PSYCHOTHERAPY OF DEPRESSION IN CHILDREN AND ADOLESCENTS

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Severe and Mild Depression

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PSYCHOTHERAPY OF DEPRESSION IN CHILDREN AND ADOLESCENTS

Jules Bemporad

The treatment of depression in the pediatric age group must consider the psychopathological symptoms against a framework of the developmental process. The clinical manifestations, causes, and therapeutic options vary greatly with age and one has to be flexible both in terms of understanding the disorder and in the therapeutic course of action. As outlined in chapters 4 and 8, true depression is not seen before late childhood, and even then it is quite rare. In over a dozen years of private practice of child psychiatry as well as of directing a psychiatric division in a large pediatric hospital, I have seen only a handful of prepubertal children who were truly depressed. Many children appeared sad or unhappy, but each was reacting to a readily discernible stress in the environment and had not as yet crystallized modes of interaction or ideas of the self which would perpetuate this sense of unhappiness. In every case, the unpleasant affect responded proportionally to ameliorating the environmental situation. Children with chronic illnesses which have prevented the attainment of age-appropriate satisfaction, or children with chronically punishing and depriving home situations, regularly react with

sadness but rarely feel badly about themselves as well. They are upset over having an illness or over being criticized and ignored by parental figures.

Even when there is a sense of self-blame, it is not the same as in the adult depressive. The lowering of self-regard shifts from situation to situation and responds readily to happier surroundings. For example, I have found that many children with learning disabilities believe they are basically inadequate and may be chronically unhappy if they are in a situation in which academic achievement is highly prized. Parents and teachers unconsciously convey the message that they could do better if they only tried harder. Competitive peers also may select these children for teasing and taunting, adding to their sense of being different and inferior. However, these children respond well to a more understanding environment which appreciates their other abilities, and their non-academic capabilities can be utilized therapeutically to build a better sense of self. Often such children are excellent artists, able athletes, or adept mechanics, and these assets are enhanced to balance their frustrations in the academic area. Children with learning disabilities usually find compensatory areas of achievement on their own, without therapy, although all too often these achievements are in the area of delinquency.

This digression into learning disabilities may serve to stress the difference between a child who is unhappy because of some current problem and a child who is depressed. Depression-—in my opinion—involves a self-

perpetuating pathologic mode of interaction fostered by unconscious cognitive distortions. These distortions are the result of child-parent interactions and result in an excessive need of others for maintaining self-esteem, a self-inhibition from achieving gratification independently of the dictates of significant others, and an unrealistic self-regard in terms of effectiveness. It is not until late childhood that the individual can distort his interrelations so as to repeat older patterns. Before this time, the child simply reacts with unhappiness to a reality situation which is perceived according to age-appropriate cognitive modes. Therapy aims at removing or diminishing the source of frustration, on the one hand, and building or maximizing areas of gratification and esteem, on the other. Therefore, with young children a certain amount of environmental manipulation and family involvement is necessary.

As the child approaches puberty, however, these therapeutic efforts are no longer effective; the child carries within himself the sources of his dissatisfaction and imposes a distorted view of himself and others on his activities. In general parlance, one speaks of problems having been "internalized" and no longer "reactive." Changes in the behavior of others, especially parents, is still of benefit but now individual psychotherapy becomes the treatment of choice. The child should be made aware of his distortions, his tendency to repeat the past, and his own responsibility for his problems within the context of the relationship with the therapist.

In many respects the therapy of depression at this age is similar to that of adult depressives. However, there are some significant differences which should be emphasized. First is the limitation on abstract thinking. In contrast to the adult, the child finds it difficult to utilize verbal interpretations of a general nature and apply these to various areas of his life. Interpretations have to be concrete, specific, and practical. Everything must be put in such a way as to be immediately usable and comprehensible to the child. Similarly, interpretations may not carry over from one session to the next, and much repetition and patience is necessary.

Second, therapy with children should aim at being a developmental experience in itself. There is less reconstructive work than with adults and more of a shared process of growth. Therapy sessions are not considered as separate from other life experiences by children and so the relationship to the therapist is very reality-bound and influential in promoting growth in itself, aside from the content of the sessions. In brief, therapy with children is much less artificial than with adults; for the child, it is a living relationship with another adult and is treated as part of the totality of experience. This implies that the therapist does not spend a great deal of time correcting the child's distortions by verbal interpretations; rather, the therapist demonstrates by his very behavior that he does not accept the child's mistaken estimation of himself and others.

