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DEPRESSION and MOURNING

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Depression in childhood has been a controversial subject in clinical and theoretical circles because there is a lack of agreement about the relationship between the intent and significance of utilizing the same terms and psychological concepts for children as for adults. This controversy has historic roots centered on the changing meaning that children have for adults, especially during the past 300 or 400 years. During this period, children have gradually been recognized as representing the adults' claim on the future—immortality—rather than as chattel to be exploited for the present. Thus, there have been many obstacles to the recognition that children are not homunculi, having their developmentally appropriate emotional and mental reactions which are different than but forerunners to adult reactions.

In the consideration of depression and mourning in childhood, the major question is not whether these reactions and processes are the same as for adults. They are not. The major question is whether it is productive, recognizing the dynamic maturational and developmental continuum that is encompassed, to use the same terms and to establish connections between these childhood and adult conditions.

Emotional responses are universal in children and adults, though the understanding of their tone, content, and meaning often require interpretation. Certainly, emotional expressions and processes are motivated

as well as reactive. In an important sense, emotional responses and expressions are adaptive or coping devices, but they also can become associated with or characteristic of deviant or inhibited development and behavior. Depression should be viewed as related to deviant as well as to normative development in children as well as in adults. Depressive reactions may constitute first steps toward restitution, as well as an indicator of success or failure in coping with loss, or a symptom and sign of illness. Thus, depression cannot be understood unless it is related both to the dynamic human psychological context in which it arises and to the developmental tasks confronting the individual who is depressed.

In this chapter the terms "depression," "depressive reactions," and "mourning" will be used, with the assumption that it is productive to use the same terms in childhood as in adulthood, though their meaning is not identical. Developmental considerations and qualifications will enable us to avoid the major disadvantages of utilizing the same terms for children as for adults.

Developmental Perspectives

When a child is sad, feels hopeless or inadequate, his capacity, before adolescence, to tolerate and cope with these reactions as a mood or emotional state (affect) is limited. It is questionable whether the effect of sadness,

depression, and feelings of helplessness can be experienced and communicated before certain levels of ego and superego development are achieved. For these reasons, depression in childhood is usually observed as behavior to ward off or react against the impact of feelings of sadness and a sense of loss, hopelessness, or inferiority.

Paradoxically, in children under the age of two years, as demonstrated by Spitz, Provence and Lipton, and others the child initially may show the reaction to loss by facial expressions and lack of motor activity. The facial expressions in these abandoned infants, and also those who have been significantly maternally deprived, have been described by scientific observers as forlorn, sad, apathetic, blank, unresponsive, and nonsmiling. Later, psychophysiological equivalents such as diarrhea, anorexia, vomiting, and skin disorders may be noted. As the child becomes a toddler, motor activity away from what is intolerable, namely, feeling sad or unloved and helpless, and toward relief, namely, a replacement or distraction, is increasingly characteristic.

In adults, the emotions and moods that are characteristic of depression can be tolerated to a much greater extent. In normative depressive reactions, the adult is able to tolerate the mood and to reflect about what can be done, if anything, about it. If there is no immediate action that is appropriate, the adult will use thinking and memory, adaptive trial actions, to understand,

tolerate, and get beyond the depression to other aspects of experience and life.

Assuming that the perception of emotional states (affects) and their communication are an ego function, depression as experienced by adults would require the following preconditions :

1. The availability of memory and thinking as a sense of the past and their continuity with the present and future.

2. The capacity to inhibit or store up motor discharge when psychic tension or discomfort is increasing.

3. The capacity for the closeness and tenderness that is characteristic of the oedipal period and the resolution of the oedipal conflict in which there are haunting sad feelings of loss and failure to achieve a romantic intimacy with the primary love object.

Many observers indicated that such a structure and intensity of sadness, depression, and painful nostalgia (helpless to win out in terms of oedipal strivings) is not available and not experienced until adolescence.

