



PSYCHODYNAMICS OF
DEPRESSION AND SUICIDE IN
CHILDREN AND ADOLESCENTS

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Severe and Mild Depression

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Table of Contents

Depression and Development

Infancy

Early Childhood

Middle Childhood

Late Childhood

Adolescence

Conclusion

Table 8-1

Suicide in Children and Adolescents

Statistical Data

Motivation

Illustrative Case Study Of Suicidal Child

Suicidal Behavior In Adolescence

REFERENCES

PSYCHODYNAMICS OF DEPRESSION AND SUICIDE IN CHILDREN AND ADOLESCENTS

Jules Bemporad

Chapter 4 was concerned with an exposition of the clinical syndromes of depressionlike disorders in children and adolescents. This chapter will attempt a deeper look at the phenomenon of childhood depression, going beyond clinical descriptions to theoretical issues.

For decades the classical psychoanalytic position on the possibility of depression in childhood was firm and unanimous: it could not exist. Rochlin (1959) plainly stated that depression, by definition, is a result of an inward deflection of aggression mediated by a strong superego. Since the superego does not exist in young children, neither could depression. Beres (1966) also expressed the belief that depression, as a primary superego phenomenon involving intersystemic conflict, must be manifested by predominant sustained guilt which is absent in children.

Even psychoanalysts who did not emphasize the older retroflected anger hypothesis of depression expressed grave doubts over the possibility of

this affect or its development into the clinical syndrome before adolescence. Rie (1966) in an excellent review of the theoretical literature argues that even if depression is conceptualized as low self-esteem resulting from a discrepancy between the ego ideal and the actual self, there is great difficulty in applying this model to children. The difficulty is that a stable self-representation is not expected to develop, on theoretical grounds, until adolescence. Rie concludes, "Hence, the major dynamic elements of depression, perhaps not inappropriately regarded as the essence of depression, and indeed some of their structural antecedents, seem not to be generated in toto until the end of latency age" (p. 679). Mahler (1961) also sums up the matter quite unequivocally: "We know that the systematized affective disorders are unknown in childhood. It has been conclusively established that the immature personality structure of the infant or older child is not capable of producing a state of depression as that seen in the adult" (p. 342).

Despite this unanimity of distinguished opinion, depressionlike states do appear in children, theory notwithstanding. Mendelson (1974) has taken the theorists to task over their lack of clinical familiarity with the subject matter that they have so elegantly discussed and dismissed. He writes of the theoretical literature on childhood depression: "It would seem that in no other area of the psychoanalytic literature on depressives are the theoretical papers so far removed from the observations that any clinician can make in

the course of his daily practice” (p. 165).

The conflict between theory and observation is far from new in the history of thought (Kuhn, 1962). When such a clash occurs, either the observations are in error or the theory needs revision. As documented in chapter 4, more clinicians are reporting depressionlike states in children; thus we must turn to the underlying theory in our search for error. Indeed, most of the authors who make the claim that depression in childhood is *a priori* impossible subscribe to the orthodox Freudian view of melancholia. If a different theoretical framework is adopted, then a more workable and harmonious interrelation between deduction and observation may evolve. What appears to be most sorely needed is a system of childhood development that stays within the general boundaries of psychoanalytic thought and modifies certain postulates to be more in line with clinical observations and experimental research. Unfortunately, much classical psychoanalytic thought has ignored findings from allied disciplines, and due to this insularity it has become limited in dealing with various clinical problems. The growth or true evaluation of any explanatory system appears to require a healthy interchange between observation and inference.

Even on a strictly theoretical level, the classical psychoanalytic formulations can be found wanting in certain considerations of the development of affect in children. There does not appear to be a sufficient

acknowledgement of the gradual accretion of abilities or the gradual consolidation of internal psychic structures over a period of years. Even if the usefulness (one cannot say validity) of such concepts as the superego or the self-representation is agreed upon and accepted, the consolidation of these structures must be thought of as a very gradual process. However, a more evident failing of classical theory is its almost total disregard of cognitive factors in the affective development of the child. The ability to experience certain affects and the advancement of cognitive structures are continuously intertwined throughout development. As indicated by Piaget (1951) cognition and affect are but two aspects of the same evolving unity of the child's psyche.

Without the ability to cognitively appreciate certain aspects of experience, specific affects can not be experienced. Therefore a consideration of cognitive development must go hand in hand with any attempt to understand the development of affect. This does not necessarily mean that the processes of understanding that give rise to emotions must be conscious, any more than Piaget's cognitive schemata are explicitly conscious. Rather, these schemata are unconscious principles that organize experience and give the experience its meaning and thus its emotional content.

This concomitant aspect of cognitive and affective development has been described by Arieti (1967), who postulates that there are various levels of emotions which develop during ontogenesis. This view is founded on a

good deal of theoretical logic as well as experimental evidence. Werner (1948) definitively showed that one of the major processes of development is differentiation. He conceived of the child as proceeding from a relatively global “syncretic” state to an articulated, differentiated mode of being. Therefore, the global positive experiences of the young infant gradually become separated into bodily pleasure, mastery, love, joy, or quiet satisfaction. Similarly, global negative experiences differentiate into the adult states of pain, fear, anxiety, depression, or despair. Although somewhat corrected by the recent developments of ego psychology, classical psychoanalysis has been guilty of a double error: ascribing an excessively precocious cognitive system to the child and an excessively immature motivational structure to adults. Just as young children cannot grasp the realities of the world as seen by the adult and therefore cannot experience the exact emotions of adults, mature individuals—by virtue of their developed cognitive state—are motivated by more highly differentiated feeling states than children. Experimental studies which partially support this view have been performed by Kohlberg (1969) in the area of moral development and by Loevinger (1976) in regard to overall ego development. These studies are extremely relevant to the study of the individual’s affective experience at different stages of development, since they reveal a progression of the predominant modes of thought through ontogenesis. These studies have found that it is not until relatively late in childhood that the individual

proceeds beyond a conformist point of view which simply accepts social rules without a great deal of self-awareness or freedom to reflect on multiple possibilities in situations. Loevinger states that many individuals never advance beyond this level and their inner life remains filled with banal clichès, shallow emotions, and simplistic moralizing. While it is possible that adults at this level of psychic development can experience depression, it appears certain that children who have not reached this level are incapable of depressed feelings, according to Loevinger's system.