For example, one depressed eleven-year-old boy felt he had to make grades that were beyond his academic capabilities, and he was surprised that the therapist was not dissatisfied when he did not earn an A on his report card. In this manner the child learned that a significant person in his life did not react with anger to his alleged lack of achievement. This utilization of the relationship is much more effective than a verbal interpretation such as “you expect too much of yourself’ which might be appropriate for an adult. Children treat therapy as part of life, and respond to actions rather than words.

Since the child is still in a fluid state of development, therapy is often easier and shorter than with adults who have already consolidated modes of thinking about themselves and others. Children change more rapidly once they have begun to trust the therapist and to allow therapy to influence their lives. Therapy is partially a transferential repetition of an earlier child-parent relationship, and partially a new experience which will shape the future psyche of the patient.

However, this advantage is balanced by a strong limitation. Children have less control over their everyday lives and continue to be greatly influenced by other significant adults. In this sense, therapy is rarely effective if the home environment continues to be detrimental to change. The child cannot move out, switch jobs, or make radical changes in his day-to-day life.

He is still realistically dependent on the whims of others, and those powerful others quickly can undermine the changes that are laboriously achieved in the office. In undertaking therapy with a child, therefore, one really must deal with the resistances of the family as well as those of the patient. A good working alliance with the parents is needed as well as a therapeutic relationship with the child. Often the parents are well-intentioned but still unconsciously sabotage progress toward health. These automatic reaction patterns must be pointed out so that the parents realize their contribution to the continuation of psychopathology.

One of the potent contributors to child psychopathology, which is rarely mentioned in the clinical literature, is the home atmosphere. This is a vague concept and is difficult to describe accurately, yet it must be considered in the formulation of the factors that influence behavior. The atmosphere in the homes of depressed children is, quite simply, depressing. Sometimes there is a depressed parents or a chronically ill relative. There is a general solemnity and a lack of spontaneity, joy, and laughter. There is a deadly seriousness that contaminates the inner life of all the family members. There is also a stifling network of extreme interdependence in which the psychic welfare of others inordinately becomes the emotional burden of the child. The child feels a sense of disloyalty if he enjoys himself while his parents are so unhappy. He sets himself the task of brightening their lives, a task at which he can never succeed. At other times the child is made to feel that he must devote all his

energies to pleasing the parent who withholds love or rewards except for acts of obedience and servitude. Independent behavior or external influences threaten the domination of the parent and are met with guilt-provoking rebukes or belittlement. These families were accurately described by Cohen and her co-workers (1954) in their retrospective studies of adult manic-depressives. (This work has been summarized in chapter 2.) In general, the common thread that runs through families with a depressed child is that the child has been unfairly burdened, at too early an age, to feel responsibility for either the happiness or the aspirations of the family unit.

This situation is most inopportune, for one of the major tasks of late childhood is for the child to establish a sense of worth in the community, apart from his family. If the parents contaminate this autonomous sense of esteem with guilt, or pervert it so that esteem is desired for the family instead of the self, then not only depression but also a significant developmental stasis may result. It is in this sense that developmental tasks must be kept in mind when doing therapy with children. One must constantly be alert not only to the present symptoms, but to the blocks to normal growth that the current situation may be creating within the child. In the older child, a gradual devaluation of the prior inflated importance of the parent as well as turning to extrafamilial figures for self-validation are necessary for normal development. These crucial processes are all too often sabotaged in the life of the depressed child, as well as in the life of the later depressed adult.

This lack of individuation is also prominent in depressed adolescents who, in contrast to children, are not at all rare in clinical practice. These youngsters are bound to the family by ties of guilt and obligation and they are unable to participate fully in activities outside the family circle. While they may do well academically or even socially, they are basically achieving for the family and not for themselves. Hendin (1975) described a group of severely depressed college students who had attempted or contemplated suicide. Hendin found that a close tie to the parent was a central feature of the problems of these individuals. They saw their relationship to their parents as predicated on relinquishing all personal pleasure or freedom. In college they encountered the potential to become free but were threatened by it, for it would sever the needed emotional tie with the parent. Hendin described these students as having been raised to be quiet drones who never showed excitement or pleasure, but who grimly strived for the parental ideal, the achievement of which they felt was their sole purpose in life.

