MANIFEST SYMPTOMATOLOGY OF DEPRESSION IN CHILDREN AND ADOLESCENTS

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Severe and Mild Depression

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wicked and should be dead or killed. This type was observed in the ten- to thirteen-year-old group. This study is significant; it demonstrates how even in middle to late childhood the normal developmental process can influence the expression of symptoms. The youngest children had difficulty verbalizing their feelings and their depression seemed to take the form of an overall sadness. The eight- to ten-year-olds could put their feelings into words and were able to identify states of self, but they did not as yet have a sense of inner evil. They continued to gauge their feelings as a response to others. Only as the children approached adolescence was there an internalization of some of the cognitive conditions for depression, the feeling of guilt and wickedness which justified the dysphoric state and perpetuated it despite environmental changes.

Illustrative Case History Of Depression In An Older Child

The example of the following child clinically illustrates severe depression in late childhood. Jimmy, an eleven-year-old boy, was seen after he wrote a series of pathetic, demanding notes to his parents. The notes were all repetitions of the same theme: that he was worthless and a failure and undeserving of their love, yet greatly needing their love. He had also asked his mother if it was a sin to commit suicide. The family history was remarkable in that the father had suffered from chronic depression since adolescence. He was a strict Catholic who constantly read inspirational books in search of a

meaning in life. At home he was frequently unavailable, although he managed to put up a “good front” at his job. The father’s side of the family had a high incidence of severe mental illness.

When seen for an evaluation, Jimmy was quiet and noncommunicative. He looked sad and was able to verbalize that he did not like himself. He stated that God had let him down and he was letting God down. When he was able to elaborate on this statement, he explained that he felt he had been born a poor athlete and a poor student, but he had not done his part by trying hard enough to overcome his innate deficiencies. He was totally convinced of his basic worthlessness, and furthermore he detested his weakness in not being able to overcome his alleged liabilities. Further contact revealed that because of his poor coordination, Jimmy was tormented by his peers and his brothers. He could find no area in his life in which he felt adequate or even safe. As a result of the excessively religious atmosphere at home, he believed that much of his misery was his own doing and he was a sinful creature because he gave in to feelings of failure. He also had been taught covertly to keep his feelings to himself and to be steadfast in the face of adversity. Actually, he felt like a little boy who wanted to be nurtured by his parents but he could not allow himself to express these longings openly. He felt overwhelmed by feelings of shame and inadequacy, but could not confide in anyone. He finally managed to allow these feelings to be partially communicated in his notes to his parents, although after writing them he refused to talk about their content

with his mother or his father. Little Jimmy found himself in a desperate situation; he perceived himself as failing in what he believed his parents expected, but he could not bring himself to discuss his sense of frustration because of prior training. Similarly, he could not confess his terror of bullying peers. Instead he concluded that he was inferior. The more he suffered from his frustrations, the more he wanted nurturance at home, and the more he felt ashamed of his self-perceived infantile needs. He was a failure to himself, to his parents, and ultimately to God. He gradually began avoiding peers and stayed close to home. He lost interest in school and tried not to go by feigning illness. He withdrew, while being careful to look sad at dinner or when his family was present. Finally, he fortunately evoked a sympathetic response in his parents by his notes which initiated treatment and eventual recovery.

Attempts at Classification of Childhood Depression

Despite the theoretical debate over the possibility of true depression before adolescence, a few papers have appeared which take the occurrence of childhood depression as a clinical fact and attempt to classify these dysphoric states on such empirical grounds as response to treatment, the presence of precipitating events, or associated psychopathology.

Eva Frommer (1968) maintains that depression is quite common in childhood, accounting for 20 percent of all childhood psychopathology. She

describes three major subgroups and one small additional grouping which may be a juvenile form of manic-depressive disorder. The first group is designated “enuretic depressive” because of the high incidence of bladder or bowel incontinence. In addition, these children exhibited learning disabilities and social withdrawal. Complaints of depression were present in only 19 percent of this group. Frommer states that treatment is prolonged and difficult, requiring more than antidepressant medication or group therapy. Removal from the home environment is sometimes indicated.