Therefore, when conceptual systems other than classical psychoanalysis are considered, the question of depression in childhood becomes transformed. As stated in chapter 4, the problem is not whether adultlike depression can occur in childhood, but how the cognitive and affective limitations at different stages of childhood modify the experience and expression of emotions in general. Therefore the most fruitful approach to a theoretical discussion of childhood depression might begin from a developmental standpoint, although our current knowledge of the inner life of children is still very far from adequate. The implicit assumption in this discussion is that any affect necessitates the presence of unconscious cognitive structures which develop through childhood.

Another assumption is that depression is a direct affect much like anxiety (see Sandler and Joffe, 1965), free from complicated

metapsychological events that are automatically experienced in certain situations by susceptible individuals. At the same time, depression is seen as a complex affect (see Arieti, 1967) which presupposes a good deal of cognitive maturation. Thus a more realistic search for the vicissitudes of depression would focus on ego development rather than the previous psychoanalytic emphasis on the evolution of the superego.

Depression and Development

Infancy

Syndromes which are phenomenologically comparable to adult depression have been described by Spitz (1946) and by Engel and Reichsman (1956). Spitz delineated the well-known entity of “anaclitic depression” described in chapter 4. Engel and Reichsman reported a thirteen-month-old girl who withdrew into a state of sleep when strangers approached. From their observation of this young child, Engel and Reichsman postulated an innate “conservation withdrawal” reaction which they believed to be an infantile prototype of the “giving up” attitude in adult depression.

Although Spitz’s observations included crying, withdrawal, and sad faces, he did not believe that this infantile behavior was the result of the same intrapsychic situation manifested by adult depressives, because the infants

lacked the formation of a tyrannical superego which would direct aggressive drives toward the ego. However, Spitz speculated that self-directed aggression did play a role in these infants' symptoms since they lacked an external love object (the mother) who would both absorb the released aggression and stimulate the expression of libido, which would neutralize the aggression. Being deprived of a maternal figure, these infants directed their instinctual drives on themselves. In this manner Spitz appeared to maintain the concept of self-directed aggression as basic to depression while bypassing the theoretical problem that the infants had not yet formed a superego. However, even if Spitz's formulations are tentatively accepted, the problem remains as to who is the ultimate recipient of these aggressive drives. Jacobson (1971) postulates an aggressive cathexis of the self-representation in adult depression, but can we ascribe self-representation to a six-month-old infant? Can we equally postulate a pathognomonic introject as the recipient of the aggression?

Herein lies the problem that arises when we consider Spitz's model of "anaclitic depression" as a form of depression at all. It appears that the young infant is simply too immature and his psyche too unformed actually to experience depression. There is certainly grave doubt whether infants of this age have any awareness of themselves, or what type of mentation actually exists. Piaget (1952) has in fact called the first eighteen to twenty-four months of life the sensory-motor stage, emphasizing his belief that at this

early age mental life consists mainly of innate reactions, habit sequences, and possibly physical discomfort.

However, infants do appear distressed by separation from their mothers and after some time withdraw into a sort of detached, defensive state that Bowlby (1960) described. Thus there is a great temptation to ascribe feelings of depression to the infants' experiential state. This is a dangerous undertaking, for in so doing we may be projecting our own adult affects on the minds of infants. Anna Freud (1970) warned of this danger, writing that "some psychoanalysts credit the newborn already with complex mental processes, with a variety of affects which accompany the action of the various drives and, moreover, with complex reactions to these drives and actions, such as for instance guilt feelings."

We shall probably never exactly know what the infant who has been separated from his mother actually feels, but we can safely assume that he does not experience the same range or depth of emotion that are part of the adult's inner life. The abandoned infant has served as the prototype of adult depression, but such a relationship must be taken as metaphorical at best.

The dissimilarity between these infantile states and adult depression becomes more striking when we learn that lack of cognitive stimulation (Dennis and Najarian, 1957) or even malnutrition (Malmquist, 1971) can

produce the same behavioral result. Yet these findings are not so surprising, since the mother serves the infant in countless ways. To use Piaget's terminology, she is the primary "ailment" for the infant's budding schemata. Her deprivation results in stunting psychic development, whether it is affective, cognitive, or motor. Probably all of these discrete functions may be syncretically intermeshed at this early age (Werner, 1948). Therefore loss of the mother may represent the same thing as losing stimulation or tangible nourishment. The mother allows the infant's mind to develop. Through her, the infant forms a sense of self and can begin to anchor himself in reality. The absence of proper mothering, because of its significant role in maturation, thus can result in such long-range deviations as described by Spitz and Bowlby. Early deprivation, if prolonged, does not lead to later depression, but to either retardation or psychopathy.

In this light, it might be more correct to classify the reactions of the infant as development deprivations that are unpleasant but which may be as globally experienced by the immature psyche as persistent nonspecific pain or the absence of external stimulation. Since mental development may well begin with emotion and the infant may be capable of suffering long before it can think, there is no doubt that these states are painful, but there can be little relationship to the later pain of depression.

Even in later infancy, such as in the cases described by Engel and

Reichsman (1956) and Bowlby (1960), it seems that turning away from the environment represents a possibly innate withdrawal reaction from an ungratifying world rather than true depression. In Bowlby's experience, after a period of time infants eventually will come out of their withdrawal and begin to interact with strangers.

Early Childhood

This developmental stage may be defined arbitrarily as beginning with the infant's psychological individuation from the mother. During this time there is a shift in the child's gratification processes; he now delights in actively doing rather than in being given to and passively nurtured (Mahler, 1968). This is the era of normal oppositionalism and the embryonic testing of the will. There is a delightful "love affair with the world," in which normal fears, apprehensions, or inhibitions are overruled by a constant curiosity about the external world. Clinical reports of depressionlike symptoms at this exuberant age are conspicuously absent. Yet this may be a crucial period for laying the initial groundwork of later depressive episodes.

