

American Handbook of Psychiatry

A microscopic image of a brain section, showing the intricate structure of the cerebral cortex. The image is oriented vertically, with the top of the brain at the top of the frame. The tissue is stained, showing various shades of brown and tan, with prominent gyri and sulci. The overall appearance is that of a detailed anatomical study of the brain's surface.

Depression and Suicide

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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

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DEPRESSION AND SUICIDE

In 1961 Grinker et al. stated, "It is a curious phenomenon, that, although depressions are so frequent, not only in hospital practice but also among ambulatory patients seeking clinical and private office care, very few investigations have been made on this syndrome as contrasted with the intensive work carried out on schizophrenic, psychosomatic and other psychiatric conditions." Over the past ten years this situation has been partially corrected. Numerous studies have been published, mainly on the possible biochemical basis of depression and even more frequently on the response of depression to various anti-depressive medications. Almost all the work done has been concerned with the adult patient.

The question of depression in children and adolescents has continued to receive little attention. The indexes to Kanner's *Child Psychiatry* and the first edition of the *American Handbook of Psychiatry* do not include the term. Beck, in a 370-page monograph on depression, failed to refer to depression in children and adolescents, while Klerman, in a very recently published review of clinical research in depression, did not cite a single paper on this topic.

Why is there such a striking discrepancy in the attention paid to depressive reactions in adults as compared with children and adolescents? Several factors are responsible. Some authors, among them Rochlin, have

concluded, on purely theoretical grounds, that “clinical depression, a superego phenomenon, as we psychoanalytically understand the disorder, does not occur in childhood.” Others have stressed the absence in children of the usual clinical signs and symptoms that characterize depression in adults. As Lehman wrote,

There has always been agreement among clinicians about the phenomena that characterize the psychiatric condition which we call depression or sometimes melancholia. The characteristic symptoms are: a sad, despairing mood, decrease of mental productivity and reduction of drive; retardation or agitation in the field of expressive motor responses. These might be called the primary symptoms of depression. There are also secondary symptoms—feelings of helplessness; hypochondriacal preoccupations; feelings of depersonalization; obsessive-compulsive behavior; ideas of self-accusation and self-depreciation; nihilistic delusions; paranoid delusions; hallucinations; suicidal ruminations and tendencies.

We seldom encounter similar clinical pictures in children and preadolescents. This has led Rie, following a review of the literature on depression in children, to conclude, “An examination of the implications for child psychopathology of the dynamics of adult depression, including the roles of aggression, orality, and self-esteem, generates serious doubt about the wisdom of applying the concept of depression to children.” He then stated: “There may be room to believe that the fully differentiated and generalized primary affect characterizing depression, namely despair or hopelessness, is one of which children—perhaps prior to the end of the

latency years—are incapable.” Recently, however, several authors concluded that depressions do occur in children and adolescents. I have indicated that in order to recognize depressions in children and adolescents “we have to cease thinking in terms of adult psychiatry and instead become accustomed to recognizing the various manifestations by which depression may be represented in younger people.” A few earlier papers also indicated that even the classical type of depression might occur in the very young. In 1946 Spitz and Wolf described a group of institutionalized infants with symptoms of withdrawal, insomnia, weeping, loss of weight, and developmental retardation. Some of these symptoms progressed to stupor and death. The authors coined the term “anaclitic depression” to describe what would better be called an infantile depression. Separation from the mother between the sixth to eighth month, for at least a three-month period, was postulated as the cause of this reaction. The better the mother-child relationship had been, the more severe the reaction following separation. In the same year Goldfarb described intellectual and social retardation in a group of institutionalized children as owing to emotional deprivation, but did not use the term “depression.”

Engel and Reichsman described an infant with a gastric fistula who spontaneously developed a depressive reaction and in whom they could induce a depression experimentally. After the infant recovered from depression and marasmus, she would react with a depressive-withdrawal

reaction when confronted with a stranger, but would recover when united with a familiar person. The authors believed this reaction was due to loss of the mother and the infant's awareness of her helpless state. Sandler and Joffe posited a similar explanation for childhood depression. Bowlby, who exhaustively studied the effect of separating a child from its mother, described three stages that the child undergoes when separated from the mother: protest, despair, and detachment. All these can be considered as various stages of depression in youngsters, though Bowlby preferred to use the term "mourning."