There is some question as to whether this group of children can actually be classified as depressed. They appear to be unfortunate and unhappy children who because of a combination of factors are neurologically immature and have learning disabilities and incontinence. Such children often get into chronic power struggles with their parents which increase their frustrations, but they do not appear depressed; rather, they are perpetually angry and resort to passive-aggressive retaliation against authority figures. They lack the negative self-image, the feeling of helplessness, and the blaming of self which appears necessary for the diagnosis of depression. Such children have been described adequately in the literature on enuresis, encopresis, or learning disabilities without reference to affective disorders.

Frommer’s second major group is “uncomplicated depression.” It is the largest group in her sample, and the children in it manifested irritability,

weakness, and tendencies to recurrent explosions of temper. Half showed some sort of sleep disturbance and roughly one-third complained of feeling depressed. There was a lack of anxiety or decreased confidence. This group does appear to describe truly depressed children. After treatment there was significant academic improvement and others noted a change in the children's demeanor.

The third group was termed "phobic depressive" because of a high incidence of anxiety and a lack of confidence. Over two-thirds of these children exhibited abdominal pain or other somatic symptoms in order to stay home from school. Girls outnumbered boys by two to one in this group. Although Frommer calls such children depressed, they seem to fit the classic pattern of "school phobia." Gittleman Klein has recently studied a large group of such children and concludes that they are impaired by an abnormal persistence of separation anxiety so that they must stay near the mother figure. If they are allowed to remain with the mother, they are happy and relaxed. If they are forcibly separated, they exhibit panic and somatic symptoms. In neither situation are they depressed.

The last group described by Frommer are children with transient outbursts of temper alternating with periods of quiet reasonableness. She speculates rather cautiously that this group may be showing early symptoms of manic and depressive mood swings.

Frommer's work suffers from a lack of psychodynamic investigation as well as from her omission of the age ranges or developmental levels of her patients. However, the greatest drawback of her study is her overinclusion of nondepressed children in the depressive categories. Clinical depression entails more than situational unhappiness brought about by family conflicts, learning disabilities, or separation from parents.

A more profound and usable classification of depression in childhood has been presented by Cytryn and McKnew (1972). These authors differentiate between a depressive affectual response and a depressive illness, in which the depression is of long duration and the sad affect is associated with disturbance of vegetative functions or impairment of scholastic or social adjustment. In more severe cases, the child's thinking is said to be affected by feelings of despair, hopelessness, general retardation, and suicidal ideation. Having established these clear criteria of depressive illness, Cytryn and McKnew delineated three types of depressive disorders in children who ranged from six to twelve years of age.

The first type was classified as "masked depressive reaction" and was characterized by hyperactivity, aggressive behavior, psychosomatic illness, or delinquency. These children also exhibited periods of overt depression as well as depressive trends on psychological testing. The families of these children were chronically disorganized but showed no history of depression.

If I understand the authors' concept of masked depression correctly, it is different from so-called depressive "equivalents." Cytryn and McKnew do not speculate that nondepressed behavior such as delinquency is a childhood expression of depression; rather, this behavior is seen as a defense against feeling depressed. Occasionally the defense breaks down and the underlying depression becomes manifest.

The second type was called "acute depressive reaction" and it resulted from a clearly identifiable environmental cause, usually invoking the loss of the attention of a loved one. These children exhibited clear symptoms of depression for a short period of time and then recovered quickly. There was usually a history of good premorbid adjustment and their families demonstrated considerable strength and cohesion as well as an absence of depression. It might be difficult to separate such children from those exhibiting a grief or mourning reaction. It is speculated that the child's defenses are momentarily shaken but that reconstitution usually follows unless there are persistent environmental traumas.

Finally, they described a more severe "chronic depressive reaction" in which there was no history of a precipitating event. These children did not reconstitute rapidly and showed evidence of long-standing depression. There was a history of repeated separation from loved ones and deprivation beginning early in life. All of these children had at least one parent who

suffered from recurrent depression.

