DEPRESSION

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Depression

During latency, the presence of a sustained depressed affect and mood is not a mandatory feature for making the diagnosis of clinical depression. A depressive affect is often present in these conditions and, when present, is a bellwether in making the diagnosis. It is possible, however, to recognize depression in a child whose clinical condition is limited to the following diagnostic criteria: frequent crying for no apparent reason, lassitude, declining attention to school work, complaints about other children, loss of appetite, constipation or other gastrointestinal complaints, loss or shrinkage of the future autobiography, hypochondria, itching all over, difficulty in separating from parents, nightmares, frequent awakening, suicidal gestures, and accident proneness. Even in the absence of a depressive affect these are signs and symptoms of depression in childhood. These clinical findings should alert a clinician to the possible presence of depression.

How can there be a depression without a depressive affect? Such a situation is not foreign to adult psychiatry, in which such conditions are labeled masked depression. In these conditions, the affect "depression," the name used to identify the entire syndrome, need not always be present. Depressive affect is only one component of the syndrome that bears the name depression. Other aspects of the syndrome, though, may dominate the clinical picture.

In adults, there are depressive affect equivalents, such as elation, hypomania, and somatic symptoms. There are also phobic symptoms, vegetative symptoms, and motivational impairments. These psychological symptoms, which mask the depressive affect, are in fact the products of defenses which defend against the affect. When these dominate, and as a result make the affect not apparent, the syndrome *depression* may still be present.

The situation is somewhat different in the child. Depression is more often buried than masked during latency. The mildly depressed latency-age child can master the depressive affect by processing it through fantasy. States of latency may be produced in which no apparent problem is to be seen. As often as not, adult caretakers are grateful to see the child appearing happy, and comfort themselves with their misdiagnosis. More severe forms of depression in latency-age children may present with depressive

syndromes resembling frank adult depressions, as well as adult-type masked depressions whose manifest forms resemble common neuroses.

Heuristic Axioms

There is an axiom applied to the study of childhood psychopathology, which states that depression is rare in childhood (Despert 1952). This belief is the product of the burying and masking functions described above. The goal of this chapter will be to explore why the axiom appears to hold for children 6 to 12 years of age, and to understand the mechanisms that produce this phenomenon. In so doing, various principles of psychopathology will be explicated, and these can be of advantage in preparing psychotherapeutic strategies.

The observed rarity of depression in childhood is a result of the common tendency to judge children by adult standards. Symptoms from the world of childhood are overlooked in the search for that which for the most part belongs in the domain of adult psychopathology. If one seeks to describe a clinically manifest depression as we see it in adults, then "depression in childhood" is rare indeed. It should be kept in mind, however, that because of the different organization of the ego that exists during the latency phase, symptoms during that period tend to constitute their own characteristic groupings, or syndromes. The childhood syndromes of depression are no exception to this. If we search for full-blown adultiform depressions in the child, few will be found; in actuality, depression during the latency-age period is masked in its own way, but is not excessively rare. The style for the handling of affects in latency is different from that in adulthood. Therefore, we can expect that even in situations in which depressive affects do begin to appear, alternative symptomatologies will be introduced to a much greater extent than in adults.

Clinical Manifestations of Depression

What are the clinical manifestations of depression in adulthood, against which the symptom complexes of the child are so often judged? They are vegetative *signs,* such as psychomotor retardation (a slowing of speech and motor movements); tearfulness; constipation; poor appetite; disturbed sleep patterns (multiple awakenings, insomnia, early morning awakening); facial pallor; difficulties with

partings, especially when leaving a clinician's office (Japanese psychiatrists refer to this as *stickiness);* suicide attempts; and such mood *symptoms* as malaise; ennui; depressed mood (sadness); a sense of low self-worth; suicidal ideation; negative-content hallucinations; self-recrimination; a sense that the depressed state has always been present; anxiety; guilt; an empty feeling in the stomach; a sense that current time is all the time that there is, and a feeling that one is living in a black box. In the absence of any major stress, one should especially beware the presence of itching and of psychomotor retardation associated with a family history of depression. This last set of symptoms indicates an endogenous depression, which requires medication and further workup to rule out the organic conditions that produce depressions (i.e., brain tumor of the temporal lobe, endocrine abnormalities, pancreatic cancer, and pernicious anemia—the latter two are quite rare in children).

As an expression of a disordered personality state over a sustained and continuous period, such adult symptom complexes, even in part, are hard to find in children during latency. It is not till patients reach the age of 14 or 15 that one begins to see depression in its adult form. In the clinical practice of the author, there has been an uncanny number of girls in whom symptoms of sustained depressed mood first became apparent at exactly 12 ½ years of age.