At this stage the child appears to be faced with a critical choice: to satisfy his own pleasure in the exercise of his will and risk the censure of the parent, or to inhibit his spontaneity and insure the love of the parent. Silverberg (1952) has beautifully called this the conflict between the "heroic"

and “unheroic” solution to childhood. Obviously, the eventual decision depends on the temperament of the child, the personality of the parent, the presence of siblings, the economic standard of the family, and an infinity of other factors. However, the initial battle between self-gratification and the surrender of the burgeoning self for the insurance of love leaves its scars long after the war is over. If the parent insists on perfect behavior or is threatened by the willfulness of the child, then a sense of self-inhibition will gradually crystallize and sow the seeds of later self-denial and fear of personal fulfillment. If there is as an additional complication a depressed parent who cannot participate in the joyous excitement of the child’s discovery of the world, then a certain sense of deadness and lack of spontaneity may also evolve.

In retrospective studies, Cohen and her co-workers (1954) found that the mothers of later depressives were uncomfortable with their child’s emergence from a passive infant into a willful toddler. Green (1946) in another context indicated that middle-class mothers create an exorbitant need for love in their children and then utilize the threat of withdrawal of love as a disciplinary measure. It may be just this form of sabotaging of the will not through physical punishment but through threats of abandonment or through shaming that causes the child to begin to associate free expression with loss of love or with causing harm in needed others. Mahler (1966) contended that the origins of a depressive mood state lie in the abrupt and

simultaneous collapse of the young child's belief in his own omnipotence as well as that of his parents. This view also appears to ascribe psychological processes which are too sophisticated to the young child. Although the preschooler may act as if the world is his oyster and show an alarming lack of fear in dangerous situations, we cannot therefore assume that he believes himself (or others) to be omnipotent. Rather, the young child derives a primitive sense of pleasure in doing, what Freud termed *funktionlust* and Mahler herself described so well as part of the practicing subphase of the separation-individuation process. The roots of depression appear to reside in parental punishment and lack of response to the child's normal exploratory and mastery behavior, which leads to an automatic and unconscious inhibition of activities necessary for later development of an independent sense of worth through individual accomplishment.

Such children present a clinical picture of seriousness, a lack of spontaneity, and often a clinging relation to the parent. While displaying precocious self-control, they are immature in terms of venturing away from the needed parent. These children are being trained to inhibit and distrust their natural inclination toward mastery and autonomous gratification. They are already substituting their parent's pleasure for their own in order to continue the needed security of the parental relationship. To use Sullivanian terms, they are foregoing satisfaction needs for the insurance of security needs.

These children cannot be called depressed, although they may appear sad, frightened, and unduly serious. We do not know their feeling state; although they are able to verbalize, they cannot yet identify or describe emotions through language. We may diagnose these children as overly inhibited and at risk for later depression. Because they still inhabit an age-appropriate action world, they express their pathology through overt behavior. Even then they can alter their mood state readily as the situation demands. Thus if they are fortunate enough to attend a nursery school or be with adults who appreciate their spontaneity, they quickly become fun-loving active youngsters. As Mahler (1966) aptly observed, they tend to show their symptoms in the presence of the parent, possibly because it is the parent who demands the submissive, controlled reaction. They do not as yet generalize these patterns and have not yet fully internalized the parental controls. Their behavior is normally tuned to the rewards and punishments that arise from the environment and not from within.

Middle Childhood

As the child grows to school age, longer periods of genuine sadness have been observed. These children are clearly unhappy although they are usually unable to give reasons for their plight. As this age, the child simply responds to his surroundings without much thought about who he is or how good or bad he is. Being good is what brings external reward and being bad is

whatever provokes external punishment (Piaget, 1932). The child cannot form a stable sense of self in terms of worth and quite appropriately confuses fantasy with reality in his thoughts about himself. He does not have the capacity to sustain a consistent and continued low estimation of himself if any true estimation of self is indeed possible. Nevertheless, depreciation from others can adversely affect the child's mood. As Anna Freud (1970) remarked:

Neurotic symptom formation waits until the ego has divided itself off from the id, but does not need to wait until ego and superego also have become two independent agencies. The first id-ego conflicts, and with them the first neurotic symptoms as conflict solutions, are produced with the ego under pressure from the environment, i.e., threatened not by guilt feelings arising internally from the superego but by dangers arising from the object world such as loss of love, rejection, punishment (p. 25).

Therefore the child can easily react with sadness to a chronically depriving environment or to an acute loss of needed sources of gratification. He may appear sad but this does not automatically imply an internal conflict. However, reports of such children (Sandler and Joffe, 1965; Poznanski and Zrull, 1970) do report some evidence of a cognitive transformation toward depression; these children are described as expecting bad treatment from others. Although they do not demean themselves, these children can generalize from their past frustrations with their parents to an intuitive attitude toward the rest of humanity.

Another reported finding is a tendency to give up when disappointed,

which sets up a future predisposition toward hopelessness and helplessness after a blow to one's sense of self. It may well be that this early form of resignation results from accumulated experiences in which mastery was prevented and failure was insured by the responses of significant others. Therefore rejection or inflated, unrealistic demands by parents can lead to a sense that the child cannot win, that trying makes no sense. These findings tend to support Seligman's (1975) "learned helplessness" model as the root of depression. However, the actual situation is not so clear-cut. What seems to occur is that the parents reward certain behavior and show love, but only for activities that undermine the child's individuation and self-gratification. At this age the child's sense of worth is normally dependent on the responses of parental figures, so that their disapproval or rejection will have devastating effects and will inhibit the behavior that brought disapproval. As Sandler and Joffe remark, "It not infrequently happens that the child's parents are in unconscious opposition to progressive individuation, and the influence of the parents may be perpetuated in their successor, the superego" (1965, p. 54). At this age the child has not internalized a view of himself or a set of prohibitions, but he begins to automatically inhibit those behaviors that threaten to cut off the needed flow of approval from the parents.

We can perhaps define two types of dysphoric states in children of this age—one in which the parents gradually inhibit responses that would yield a sense of satisfaction or pleasure, and another in which the child directly

responds to the deprivation of gratification in his environment. The former type can be seen in families in which the parents set up unrealistic ideals, use shame as a form of punishment, and are threatened by the child's individuation. The latter type is seen in homes where the parents are consistently rejecting or where they are themselves depressed. However, such dysphoric states frequently can be observed in children who are physically ill and whose illness interrupts their normal, everyday enjoyable activities.