Before the pre-pubertal and adolescent periods of awareness, the conditions of sadness (loss), loneliness (aloneness), and helplessness are warded off by motor discharge or by obsessional preoccupations because memory, capacity for postponement, and anticipation are not adequately

developed to promote the feeling and expression of depression. In fact, when a younger child is depressed and because of traction or paralysis cannot move adequately, the failure of defense against depression is often manifest as withdrawal, apathy, and regression.

In a young child the capacity is lacking to use memory as a dependable, comforting mental activity that will enable the child to have the loved person with them psychologically, as well as to project ahead and anticipate that the lost love object can or will return in the near future. The young child also lacks the capacity for generalizing to an expectation that a substitute can be found or provided for the dead or lost love object. This is also a function of the inability to differentiate and individuate in the young child. Consequently, the young child, not fully understanding loss and not being able to cope with feelings of helplessness, attempts to erase or deny the loss, to pretend that the loved person will return, or to attempt to latch on immediately and relatively indiscriminately to another adult as a concrete replacement.

When the panic or discomfort associated with feelings of loss, hopelessness, helplessness, and inferiority is experienced, the young child appropriately attempts to lessen the shattering, painful feelings by acting concretely. He moves to discharge tension and to get away from the internal overwhelming sadness or helpless feeling by externalizing his concerns and fears. Instead of feeling sad, he is afraid there will not be enough food and

tends to overeat. Instead of feeling helpless, he more actively becomes busy to reassure himself that he can do what he had done before the impact of his depressed reactions. Instead of feeling hopeless and inadequate, he tries to find out in concrete ways that life, food, warmth, love, and gratifications will continue.

A five-year-old boy's father was killed suddenly in an automobile accident. When the boy, who had been very close to his father, was told, he blinked, moved away from his mother, came back, and asked fearfully, "Will we have enough to eat?" Although depression in childhood is not limited to the loss of a love object, this experience is most commonly used as an example of a condition that evokes the reactions associated with depressive and mourning reactions characteristic of childhood.

It should be clear that sadness and other depressive reactions are also an essential part of the emotional repertoire that well-functioning adults are assumed to have a capacity for if their development has been full and balanced. As Hartmann stated, "A healthy person must have the capacity to suffer and be depressed." Later, Hartmann added that "what appears as pathological' in a cross- section of development may, viewed in the longitudinal dimension of development, represent the best possible solution of a given infantile conflict." There can be no human life without loss and disappointment. At the same time, no human being can adequately relate to

other human beings in an affectionate and enduring manner unless he can identify and empathize with his friends, relatives, coworkers, and fellow citizens, including those times when people are depressed. Thus, we expect that a child who is developing well, who is healthy and able to achieve object constancy, will be able to increase his capacity to feel and cope with sadness, loneliness, hopelessness, and inadequacy when it is appropriate and when it becomes the basis for understanding others as well as accepting oneself in a more realistic and understanding way.

Theoretical and Clinical Perspectives

Greenacre stated

> Depression, as a symptom, is as ubiquitous as life itself, and, in a mild degree, appears "naturally" as a reaction to loss which no life escapes. Its occurrence under these conditions is so regularly present as to be accepted as an accompaniment or sequel to loss which need hardly be questioned. It is, however, a positive, forceful affective state, though in a negative direction as in contrast to apathy or indifference which it may superficially simulate, and it implies inherently some degree of identification of the subject with the object loss. It is certainly the intensity, the excessive duration and the domination of the organism by the affect rather than its occurrence, which is pathological.

In childhood, the intensity of feeling depressed is not tolerable as an emotional state, and therefore the depressed child acts to relieve himself and to ward off the threatening, overwhelmingly painful feeling. There is also evidence in instances of permanent loss, that until the child has become pre-

pubertal (approximately nine to eleven years of age), he cannot conceptualize the permanence and inevitability of the process of dying and of death. Loss is experienced according to the developmental capacity, cognitively and emotionally. In fact, it may be heuristically productive to view the permanent loss of a primary maternal person in the first two or three years of a child's life as productive of a psychosomatic depressive state. As Anna Freud indicated, "It is an old finding that the satisfaction of early body needs opens up the way to object attachment and following this to the individual's general capacity for object relationships." Conversely, the loss of this primary love object, who has served as a vital source of stimulation and regulation, as an activator and auxiliary ego, will evoke depression that has its physiological as well as psychological expression.