Let us review the clinical manifestations of depression during the latency period. They are: listlessness and lassitude; a decrease in school performance; moodiness; general unhappiness; being hard to please; rapid changes of mood; a tendency toward crying; clinging behavior; a return of thumb sucking; somatic symptomatology involving the digestive tract (diarrhea and vomiting); generalized and often intractable pruritis; complaints about other children; loss of appetite; loss or shrinkage of the future autobiography; hypochondria; difficulty in separating from parents; nightmares; sleep disturbances; accident proneness and other forms of aggression directed towards the self, such as suicide attempts; hallucinations with negative content and, rarely, the mood changes found in adult depressives.

The sharp descriptive difference between adult and latency-age depression presents a difficulty: If depression as we know it in adults is so rare in childhood (specifically during latency), how are we to define a state in childhood as *depression*? Obviously, it is required that we search out the fundamental elements and the nature of depression at different ages, so that we will not be misled by the fact that surface symptomatologies differ at various stages of life. This principle is not new, but the application is

perhaps unique. For example, one can identify a person as being past middle age when the surface symptomatology is that of an involutional depression.

It is likely that the appearance of adultiform depression at adolescence is the result of a cognitive change associated with puberty and successful resolution of a psychological phase of development, with a transition into a new phase of ego organization. We shall return to this in later chapters devoted to the cognitive changes that accompany the shift from latency to adolescence and to details of the transition to the new phase of personality development. The interesting observations by Spitz (1946) of prelatency children who unquestionably suffered from the physiological and psychological signs of the adult form of depression rule out the idea that there is a primary physiological change that produces adultiform depression upon the appearance of adolescence.

Diagnosing Depression in the Absence of Depressive Affect

How can one determine that a clinical syndrome free of depressive affect and occurring in childhood is depression equitable or similar to depression as found in adults?

What is required is to discover the nature of depression. The extrinsic forms, consisting of many varied syndromes, symptoms, and signs, which represent the outcomes of varied psychological situations in early childhood, are too protean to help us define a common intrinsic characteristic. This must be found in dynamics and origins. There is a general principle in the field of pathology, that human tissue has specific and, at times, age-geared responses to trauma. This applies to psychological as well as physical trauma. In the psychological sphere, trauma from any age or time can be carried forward by the function of memory into later times, when the remembered trauma is responded to by the cognitive styles and defenses of the later age. These age-specific responses can be observed and described; they are more accessible to study than were their antecedents. They tend to overshadow the flow of the underlying psychological processes that produce periods of clinical depression, progression, and regression through cognitive and genetic psychological phases. The antecedents of depression shape the reactions of later times. Ego functions geared to the cognition of the age shape responses. In depression, responses involve sensitivity to loss of objects, loss of self-esteem, shortfalls in the pursuit of the ego ideal, the mobilization of guilt, and the internalization of conflict. These responses produce, in each phase, specific reactions

that constitute depression for that age.

Thus, in approaching depression in the latency-age child, we must keep in mind that his depression will have the characteristics of the condition as it is seen in latency, not those of depression as seen in an adult. We should also remember that the term depression describes a multitude of emotional states and their equivalents. There is no one depression; therefore, there is no single description or explanation of those states related to adult depressions as they occur during the latency period. Masked depression, or *depressive equivalent*, can be diagnosed in both adult and child. What the clinician describes may, on the surface, appear to be a phobia, a psychosomatic symptom, or a sleep disturbance. How is it possible, then, to draw the conclusion that a psychological manifestation is a symptom that masks and represents depression, rather than a clinical phenomenon sui generis, i.e., a true phobia or obsessional neurosis? If we find components of depression in a clinical state, we consider the possibility of depression. If while we analyze someone for phobia, the phobic defense is lifted and a depression appears, we are justified in saying that the phobia masked a depression, or at least that phobia and depression are variant manifestations of the same underlying psychological conflict or processes.

Reconstructing the Antecedents of Depression

The appearance of depressive equivalents indicates the presence of something so intrinsic to the state of depression that a diagnosis of depression can be made in the child in the absence of clinical depressive affects. There is a general axiom in studying psychopathology that underlying causal processes may be shared by disparate manifest symptoms, and that these causal processes and their sources are the antecedents of the manifest symptoms. If we apply this axiom to depression, we can say that a depressive equivalent shares origins with frank depressions. It follows that we can identify a depressive equivalent as depression if we can detect the antecedents of depression in the history of the patient. To do this, we must have a reconstruction of the antecedents of depression against which to compare our clinical findings.

A number of approaches are available to us in reconstructing the antecedents of depression. They provide multiple clues to the psychological origins of depression. These clues in turn offer insights that are useful in approaching depression from the standpoint of psychotherapeutic strategies and

prevention.