The most extreme illustration of this latter form of dysphoria is a six-year-old boy reported by Bierman, Silverstein, and Finesinger (1958). This child had been hospitalized because of poliomyelitis. After two months of illness he manifested symptoms reminiscent of adult depression. He seemed to give up hope and lapse into a depressionlike withdrawal as he experienced day after day of frustration, confinement, and inability to participate in his usual gratifying activities. However, there is no record of self-recriminations, feelings of guilt, or low self-esteem. He was simply very unhappy at having lost the use of his legs. This was a true loss of enormous magnitude, and the child's response seems completely understandable and appropriate. His mother visited him regularly but her presence was insufficient in relieving the child's quite realistic sense of chronic deprivation. With clinical recovery of the primary illness, his mood returned to normal. This case is instructive since it demonstrates that children of this age are capable of extreme sadness

under chronically frustrating circumstances, but these moods are reactive to the environment and the child does not perpetuate a depressive mood in the absence of an external cause. However, one need not go to the extreme of a crippling illness and prolonged hospitalization to produce these moods; a chaotic family or a disapproving parent usually suffices.

Even in such instances the sadness is relatively short-lived. This short duration may be due to two major underlying characteristics of children of this age group: they are still creatures of the moment, and they will readily defend themselves against unpleasant feelings. The latter trait may account for conditions described as “depressive equivalents” or “masked depression” in children. Feelings of sadness often are defended against purely by distraction. The child simply attends to other more pleasant matters rather than to the environmental conditions that are causing him pain. If his attention is focused on these conditions, he will display the appropriate affect. However, this does not prove that an underlying or unconscious depression was present all along, seething beneath a seemingly happy exterior. The child maintains an amazing capacity to forget about tilings when not confronted by them. When this trait is coupled with normal childhood hedonism, it becomes clear why depressionlike symptoms should be rare and fleeting in this age group. It is only when the behavior appears to be excessive in its denial of an everpresent frustrating reality or the behavior is extremely maladaptive, that one should suspect a pathologic defensive denial of unpleasant affects, similar

to what is seen in some adult hysterics.

The problem of “depressive equivalents” is more complex and at times confusing. Toolan (1962) lists eating and sleeping disorders, colic, and head-banging as depressive equivalents in infants, and temper tantrums, truancy, running away from home, and accident proneness as similar states in older children. Sperling (1959) suggests that sleep and gastrointestinal disorders in children may be equivalent to depression. These authors speculate that children cannot express depressive affect in an adult form, and these symptoms represent a childhood form of the disorder. This concept of symptom expression is clearly different from the “masked depression” described by Cytryn and McKnew (1972), who emphasize it as a childhood form of defense against feelings of depression.

Rie (1966) has written a thoughtful and thorough critique of the concepts of depressive equivalents in children. Briefly, Rie’s major arguments are that: (1) There is no logical connection between the equivalent symptom and the alleged underlying depression. (2) There is no proof that any feeling of depression exists for which the symptom is taken as an equivalent. (3) Depression is inferred on the basis of theory only, so that any child who does not manifest depression directly after a loss must be expressing this painful affect in some other form. (4) Any symptom that can be interpreted as symbolic of oral deprivation (i.e., an eating disorder) has been mistakenly

termed a psychodynamic equivalent to depression. Once again clinicians have projected their own expected reactions onto the psyche of a cognitively immature organism. Rather than assuming that depression must be present but expressed differently from adults, the possibility of the experience of adult forms of depression in a young child should be investigated more rigorously. This “adultomorphic” distortion perhaps has been utilized more in the study of childhood depression than in any other pediatric psychiatric problem. The concept of depressive equivalents has done much to confuse the diagnostic status of childhood depression by allowing almost any symptom to be so classified. Until we know more about the inner life of children, it might be best to refrain from using this questionable concept.

In summary, children of early school age do display periods of prolonged unhappiness in response to chronic environmental stress. They are increasingly sensitive to the rejection of others as well as to deprivation of gratifications. However, these moods are rarely sustained and respond readily to external changes. Even in these states of sadness, there is no evidence of guilt or lowered self-regard. What may be present is an abnormal pressure to make the parent happy or to thwart personal satisfaction to obtain favor with the parent.

Late Childhood

At this stage of development, the child's cognitive abilities appear to allow for a system of thought that includes the sense of responsibility toward others, the internalization of values and rules, and a budding sense of one's self. Children of this age are normally less concerned with their families and more with the judgments of peers and society. However, they carry within themselves and into the community the internalized family belief systems that have been learned from the parents. Depending on the particulars of this belief system, the child will face frustration in a variety of ways^[1] and derive different coping mechanisms. It is at this age that Sandler and Joffe's (1965) theoretical differentiation between depression as a psychobiological response and a clinical illness may assume particular importance. Children of this age not only react to disappointment or the loss of well-being with an initial depressive affective reaction, but they may continue to evolve a more chronic depressionlike illness. At this time the consolidation of adaptive processes takes place, so that the child will respond to stress in a repeated and characteristic manner. One such response, described by Sandler and Joffe (1965) and others, is to capitulate in the face of frustration and to develop a sense of overwhelming loss, a feeling of personal impotence, and shame.

The cognitive growth of the preadolescent years also allows for a recognition of the self which can be morally evaluated. The child may believe himself to be unworthy or unsatisfactory in the face of life's demands. Therefore, reports of dysphoric states at this stage do mention lowered self-

regard. For example, McConville et al. (1973) described a subgroup of depressed children from eight to ten years old who expressed fixed ideas of negative self-esteem. Similarly, Poznanski and Zrull (1970) observed that older depressed children expressed disappointment in themselves rather than simply reacting to an external unpleasant situation.

Much of the deprivation of this age group appears to result from the child's thinking about his predicament and arriving at certain conclusions. The affect state is not an automatic consequence of experience, as in younger children; rather, it is a personal logical evaluation of the experience. Children of this age who cannot attain the parental ideal become depressed because they perceive this circumstance to be a personal failure and not simply that the parents are themselves unhappy. Similarly, older, repeatedly rejected children are reacting to their own belief that they are unlovable rather than only to the immediate pain of the rejection. Therefore, depression at this stage takes on a more cognitive, evaluative characteristic and in this sense is no longer the immediate, stimulus-bound sadness of the younger child. The younger child might directly seek dependency gratification or openly regress to infantile needs in the face of frustration, but these preadolescent children inhibit expression of these desires of which—like the adult—they feel ashamed. Behavior is scrutinized and evaluated in terms of the self. This cognitive aspect causes older children to remain depressed regardless of changes in external circumstances. Because of these self-perpetuating and

self-evaluative aspects of the child's dysphoria, it may be correct to speak of actual depressive illness at this age. The point is that the depression results from cognitive conclusions which may be erroneous but are one step removed from the immediate environment.