Earlier, Despert stated that "depression in children is not so uncommon as a survey of the literature would indicate." Out of 400 children she treated, 26 were described as having "depressive moods and/or evidencing preoccupation with suicide or expressing realistic suicidal threats." Eleven children who reacted to the death of a parent with depression were described by Keeler. He noted that children often mask such feelings and recommended the use of psychological testing to help the clinician recognize these emotions.

A six-year-old boy with acute poliomyelitis, who developed a severe depression, was noted by Bierman, Silverstein, and Finesinger to resemble adult depressives. "He looked sad and depressed, so much so that the interviewer was prompted to record that he had at times what one would call in an adult a melancholic facies. He talked in a low, weak, sad voice." This

depression lasted for two months after his departure from the hospital. The authors noted that the youngster “said very little directly about his disability, but in his doll play and psychological test performance a great deal was revealed which bears on the topic of body damage and hence on the narcissistic injury. The extent and severity of the perceived damage far surpassed those of the disability as objectively measured.” Lowered self-esteem, similar to that seen in adult melancholics, was emphasized by the authors.

In an eight- to eleven-year-old age group seen in outpatient therapy, Harrington and Hassan noted that seven girls out of a group of fourteen were depressed. They described “a common syndrome of weeping bouts, some flatness of affect, fears of death for self or parents, irritability, somatic complaints, loss of appetite and energy, and varying degrees of difficulty in school adjustments.” They also noted the comparison to the clinical picture seen in adult neurotic depressives and related the depression to self-depreciation and ego weakness.

Agras studied the relationship of school phobia to childhood depression in seven children between the ages of six and twelve. He suggested the term “depressive constellation” to describe a propensity toward depression in both mother and child. He described “a syndrome comprising depressive anxiety, mania, somatic complaints, phobic and paranoid ideation” which he believed

to be “close phenomenologically to the depressive disorders of adults.” Campbell also related school phobias to depressive reactions in children, though he believed them to be a variety of manic-depressive disorders. Homesickness in children was described by Statten as a “symptom complex, usually associated with separation from home, which reflects an underlying depressive state, to which a child is attempting to adjust.”

Sperling introduced the term “equivalents of depression” in children. She and I emphasized that the clinical manifestations of depression in children differ from the picture as seen in adults. Both studies mentioned anorexia, gastrointestinal disorders such as ulcerative colitis, and sleeping difficulties as indications of depression, especially in infants and younger children. They also both noted that the mothers of such children are often depressed. Ling, Oftedal, and Weinberg described headaches as a symptom of depression in ten out of twenty-five children with the presenting complaint of headache. He also noted a strong family history of depression in such cases.

In the latency-aged child I described behavioral difficulties such as truancy, disobedience, temper tantrums, and running away from home as depressive equivalents. I added, “The youngster is convinced that he is bad, evil, unacceptable. Such feelings lead him into antisocial behavior, which in turn only further reinforces his belief that he is no good. The youngster will often feel inferior to other children, and that he is ugly and stupid.”

Preadolescents exhibit similar behavior. Denial is frequently utilized as a means of avoiding facing depressive feelings. Boys find it especially difficult to express depressive feelings, as they often regard them as evidence of weakness.

Younger adolescents may evidence depression by boredom, restlessness, an inability to be alone, a constant search for new activities. Many adolescents exhibit such symptoms occasionally, but the persistence of these traits should be suspect. Depression may also be manifested by feelings of alienation, isolation, and emptiness. The tendency of adolescents to group together in fraternities and communes is often an attempt to find support in each other and relief from such feelings. Many will resort to the frequent and excessive use of drugs and alcohol to escape their painful emotions. Sexual activity, often of a promiscuous nature, is frequently attempted to alleviate feelings of depression and loneliness. Such behavior, though temporarily successful, often leads only to guilt and further depression. Many a teenage girl has become pregnant out of wedlock in the vain attempt either consciously or unconsciously to escape feelings of boredom and depression.