One approach, which reveals a common early life history for the child and the adult depressive, is the technique of reconstruction of the early childhood experiences of patients who have manifest depression in adult life. Another is reconstruction derived from the play of depressed children. Comparison reveals similar roots. A related approach has been direct observation of patients with depressive states in early childhood with subsequent following of these patients into latency and adult life to see if common roots produce different specific symptom groupings at different ages. Yet another clinical approach studies the dynamics of the various depressive symptom clusters for evidence of similar dynamics.

We turn first to the workers in adult psychoanalysis who reconstructed the antecedents of depression. Abraham (1924) described the precursor of depression as an early childhood object loss. The experience of depression in an adult was seen to be the re-experiencing of the feelings that occurred with the loss of the breast (maternal nurture and tenderness while nursing). Abraham's concept is that the loss of an object along with the affects associated with it (paradigmatically the loss of the breast/mother) can be seen as the primal experience from which depressive experience and feelings are derived. He concluded that suckling, eating, introjection, and fantasy, all oral-phase activities, are associated and that they play a role in the formation of depressive states. Therefore, depressive states have these factors in common whether or not depressive affect is present. Symptom variation results from the interplay between these factors (dragged from the past to the present by memory) and the age-appropriate organizations of defense.

Lewin (1950) described the paradigmatic prototype of depression as lying in infantile sensations while sucking at the breast, falling asleep at the breast, and being "swallowed up" by the breast. Clinically this would be manifested in eating, sleeping, and angry fear of having one's identity swallowed up as a result of a psychological fusion with another person. Withdrawal into fantasy associated with denial of problem stimuli is one of the elements that characterizes depressive states.

Freud (1917) noted that aggression turned on the self was the basic characteristic of depression. This leads us to the conclusion that aggression turned on the self, such as accident-proneness and self-

destructive activities (e.g., suicide attempts), can be considered as depressive equivalents.

Depressive States during Infancy

An important contribution to the understanding of depression is derivable from the work of those who have studied directly the age period to which psychoanalytic investigators have assigned the psychological origin of depression. A. Freud (1936), Spitz (1946), and Mahler (1969) have focused their attention on the periods of early life at which individuation and separation first occur. Separation experiences at that time have been implicated as psychopathogenetic by those who have studied depression in adults. In turning to their work, we move from those who have reconstructed the childhood antecedents of depression to review the work of those who have done direct observations of the very phases in which the precursors described are being generated.

With the separation-individuation phase introduced by the experience of separation and stranger anxiety, the child gives evidence of an awareness of the absence of the mother. The child, not yet able to reconstitute an image of the mother to comfort himself, becomes very anxious at separations. This is one of the prototypes of depression. As the child approaches 18 months, he gradually develops *object constancy* (a term introduced by Anna Freud). This is the ability to evoke the image of the lost object and to comfort oneself with this object-image. Many depressions occur in individuals who either fail to develop a consistent capacity to recall the comforting object's image or who had, and still recall, inconstant objects from the start. We say such people have poor object constancy. They feel a sense of loss. They feel deserted, and develop a low sense of self-esteem. In trying to re-evoke earlier object relations, ego states, and affective states, they find themselves confronted with a disappointing comforter.

These concepts have been strongly reinforced by Spitz (1946) in his work on hospitalism and anaclitic depression. He discovered that after the eighth month of life the substitution of poor mothering for a good mother results in a marked change in the child. Over a period of months, the child gradually develops a depressive affect, a slowing of movement, tearfulness, and what appears to be a full-blown depression manifesting the characteristics of depression in adulthood. The child is characterized by "weeping, tears running down the face, shaking of the whole body" (p. 315). There are also insomnia, loss of appetite, loss of weight, and retardation of movement. The clinical condition described is

comparable to that of adult depression.

Reconstructions of the early life experience of the adult depressive have focused primarily on the influence of the events of separation during the first year of life (i.e., reconstructions and direct studies of the origins of depression in the oral phase). Bibring (1953), however, went beyond this. He pointed out that depressions associated with and derived from the oral (separation-individuation phase) are not associated with guilt; rather, they are responses to separation and loss. Depressions with guilt, which deal with loss of self-esteem in terms of falling short of an ego ideal, derive their characteristics from the affects of the period when punishment fears come to relate to internal punishers. When this context is internalized, aggression turned inward is allied with conscience; and painful guilt and depressive affects are then the clinical manifestations. Thus, during the phallic part of the oedipal phase, depression associated with guilt finds its origins and the paradigms for later expression. Therefore, a person whose depression is derived from a sense of object loss associated with the oral part of the oedipal phase (this is the point at which the child is aware of the parents as a couple who have left him out) usually has a sense of low self-esteem associated with depression, but not guilt. A sense of guilt in depression is seen where castration wishes and fear of retribution from the father are important elements. As the child enters latency, these feared attack-oriented elements are internalized to fuel the superego-motivating affect of guilt.