This last group supports the findings of Poznanski and Zrull (1970) that the depression of the children they studied was not reactive to an immediate trauma, but part of an ongoing life process. They also found a high incidence of parental depression, frequent harsh treatment of the child, and overt parental rejection. It would appear that Poznanski and Zrull are describing the "chronic" type of child in Cytryn and McKnew's classification. The former authors may have set more stringent criteria for the diagnosis of depression and excluded those children classified as having "masked" or "acute" depression by Cytryn and McKnew. The possible merit of this more narrow definition of depression is that it allows for a study of the natural history of the disorder by excluding children whose depressive symptoms may be part of a transient grief reaction, or submerged beneath delinquent activity or other defenses. For example, in an important follow-up study Poznanski, Krahenbuhl, and Zrull (1976) found that half of their original sample (now in adolescence) was still depressed. An additional finding was that the childhood aggression had diminished and pathological dependency, common in adult depression, was more prominent. Among the patients who were still depressed, the pattern of parental rejection and deprivation had continued. It can be hypothesized that in these cases, the causes of depression became internalized and adequate coping mechanisms were prevented from crystallizing. On the other hand, it may equally be speculated that the

"masked" type of depression described by Cytryn and McKnew would eventually follow a delinquent career and the "acute" type would not show pathology in adolescence.

Perhaps a follow-up study by these authors will clarify these questions as well as justify labeling children as depressed who are able to defend against depression or exhibit a transient state of grief over an environmental trauma. The theoretical problem (to be considered in chapter 8) is whether children who do not exhibit prolonged depression can be truly classified as suffering from a depressive illness. Children who exhibit equivalent or masked depressions may not be actually depressed. Rather, the examiner may infer that they should be depressed because of their difficult life circumstances. If these children can muster defenses against adverse environmental situations, then there may be a question as to whether they should be considered to be suffering from depression.

Taking these problems into consideration, Malmquist (1971) has attempted an all-encompassing diagnostic classification based simply on the predominance of depressive affect. He includes criteria of different conceptual levels, such as descriptive clinical features, age, and etiology. His classification is presented in Table 4-1.

Malmquist arrived at this classification by an exhaustive review of the

literature. His system is extremely valuable in briefly presenting all of the possible states that have been called depression in children. His classification, reproduced here as Table 4-1, can be taken as a summary of current knowledge of the symptomatic picture of childhood and adolescent depression. The reader is free to agree or disagree with the inclusion of certain subgroups, but all are essentially reported by Malmquist. The common thread of depressive affect[1] as the sole criterion for diagnosing depression cuts across theoretical differences but may ultimately be misleading since, as mentioned, a sad affect can be seen in numerous non-depressive conditions.

Table 4-1

Classification of Childhood Depressions

I. Associated with Organic Diseases

A. Part of Pathologic Process

1. Leukemia

2. Degenerative Diseases

3. Infectious Diseases

4. Metabolic Diseases—Pituitary Disease, Juvenile Diabetes, Thyroid Disease, etc.

5. Nutritional or Vitamin Deficiency States

B. Secondary (Reactive) to a Physical Process

II. Deprivation syndromes: Reality-Based Reactions to Impoverished or Nonrewarding Environment

A. Anaclitic Depressions

B. “Affectionless” Character Types

III. Syndromes Associated with Difficulties in Individuation

A. Problems of Separation-Individuation

B. School Phobias with Depressive Components

C. Developmental Precursors of “Moral Masochism”

IV. Latency Types

A. Associated with Object Loss

B. Failure to Meet Unattainable Ideals

C. “Depressive Equivalents” (Depression without Depressive Affect)

1. Somatization (Hypochondriacal Patterns)

2. Hyperkinesis

3. Acting Out

4. Delayed Depressive Reactions

a. Mourning at Distance

b. Overidealization Processes Postponing Reaction

c. Denial Patterns

5. Eating Disturbances (Obesity Syndromes)

D. Manic-Depressive States

E. “Affectless” Character Types (Generalized Anhedonia)

F. Obsessional Character (Compensated Depressive)

V. Adolescent Types

A. Mood Lability as Developmental Process

B. Reactive to Current Loss

C. Unresolved Mourning from Current Losses

D. Earlier Losses (“Trauma”) Now Dealt with by Ego

E. Acting-Out Depressions

F. Schizophrenias with Prominent Affective Components

G. Continuation of Earlier Types (I, IV)

Source: From "Depression in Childhood and Adolescence" by C. Malmquist, *New England Journal of Medicine* 284 (1971). Reprinted by permission.