Bodily complaints encountered in adolescents who are depressed are often similar to symptoms found in depressed adults. Fatigue is a frequent presenting complaint. It is especially significant when present upon awakening in the morning. Hypochondriacal complaints and bodily

preoccupations should always make one suspicious of an underlying depression in any adolescent.

Difficulty in concentration is one of the most frequently encountered complaints presented by depressed adolescents. Teachers, guidance counselors, and physicians should always take this complaint seriously. Previously bright students will begin to fail academically, much to the amazement of parents and faculty alike. These students will become discouraged, convinced that they are not able to cope with their studies. Such a conclusion can only diminish their already weakened self-esteem and lead to further depression. Nicoli,³⁷ studying dropouts from Harvard University, concluded that “depression is by far the most frequent and the most significant causal factor in the decision to interrupt or terminate one’s college experience.” He related the depression to an

awareness of a disparity between the ideal self as a uniquely gifted intellectual achiever and the real self as one of thousands of outstanding students struggling in a threateningly competitive environment. This awareness, gradual or abrupt, results in the clinical picture frequently observed in the dropout; feelings of lassitude, inadequacy, hopelessness, low self-esteem, and inability to study.

We have very little information as to the effect that depression, occurring during the adolescent years, will have on future psychic functioning. Hill wrote that “suicide is significantly more common in depressed women who lost their fathers at age ten to fourteen, and to a lesser

extent at fifteen to nineteen. Men and women whose mothers died in the first ten years of their lives also attempted suicide more often.” This suggests that these children may have become depressed following their parents’ death and continued as depressed adults. I believe that though some may spontaneously overcome depressive feelings during adolescence, many do not. One can only speculate what influence depressive feelings during adolescence can have on the psychotic depressions of the involuntal years.

Many depressed adolescents utilize denial and acting out as a means of avoiding depressive feelings. Such acting out may lead to serious delinquent behavior, as described by Kaufman and Heims: “A crucial determinant (in delinquency) is an unresolved depression, which is the result of the trauma which these children have experienced.” They noted further: “We consider the delinquent acts of taking and doing forbidden things or expressing resentment and hostility to the depriving world as the child’s pathologic method of coping with the depressive nucleus.” Burks and Harrison¹³ came to a similar conclusion, viewing aggressive behavior on the part of many delinquents as a method of avoiding depression. Kaufman and Heims²⁹ theorized that delinquents suffer from a severely impoverished self-image and a profound emptiness of ego, comparable to the emptiness of the schizophrenic ego.

During mid-adolescence classical depressive reactions are frequently

encountered. In addition to many of the classical signs and symptoms of depression, the adolescent often exhibits a confused self-identity. He may complain of being isolated, unworthy, and unlovable. Such a youngster may appear to resent his parents, yet in reality is overly dependent on them. Separation from home and parents, owing to leaving for service or college, will often lead to a profound homesickness and depression. The separation from the parents, though often eagerly desired, is experienced as a loss of love.

In reviewing the histories of depressed adolescents, one discovers that many exhibited behavioral difficulties prior to the onset of their depressive symptoms, difficulties which have previously been called "depressive equivalents."⁴⁷ Thus the thesis that such symptoms are manifestations of depression in younger persons would appear to be substantiated. It is of interest that the behavioral difficulties usually disappeared when the overt clinical picture of depression developed.

In a discussion of depression in children some mention must be made of the incidence of manic-depressive psychosis. There is almost unanimous agreement that manic-depressive reactions are extremely rare in children and young adolescents. Kasanin and Kaufman were able to describe only four effective psychoses before sixteen years of age, and all four cases presented initial symptoms after fourteen years of age. Anthony and Scott,⁴ after an

extensive review of the literature on manic-depressive psychosis from 1884 to 1954, discovered only three cases in late childhood that they felt qualified for the diagnosis; they added one case of their own where the initial symptoms occurred at twelve years of age. Campbell is one of the few authors to believe that manic-depressive psychosis is not unusual in children. His views have not received much recognition. Hyperactive, manic-like behavior is often observed in children and adolescents, but on careful clinical observation and study it is almost always diagnosed as the symptoms of a hyperactive, brain-damaged child or an excited schizophrenic.