Anthony and Scott (1960) reported a twelve-year-old child who manifested a depressive episode which may illustrate some of the features of depression in late childhood arising from pathological needs. Although this child's symptoms were much more severe than normally seen at this age, the underlying psychodynamics are not uncommon. This boy developed a severe depressive illness with manic interludes after his parents decided to adopt a ten-year-old boy to act as his companion. The patient suffered neither the loss of a love object nor the loss of gratifying activities, but was described as succumbing to depression as a result of the imagined loss of his favored status with his mother. His premorbid history was significant in many aspects: he was always overly close to his mother, he was timid and self-conscious, he rarely played with peers, he was unhappy at school (although he did well academically), and he generally solved his problems by giving up or by running to his mother. The authors described this patient as deriving a sense of omnipotence from being the "only fruit" of his mother's womb and the most precious thing in her world. The thought of sharing his mother with another child meant the loss of his inappropriate sense of self-meaning and an end to his pathological tie with her.

This child clearly suffered a depressive illness not only on the basis of his symptoms, but because his reaction was not in concert with the realistic stress; it evolved from his own distortions of the situation. His need for his mother was so great, and he had been so prevented from normal individuation and deprived of self-reliant sources of meaning and gratification, that at age twelve the prospect of another child entering the charmed mother-son circle was sufficient to cause a depressive decompensation.

Even in children who are this cognitively mature, however, the depression is not the same as in adults. The older child's self-evaluation is still more malleable than the adult's and more readily responds to positive environmental experiences. The negative sense of self is not so crystallized as to automatically devalue all successes or shun all gratifications. However, the major difference between depression at this stage and the adult variant is a lack of future orientation. The child during latency cannot truly relate his present state on a continuum with his future experience. Rather than denying the future defensively, he simply does not think of it. Rie (1966) made the pertinent observation that one of the crucial differences between adult and child depression may be the absence of hopelessness in the latter. Rie cited numerous definitions of adult depression and stressed that they all contain some reference to a time perspective that includes a representation of the future. He further argued that if the individual before adolescence cannot

comprehend concepts such as long-range goals and their relationship to present strivings, the meaning of infinity, and the absolute permanence of loss or disappointment, then such an individual could not experience hopelessness and despair, two cardinal features of adult depression.^[2]

Rie's arguments appear to be theoretically sound since Piaget (1952) also concluded that until early adolescence the child is wedded to the "concrete" and not capable of abstractions that would be involved in projecting himself into the future. Rie's conclusions also concur with clinical observations. Children do not complain of being unable to face tomorrow or that they will remain eternally depressed. They do not deny the prospect of an unbearable future; they simply do not think of it.

Adolescence

It is not until the end of childhood that depressive episodes truly comparable to adult states are seen clinically. The depressions of adolescence equal the adult forms in severity, surpass them in self-destructiveness, and still betray a characteristic developmental stamp. As mentioned before, the child does not appear able to conceive of his future; however, the adolescent seems capable of little else. The concept of time looms large in adolescent thought and in adolescent depression. There is the terrifying sense that all actions or experiences are irrevocable and everlasting, and result in eternal

shame and despair. This overemphasis on the relationship of today with tomorrow is beyond the capacities of the child and is usually tempered by a greater life experience in the adult. For the adolescent, however, all seems lost and nothing can be redeemed.

Erikson (1959) has examined this distorted sense of time in his studies of disturbed adolescents who, from a different vantage point, can be seen as experiencing severe depressive episodes. Erikson notes: "Protests of a missed greatness and a premature and fatal loss of useful potential are common complaints among our patients as they are among adolescents in cultures which consider such protestations romantic; the implied malignancy, however, consists of a decided disbelief in the possibility that time may bring change, and yet also a fear that it might" (1959, p. 26). This fear of time and the inability to handle time appear to give adolescent depression an urgent, overwhelming quality.

Another factor that influences the expression of dysphoria in adolescence is the lack of moderation in thought. The adolescent appears to live in an all or nothing world; he gives seemingly unimportant events an inflated status and responds to them in a dramatic, all-consuming manner. Here again, the adolescent appears to lack sufficient maturity to put everyday events in proper perspective. Everything has an air of finality and, at times, of desperation.

Perhaps these attributes of adolescence are magnified by the social pressures that are exerted at this developmental phase in our own culture. In our society, youngsters are constantly reminded that they are building for their future lives—whether it is in terms of career, marriage, or social acceptance. This is also the age when many individuals are away from home for the first time, feeling unprepared for this responsibility and yet ashamed of what they perceive to be childish, dependent strivings. Such adolescents are so accustomed to living out the dictates of another that the availability of freedom leads to self-doubt and utter loneliness. They often form a tie with a new authority on whom they can depend for direction and meaning.

Other adolescents carry with them the need to reach some parental ideal only to find that either they are not able to reach it or to do so would mean giving up their own chance for individuation. Anthony (1975) uses John Stuart Mill's early difficulties to exemplify some pertinent aspects of depression in adolescence. Anthony writes that one day young Mill asked himself the crucial question: would he be happy if he accomplished all that his father had asked? Mill was forced to answer no, and of that moment Mill wrote, "At this, my heart sank in me; the whole foundation on which my life was constructed fell down ... I seemed to have nothing to live for." Anthony explains "he fell ill when he became aware that the realization of his father's aims in life would not satisfy him, and he regained his mental health (to the degree that this was possible) when he understood that the death of the

father brought with it the growth of identity, autonomy, and responsibility for the son” (1975, p. 448).

Not all adolescents are as fortunate as young Mill. Many continue to strive for the parental ideal which has become their ideal, denying life and pleasure and ultimately succumbing to depression whether or not the goal is ever reached. In adolescence one may observe the shaping of the characteristic forms of depression: the need for others, the dominant goal, and especially the ascetic self-denial that gradually erodes any experience of pleasure or meaning.