This section must end on a note of frustration and an admission of incompleteness. As yet there is no adequate classification of depression in childhood, nor are there any agreed criteria for the diagnosis of depression before adolescence. It seems almost plausible to base a classification on the developmental process as McConville (1973) tentatively attempted. Children are limited by their cognitive and affective capacities in their ability to experience and express feelings of depression. What elicits depression also obviously changes as the child matures. Young infants do not have problems of self-esteem, just as preschoolers cannot be said to be haunted by a fear of a deprived future. Ultimately the question of childhood depression may be solved as our knowledge of normal development increases.

Depression in Adolescence

In contrast to the questionable existence of depression in childhood, there is little doubt that depression definitely is experienced by adolescents. The difficulty with this stage of development is that depression may be too ubiquitous. The normal mood swings of the adolescent may give the impression of an epidemic of depressive disorders occurring after puberty. The problem is in differentiating the truly depressed youngster from the normally moody adolescent who is showing transient episodes of dysphoric

affect as an overreaction to relatively trivial disappointments. Jacobson (1961) has investigated the causes for the adolescent's moodiness and she believes that emotional lability is a manifestation of a remodeling of the individual's psychic structure secondary to massive biological, social, and psychological changes. Jacobson views adolescence as a time when the individual must break with ties from the past (including old identifications with adult figures) to forge a new image of the self. The individual is pressured by both the id and the superego in the formation of a new identity, leading to alternating periods of sexual and aggressive acting out; repentant, moralistic behavior; as well as feelings of guilt, shame, and inferiority. According to Jacobson the ego does not gain sufficient stability until late adolescence so that, in the first few years following puberty, there are bound to be mood swings reflecting the dominance of id or superego forces over a relatively weak ego. Depression may be experienced as part of adolescent development for additional reasons: the relinquishing of childhood ties and pursuits, the failure to live up to unrealistic ideals, and as the result of guilt conflicts. Jacobson views adolescence as a turbulent time, with extensive psychic alterations, mood swings, and transient depression to be expected.

Other authors (Weiner, 1970) have disagreed with the view that adolescence must be a stage of turmoil and emotional lability. Disturbed adolescence is not the rule, but is the result of a disturbed childhood and the forerunner of disturbed maturity. This debate goes beyond the scope of this

work but in my opinion the truth is somewhere between these two positions. The clinical literature based on severely disturbed adolescents probably has been too generously applied to all adolescents. Also, the cultural milieu may greatly affect the turbulence of adolescence. Certainly not all adolescents go through the painful traumas described by some authors. For some individuals this is not only a peaceful but a very satisfying time of life. Nevertheless, our own culture places the adolescent under a great deal of stress in terms of sexual inhibition, limitations of freedom, pressure for social and academic success, and a lack of a definable cultural role, so that disturbed behavior is not surprising.

There is also a lack of maturity of judgment that affects the adolescent, regardless of cultural milieu that may predispose him to impulsive acts and inappropriately extreme reactions. As pertaining to depression, some adolescents present such an air of urgency and total despair, as well as an alarming tendency toward self-destructive acts, that a more malignant schizophrenic process is suspected. Some adolescents become extremely agitated and others withdraw from all contact with peers. One youngster, for example, spent days alone in his room with blankets over his face while listening to records, and he refused to take meals or talk with his family. There is also an unrealistic sense of finality in the thinking of some adolescents; failure to make the school honor role means that one will be marked for life as a failure, or rejection by a peer means that one will never be

acceptable to others. This lack of perspective makes the symptoms more severe and more dangerous. A related quality of cognition in some adolescents is a lack of moderation. People, society, or they themselves are all good or all bad, depending on most recent experience. One very bright fourteen-year-old boy who had been disappointed by the treatment others accorded him in his first few days of high school spent his first session on a long tirade about the innate evil of mankind and the dehumanizing effects of a materialistic society. His erudite argument was motivated by his not being given the deference he thought he deserved. Within a few weeks, after he had adjusted to his new surroundings, the world became benevolent and capitalism was now a viable system of economics. Fortunately many of these adolescent depressions are characterized by their brevity as much as by their intensity.

Other depressions, however, become chronic and no longer respond to an amelioration of external circumstances. These youngsters present depressive symptoms similar to those found in adult patients, or they may present age-specific defenses against depression. Among these defenses are restlessness, drug use, group affiliation, delinquency, or sexual promiscuity. Easson (1977) has reviewed the myriad defenses against depression in adolescence and related each to the underlying causes of a painful affect. Self-contempt may result in rebelliousness, drug use, or aggressive acts. Depression resulting from frustration of dependency needs may produce

agitation, anxiety, and a desperate need to substitute new gratifying figures for the lost parents, leading to joining a gang or indiscriminate sexual unions.