Psychological testing can be most helpful in recognizing depression in children and adolescents. As already mentioned, many depressed youngsters find it difficult to openly face and discuss their painful feelings. In fact, many will utilize denial to a considerable degree and cover up their depressive feelings with aggressive behavior. One must always bear in mind that the psychodiagnostic picture is often different from that seen in adult depressives. Anger is usually openly expressed, while depressive feelings remain in the background, the reverse of the usual adult patterning. There may be a diminution of color responses on the Rorschach. The Rorschach also shows images of body emptiness, as well as angry, aggressive, sadistic ones. On the WISC or WAIS, one usually finds a higher performance than verbal score—once again the reverse of that seen in adult depression. This patterning is similar to that shown by sociopaths and may be related to the

tendency toward acting out already described.

Dream and fantasy material can be of assistance in the study of depression in children and adolescents. They often dream of dead persons calling them to the other world. Not infrequently they dream of being attacked and injured. On other occasions their dreams will picture bodily emptiness or loss of various parts of the body. Kaufman and Heims and I interpreted such loss of bodily parts to a loss of a significant relationship rather than to castration anxiety. The fantasies of depressed youngsters constantly refer to the theme of being unloved and unwanted. They frequently fantasize that they belong to another family. Fantasies of running away from home and of being dead are also frequently encountered. Associated with both these is the recurrent thought that someone (usually the parents) will be sorry for having treated them so badly.

Diagnosis

The new classification of the American Psychiatric Association is very unsatisfactory concerning the classification of childhood disorders. Depression is not even mentioned. Faux and Rowley, however, proposed the following categories of depression in children and adolescents:

Grief Response (Functional Depression)

Overt depression manifested by feelings of futility, guilt, unworthiness, or self-destruction.

Depression masked by manipulative expression.

Depression masked by denial.

Depression masked by hostility.

Depression associated with withdrawal and fantasy.

Endogenous Depressive Diathesis (A term that implies an idiopathic constitutional tendency; possibly the early manic-depressive should be so categorized.)

Depression Associated with Cultural Deprivation (A circumstance in which there is insufficient stimulation, which results in listlessness and apathy.)

Depression Associated with Physical Incapacity (Medical disorders: diabetes, polio, muscular dystrophy, etc. Mutilation: amputations, burns, etc.)

Drug-Induced Pseudo-Depression (A type of reaction that occasionally occurs when hypnotics, anticonvulsants, or sedatives are used in the treatment of emotional or physical disorders.)

Therapy

The management of depressive youngsters must of necessity be individualized. The approach will vary, depending on age, family composition, clinical picture, facilities available, and so on. The infant diagnosed as anaclitic, or with infantile depression, needs an immediate change in his living arrangements. Such an infant needs one significant person to care for him, ideally his mother. We must not forget Spitz's and Wolf's warning that such children may not recover if the clinical condition continues beyond three months. While the therapy of such youngsters is important, the prevention of such reactions is even more so. Infants should be separated from their mothers only when absolutely necessary. If infants and children need hospitalization, mothers should be encouraged to visit daily, to care for and feed the child. If an infant must be placed in an institution (for example, prior to adoption), every effort should be made to assign one adult to care for him.

The management of children and early adolescents who mask a depression with behavioral difficulties must be similar to that suitable for acting-out youngsters in general. As a rule, such youngsters do not realize that they need help, and often their parents do not either. These youngsters are usually referred by school and court authorities. Psychotherapy as a general rule is often a difficult pursuit, since they not only do not recognize the need for help but use denial and projection to avoid facing their painful feelings of depression and emptiness. The therapist must help the youngster realize that he is unhappy and that his acting out is a symptom of his

depression. Patience is required, as usually a considerable time will elapse before the patient is able to confront and talk about his depressive feelings. One must avoid premature interpretations lest the youngster be frightened and discontinue therapy. Such youngsters will often test the therapist to prove to themselves that he cares for them, no matter what they do or how they behave. One must also bear in mind the fact that they may appear to earnestly desire and need a close relationship with the therapist, but will often become anxious if they achieve such closeness, fearing that they will lose it as they have lost other significant persons in their lives. If therapy does succeed with these youngsters, the therapist must be alert to the appearance of frank depressive symptoms, which necessitates a different technical approach.

