

# Variations on the Theme of Depression

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Freud in 1917 published his classic paper on mourning and melancholia describing the essential features of melancholia (depression) as "profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity and a lowering of the self-regarding feelings to a degree that culminate in a delusional expectation of punishment." Much has developed in the knowledge of depression since 1917, but even more has become known about the development of personality and its various stages as well as the psychic structures involved.

If we pass over the work of Melanie Klein who believes every infant goes through a depressive position in the first year of life, we are left with two opposing views about the diagnosis of depression in childhood. These center around the fact that a child before five years of age has not developed a superego (conscience) and therefore "the savage intrapsychic attack of the superego on the ego resulting in loss of self esteem" does not take place as is seen in depressive reactions in older children or adults. To define, the ego refers to the executive portion of the personality which perceives, discriminates and integrates stimuli from the external and internal world. The superego, also a theoretical construct, is that part developed by incorporating standards of the parents and of society as perceived by the ego. The conscience is the conscious portion of the superego, and unconscious prohibitions and ideals are also operative without one's awareness.

The classic work on anaclitic depression by René Spitz (1946) was followed by Engle and Reischmann's case of Monica. In 1951 Bibring saw depression as "the emotional expression of a state of helplessness of the ego." In 1965 Sandler and Joffe from Hampstead Nurseries under the leadership of Anna Freud referred to it as "an effective reaction where a child is faced with a specific type of threat to his well being, whether it be the loss of an essential love object or the thoughts of

having been deprived of an 'ideal state.'" This latter, for example, could happen with the birth of a sibling. They feel that there are many quantitative differences in the manner in which children respond to mental pain induced by such threats. It has been shown that mental pain mobilizes anger although in a child this is often inhibited and turned against the self by the process of identification with the aggressor as is seen in head banging.

It must be remembered that depression in childhood has an evanescent quality in which the obvious signs of depression do not persist openly as in adults. Sandler and Joffe refer to nine items common to depressed children seen analytically at Hampstead Nursery where the material was recorded in the Hampstead Index (1962). I would like to list these:

1. They look sad or unhappy
2. There is a withdrawal with little interest in anything
3. They are discontented with little capacity for pleasure
4. They communicate a sense of feeling rejected and readily turn away from disappointing objects
5. They are not prepared to accept help or comfort even though it is offered
6. There is a tendency to regress to oral passivity
7. There is insomnia or sleep disturbance
8. There are autoerotic or other repetitive activities
9. The therapist often reports difficulty in making sustained contact with the child

I feel that Spitz, Bibring, Engle, Sandler and Joffe and others record evidences of depression in children, taking into account the child's stage of maturation.

On the other side of this contention, Beres (1966) and Rochlin (1959) feel there can be no depression according to Freud's definition before five years of age because of the lack of superego formation. Bowlby in 1960 presented a paper on grief and mourning in infancy, claiming infants react to loss and separation as do adults, although the latter have completed their personality development. This brought forth a storm of discussion from Anna Freud, Max Schur and René Spitz.

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I bring you this brief and incomplete review of the past twenty years to show the confusion about the diagnosis of depression in childhood. I would like to present briefly two cases, both of which I call depression and both of which differ; and as I see them both can be classified clearly under the Sandler-Joffe definition with which I side.

### Case Summary—*Laurie Jo*

Laurie Jo, now seven years and three months, whom I have seen for over a year for failure to grow, is finishing the first grade. She is the second of three children with an 18 month older sister and a 14 month younger brother. She was a full term, normal delivery baby weighing 6 lbs. at birth and gaining weight appropriately. She walked at a year and at this time was weaned from the bottle. Her mother felt she seemed quite different "from her older sister" and also felt that she was a very stubborn toddler who refused to be toilet trained at two years of age. Growth proceeded normally until she was two and a half to three years of age, despite the birth of her brother at 14 months. When Laurie was two and a half years, her mother had a depression requiring the use of tranquilizers for several months. Her father at this time changed jobs with a pay cut after he had contracted for a new home, and during this period of family crisis, Laurie began to vomit at night five to seven times a week. She began to wet and soil and to be very constipated. She often choked on food and she screamed without reason for long stretches. When hospitalized for tests at MCV at five years and three months, Laurie showed a height of 35.8 inches, a weight of 23 lbs. and a bone age of two and a half years. She was diagnosed as growth failure based on partial hypothyroidism and chronic constipation. The partial hypothyroidism showed very little evidence beyond the growth failure with the exception of the radioactive iodine uptake which was less than half what it should have been at 24 hours. She was placed on a half grain of thyroid daily for a month, increasing to a grain and later to a grain and a half. In the subsequent four months she grew almost half an inch, gained a pound and a quarter, and was still constipated and without energy, screaming and irritable. The family was seen in our clinic two months later, December 30, 1968, when Laurie was five years and nine months. At that time mother told the worker that Laurie was not happy or excited over her Christmas toys. Laurie was in a pre-school for retarded children and the report from the teacher was that she was showing evidence of some slight increase in her activity. By the time I started seeing Laurie in therapy at the age of six years and one month, she had been moved to a regular private kindergarten on the advice of this pre-school teacher. This move was based on a normal I.Q. I have seen Laurie and her mother weekly through the year and am now seeing them every two weeks.