Depression during Latency

We have reviewed three areas: theories of origin for adult forms of depression, reconstructions of the sources of depression which are rooted in early childhood, and depressive states in early childhood. We turn now to the direct study of frank depression and equivalent symptomatologies in latency-age children. In this way, we can establish diagnostic principles with which to identify these conditions. Once they are identified as a group, their origins and their differences may be studied as a unit. Thus we can confirm the underpinnings and antecedents of depressive symptomatology in latency. The intrinsic nature of depression in its many manifest forms is allied to this understanding.

In the studies done with youngsters who have exhibited some form of manifest clinical depression during the latency age period, at least three distinct clinical entities appear: emotional acrescentism

(affect starvation), frank depression, and depressive equivalents.

The Affect-Starved Child

Emotional acrescentism (affect starvation resulting in failure to grow emotionally) is a term introduced by L. Sachs (1962), who studied latency-age children who had been markedly deprived and neglected in early childhood. In them she discovered a tendency toward concrete thinking, hallucinations, high degree of verbal skill, and an engaging personality. These youngsters tend to form very quick and close attachments with older people. They appear to be very loving, but they have one remarkable characteristic: they appear incapable of remembering the good things that were done for them by the people to whom they attach themselves. One such child punched a nurse when she spent extra time with a new arrival on the ward. She had even planned to adopt the puncher until that time. These children do not appear to be depressed in early latency, but they become resentful, angry, and depressed in late latency. Although they seem gracious and well-relating, this is a misleading observation.

In actuality, they have a poor ability to establish a consistent, reassuring image of a new object. The resulting limited ability to change their view of people, even after contact with loving caretakers, leads to a view of people as lacking kindness, reliability, or trustworthiness. This leaves them in unremitting recollection of a deep, unfulfilled object hunger that is only slowly modified by reality experiences, if at all. They rarely achieve a relationship close enough to produce a sense of loss that would limit hostile, demanding, regressive states. Therapists confronting such children need to be aware of the unmoored nature of the child's object ties. These children are as unreliable as landless wanderers and marauders. A therapeutic goal is to provide an anchoring relationship. There is a need for consistency over extended periods of time.

These children's sense of that of which the world consists is hopelessness in the search for a reliable harbor from loneliness and a sense of betrayal. This gives these young people the makings of depressive symptomatology at any age—infancy, adolescence, or adulthood.

Latency's unique dynamics hold the depressive symptoms at bay. The affects can be defended

against by the fantasy structures produced by the structure of latency. If followed to late latency, their object hunger and manifest use of the mechanism of denial and fantasy become apparent. At about the age of 11, they change markedly. Fantasies of magical gratifications give way to disgruntled awareness of their hopeless reality as they feel it to be. They may begin to steal. They begin to show marked aggressive acting out. Suicidal ideation and manifest depressive affects soon follow. Rare is the person in this group who has depression with guilt. This is a prime example of a depression with marked oral features. These children are usually identified and brought for treatment, either when they explode briefly during early latency or during the period of decompensation that occurs at about 11 years of age.

Sachs (1962) felt that she was describing here those children who have had the early life experiences observed by Spitz in his work (1946) on anaclitic depression (i.e., severe emotional deprivation and poor object relations). She described the affect-starved child in early latency as follows: clinging object relations, outgoing, charming, crying pitifully when frustrated (p. 637). In late latency, after about age 11, she describes poor superego development, marked sullenness, moodiness in passive individuals with unpredictable flare-ups, suicide attempts, and an absent sense of guilt.

Frank Depression during the Latency Age

Connell (1973), Sperling (1959), and Bemporad and Kyu (1984) have written about their observations of children with clinical depression. Three symptomatically depressed latency-age children were identified by Sperling in her clinical practice. Twenty cases seen by Connell were identified and gathered as the result of a request that children from all over Australia who manifested signs and symptoms of clinical depression be sent to her hospital for a research study. The relative rarity of overt symptomatology is evident from the sparsity of cases observed in both private practice and research settings. There was remarkable agreement between Sperling and Connell in regard to the description of their clinical findings. It is striking that Connell discovered four patients who were unusually depressed and responded to Tofranil (imipramine), indicating that the rudiments of the two types of depressive illness seen in adults (endogenous and exogenous) are recognizable in childhood. Contrary to the usual findings in adults, the endogenous depressions (depressive affect and mood, severe vegetative signs, response to tricyclic amines) were associated with easily identified precipitating causes. Whereas in adults the precipitants of depression are easily detected only with exogenous depressions, in children

visible precipitants are an almost universal phenomenon.