Working with the more overtly depressed adolescent patient presents different problems. Some therapists become frightened of the potential suicidal risk and unnecessarily urge hospitalization. Other therapists may become bored and impatient at the slow progress and find it difficult to listen to a continual recital of hurt, unhappy feelings. Still others may be unduly sympathetic, thus encouraging the patient to preserve his depressive feelings, since relinquishing them may mean loss of the therapist's interest and concern.

The depressed adolescent, even more than most patients, must depend

on the therapist relationship as his main support. He must be able to trust the therapist and rely on him. Only then will he gain the strength and courage necessary to confront his depressive feelings. These depressed patients are often very demanding of the therapist's time, attention, and concern. They swing between trust and distrust for a considerable period of time before they can realize that the therapist will not desert them. Since most depressed patients feel unworthy and unlovable, it is understandable that they doubt that anyone can truly care for them. Therapy with the depressed adolescent in general is facilitated by the patient's recognition that he is unhappy. Unlike the acting-out, depressed child, these patients are usually desirous of help. Not infrequently, however, they have to convince their parents, teachers, physician, and so on that they require psychiatric care. All too often their complaints are tossed off lightly as growing pains or with "All adolescents are unhappy at times" or "Pull yourself together and stop feeling sorry for yourself." It is not unusual for such an adolescent to resort to a suicidal attempt in order to have his problems taken seriously.

In most instances, depressed adolescents require intensive therapy. Simple techniques, such as support, suggestion and reassurance, or environmental manipulation, appear to resolve the problems, but all too often the improvement will be short-lived. Placement away from home is seldom indicated unless the suicidal risk is high. In fact, it is extremely important to have the parents actively involved in the therapeutic program so they can be

helped to understand the feelings of loss of love that affect their child. The parents also will often need help with their own feelings of responsibility and guilt. For these reasons many believe family therapy to be of great value in treating depressed adolescents. At this moment, however, it is too early to evaluate the effectiveness of this new technique, compared with individual therapy of child and parent.

Most clinicians appear convinced that antidepressant medication is of great assistance in the management of adult depressive reactions. Children and adolescents appear to respond less favorably. One might speculate that perhaps younger patients metabolize these compounds differently than older patients. Close clinical observation would appear to indicate, however, that whenever the child or adolescent originally presents a clear-cut depressive picture, the response to antidepressant medication is similar to that observed in adults. A less favorable response is seen in the depressive reactions manifested by behavioral difficulties. Ling et al. reported favorable responses to antidepressant medication in youngsters, aged four to sixteen, presenting headaches as a mask for their depression.

There appears to be very little use of electroconvulsive therapy (ECT) in treating the depressive reactions of children and adolescents. During the past ten years, many clinics have discontinued electroconvulsive therapy in adult depression, except following an unsuccessful trial of antidepressant

medication or where the suicidal risk is evaluated as being very high, so that the therapeutic time lag that occurs with antidepressant medication is dangerous. At present, very few child psychiatrists use electroconvulsive therapy. I would recommend that it be used only as a last resort with adolescents who present a clinical picture of overt depression, when psychotherapy and medication have proven ineffective.

Suicide

Suicide and suicidal attempts are not infrequent in childhood and adolescence, although even professional persons have been slow to recognize that fact. This has been due in large part to the belief that adolescents do not become depressed and hence are unlikely to commit suicide. As a matter of fact, the rate of suicide among adolescents has shown the greatest rise of any age group. The rate at ages fifteen to nineteen years rose nearly 50 percent, from 4.0 per 100,000 during 1950-1952 to 5.9 per 100,000 during 1960-1962. Jacobziner stated that

Suicide in adolescence has increased and is assuming proportionally greater importance as deaths from other causes decline. Of the total number of reported suicides in the United States in 1962, 659 individuals were less than 20 years old. One was a white male seven years of age, 102 were between ten and fourteen years, and 556 were in the fifteen to nineteen age group. A total of 499 were male and 160 female, a sex ratio of over 3:1.