I agree that she presented some signs of low thyroid activity as evidenced by the deficient radioactive iodine uptake; however, I feel this girl was seriously depressed as evidenced by her failure to grow due to the suppression of thyroid activity after two and a half years of normal growth. Her irritability and withdrawal, the fact that she had no pleasure in toys or play, her clinging, her apparent retardation and, most of all, the very sad affect on her face were all evidence of her depression. It is possible also that her frequent vomiting at night contributed to her growth failure.

When I first saw Laurie she was a tiny, frail child with large blue circles under her eyes. She walked up and down stairs a step at a time, holding the bannister. She clung to her mother when at home, never playing outside with the children. What, however, was most distressing to her parents was that Laurie at times would scream without reason for two to three hours. Mother and father both felt this was unbearable and they excluded relatives from visiting them because of their guilt and discomfort. Both parents felt absolutely helpless when she screamed, and both were open about wanting to beat her. However, this they did not do and it was only with difficulty that they could admit to any but "good feelings" toward Laurie. The father was especially distressed that she exhibited no curiosity or friendliness with him. Laurie was also jealous of her 14 month younger brother who was bigger than she by now.

Because she is tiny and very pretty, Laurie tends to be infantilized by others. There was grave doubt that she could move to kindergarten and later from kindergarten to first grade. Her mother expected both of these to be failures; however, both moves have been most successful and Laurie is in the upper half of a younger section of the first grade. Until very recently Laurie has expected to fail as mother expected her to fail, and it has only been in the last month that she has felt that she would graduate to the second grade. Increasingly her reading has been of enormous pleasure to her. I think at this time it would be easy to think that her lack of development and her depression were due to sibling jealousy for her brother, but they did not commence until she was over two and a half years of age at which time her mother suffered a real depression. In therapy there seems to have been withdrawal, helplessness, expectations of failure, oral aggressive and sadistic fantasies, thoughts of death and death wishes towards her maternal grandmother and mother and great fear of her anger. There was an inability to demand, later followed by greedy wishes to get everything, overt rivalry with older and younger siblings, and later with peers and other patients whom I see. Finally, she reached a stage of object constancy with the therapist and with her father more than her mother which could be verbalized on her part. Currently she is approaching the oedipal resolution, wishing to be the queen in her

school play and to sit on the stage the entire time. She draws pictures of her parents with her father as an indian, always "smiling" and her mother as an indian "often angry." Eating has never been a problem since I have known her. Enuresis and constipation stopped when her mother left a light on in the bathroom for her. It is apparent that at this stage she is ambitious and very envious of boys, much as her mother is ambitious and envious of men. Neither can tolerate entirely their open angry feelings.

To me it is most interesting that after 16 months of thyroid supplement, growth rate per month in height and weight were only slightly increased. After six months of therapy, however, the height and weight rates per month doubled. She is told currently that if she continues to grow at this rate, she will be of normal size at ten years.

Her mother is an intelligent and very compulsive woman, the only member of her family able to move away from her own very rigid, domineering mother. Laurie's mother equated her with her own older sister, the second in her family, who at the age of 34 has never dated or left home. Laurie's mother expresses extreme disinterest in this sister behind which is real hatred and jealousy. She has "expected" Laurie to fail in many enterprises as her sister did. She also often places Laurie last in the family concerns. For example, she is unbelievably stingy with Laurie. Until January 1970 mother kept the crib sides on Laurie's bed which had been totally unnecessary. Mother was very guilty about Laurie in therapy and about her anger towards Laurie, but this is much better with treatment and with Laurie's growth and successes. I find it very interesting that the mother's oldest brother also has a second child, a boy, with severe growth failure and many symptoms like Laurie's.