The symptomatology of the clinically depressed child bore similarities to that of adult depression, although there was not a perfect concordance. In the child with masked depression, this discordance is greater, the main point being the primacy of the depressed mood in the adult. Sperling felt that this discordance in symptoms might be the source of the apparent rarity of "depression" in children. As she pointed out, "Depression is not rare in children. However, it's not easily recognized because its overt manifestations are in most cases different from those of adults" (p. 383).

The twenty-three cases diagnosed as depression by Sperling and Connell had manifest sustained clinically depressed moods. Inclusion in Connell's group required depressed mood sustained for more than three months. It is this symptom that is rare in childhood. Sperling felt that the diagnosis of depression could be made more often if the criterion of sustained depressed affect were eliminated. In her view, depression in childhood is indicated by the following criteria: for youngsters before the age of 4, look for listlessness, moodiness, and general unhappiness, with food intake and sleep patterns affected; in the latency-age child one should watch for listlessness, moodiness, general unhappiness, a tendency toward crying, oral symptoms such as thumb sucking, somatic symptomatology in the digestive area (here she included food intake and eating disturbances as well as ulcerative colitis), pruritis (generalized and intractable itching), and sleep disturbances. In addition, accident proneness and direction of aggression toward the self, such as suicide attempts, were not considered unusual in an extended group of youngsters with these findings but no severe sustained depressive mood. In looking for causal factors, Sperling looked to early childhood, where she found "an impaired mother-child relationship with fear of the loss of the object" (p. 393). [Note the relationship of this to Abraham's (1924) findings.] She felt that this was the condition necessary to treat in dealing with depressions and depressive equivalents in children.

Connell had little doubt that the children whom she studied suffered from a condition "involving mood disturbance that resembled adult depressive illness in some respects but also had characteristics of its own, chief among which were somatic symptoms and antisocial behavior" (1973, p. 84). Early wakening, anorexia, abdominal pain, headaches, wetting, and soiling were some of the concomitant symptoms noted in her depressive studies. The depressive mood in both Sperling's and Connell's groups

was unquestioned.

Depressive Equivalents during Latency

One might be drawn to the conclusion that children younger than 4 can have depressions with all the characteristics of an adult depression. In those older than 14, one can also find the characteristics of adult depression with some frequency. There appears to be *some interposed phenomenon* during the period from 5 to 13 that alters the course of the symptomatology of clinical depression in the majority of patients, so that overt depressive moods become rare and short-lived and the patients manifest their depressive illness in masked and cryptic forms.

The interposed phenomenon must be a factor that deals with uncomfortable affects in a way that removes them from awareness; and one such phenomenon might be the structure of latency. The latency-age child has an organization of ego defenses that deals with uncomfortable affects through repression of the fantasies associated with them. There is fragmentation of the fantasies and displacement of their parts into symbolic representations less porous to the affects associated with the original concepts. These displaced symbols are regrouped into pleasant or mastery-oriented fantasies. They can be used for the discharge of drives and the mastery of humiliating experiences without clinically manifest uncomfortable affects. The structure of latency and its fantasy products thus become defenses against affects. Depressive affects are amongst the uncomfortable ones that can be dealt with in this way. Therefore, even severe depressive states during latency show less depressive affect than is found in their adult equivalents. For this reason, during the latency period, depression is less important as a symptom of psychopathology than it is in adults.

Depression as a symptom in latency tends to be a transient affect, fleeting in its availability to consciousness, and attenuated as the result of the defensive mobilization of fantasies and depressive equivalents. Depressive affects may be found to underlie persecutory states, unsuccessful attempts to adjust to new peer groups, psychosomatic responses, obsessional states, hyperactivity, and oral regressive states accompanied by overeating and overweight.

"Normal Depression" in Latency

In the latency-age child, sustained manifest depressions are most often seen in normal situations such as mourning and related reactions to loss. Object loss is processed through identification during mourning, introjection, and finding new objects, as in other age groups. The latency-age child also has a *structure of latency* to call into service. Through this group of ego functions, the child is able to create fantasy by which the experience of loss can undergo a catharsis, much as adults experience catharsis when seeing dramatic performances.

Periods of manifest depression may also occur when a child has fallen short of the demands of his superego, producing anger directed at himself. The superego has three primary groups of functions. These are the ego mechanisms that enforce the superego demands, the superego demands themselves (a sort of book of rules), and the superego-motivating affects. The last are the driving force for acting on the demands of the superego; they may also limit actions. Behaving in accord with superego demands brings pleasant affects, whereas running counter to them evokes displeasure. These affects, in effect, dominate human social behavior. Uncomfortable feeling states are created in a person equipped with an immature superego. These are triggers for depression, and may serve as the equivalents of depression. Usually a person is guided to acceptable behavior by the threat that these affects will become manifest. Self-control brings equanimity. Loss of control brings discomfort and reactive depression in those states in which behavior falls short of one's own expectations. It is in the area of the superego-motivating affects that unconscious guilt and unconscious depression serve as constant watchmen and guides.