Suicide ranks as the fourth leading cause of death in the fifteen-to-nineteen age group. It is surpassed only by accidents, malignant neoplasm, and homicide, and it surpasses deaths from tuberculosis, leukemia, nephritis, rheumatic fever, appendicitis, and all contagious diseases. It should not be overlooked that all figures for reported suicide are underestimated, probably more so for children and adolescents than for adults. The Suicide Prevention Center of Los Angeles estimated that up to 50 percent of all suicides are disguised as accidents. Since we are increasingly aware that many accidents are attempts at self-destruction, and accidents currently lead all the causes of death in childhood and adolescence by a large margin, the inference to be drawn is apparent.

Males consistently outnumber females in deaths by suicide, in all age groups throughout the world. The incidence of suicidal attempts, however, shows a reverse sex ratio; females greatly outnumber males at every age. I reported an incidence of seven to one in studying the Bellevue Hospital adolescent population. If it is difficult to obtain accurate figures for suicides, it is almost impossible to do so for attempted suicides. Jacobziner estimated the ratio of attempted suicide to actual suicide at 100 to 1.

There have been surprisingly few studies on suicidal attempts by children and adolescents. Bender and Schilder reported on eighteen children under eighteen years of age who threatened or attempted suicide. They were

described as reacting to an intolerable situation. They felt unloved, became angry, and then felt guilty for having such feelings. Balsem and Masterson reported thirty-seven attempted suicides out of a group of 500 adolescent patients. I reviewed the statistics of Bellevue Hospital in New York City for 1960. Of approximately 900 admissions to the children's and adolescents' units, 102 were for suicidal attempts and threats. Of these, eighteen were under twelve years of age, and eighty-four were between twelve and seventeen years of age. The youngest child was a five-year-old boy who attempted suicide on several occasions by burning himself with a gas heater and pouring scalding water over himself.

Analysis of the patients reported shows many came from disorganized homes. Less than one-third resided with both parents. Fathers were conspicuously absent from the homes. First children were disproportionately represented. Diagnostically, behavior and character disorders composed the largest group. In general they were immature, impulsive youngsters who reacted excessively to stresses that were often of a minor nature. The patients were divided into five categories in terms of dynamics.

1. Anger at another which is internalized in the form of guilt and depression. Usually the parents or parent substitutes were the original objects.
2. Attempts to manipulate another, to gain love and affection or to punish another. Such attempts were often directed against

the parents, with the fantasy of “You will be sorry when I am dead. You will realize how badly you treated me.”

3. A signal of distress. The youngster often feels impelled to make a dramatic gesture to call the parents’ attention to his problems, which the parents have often overlooked or ignored.
4. Reaction to feelings of inner disintegration, for example, in response to hallucinatory commands.
5. A desire to join a dead relative.

Schur described nineteen adolescent patients who attempted suicide. His group was noteworthy for hostility and self-destructive behavior. He postulated a mechanism similar to mine, namely, the child felt rejected and became angry with his parents. This caused the parents to become increasingly angry with the child, and thus a destructive cycle was established.

The proper evaluation of suicidal patients is never a simple matter, but it is especially challenging in the case of children and adolescents. It is not unusual to encounter an adolescent who has made a serious suicide attempt and yet appears angry, not depressed, as an adult would be in the same situation. All suicide attempts, no matter if the threat to life was minor, should have a thorough psychiatric evaluation. Whenever possible a period of

observation in a hospital is indicated. This can usually be arranged in the pediatric service of a general hospital if an inpatient psychiatric service is not available. Hospitalization not only protects the child against harming himself, but enables one to evaluate the child in a neutral setting, as well as the parents and family situation, before making definitive therapeutic plans. In addition, it may interrupt the conflict often present between suicidal patients and their parents. It is not unusual for parents to minimize the suicidal potential of their child's actions, or even to be angry with him for causing them personal distress and for disgracing the family. If the child does return home, the parents must be actively involved in the treatment program, otherwise efforts to help the child will usually fail.

