suppressing the immune system at the cellular level, both those features that are innate and those the system acquires. Simultaneously, the hormonal aspect of the immune system, the inflammatory system, is in a state of constant hyperactivity, engendering systemic inflammatory diseases, among them the so-called autoimmune diseases (Dube et al. 2009; Song et al. 2018). In addition, recent studies indicate a relationship between Post-Traumatic Stress Disorder (PTSD) and neurodegenerative diseases such as Alzheimer's and Parkinson's.

15.5.2 Updating the Concept of Causality

The knowledge that health professionals have now acquired regarding the potentially adverse impact of certain types of lifetime experience on human health ***obligates*** *them to re-examine the traditional medical understanding of causality.*

For a proper diagnosis to be determined and an adequate treatment offered, the cause of a health problem must be identified correctly; it must not be conflated with aspects and effects of phenomena that are contextual. To paraphrase how a group of scientists at Harvard Medical School put it recently: Whenever the effect of lifetime adversity on the brain is mistakenly labelled as the "cause" of a psychiatric disease, what results is *biased* knowledge (Teicher and Samson 2016; Teicher et al. 2016; Ohashi et al. 2017). Moreover, such "knowledge" masks the actual sources of a variety of types of morbidity and mortality, ones that are apparently intrinsic to the structures of our societies (Farmer et al. 2006; Jones 2000). Treatment based on such mistakes misleads the medical gaze *towards* diseased individuals and groups, and *away from* the pathogenic conditions that they live *with* and *in*. However unintentionally, medicine thus becomes complicit in obscuring abuses of power and all kinds of societal injustice. Must such consequences remain unexplored within medicine because they are defined as lying outside the mandate of the profession?

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