Other adolescents may rebel against the dictates of the parents, often doing themselves harm in the process. They wish to make the parent feel guilty for what he has done to them and so they try to hurt the parent by hurting themselves. In this way they are using the same indirect manner of coercion through guilt that the parents used on them. Despite their self-proclaimed freedom, they are still tied to the parent in an ambivalent and yet needed relationship.

Still others replace the parent with another dominant other and establish a new bargain relationship outside the family circle. These youngsters appear to do well on a superficial level, and it is only after the relationship has either ended or failed to satisfy them that the pathological aspects of the bond become apparent.

Finally, some adolescents experienced childhoods in which they were overly sheltered and not really allowed to develop independent competence in any area. Their sole task was to gratify the dominant parent who expected little beyond obedience. While secure at home, these adolescents feel—and in some aspects are—incapable of facing the demands of life outside the family circle. They collapse in the face of expectations they feel they cannot fulfill, and recoil from strangers who do not accord them the special treatment they believe they deserve.

In doing therapy with depressed adolescents, developmental tasks again must be kept in mind. This is a time of testing the self in society. This process usually starts in late childhood with the child's participation in peer-oriented activities, but it really comes to fruition in adolescence. At this time the youngster encounters intimate relationship with nonfamily members. He begins cognitively to consider alternate systems of values and different life styles than those to which he was exposed in the family unit. At the same time he cannot rely on family status or backing for his place in society, and he is

essentially on his own for the first time. Acceptance or rejection by peers or by esteemed adults depends on his own abilities and personality. Thus there should be a gradual weaning from the family and a looking toward society for sources of meaning and gratification. Much has been written about the pressures of this weaning process in contemporary middle-class culture. This is a troubled time for most individuals and a good deal of floundering as well as unrealistic optimism and pessimism is to be expected. However, the process is even more difficult for youngsters who cannot feel free from their families or who believe that they must redeem the family's honor in society's marketplace. These are often the adolescents who become depressed, and treatment aims at both altering the cognitive distortions that predispose one to depression and insuring that the individual can master the specific developmental tasks of adolescence.

Joan: A Case Of Mild Depression

A clinical example of an adolescent who believed she could not face life outside the family unit was Joan, a fifteen-year-old girl who had had mild feelings of depression for about six months. She described herself as unable to enjoy anything and not caring about anything anymore. She admitted some suicidal thoughts but felt she was too cowardly to act on them. She felt markedly uncomfortable outside of her home and so stayed with her family a great deal, but found that she was bored by the company of her parents. Even

going out to dinner with her father, which had been a special treat in former years, was no longer enjoyable. Her grades had dropped and she remarked that she saw school as a waste of time. She had gone to a few dances and parties but left after feeling herself too uninvolved and preoccupied with her own thoughts.

Her history was significant in that Joan had suffered from extreme separation anxiety throughout childhood. She resisted going to nursery school and later developed stomachaches on school mornings in the third and fourth grades. Her mother believed that these somatic symptoms began after an unpleasant experience with a second-grade teacher who was a perfectionist and intimidated Joan in class. This experience was undoubtedly detrimental but it also became clear that Joan’s mother was an anxious, depressed woman who was overly occupied with her own problems and could not devote herself to her children. Later in therapy Joan reproached her mother for never having taken the time with her or her sister Nancy to stimulate interests or to teach them activities in order to bolster a sense of adequacy. In contrast to the mother’s aloofness, the father made Joan his “little princess” and showered affection upon her, but only for being a helpless and pretty little girl. He never encouraged her to achieve for herself, but he used Joan to comfort him. The younger sister, Nancy, was rejected by both parents and in her teens turned to delinquent activities for recognition from peers. Joan’s role was the good girl while Nancy was clearly the bad,

rebellious child.

The home atmosphere was consistently gloomy and tense. Although the family was affluent, there was always talk of a shortage of money and long discussions about the family business, in which one member was always accusing the others of cheating him of his proper share. The parents argued frequently about money, and it was possible that the mother overspent in an effort to hurt the father and also to fill an empty life with material possessions. The father was quite status conscious, but under his well-groomed facade he was actually stingy and controlled the family by carefully doling out money as a reward for obedience. Joan was indulged by him as long as she was "good," meaning that she was never to assert herself or rebel against his authority. There was a clear, unspoken rivalry between Joan and her mother which neither of them openly acknowledged.