Discussion

We can now conclude that while young children do not show depressive reactions similar to those seen in adults, such symptoms are present in adolescents from approximately age fourteen. Is this because the child under fourteen does not become depressed, or does he manifest depression in a different fashion? Although there is no general agreement on this point, careful analysis of the evidence would indicate that the latter is the case. This should not surprise one, as for many years child psychiatrists and child analysts debated the existence of childhood schizophrenia. It was maintained by many analysts on clinical grounds that children could not become

schizophrenic. It is now established that children can become schizophrenic, even though the clinical picture differs from that seen in adults. It is significant that the clinical picture in childhood schizophrenia begins to resemble that of the adult also at approximately fourteen years of age. We must be constantly aware that the child is a developing organism and therefore expect the clinical picture to vary with the maturational level of the child. We should not allow theoretical formulations to influence our clinical judgment. As Boulanger wrote,

A psychoanalyst may very well be reluctant to perceive in a child the equivalent of an adult's melancholia, for he is besieged at once by all the points of theory which are unsettled and passionately disputed within the school: the organization and function of the ego, superego, and object relationships, the origin of the Oedipus complex and the complexities of the instinctual development, the purpose of masochism and the validity of the death instinct.

The classical papers of Abraham and Freud postulated that a harsh, punitive superego turned aggression and hostility against the self, leading to depression. The depressed person was considered to have identified with the ambivalently loved lost object. The oral component of depression was emphasized by both Abraham and Freud. Klein described what she called the depressive position of childhood in oral terms. She considered this to be a normal developmental stage for all infants. Her theory has not, however, met with a very favorable reception. Most psychoanalysts since Abraham and Freud have theorized that depression follows the loss of a significant love

object, whether the loss be fantasy or reality. Bibring advanced the theory that self-esteem is the key to understanding depression. "Depression can be defined as the emotional expression of a state of helplessness and powerlessness of the ego, irrespective of what may have caused the breakdown of the mechanism which established ... his self-esteem." He indicated that the basic mechanism is "the ego's shocking awareness of its helplessness in regard to its aspirations."

The concept of self-esteem has assumed such significance in the theory of depression that Rie was led to ask "at what point in the child's life such an experience develops with sufficient intensity to constitute what has been called low self-esteem." Quoting Erikson and Loevinger, he went on to state, "It may be no accident that this level of ego identity, or ability to conceptualize oneself, and the typical adult manifestations of depression are both generally agreed to occur at the earliest during adolescence." Rie believed that an effect of helplessness is an essential picture of depression. After quoting Schmale and Lichtenberg he concluded, "There may be reason to believe that the fully differentiated and generalized primary affect characterizing depression, namely despair or helplessness, is one of which children perhaps prior to the latency years, are incapable."

The modification of Bibring's theory of the significance of self-esteem in depression by Sandler and Joffe answers the objections of Rie. They "stress

rather the basic biological nature of the depressive reaction, related to pain (and its opposite, 'well-being'), rather than the psychologically more elaborate concept of self-esteem." They continued that depression "can best be viewed as a basic psychobiological affective reaction which like anxiety, becomes abnormal when it occurs in inappropriate circumstances, when it persists for an undue length of time, and when the child is unable to make a developmentally appropriate reaction to it." They also revised the theory of the loss of the desired love object:

While what is lost may be an object, it may equally well be the loss of a previous state of the self. Indeed we would place emphasis on the latter rather than on the fact of the object-loss per se. When a love-object is lost, what is really lost, we believe, is the state of well-being implicit, both psychologically and biologically, in the relationship with the object. The young infant who suffers physical and psychological deprivation in the phase before object-representations have been adequately structured may show a depressive response to the loss of psychophysical well-being. Even an older child, who can distinguish adequately between self and object-representation, may react with depression to the birth of a sibling; a reaction which is not in our view an object-loss but rather a feeling of having been deprived of an ideal state, the vehicle of which was the sole possession of the mother. ... If his response is characterized by a feeling of helplessness, and shows a passive resignation in his behavior, we can consider him to be depressed.