In this connection, Edward Bibring stated,

> Basic depression represents a state of the ego whose main characteristics are a decrease of self-esteem, a more or less intensive and extensive inhibition of functions, and a more or less intensely felt particular emotion; in other words, depression represents an affective state, which indicates a state of the ego in terms of helplessness and inhibition of functions.

Bibring further linked anxiety and depression as basic feeling states characterized by helplessness, when he said,

It may be helpful to compare depression with the feeling of anxiety, particularly since the latter has been brought in close connection with the

feeling of helplessness [by Freud]. Both are frequent—probably equally frequent—ego reactions, scaling from the mildest to the most intensive pathological structures. Since they cannot be reduced any further, it may be justified to call them basic ego reactions. From the point of view elaborated here, anxiety and depression represent diametrically opposed basic ego responses. Anxiety as reaction to (external or internal) danger indicates the ego's desire to survive. The ego, challenged by the danger, mobilizes the signal of anxiety and prepares for fight or flight. In depression the opposite takes place; the ego is paralyzed because it finds itself incapable to meet the "danger." In extreme situations the wish to live is replaced by the wish to die.

However, anxiety and depression are not mutually exclusive. A person may be anxious and depressed, a mixed state often noted in children with an underlying failure of self-esteem. In such child patients the anxiety state may cover an underlying and threatening depression with a paradoxical increase in manifest motor activity.

Direct observations of children, especially those in intensive psychotherapy or psychoanalytic treatment, have confirmed the utility and theory-building productivity of Bibring's formulations. In the context of intensive therapy, as reported by Furman, Kliman, McDonald, and others, many of these characteristics of sadness, depression, and mourning can be discerned. This suggests that the ego-strengthening effects of the treatment

and the therapist enable the child to forego the defensive, warding-off reactions to the depressive condition, the very reactions that ordinarily indicate an underlying depression in children. This would clarify the apparent controversy in the literature about children's capacity to experience depression and to mourn when there is a permanent loss of a primary love object.

An elemental manifestation of depression is that seen in anaclitic depressions. Spitz characterized this state as follows: "Apprehension, sadness, weepiness. Lack of contact, rejection of environment, withdrawal. Retardation of development, retardation of reaction to stimuli, slowness of movement, dejection, stupor. Loss of appetite, refusal to eat, loss of weight. Insomnia." He added to this by saying: "To this symptomatology should be added the physiognomic expression in these cases, which is difficult to describe. This expression would in an adult be described as depression."

The following case illustrates many of the clinical and theoretical issues that are involved. An eight-and-one-half-year-old boy had been in psychoanalytic treatment for almost two years when his father died suddenly of a subarachnoid hemorrhage. Just prior to his father's death Eddie had been expressing a great deal of aggressive rivalrous feelings toward his older sister and brother and had begun to realize that much of this feeling was displaced from his father onto his siblings. Eddie was referred for treatment because his

stubborn, provocative behavior had begun to interfere with his social relationships at school, to be associated with a negative attitude toward his school work, and to lead into physically daring and risk-taking acts.

In the two interviews just prior to his father's death, Eddie was preoccupied with his envy of his analyst's children and expressed his resentment about the analyst's involvement with his wife and children. Negative oedipal longings were clearly expressed in the transference and could be verbalized and interpreted in preparation for working through his defensive and regressive reactions and tendencies.

Because of his father's sudden death the analyst was the first person to inform Eddie about his father's death. Eddie's first reaction was that of sadness and helplessness conveyed by his facial expression and the posture of his body. Then he asked anxiously and slowly, "Will we have to move? How can we pay for the house? Can you help my mother? She doesn't have enough money to buy food for us." He then spoke apprehensively about money for the treatment and wondered if I would have to stop seeing him. The sadness and apprehension about insufficient supplies and helplessness were replaced after one week by wild, provocative behavior.