Diagnostically, Laurie qualifies under eight of the nine categories given by Sandler and Joffe. Only in the category of oral passivity this is not true; instead one sees oral aggressivity in the screaming, the voluntary regurgitation and in her first drawings for me.

#### Case Summary—*Lisa*

My second case is Lisa, age four and a half, black and living with 16 other people in a house headed by a blind grandmother. Lisa seldom speaks. She is a large, sad, withdrawn girl constantly sucking her thumb, who does not try anything new and at times retreats entirely when urged to try something new. Very occasionally she fights briefly but violently. With any change of scene, such as the class going outdoors, she clings to the teacher and cries. After my first visit, with her, she cried for her "mama" when I left. Outdoors she does not play but eats sand unless restrained. She is not curious and cannot organize her play in terms of new sequences nor does she seem to even anticipate pleasure from play. One might feel that she

is retarded except that after several of my visits, often interrupted by a hyperactive cousin, she was able to move towards a truly more creative way of playing with the objects we had. I only go every two weeks to her home, but she always greets me when I appear and then clings to me. At the Christmas party she could not sing Jingle Bells with the others although she knew it well, but she went often to get more gifts without opening those she had.

Home life is that of the truly disadvantaged—no mother or father since birth, many inconsistent mothering figures to whom she is a burden as well as a pleasure, no consistent place to sleep. All her efforts to imitate older people are discouraged and she is ignored or smacked. There have been few consistent emotional interchanges between mothering figures and this child, which according to Dr. Spitz are the precursors of the verbal dialogue. He feels that by the end of the first year the child shows imitation and identification with its parents in the never ending minutia of these exchanges. One has only to see the movie by Sylvia Brody and Axelrad to recognize this and what it does for a child's development. Lisa, to whom this chance to imitate is often absent, shows incomplete ego formation and incomplete infantile clinging relationships with any possible love object. She also often shows an inability to perceive or learn as a result. Dr. Metcalf in Colorado has shown that as early as the neonatal period the mother-infant interaction influences the infant's neonatal sleep as measured by the EEG. I have suspected this since my colic studies 17 years ago.

Lisa, as well as Laurie, is a depressed child; but the difference is that she has never had a love object so never really lost one as Laurie "lost" her mother first to her brother and then to her mother's depression. Laurie showed the affective expression of a state of helplessness and powerlessness due to the superego-conflict which prevented her from directly expressing her ambivalent anger at her mother for her brother's birth and mother's depressive withdrawal. Bibring (1951) states that it is exactly from this tension between such a wish to be good and loving and not aggressive and hateful that depression results. Lisa, on the other hand, has retreated to helplessness and possibly hopelessness because each phase of development of her ego has been curtailed or disparaged by those around her.

#### Summary

However the argument about diagnosis of depression in childhood is resolved, there is much for the child psychiatrist to learn from these two cases. While Laurie's emotionality was recognized, nothing beyond the use of tranquilizers was done about—probably because no child psychiatrist was available in Williamsburg. There is still feeling on the part of some doctors that Laurie's growth failure is entirely a medical illness;

so we have education to carry on with fellow physicians. More important to me, I see from the second case a new task for the child psychiatrist—working out plans that will make the early years of life for a child like Lisa, especially the first two years until speech has developed, richly rewarding for her development in terms of daily experiences with a mother who is able to invest herself appropriately in mutual inter-exchange. Mothers of disadvantaged children are seldom able to offer their child what they did not have themselves, and any such programs for the child must include simultaneous though different programs for the mother. It is my opinion and that of others, including Dr. Maria Piers at the Ericson Institute in Chicago and Dr. Lois Murphy who I heard recently with Dr. Spitz and Dr. Reginald Lourie in Washington, that in many ways massive programs must be devised to eradicate the development of depressed, disadvantaged children. We should have learned our lessons from the orphanage and the Kibbutzim which made it clear that food and housing are not enough to prevent the repetition with each generation of depressed unstable individuals who, like Lisa, have difficulty learning and will repeat the generational cycle of the disadvantaged.

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