In addition to the superego-motivating affects, a second form of unconscious affect guides intentional behavior—affect that has been experienced on the surface of consciousness and then been repressed. It has been held in repression by the mechanism of displacement and maintained there by riveting attention (cathexes) onto substitute ideas and symptoms. In this second form lies the mechanism for the development of the aspects of depressive symptomatology that diverge from depressive affect.

Depressions often signal the presence of an immature superego. Such a superego is commonly understood to be sadistic and cruel to the person of whose personality it is a constituent. In part, painful depression is a sign of its cruelty. The mature superego guides behavior while recognizing the wisdom of

responding to id wishes. There is the sense that nothing that is human should be considered foreign, whereas the immature superego is brutal in its criticism. Immature parents engender immature superegos in their offspring. The immature superego does not cause depression, but it colors the quality of the depressive reaction in a child, thus causing depressions to be more severe. The more immature the superego, the harder is a person on himself in situations of disappointment.

A common source of depression is a situation that stirs anger and at the same time frustrates its expression. Another source is any situation that humiliates the child. A child's small size renders outwardly directed anger futile—the world does not change in response to little howls or to the beating of tiny fists. Latency-age defenses convert anger into the signs and symptoms seen when a child is confronted with such situations.

The specific mechanisms used to deal with angry feelings (the aggressive drive) are twofold: projection and actualization. Both defenses effect a mastery of humiliation through living out a displaced victory over fears or memories. Peers or other reality elements serve in the way that play symbols do. They "actualize" (i.e., make real) fantasies in which the child succeeds.

In addition to mastery through fantasy, the thrust of these defenses is to shift the drive cathexes from the self, drawing energy away from an inward turning of the drives. Such inward turning of the drives on the self is the characteristic mode of energy discharge associated with the production of depression in adults (see Freud 1917). When there are overt evidences of depression akin to that of the adult in the life of the latency-age child, there has been a failure of these latency mechanisms and the latency-age ego organizations (e.g., restraint and the structure of latency). As a result of these failures, aggressive energies turn inward, and depressive symptomatology is released.

Before the issue may be considered closed, it will be necessary to explain the emergence of the adult form of depression with the onset of adolescence. We have noted the fact that failure of the defense mechanisms of latency will release depression. Frank depression and the state of latency are mutually exclusive. The defense mechanisms of the latency period begin to crumble in late latency as a result of an improvement in cognition. The resolution and working through of stressful situations by means of fantasy passes when the ludic symbol is no longer available to the waking child. In the latency years, it is

possible for a child to avoid confrontation with his problems as a result of the ability to redirect his energies and change his world through the manipulation of symbols. Once he reaches adolescence, the child must face his affects. His attention is called to the irritants in his real world.

There is a useful clinical insight to be derived from this shift from an internal resolution of conflicts to one that requires the cooperation of the world. Latency calm in the child lessens the chance that there will be meaningful communication between child and adult during adolescence. Parents tend to take a child's peace of mind for granted during latency. The calm of latency with its ability to turn off affects, as though the child is no longer bothered by a trauma, fools parents who are all too eager to believe that childhood is a time of blissful ignorance. A parent who is aware that either his actions or other circumstances are affecting a child may well have considered a heart-to-heart talk "next morning" to help the child deal with (confront and master) the problems. Perhaps the parent plans to cancel another activity to make time for the discussion. If the structure of latency has done its task, then at the time of the planned talk, the child will appear comfortable and content with his play. Thereby, the chance to set up or continue the parent-child line of communication is not taken. The child seems well, the parent is content. Each goes his separate way. With the coming of adolescence there is a return of sustained awareness of affects. A sharp focus on identifying the sources of emotional discomfort could support discussion. Because no provision for sustained communication had been established in latency, the separate ways continue. Parent and child grow apart. The conflict of generations in adolescence can be seen as a residue of the capacity of the ego structures of the latency-age period to mask problems and affects, leading to a decline in the interpersonal skills that detect, defuse, define, and resolve problems through open discussion.