The effect of this type of family constellation on Joan was that she never learned how to fare for herself. She expected the world to respond to her much as her father did. She thought she would be special to others just by wearing pretty clothes or by passively appeasing them. In her late childhood years, she made few close friends although she did enjoy going shopping with other girls. Aside from her sophisticated knowledge of clothes and cosmetics, she had no interests and had developed almost no talents. She had started piano lessons and dancing classes, but had been allowed to quit when she had

to put forth effort in these pursuits. Her parents never demanded good grades and she was able to be an average student with very little work.

In therapy it became apparent that no one had ever considered Joan as a separate human being. Her mother treated her as an obstacle to her own vague ambitions, while her father used her for his own purposes —as a source of affection in a barren household. When Joan reached puberty, she expected to live a romantic life similar to the heroines of the soap operas she religiously watched. Instead, no one paid any attention to her. She was not particularly pretty or really socially adept. Because she was not given special attention, she retreated more and more to her home. However, the mother was rarely home, having embarked on a career; and the father no longer babied her and even turned away from her, possibly as a result of being threatened by seeing her as a sexual stimulus.

As a result of being tied to the home and lacking any personal initiative or independent avenues of esteem, Joan could not cope with the task of individuation required at adolescence by her social class. She had been reared to become a princess but now no one acknowledged her as such. She tried to rescue her sense of importance by choosing a boy who was her senior by a few years. Joan hoped that he would respond to her in the same manner as her father had when she was a child. She expected him to salvage her sense of importance and desirability. This young man at first politely told Joan that he

was not interested in her. When she persisted, he was fairly brutal in his rejection of her, telling her exactly how he saw her. At this confrontation, Joan's world collapsed. She saw herself as inadequate in every way and she was filled with shame and despair. Her father tried to comfort her but she realized that his attentions no longer sufficed to make her happy. She wanted to be recognized and needed outside the home, but felt she could never achieve this aim.

Therapy lasted for three years in which Joan gradually was able to alter her expectations of herself and others. At first she wanted everything done for her, including the diminishing of her depression. An early dream demonstrates this lack of personal initiative and her reliance on others. In the dream Joan announced to her parents that she was going to kill herself. They offered no protest and did not react. Joan then started crying loudly, causing her mother to call a doctor. The doctor arrived and made her feel better. This dream implied that the therapist should take over the nurturing role of the parents, that the therapist should make her feel better since her parents could not. There was no effort on Joan's part in the dream except to cry loudly. On a positive side, the dream may have indicated that the therapist, in contrast to the parents, appreciated the seriousness of her despair.

In working with youngsters like Joan, I have found that better results are obtained if one is active and direct, making concrete suggestions and

offering avenues for change. These youngsters have an urgent need for relief and change, so that they do not respond well to the prolonged, introspective, and reconstructive aspects of therapy that form so great a part of the treatment of adults. In view of these special aspects of therapy, specific suggestions for new activities were discussed with Joan. There was also an open discussion about having to learn to do things for herself and not being able to rely on her parents any longer. These sessions were followed by a somewhat encouraging dream: Joan realized that a building she was in had caught fire, she ran to an elevator, and was able to save herself by fleeing the building. This dream may have demonstrated Joan's beginning awareness that she had to rely on herself to overcome her depression.

Joan's depression lifted in the course of a few months. She realized that the social reality of her life was neither as effortless as she had expected it to be as a child nor as hopelessly unattainable as she had felt after her rejection. Despite this improvement in her clinical condition, therapy was continued to correct other distortions about herself and others which could have led to problems in the future. Also, while she was rid of her feelings of depression, she was far from emancipating herself from her family or feeling comfortable among her peers. She continued to worry about being an old maid and of never being loved. She read the popular novel *Sheila Levine is Dead and Living in New York,* which recounts a depressed woman's unhappy love affairs in a most self-deprecatory way, and she closely identified with the heroine. The

recitation of these worries were countered by the therapist suggesting that she leave the future alone and concentrate on living a gratifying life in the present.

Toward this end, Joan attempted to socialize without the expectation of special treatment, immediate acceptance, or the fear of eternal rejection when others just treated her neutrally. She eventually formed some relationships with other girls and was able to confide in them and obtain a sense of closeness. It was important for her to see herself as neither privileged nor deficient, but on an equal status with others. In time, her group of friends met some boys and started going out as a group. While there were no one-to-one relationships, they accepted each other and enjoyed doing things together.