Thinking in developmental terms, Sandler and Joffe realized that, as the child grows older, the object loss becomes of greater significance than the loss of the state of well-being embodied in the relationship to the object. They summed up their definition of depression "as a state of helpless resignation in

the face of pain, together with an inhibition both of drive discharge and ego function.” They were aware that some children will make strenuous efforts to regain the former state of well-being, that some may react with anger and aggression, while others will regress to more immature levels.

The thesis that depression is a reaction to loss, either of an object or a state of wellbeing, with a feeling of diminished self-esteem and helplessness, enables us to understand the various manifestations of depressive reactions at different ages. The result of any object loss will depend on the individual’s ability to tolerate pain and discomfort, be it physical or mental, and the developmental stage when such loss occurs. The younger the child the more serious the consequences. The infant may remain fixated in his ego development or even regress. At times, the impairment of ego development will hinder intellectual growth. The ability to form adequate object relationships may be significantly impaired. This will interfere with the ability of the individual to identify with significant figures in his life. Such disturbances in the process of identification will adversely affect the development of the superego, ego ideal, and the whole personality structure.

When the loss takes place during latency and early adolescence, the youngster will often exhibit hostility and anger toward the person whom he feels has betrayed and deserted him. This often leads to serious acting out and delinquency, which may temporarily help ward off painful feelings of

helplessness and impotence. These defensive operations unfortunately seldom if ever prove successful and only lead to further conflict with the parents, who become increasingly antagonistic toward the child, who desperately needs their love and support. Some children will inhibit the expression of anger toward their parents and turn it against themselves. Such a child will consider himself to be evil, and such a self-image will lead to the acting out so commonly seen in depressed children. This behavior will reinforce the child's poor self-image, further lower his self-esteem, and increase his feelings of helplessness and depression.

Numerous defensive operations are used by children and adolescents to guard against the painful feelings of depression. The most frequently encountered are regression, repression, denial, and projection. We often note displacement onto somatic symptoms during adolescence. A reversal of affect is seen in some youngsters. Toward mid-adolescence, significant maturational changes occur in ego functioning, especially in the area of reality testing. The youngster will use denial to a lesser extent; he will see his parents' role in his object loss. This will not only increase his anger toward his parents but will also increase his guilt for having such feelings. The hostile feelings toward the parents become directed in mid-adolescence toward their introjects within the youngster, since, as I described elsewhere, the superego does not fully develop until mid-adolescence. These changes, plus the knowledge that reality will not change and that he will not regain his lost love

object, reinforce the adolescent's feelings of lowered self-esteem and helplessness and produce the clinical picture of overt depression.

Another factor that contributes to the formation of depression in adolescence is the resolution of the Oedipus complex, with its sense of parent loss. This sense of loss is increased when the child leaves home for the first time for boarding school or college. Many youngsters at that period still need parent substitutes with whom they can relate in order to diminish their feeling of parent deprivation. Others meet this need by relating closely to their own peer group, as is clearly illustrated in the so-called family communes. Those who fail to obtain some close relationship at this period frequently succumb to serious depressive reactions.

Finally, no review of the factors associated with depression in children and adolescents should overlook a possible role of the endocrines. A therapist cannot ignore the fact that many depressions occur and/or are accentuated concurrently with periods of endocrine imbalance or stress, for example, puberty, menstruation, and the postpartum and menopausal periods. What such a role may be is as yet completely unknown, though it is hoped that current studies will help elucidate the role of the hormones, particularly those, including the hypophysial secretions, related to sexual function.

In sum, a comprehensive review of the literature reveals controversy as

to whether children under twelve years of age become depressed. The evidence indicates that they do, but that the clinical picture varies considerably from that seen in adult depressives. From fourteen years on, adolescents often exhibit the usual adult depressive symptoms. A theoretical explanation for depressive reactions in children and adolescents is offered to explain the varying clinical picture in terms of maturational changes.

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