Depressive Elements in Late Latency-Early Adolescence

The period of late latency and early adolescence is a time when the person races forward toward individuation and social maturity. The pace is set by peers and society. The child, confronted by tasks beyond his ken or by situations that are foreign to his experience, is often at a loss. There may have been insufficient time to develop an identity upon which to fall back. A sense of being overwhelmed, lost, and rudderless confronts the child. The sense of inadequacy that ensues may be warded off by a regression to a state in which maternal nurturing is evoked to comfort and guide the perplexed child. This state of

orally regressed dependency is accompanied by depressive affects and equivalents. Children in this state can be seen clinically to spend all their time watching television while eating and growing fat. Beware allergies, asthma, and hives in these young people, for upon entering adolescence, the depression that is inherent in the adjustment of these youngsters may be unmasked.

Such states can be prevented by early encouragement of the child to become independent of the parent. The ego function that is the ability to evaluate potential danger in new situations should be developed by permitting the child ever-increasing freedom of movement in consonance with the experience of other children. Overprotective parents tend to cause this sequence of events to take a pathological turn.

It is important to take into account dependency and aggressive and regressive needs to understand adolescent depression. All three elements come jointly into focus when we remember that two of the three primary tasks of adolescence are the achievement of removal (separation from parents as the primary objects for drive gratification) and coping with passivity. Natural urges push the child toward removal. Social wants "sin against the strength of youth" and keep the children home in the *best* of circumstances. Adolescents are all dressed up with adult bodies, but without the right, or the money, to have a place to go. Parents control the roost; the child must accede to parental will. Anger is the result of this forced dependency. The child may either fight or flee into a regressive surrender. Storms of depression accompany these battles between the generations. Estrangement from the parent may give rise to strong reactions, in which parental images are introjected and added to earlier imagoes as a means of dealing with the loss of the same rejected parent. This is bound to intensify the conflict and the depression, which without the structure of latency can no longer be masked.

The *introject* is an important concept in understanding adolescence. In essence, parental images and characteristics become part of the child's inner experience of himself. Depression arises when there is conflict between the ideas, wishes, and pressures of peers and the internalized wishes of the parent of early life. The introjected, harshly punishing parent is transformed into the cruel immature superego and—in the context of our topic—the impetus, spirit, and soul (psyche) of depression.

The development of identity and the regulation of self-esteem are also primary tasks in

adolescence. If children may become depressed when they fall short of their own expectations, imagine what a quandary a child would be in if the expectations themselves were uncertain as the result of a fluid identity. This occurs in the affect-starved child and also in the normal state of changing and vacillating identifications with parents, peers, and culture heroes that is part of the adolescent scene in our day. It is no wonder that suicide is the fourth leading cause of death among young people aged 15 to 19. Aside from the fact that it is during this period that organically (e.g., endogenously) based depressions make their first strong impact (marijuana/Quaalude suicidal depression, suicide through substance abuse, monopolar depressions, schizophrenias) and inexperienced drivers first take to the road and drive as though they were immortal, there is the problem of passivity. Children want independence, and parents are loath to let them go. The more primitive the parent, the harsher the superego of the child and the deeper the hurting potential of the depression. Suicide is a possible vent for these forces.

Fantasy Denial and Depression

Fantasy and depression are distinct and different entities. During latency it can be seen that they can achieve a function in common, in that their presence obviates the need for response to problems in reality that require direct handling. Other mental processes that share this function are denial, dreaming, and promises made to oneself, often during therapy or analysis, that the problem will be resolved. In all five of these mechanisms, a problem that requires attention can be put aside as a result of a mental activity. Of vital importance is the fact that the problem persists in spite of a facile sleight of the ego's hand. Examples follow.

Denial

> A 7-year-old boy, who often railed at therapy and refused to admit that there was any need for treatment, presented a therapeutic problem, in that there was nothing to talk about. This was in spite of the fact that his mother manhandled him, threw him bodily into water, and often left him for extended periods with inadequate caretakers. One day, he began his session with the announcement that a funny thing had happened on the way into the office from his mother's car. Said he, "I just got all better." His denial obviated the need for further intervention while it blocked pathways to insight into the cause of his disruptive school behavior.

A man in his 40s, who was quite hostile to his wife and often wished to leave her, developed anxiety episodes, almost daily, in response to her criticisms and intrusions into his plans. He felt free of tension after a dream in which he saw a plane containing his wife crash in flames. The effect of the dream was to help him reset his affects. He was less tense after discharging his anger at her through the dream. The problems with the wife had not been confronted.

At times, and especially in children, dreams like this one are linked with so much anxiety that the child awakens. Such REM nightmares are by nature more constructive than ordinary "resetting" anxiety dreams. Instead of clearing the air of affects, they alert one to the fact that there is a problem to be solved. These dreams are depressive equivalents.

> A child of 5, who had witnessed his brother having a convulsion, awakened repeatedly from a dream in which a large monster attacked him. In therapy, a cut-out doll in the form of the monster was used repeatedly in play to help the child master the memory.