As a result of extrafamilial involvements, Joan became more sure of herself and of her place in adolescent society. She then was able to cross a line she had never dared to even imagine in previous years: she was able to get angry with her father. Her father had blown up at Nancy and struck her. In the ensuing family argument, Joan took Nancy's side and critically attacked the father. This was a big step for her; it showed that Joan could realistically evaluate her father and her need of his praise no longer blinded her to his faults.

The recounting of this episode in therapy was utilized as an opportunity

to begin to review with Joan her past experiences and the reasons for her current problems. A good deal of reconstructive work was accomplished and Joan was able to understand how she was tied to her family by a distant mother and an indulgent, yet controlling, father.

The remainder of therapy dealt with applying insights to everyday life, and with stressing the need for independent activities and autonomous avenues of meaning. Joan did find a boyfriend, and proved to be capable of emotional intimacy and of giving love and affection. She never achieved her academic potential but did decide on a business career which pleased her. She was never able to form a truly good relationship with her mother, who could have helped her greatly in her growth toward maturity, but this failure at closeness seems to have been more a result of the mother's resistance than a reluctance on the part of the patient. In other respects Joan was able to enjoy herself, had an accurate image of herself, felt comfortable on her own, and did not force others to give her the special deference she had been accustomed to receiving from her father.

Paul: A Case Of Severe Depression

Joan's depression can be considered mild. However, adolescents also present melancholic episodes as severe as those seen in adult patients. One such patient's treatment is briefly presented here as a contrast to Joan's

relatively benign course.

Paul was an eighteen-year-old college dropout who was seen following a bona fide suicide attempt. Paul had taken a large number of assorted pills after breaking off with a girl friend. He intended to die, but the mixture of pills was fortunately not lethal. Paul's history revealed evidence of psychopathology dating back to early childhood: he always had been shy and seclusive, he had had difficulty separating from his mother, he was afraid of peers, and his school performance was erratic despite a superior intellectual endowment. He also found it difficult to express his feelings and suffered severe stomach cramps in times of stress. (His sister had developed an ulcer in childhood and their mother was plagued with migraine headaches.)

When first seen, Paul could hardly carry on a conversation. He was in extreme mental torment and repeatedly stated that he wished he were dead. All of his brilliance and mental abilities were paralyzed by an overwhelming sense of pain and despair. He paced up and down the office, often bursting into tears. He complained of severe abdominal cramps. At times he was silent, as if in a stupor; at other times he could not sit still, but had to resume pacing. He could not bear to speak of his lost love without breaking down into tears. He could neither eat nor sleep but spent his nights pacing in his room. Paul was seen daily, with frequent telephone contacts between sessions. The aid of the family was enlisted for fear of another suicide attempt. Hospitalization

was considered but Paul expressed a terror of being away from home at this time. He seemed to gain some solace from having his father with him. In view of the extensive somatic symptoms (and the remote possibility of an underlying schizophrenic process) he was started on Stelazine®. The initial sessions were spent in simply being with Paul and inducing him to talk about the thoughts that were eliciting his depression. Paul repeated that without Carrie—his former girl friend—his world was empty, his life was no longer worth living, and he felt himself to be incomplete and deprived of any hope of happiness.

The picture which gradually emerged was that Paul had been depressed for years, but recently his involvement with Carrie had relieved him of his feeling of inner deadness and had given him a reason for living. Her loss had plunged Paul into a state of total despair and hopelessness.

Paul’s history is similar to those of depressives described elsewhere in this book. In his case, the dominant other was his mother. Paul’s mother had grown up with wealthy parents in an exclusive suburb. She was given much in terms of material comforts, but little in the way of love or warmth. Her parents were greatly concerned with social standing and outward appearances, rewarding financial success and upward mobility. Paul’s father also came from a prominent family, but he had chosen music as a career, much to the dismay of his parents. As an aspiring musician he had achieved

moderate success, but was unable to support his own family in the manner of his own or his wife's childhood households. Although Paul's parents truly loved each other, financial limitations created a constant undercurrent of resentment from Paul's mother and a sense of failure from Paul's father. Both parents hid these feelings from other people, and in fact they carried on as if they were still very wealthy, despite having to exist on a middle-class income.