Conclusion

The foregoing sections have attempted to apply a developmental approach to depressive phenomena in childhood. If depression is conceived of as a sophisticated affective experience that necessitates extensive cognitive maturation, then the dysphoric states that precede the experience of depression may be seen as continuous with, but not equal to, depression. The deprivation of the infant, the inhibition of the toddler, the stimulus-bound sadness of the young child, the limited depression of the older child, and the exaggerated yet acutely felt despair of the adolescent may all be understood best against a framework of the developmental process.

The types of reaction, the causes for their manifestation, and the

underlying structural elements are presented in Table 8-1 with a parallel schema of ego development adapted from Loevinger (1976). Although obviously incomplete, such an attempt at synthesis may help in delineating the causes and types of depressionlike experience in childhood.

Table 8-1

Symptoms and Causes of Depression at Various Stages of Development

<i>Developmental Stage</i>	<i>Symptoms</i>	<i>Major Psychodynamics</i>
Infancy	Withdrawal after crying and protest	Loss of stimulation, security, and well-being supplied by the mother
Early childhood	Inhibition, clinging behavior	Disapproval by parents
Middle childhood	Sadness as automatically responsive to the immediate situation	Rejection by parents, loss of gratifying activities (i.e., chronic illness)
Late childhood	Depression with low self-esteem	Unable to meet parental ideal, unable to sustain threat to parental relationship
Adolescence	Depression with exaggerated urgency, time distortion, and impulsivity	Unable to fulfill internalized parental ideal, inability to separate from family.

<i>Type of Dysphoria</i>	<i>Loevinger Ego Development Stages</i> [3]
Deprivation of needed stimulation	Presocial, symbiotic
Inhibition of gratification of emerging sense of will	Impulsive, self-protective, fear of being caught, externalizing blame, opportunistic
Sadness, unsustained crying directly related to frustrating or depriving situation	Conformist: conformity to external rules, shame and guilt for breaking rules, superficial niceness
Depression with a cognitive component in terms of affect resulting from deduction about circumstances	Conscientious: conformist, differentiation of norms and goals, awareness of self in relation to group, helping
Accentuation of depression by cognitive distortions about the finality of events	Conscientious: self-evaluated standards, guilt for consequences, longterm goals and ideals

Suicide in Children and Adolescents

Attempted or completed suicide in children appears to differ markedly from the self-destructive behavior of adults. There are differences in frequency, sex distribution, effect of socio-cultural upheavals, and most

significantly, in the motives underlying suicide in adults and children. As will be discussed further, there is some question whether the self-destructive behavior of young children can be considered truly suicidal since they may have little appreciation of the meaning of death. There is even more question about a uniform association of suicide and depression in childhood. However, a sufficient number of depressed children and adolescents ultimately attempt suicide so that this topic may be considered here.

Statistical Data

Demographic reports (Seiden, 1969) suggest that the rate of suicide for children under fifteen years of age has changed little in this century. The general rate of 0.5 deaths per 100,000 population (for children under fifteen) (Seiden 1969) seems to have remained stable since 1900. This rate was unaffected by both World Wars (which decreased the total suicide rate) and by the Great Depression (which increased the total suicide rate). However, it is notoriously difficult to determine accurately the true rate of suicide in young children since such deaths may be greatly underreported. The suicides of young children are obviously tinged with shame, guilt, and embarrassment for the survivors so that the true nature of the death is concealed. Also, children do not leave suicide notes and there is greater opportunity for their deaths to be termed accidental.

In those cases where suicide cannot be doubted as the cause of death, it has been found that males outnumber females in actual suicides (Shaffer, 1974) although females may threaten suicide or make suicidal gestures more frequently (Mattson et al., 1969). Cultural beliefs also greatly influence the rate of suicide, especially in adolescents and young adults. Catholic countries such as Ireland, where suicide is considered a sin, have a low rate. In countries such as Japan, where suicide is considered an honorable way to die, self-destruction is the most common cause of death for individuals under thirty (Seiden, 1969). There is also some debate over hidden suicides in ghetto youths or among American Indians. "Hidden suicide" refers to youngsters who do not literally kill themselves (which would be considered cowardly) but force others to kill them through acts of delinquency or bravado. Wolfgang (1959) studied the Philadelphia police records and found a high number of such victim-precipitated homicides among black youths. Finally, while suicide is very rare in young children, its incidence increases rapidly with age and it is among the leading causes of death in older adolescents and young adults. Seiden quotes the Vital Statistics of the United States as recording the following rate of suicide by age group per 100,000 population in 1964: age five to nine, 0.05; age ten to fourteen, 0.4; age fifteen to nineteen, 4.6; and age twenty to twenty-four, 10.8. We can glean from these figures that there is a dramatic rise in the suicide rate as children grow toward maturity.

Motivation

Any attempt to deal with the motives behind the suicidal behavior of children must consider their concept of death. As stated by Seiden, many children want to kill themselves but they do not wish to die. This paradoxical statement becomes clear if we understand that many children do not consider death to be irreversible or perceive suicide as a grave act. Seiden cites the work of Winn and Halla, who found that young children attach as much significance to stealing from their mother's purse as they do to threatening to kill themselves.

The gradual development of the child's concept of death was studied by Schilder and Wechsler (1934) and later by Nagy (1959). The former investigators found that the young child does not believe in death as a natural termination of life but sees it as an event which can be caused only by violence or illness. Young children also do not believe in their own self-destruction. Death is seen as a temporary, reversible state.

On the basis of projective materials such as drawings, written compositions, and verbal responses to questions asked of 378 children, Nagy described the development of the concept of death in children. She delineated three conceptual stages: children under age five conceive of death as a temporary, reversible state in which the individual is still alive but deprived of action, as in sleep. Between the ages of five and nine, the child begins to

appreciate death as a fearful state in which one is separated from loved ones. Death is personified as a “skeleton man” who carries off children at night, and is thought of as a fortuitous external event and not as a certain eventuality. Children at this stage also identify death with physical changes (i.e., a dead person is all bones) rather than with a possible obliteration or transformation of consciousness. Around age nine, children begin to exhibit an adult view of death as the termination of life and as universal. As one boy of nine years, 11 months put it, “Death is something that no one can escape.”