In this case, there was no reality to be changed. There was only a memory to be mastered or defused. However, the principle of using a dream element, which has been converted into a ludic symbol (a paper doll), as a tool for diffusing the impact of a stressful situation is well illustrated. When the stress entails a current reality, dream elements can be used in a similar fashion. The appearance of an anxiety dream signals the presence of a stress that is not being dealt with directly. A doll used to represent a dream element may be employed to encourage fantasy from which one can identify the stress. Then the child's attention may be drawn back to the problem and techniques developed for resolving the problem directly. In this way, parental abuse or situations with peers that are the products of character traits in the patient can be brought to the surface for adjustment or analysis.

> A child of 10, with an anxiety dream of an attacking monster— from which he did not awaken—alerted his therapist through the dream to neglect on the part of the father. This insight was reached through paper doll dream associations. In a dream, the monster attacked a car full of picnickers. Each member of the party was constructed as a doll and placed in a car. The members were then identified by name and relationship. The father's tendency to yell at the child and to break appointments on weekend days was reached. Work was done with the child and the parent to correct the situation directly.

Promises Made—Often, In Therapy. When a person has clear insight into the source of his difficulties, lying in either the behavior of another person or repeated self-destructive behavior, a

promise to correct the situation through an obvious direct intervention, such as a diet or divorce, often puts the mind at ease without solving anything. More praise is merited by the disclosure "I started a diet last Wednesday" than by a promise to "go on a diet tomorrow." Many marriages remain intact because promises to oneself to leave the marriage provide a reminder of the fact that all is not hopeless and that there is an alternative to remaining in a bad situation. Hope is the comfort that such promises offer, though on the surface they appear to be constructs for future planning. There is an apt saying, "If wishes were horses, beggars would ride." In dealing with affects that are strong, it is wise to keep in mind that planning and fantasy are close kin.

Anxiety dreams that awaken the dreamer interfere with the defensive dream processing of core problem areas. If the dreamer were to continue to sleep, then the problems might be mastered for the moment. However, since no change in insight or personality has occurred, it remains only a matter of time before the problem reappears. If the dreamer awakens, the problems are saved for analysis and possible resolution with insight.

Fantasies serve functions similar to those functions of the dream that would reset affects to calm while leaving intact the propensity for repeating the difficult situation.

Fantasy. Of all the functions that serve to distract the personality from the task of dealing directly with problems, fantasy is the leading one during latency.

> A 9-year-old who was dependent upon adults to drive him about, and was affected severely by limits placed on visits with his divorced father, conducted a continuously running fantasy of being a used-car dealer.
>
> Another child, who was rejected by his peers, bragged of his gang, who lived in a distant city and whom he planned to bring to his hometown to revenge wrongs done to him.

Through fantasy, magical adjustments to problems become possible. In latency, this is necessary for the most part because of the limited physical and sexual equipment of the child. During later developmental periods in life, when cognition will no longer permit fantasy to hold sway, the role played by fantasy is retained as a legacy of latency. However, the functional elements for carrying out this role are those available in the later phase. Dreams, denial, promises, and depression take over the role played by fantasy. A healthier derivative of latency-age fantasy is future planning. This is a form of fantasy that utilizes realistic elements as symbols from which the fantasy is derived. It should be obvious

from this that an important approach to depression in the post-latency period is the harnessing of fantasy to the needs of future planning.

Depression. Depression and fantasy have similar effects during the latency years. A digression from the task of dealing with and resolving problems is the product of their presence. Clinically depressed latency-age children can, for the most part, identify the precipitants of their depression. Psychotherapeutic tasks are best served by focusing attention on these precipitants. Aggression turned inward should be identified and the true objects of the aggression discussed. Most often, children with overt depression have both impaired symbolizing functions and parents who give mixed messages and demand very high levels of achievement from the child. In situations in which masked depression (somatic symptoms, nightmares, etc.) is detected, the child should be dealt with as though a depression or a richly elaborated fantasy defense is present. Often, working through of problems with the child is insufficient. The parent(s), whose expectations and demands, thinking disorders, and doubly crossed messages confuse and bewilder the child into a state of mind that requires escape into fantasy or withdrawal into depression, must be advised, or sent into treatment in order to clear the way for a positive result in the child's therapy.

Summary

During the latency-age period, manifest depression characterized clinically by the presence of intense, continuous, and pervasive negative affects is rare. There is no lack of conditions that share with the prelatency, post-latency, and adult periods mental preoccupations and historical antecedents usually associated with manifest depression. However, the defenses of the latency age oppose and vanquish affects through the use of the countercathectic powers of symbols and fantasy.

Depression is most closely linked with the aggressive drive, both theoretically and clinically. It is appropriate, therefore, that the next chapter deals with the developmental vicissitudes of the aggressive drive.