Paul's mother seemed to have developed a sense of inferiority over her limited financial state, partially because she was snobbishly treated as a poor relation by her siblings who had married into wealthy families. Urged by a desire for vindication, she attempted to regain her status by forcing her children to succeed so as to justify her choice of marital partner. Both Paul and his sister were blessed with superior intelligence and the mother utilized this gift by insisting that they excel in academics. She was a loving and giving mother as long as her children behaved in an overly polite, exemplary manner and made top grades. If either faltered, however, she would become furious or subject the children to long lectures. She honestly believed that she was doing what was best for them, unaware of the pressures she was putting on her offspring.

Paul's father was a more relaxed, fun-loving individual who lived for "Art" and seemed satisfied with his accomplishments. However, he felt ashamed that he could not give more to his family and this shame had forced

him into a secondary role from which he rarely interfered with household matters. His work forced him to travel a great deal so that he absented himself from parental responsibilities, and even when home he did not contradict his wife in her dealings with the children.

Under his mother's tutelage, Paul grew up as a superior student but also very naive about crucial aspects of life. His sole responsibility was to make good grades, and he was discouraged from assuming other tasks which would prepare him for adult life. As he reached puberty he sensed himself to be different and weak in comparison with his peers. He attempted to compensate for these feelings by weight lifting or with tests of endurance, such as walking barefoot in the snow or camping out in bad weather. Despite these efforts, he continued to see himself as unmanly and inadequate.

He felt a great deal of anger toward his mother but was afraid to express any of his feelings. The home atmosphere was one of false gaiety, where everything was supposed to be lovely and yet all the family members realized this to be a sham. However, no one dared to question this pretense and so each suppressed feelings, which may explain all the psychosomatic illnesses.

In his early teens Paul became truly depressed when he compared himself with other boys. He felt himself an outcast, unable to relate to most of them. He was painfully shy in social situations, often developing

stomachaches at parties or dances. He did not divulge his painful feelings to anyone, but tried to find solace in solitary hobbies and in continuing to build up his body. He feebly rebelled against his mother by keeping his room a mess or by dressing in a shabby fashion, but he still needed her to direct his life and give him structure. He had difficulty being with her and even more difficulty in being without her. His happy times during this period were rare outings with his father, who also loved nature. However, the two would rarely talk when together. Both were shy, quiet people with a great deal of sensitivity, but neither could open up to the other.

When Paul started at an out-of-town college, he was totally bewildered, lacking any previous experience in caring for himself. As a result of poor planning, he had to quit college to avoid failing in his first year. This near-failure took him by surprise; it seemed as though he did not fully comprehend what was happening to him at school. Paul returned home feeling totally disgraced. He had not succeeded in his one area of achievement. It was at this time of self-devaluation that he met Carrie, and she transformed his view of himself. She accepted him as he was, without conditions, and despite his alleged failures. Carrie allowed him to feel that he was worthwhile and deserving of love. Paul felt absolutely in love and made Carrie the fulcrum of his existence. His relationship with her represented the only truly happy time of his life. He became so involved with her that when he started college again he could not attend to his studies because she was constantly in his thoughts,

and he yet again dropped out to avoid failing. After about a year of intense involvement, Carrie tearfully decided that she was too young to bind herself to one person and broke off the relationship. Shortly afterward, Paul attempted suicide.

It took a long time until Paul was able to view himself without Carrie. He had not only loved her, he had also depended on her for seeing himself as valid, important, and worthwhile. He had utilized her to fight off a former sense of self that resulted in chronic depression and low self-esteem. He could not mention her in therapy, but continued to dwell on his symptoms. At this time Paul was incapable of any analytic work, but he could still communicate about day-to-day events and not utilize his therapeutic time merely to complain. We initially discussed ways he could attempt to fight off his feelings of despair, as well as the daily transactions of his life. From these concrete, matter-of-fact sessions, a recurrent theme emerged—Paul's inability to express anger openly. From the content of his productions it could be assumed that he was angry at Carrie for leaving him, at his mother for her former treatment of him, and even toward his therapist for not helping him more. However, he never alluded to a sense of resentment toward anyone.

In one early session, Paul described how his sister had lost patience with him and "chewed him out." He took her criticism in silence but later suffered stomach cramps. His denial of anger was interpreted, to which Paul

replied that he considered himself a special sort of persoi who did not need to get angry. This interchange opened up the whole area of his defensive facade of stoicism which served to cover deeper feelings of inferiority.