Interpretations were not very helpful, and as the analyst conveyed his acceptance of Eddie's sadness and fearfulness, the little boy began to

communicate through behavior and verbalization his fear of dying, of joining his father. He played out his fear of being caged or unable to move. He dramatized dangerous behavior, pretending he would jump from the tallest building. During the second week after his father's death he began tearfully to review his father's recent life and work, to express his fear of losing control of himself and his apprehension that his mother would become sick and go away.

During the third week he began to give evidence of sporadic overeating, followed by a poor appetite for a short period. His fear of not having enough food was played out, and as he became more clear about this unrealistic apprehension he wondered how they could get along without his daddy. There were then several play episodes in which he utilized regressive reviews of himself as a baby to review his feelings about his father and to express resentful feeling that his father could not leave him if he was supposed to grow up.

In the transference, over the next six to nine months, Eddie also "recovered" his father by playing out and talking about the fantasy that his mother and the analyst would marry and Eddie would become the analyst's son. About six months after his father's death, Eddie responded with sadness and reflective memories about his mother and father when his longing for his father was interpreted in the context of the fantasy transference play that his

mother and the analyst would marry.

Of course, there was a great deal of the mourning process that reflected regressive, developmentally appropriate reviews and revisions of his relationship to and longing for his father. For example, his fearful identification with his dead father was prominent in his transient phobic reactions to sleep and to small rooms at the same time as he was engaged in eating binges.

Eddie's analysis was completed two and a half years after his father's death. Toward the end of the analysis the mourning process appeared to be well along. However, there was still a good deal of guilt about the father's death that turned up as a reluctance to do well at school. When it was suggested that Eddie was fearful of the consequences of doing well at school he initially ridiculed such an idea. Thereupon, through the analysis of a dream that was evoked in part by this interpretation, he completed part of the mourning process that had not been worked through.

In this dream Eddie is alone with his mother who is dying. He is frantic and cries out. This awakened Eddie and brought his mother running into his room. The analysis of the dream revealed Eddie's longing for his father to protect him from a threatening closeness to his mother, especially from a feminine identification with his mother. This led to an important

reconstruction in which Eddie recovered repressed memories of his father expressing concern that he would not live long enough to see his youngest child well launched into adulthood. Eddie also recovered his angry reactive feelings that his father would cheat him as compared to his two older siblings. This unacceptable anger and the magic connection of, if I live (succeed), father will die (reject me) were key factors in Eddie's reluctance to succeed academically.

Another factor was involved in this reconstruction that enabled Eddie to complete a great deal of his mourning reaction. The analysis, by agreement, was in its final phase. Eddie was fearful that ending the treatment would finish off his analyst, himself, or both. Not doing well at school represented the fear of the future and the effort to make time stand still, perhaps even to turn it back so his father would be there to help him. It represented a regressive effort to make anger safe and limit closeness to the mother.

The mourning process is periodically reawakened in children as they take on new developmental tasks in which the tie to the dead parent is an important bridge from the past to the future. It is a bridge that is so basic that it must be repeatedly traversed, especially in regard to those crucial identifications and progressive individuations that promote or can interfere with the process of identity formation as it continues on throughout the life cycle.

In her 1960 discussion of John Bowlby's paper, "Grief and Mourning in Infancy," Anna Freud stated,

> The process of mourning (Trauerarbeit) taken in its analytic sense means to us the individual's efforts to accept a fact in the external world (the loss of the cathected object) and to effect corresponding changes in the inner world (withdrawal of libido from the lost object, identification with the lost object). At least the former half of this task presupposes certain capacities of the mental apparatus such as reality testing, the acceptance of the reality principle, partial control of id tendencies by the ego, etc., i.e. capacities which are still undeveloped in the infant according to all other evidence. We have hesitated therefore to apply the term mourning in its technical sense to the bereavement reactions of the infant. Before the mental apparatus has matured and before, on the libidinal side, the stage of object constancy has been reached, the child's reactions to loss seem to us to be governed by the more primitive and direct dictates of the pleasure-pain principle.