Anthony (1967) postulated an “eight-year anxiety” in the child which consists of a preoccupation with ideas of death or dying, either about himself or his parents. In agreement with Nagy, he found that around this age the child realizes death is irreversible and also feels helpless in the face of its inevitability, since everyone is in the same predicament. This phase passes quickly and a sense of personal immunity soon reasserts itself. However, if traumatic events occur during this phase, there may be an additional challenge to the child’s defenses and pathology may result.

On the basis of these studies, it is questionable if self-destructive acts before age nine or ten can be truly considered suicidal. In many cases, even after this age (and also in some adults) the individual appears to momentarily deny the extreme gravity of death in order to escape an intolerable situation or to punish others by a suicidal act. Such extreme measures, however, only

can occur against a background of a lack of compassion and care. As to why very young children do not appear to kill themselves since they deny the permanence of death and are impulsive, a logical possibility is Shaffer's suggestion (1974) that they lack the cognitive maturity to carefully plan suicide or even the knowledge of how to carry out the act.

In rare instances in which a childhood death by suicide can be substantiated, researchers have found a few predominant themes which seem to underlie most of these acts. As early as 1855, Durand-Fardel reviewed all suicides by persons under sixteen years of age in France between 1835 and 1844. Of the 192 childhood suicides reported, he was able to study 22 such incidents in detail. Of these, ten children drowned themselves, ten hanged themselves, and two burned themselves. There is no mention of death by ingestion of toxic substances or by overdose of drugs, which today is the most prevalent form of self-destruction. However, the motives behind childhood suicide have remained essentially the same over a century. Durand-Fardel mentions fear of impending punishment, reproach for a misdeed, an attempt to punish the parents, or the wish to join a dead loved one as reasons for suicide. Overall, he makes an impassioned plea for better treatment of children. He also observes that it is the deprivation of love rather than material goods that predisposes childhood suicide: "In the poorhouse of farmers as well as in the houses of workers and educated people, one finds children that cannot take the absence of tenderness. They cannot cope with

brutality and injustice.”

Later studies have echoed these themes. Bender and Schilder in 1937 studied eighteen children under thirteen years of age who were admitted to the Bellevue psychiatric ward with manifested suicidal preoccupations. They found that these children came from backgrounds of emotional deprivation in which they did not receive the amount of love they desired or needed. This deprivation was said to arouse feelings of aggression against the parents but, because of concomitant guilt, the aggression was allegedly turned against the self, resulting in suicidal wishes. Bender and Schilder also noted other suicidal motives in their sample such as the children’s wish to punish those around them, to attain the desired love by coercion, and to be reunited with a departed love object. Despert (1952) came to similar conclusions fifteen years later, in studying a group of children who had unsuccessfully attempted suicide.

Shaffer (1974) recently investigated contemporaneous data on children who actually committed suicide. He reports detailed information on thirty-one children under the age of fifteen who killed themselves in England and Wales between the years 1962 and 1968. In over one-third of the cases, the precipitating event was a disciplinary crisis of some sort— usually the anticipation of punishment. Other precipitants in order of frequency were problems with peers, disputes with parents, being dropped from a school

team, interaction with a psychotic parent, and imitation of a “fantasy model,” meaning that the child was copying the act of a well-publicized suicide. The personality descriptions of these children were: (1) children who felt that others didn’t like them, (2) children who were quiet and uncommunicative, and (3) children who were perfectionist and self-critical. The first of these descriptions overlapped with the others, and a fourth type of personality found in six cases, that of being impulsive and erratic, did not coincide at all. Shaffer concludes that suicidal children may conform to two stereotypes: children of superior intellect who were isolated from peers and possibly became depressed; and children who were impetuous, prone to aggressive outbursts, and overly sensitive to criticism. While such stereotypes may be familiar to psychiatric profiles, the propensity to suicide is believed to reside in their familiarity with the phenomenon of suicide itself. Shaffer backs up this supposition with the finding that the families of these children showed a high incidence of attempted suicide and depression (with possible talk of suicide).

Shaffer concludes that childhood suicide is the end result of many factors, not the least of which is a certain cognitive maturity both in terms of what death actually means and in terms of being able to plan and execute a suicidal plan. Other significant variables were a disturbed family background, a depressed mental state, a precipitating incident (often of a humiliating kind), access to a means of suicide, and close experience with suicidal

behavior. Out of respect for the family's sensibilities, Shaffer did not directly interview the surviving family members and thus does not stress the emotional deprivation so strongly emphasized by other investigators.

The following case example may help in giving an idea of the familial atmosphere so often found in the evaluation of suicidal children.

Illustrative Case Study Of Suicidal Child

Donna was an eleven-year-old girl who told her teacher that she was planning to kill herself and had been contemplating suicide for some time. This "confession" did not appear to be a manipulative gesture but was divulged in the context of a personal talk with the teacher whom Donna preferred to her own mother. Donna was the oldest of four children and was expected to be responsible for her younger sibs. They would tease her but she could not retaliate for fear of being punished by her parents. Donna had been raped by a relative when she was six years old, and apparently had borne the brunt of blame for this incident. Her mother continually accused Donna of being promiscuous and of having secret liaisons with boys despite the fact that the girl was only eleven years of age. The mother kept a close watch over Donna and did not allow her any significant extrafamilial relationships. She had to be home directly after school and she frequently was beaten by both parents. One week prior to her "confession" to the teacher, Donna's mother in

a fit of rage said she would kill her and Donna believed her. She decided it would be better to take her own life instead. When the mother was seen, she denied any history of child abuse (despite documented evidence to the contrary). It was learned that the father probably had had a series of affairs which infuriated the mother. Both parents seemed to utilize Donna as a scapegoat for their own frustrations. If she had not found some comforting outsider and revealed her plan, she may well have killed herself.