With this session began an investigation into his blocking of feelings and his fear of the effects of expressing his feelings to others. He began to talk more freely and to be more introspective in terms of trying to find causes for his current predicament. He recalled his mother making schedules for him as a child and his bitter resentment toward her which he had not dared to reveal. He also recalled the sense of being overwhelmed by his mother and of being all alone with no one to help him. This feeling of isolation had persisted into the present and he continued to feel that he was apart and different from others. Only Carrie had understood him and now she was gone. Paul was not yet ready to appreciate how he had used his relationship with Carrie to fulfill narcissistic needs, but he could understand that his restriction of social contacts, his denial of hostile feelings, and his fear of his openness hurting others had predisposed him to becoming depressed. He was also ready to acknowledge that his special view of himself was only a rationalization.

After six weeks of therapy Paul’s somatic symptoms had sufficiently subsided so that medication could be discontinued and the sessions reduced to three times a week. Therapy focused on his ambivalent relationship with his mother and how this all-important tie had shaped his personality. It would

have been simple to blame the mother for all of Paul's problems, but this conclusion would have been both erroneous and antitherapeutic. Paul had to see his own participation in his problems and the fact that he continued to function in a pathological manner despite the freedom to change. Paul continued to conceive of himself and others according to childhood cognitive patterns in which he was helpless and passive and others were overly powerful and dominating. As this self-concept was explored in therapy, it helped to explain Paul's numerous self-defeating actions such as the refusal to take responsibility for himself in college, his various passive-aggressive maneuvers by which he got even with his mother, and finally his expectation that someone else would transform his life—a role which Carrie had temporarily assumed.

A striking aspect of Paul's failure to master the developmental tasks of adolescence was his inability to let experiences from everyday life alter the unconscious cognitive beliefs which he had learned in early childhood. Part of the adolescent experience is an exposure to novel ideas or ideologies, often in direct contrast to familial belief systems. Paul had totally insulated himself against change or a reevaluation of his world view. He had missed out on the necessary psychic readjustment that takes place as one leaves home and begins to broaden life experiences in day-to-day interchanges with the world. Carrie had not really widened Paul's psychological horizons. It became clear that she had fit into his expectations in an almost delusional way; she had not

been truly appreciated as a separate person, but only as a flesh-and-blood embodiment of a fantasied good mother. Paul actually knew very little about her—she existed to fulfill his nonchanging needs, just as his own existence was based on the fulfillment of his mother's unconscious needs.

Much of Paul's therapy consisted of allowing him to feel secure enough to open himself up to new experiences and to form a new cognitive equilibrium based on more realistic data. Many sessions were spent on discussions of his perceptions of actual events rather than on the extensive reconstruction that would have been appropriate with an adult patient. Past scars and their resulting distortions were not avoided, but therapy was given a much larger function as a process for stimulating developmentally appropriate growth outside the office.

The relationship to the therapist was also important in correcting distortions. Initially Paul projected on the therapist the role of omnipotent healer who, like his mother, would magically make everything better. At the same time he distrusted this needed other and had to guard against what he said or how he behaved in the office. He learned that the therapist was quite limited in offering magical relief and that essentially he had to cure himself. At the same time, he encountered an adult authority figure who encouraged freedom rather than control and who accepted feelings as important. Transference was not directly interpreted because his changing relationship

with the therapist was considered to be part of a more general adolescent growth of the self.

Paul has remained free of depression for over eight years. It is perhaps more important that he was able to move away from home, embark on a career of his own choosing, and enjoy mutually beneficial relationships with others.[1]

Summary

The cases presented in this chapter may not differ significantly from adult depressives in terms of family history, basic psychodynamics, or unconscious beliefs. Modifications in the therapeutic approach are necessary, however, when the therapist considers the developmental tasks that are appropriate for the age of the patient. The need for alteration of the therapeutic process becomes apparent if the actual phenomenological world of the child or adolescent is appreciated. Young patients learn more from action than from words, more from concrete experience than from sophisticated interpretations. Therapy must not only be an experience that corrects past misfortunes, but a situation that frees the individual so he can utilize his new experiences for continued psychological growth.

Notes

[1] After this section of the manuscript was completed, I was delighted to receive from Paul (now in his late twenties) an invitation to his wedding and a communication that he continues to feel gratified by his life and his work.

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