Later she stated, "Any assessment of the eventual pathological consequences of a separation trauma is inseparable, in our belief, from the assessment of the level of libido development at the time of its occurrence." A. Freud concluded this passage with the concept that if the child has attained the level of so-called object constancy, "the image of the cathected person can be maintained internally for longer periods, irrespective of the real object's presence or absence in the external world, and much internal effort will be needed before the libido is withdrawn."

In this same series of discussions about Bowlby's paper, Spitz pointed out, "I agree with him [Bowlby] that loss of the mother figure—or, as I prefer

to call it for the age below one year, loss of love object—is responded to by the infant with grief."

Though mourning is a special or specific instance of depression, in childhood the consideration of this phenomenon raises to theoretical and clinical visibility the developmental issues and the future research that is necessary to clarify how children react to loss and how they express sadness, grief, and depression. These insights, in turn, will enable us to develop interventions that will assist the depressed child immediately as well as interventions that are designed to protect the child's future development from delayed distortions and obstacles resulting from the trauma and disabling identifications associated with an inadequate or stunted mourning process.

Familial and Epidemiological Factors

There is a high incidence of parental depression associated with depressive reactions in childhood, a function of the child's identification with parental attitudes and expectations. Also, there appears to be significant correlation between parental death and depressions that may have been initiated in childhood but manifested during adulthood.

In examining the treatment records of 100 children treated psychoanalytically at the Hampstead Child Therapy Clinic, Sandler and Joffe

reported that a number of children of all ages showed a depressive reaction in response to a wide range of environmental or internally psychological precipitating factors. They did not report on the incidence because they found a tendency toward depression mixed with defensive reaction in most of the children in analysis with great variation of intensity and duration.

Many clinicians associate the child who is depressed with a severe object loss in his childhood. Others associate depression during childhood with a failure of self-esteem or unresolved dependency conflicts. Depressions in childhood, as with adults, are overdetermined in that a wide variety of inner conflicts and environmental pressures may be associated with depressive reactions. It is also clear that depressive reactions and depressions can be more easily discernible if the child is in an intensive psychotherapeutic alliance in which the psychotherapist serves as an auxiliary ego for the young child.

Treatment and Prevention

Prevention is mainly based on protecting the child's affectionate bonds with his primary love objects and on providing him with opportunities to gain approval and to be active in following his own interests. The latter enables the child to develop a realistic and resilient self-esteem.

In the treatment of depressed children and adolescents there often is a

good deal of resistance to treatment because the child fears exposure to the threatening depression. However, as has been cited earlier in this presentation, the evidence that a child is depressed usually emerges gradually during an effective treatment. In fact, most children are referred for treatment because of a school learning problem, impulsive behavior, or other problems. In the course of the treatment, the underlying depression becomes uncovered, and with the support and interpretive assistance of the therapist the child is able to feel and cope with the depressive reactions. The interpretation of the defenses against these sad feelings and sense of loss and helplessness will gradually enable the child to re-experience his depressive reactions and work them through.

There are depressive attitudes and feelings that are reactive to a child's handicaps, physical and intellectual. Often this tendency or trait persists in a recurrent fashion. The principles of treatment and prevention are, of course, the same in these situations.

Although the use of phenothiazines can be considered in providing relief for agitated states in association with clinical depressions, drugs are usually not necessary or helpful unless the child is suffering from a psychotic condition. In neurotic or reactive depressive conditions the child's own defensiveness wards off the feelings of depression. The aim of the treatment in these instances is to help the child through play, verbalization, and

interpretations to experience the depressed state gradually in order to gain insight, overcome the trauma, and resolve the conflicts related to the depression.

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