Suicidal Behavior In Adolescence

A totally different picture emerges when adolescent suicide is considered. Suicide among adolescents is not rare, and gestures or attempts are very frequent. Suicide ranks as a leading cause of death among the fifteen- to nineteen-year age group and 12 percent of all suicide attempts are made by teenagers (of these, 90 percent are female) (Seiden, 1969). The reasons for this high rate of self-destructive behavior are not completely understood. Some authors believe that depression is a significant predisposition and others believe anger toward others is the major determinant. Here again, semantics confuses the issue since some authors will classify depression only when there is clear evidence of anger turned toward the self, ignoring responses to loss or frustration and often labelling these latter states as grief reactions. Therefore the prevalence of depression among teenagers who attempt suicide remains largely a matter of how the particular author defines

depression.

Mattson et al. (1969) distinguished six groups of child and adolescent suicide attempters in their study of seventy-five patients at a psychiatric clinic. The motivations for each group were: (1) Loss of a love object: these patients sustained the death or desertion of a parent or peer of the opposite sex. They were depressed and wished to die in order to join the deceased person. Although lonely and sad, they did not exhibit guilt or self-recriminations (three boys, fourteen girls). (2) “The bad me,” that is, markedly self-depreciating patients: these patients hated themselves and felt they deserved to die. They viewed death as a solution and possible rebirth as a more worthy person (nine boys, eleven girls). (3) The final “cry for help” directed beyond the immediate family: these patients appeared worn out by chronic overwhelming external stress such as physical illness or family disruption (one boy, fourteen girls). (4) The revengeful, angry teenager: these adolescents clearly stated the coercive, manipulative aspects of their suicidal gestures and did not actually intend to kill themselves (three boys, ten girls). (5) The psychotic adolescent: these patients made repeated suicide threats, and suicide seemed to be a desperate solution to inner tension and confusion rather than an acting out of delusional belief (two boys, five girls). (6) “The suicide game”: these patients flirted with death in order to get peer approval and to experience a thrill. They exhibited denial of death and questionable suicidal intent (one boy, two girls).

This breakdown of a large sample of suicidal children, mostly teenagers, demonstrates the variety of motivations for self-destructive behavior. It is significant that girls outnumbered boys over two to one in suicidal threats and gestures, while the actual suicides committed in the same geographic area for the same time period were all committed by adolescent boys using firearms.

From these and other data, it may be concluded that although adolescent girls more frequently attempt suicide, more adolescent boys actually kill themselves. The main feature which seems to differentiate true suicidal intent from suicidal gestures is social isolation (Seiden, 1969). As long as there is someone to whom the teenager can turn for help or against whom he can vent his rage, true suicide may be averted. If the youngster believes no one who will care if he lives or dies, then suicide becomes a real possibility. Many of the attempts or gestures may be seen as desperate communications to others, but true suicides are well planned with no chance of survival. Two difficulties that obviously attend gestures are that the attempt may misfire and the individual die unintentionally; or if this desperate gesture is not taken seriously by loved ones, the youngster may be convinced that no one really does care and then attempt a true suicidal act.

A subgroup which has received considerable attention is the suicidal college student. Students attending Harvard or Yale showed twice the suicide

rate as nonstudents of the same age (Seiden, 1969). Similar findings were obtained from studying the suicide rates at Oxford and Cambridge in England (cited in Seiden). Investigations of the differences between suicidal and nonsuicidal classmates revealed that the former group was older, did better academically, and showed more indications of emotional disturbance. There was also a greater number of foreign students among the suicidal group, which may indicate separation from the usual social support systems and a greater sense of isolation. Some authors have mentioned fear of academic failure, extreme scholastic pressure, or shame over feelings of inadequacy and dependency as major suicidal motives in the college student. Again, there is no uniform motivation that can account of all suicidal behavior. On the other hand, Hendin (1975) proposed some common characteristics among students who attempt suicide. He eloquently wrote that some individuals are drawn to death as a way of life: they are so inhibited and tied to a past familial atmosphere of gloom and despair that they cannot tolerate the opportunities for pleasure and involvement which college life offers them.

These students see their relationships with their parents as dependent on their emotional if not physical death and become tied to their parents in a death knot. Coming to college, graduating, becoming seriously involved with another person, and enjoying an independent existence have the power to free them. In fact, the meaning of suicide and depression lies in their encounter with the forces that might unleash their own possibilities for freedom (pp. 238-239).

For such individuals, numbness is a sort of protection and the

possibility of gratifications arouses guilt over betraying a secret bond with the parent. This guilt and the understanding that it blocks pleasure leaves the individual frozen in a state of inhibition; he cannot break through the old sanctions and yet cannot endure living in accordance with them. Suicide becomes a possible solution to this conflict. Death has always held a special fascination for these individuals who, according to Hendin, by their own self-destruction appear to fulfill the parental command not to dare to live.

Hendin's work draws attention to some of the potent forces for suicide in all age groups: a lack of being appreciated for what one is, a failure of parents to instill a sense of joy and approval of life in the child, and finally, a prevailing sense in the individual that his enjoyment of other relationships or other activities is a guilty betrayal. Suicide, like depression, may ultimately result from a self-induced elimination of satisfactory and satisfying life alternatives that are not tied to omnipotent others or dominating goals. This lack of freedom to form new interests or relationships—that is, a lack of freedom to enjoy life—results in depression and ultimately in some suicides. If the adolescent can achieve some wholly personal aspect of life, free from the deadening burden of guilt and parental “shoulds,” he may escape the premature termination of his own potential. Some adolescents find solace in a relationship, a cause, or an academic interest which may lead them to liberation and away from their heritage of obligation and self-denial.

In his autobiography Bertrand Russell recalls the cold and unloving atmosphere in which he grew up. Throughout his teens he often considered doing away with himself, but he survived to live a long and productive life. He wrote, looking back at the time he was fifteen, “There was a footpath leading across fields to New Southgate, and I used to go there alone to watch the sunset and contemplate suicide. I did not, however, commit suicide, because I wished to know more of mathematics” (1967, p. 45).

Notes

- [1] The Freudian concept of the superego does not entirely do justice to the internalized cognitive system. The superego seems to be limited to punishment and idealization while the internalized cognitive system assumes many of the functions normally ascribed to the ego, such as modes of adaptation, self-assessment, and relationships with others.
- [2] Rie’s argument is equally important for showing again how depression is ultimately dependent on the development of the capacities of the ego (especially cognitive abilities) rather than simply on the formation of the superego.
- [3] Adapted from Loevinger, J. 1976. *Ego development*. San Francisco: Jossey-Bass.

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