Illustrative Case History Of Depression In A Young Adolescent

The following clinical vignette is representative of a fairly severe depressive illness in a young teenager. Betty, a fifteen-year-old girl, came for treatment after suddenly experiencing a crying spell in school. Following this outburst she refused to return to school, where she was an honor student. When seen for an evaluation Betty looked sad and lifeless with occasional tears in her eyes. She also complained of nausea and a choking sensation. She felt that she wanted to hurt herself because she was a failure, she was ugly, and she had humiliated herself in front of her schoolmates by weeping. She believed she could never become a model as she had desired to be, because she was not sufficiently pretty or poised. In actuality she was a very attractive young girl. She exuded a sense of quiet panic over being unable to control her painful feelings. There was no sleep disturbance but Betty was plagued by dreams in which she felt lost and alone or in which strange people were chasing her.

Further history revealed that Betty had not let herself enjoy anything for the past year. The reasons for her enforced anhedonia were that she felt unworthy because she sensed herself to be a disappointment to her mother as

well as to herself. She began experiencing feelings of depression after she met a boy at a summer resort. She wanted the boy to pursue her but she also felt guilty about her romantic desires. The boy did not follow through and this convinced her that she was ugly and undesirable. She also hinted that this "rejection" was well deserved because she should have devoted herself only to her studies and her family. Since this episode she constantly began to evaluate both herself and the way others treated her. Mild snubs were magnified and remembered until she felt uniformly disliked. She started hating to go to school which had become a source of alleged belittling.

Betty's mother was a very disturbed woman who resented her familial role. She had pushed Betty into nursery school despite protests and later forced her to go to sleep-away camp. She was constantly critical of everyone and pictured herself as a martyr to her family. The father withdrew into his business and seemed to avoid coming home. The only praise Betty ever received was for her academic success, but even this pleasure was destroyed by the mother's use of her daughter's grades to degrade her other children.

Betty had never truly developed a sure sense of her own worth but relied excessively on her mother's opinions. She cherished normal adolescent romantic notions which she kept secret. When these dreams were dashed by her supposed "rejection," she erroneously believed that her secret desires would never be fulfilled, and she would always be unworthy and unlovable,

just as her mother had covertly predicted. Only one experience appeared sufficient to convince her of the inevitability of a terrible fate. From that point on she unconsciously distorted the reactions of others to reaffirm her unworthiness and she selected only those responses that confirmed her low opinion of herself. Gradually her affective state deteriorated in step with her unconscious cognitive beliefs and culminated in a severe depression.

Juvenile Manic-Depressive Disorders

If the clinical status of depression in childhood is problematic, the occurrence of manic-depressive disorders before puberty is even more questionable. Kraepelin (1921) noted that a few of his adult manic-depressive patients reported experiencing their first episode before age ten, one patient as early as age five. Other investigators also have described adult patients who traced their illness back to early childhood; however, actual observed case reports of manic-depressive disorder before puberty are rare.

In the late nineteenth century and in the early part of this century, alleged cases of childhood mania were reported (see Anthony and Scott, 1960, for a detailed review) but it remains doubtful that these children were truly manic. Any cyclical behavior or period of excitement seems to have been diagnosed as mania. A close reading of these early reports is needed, since the present-day syndrome of minimal brain dysfunction—which predominantly

consists of hyperactivity, distractibility, and emotional lability—could have been confused with manic behavior. Since these symptoms depend on the amount of external stimulation, the condition could have appeared to be episodic or cyclical. Therefore it is debatable whether these early reports were actually describing hyperactive rather than manic children. When Anthony and Scott reviewed twenty-eight such case reports, applying fairly rigorous criteria for the diagnosis of manic-depressive illness, they found only three reported children who met over five of their ten criteria, and none scored over seven. All three children were eleven years old and showed alternation of depression and mania. Anthony and Scott believe that "all the other cases were open to the charge of misdiagnosis" (1960, p. 58). This conclusion fits the earlier findings of Kasanin and Kaufman (1929) that affective psychoses do not occur in early childhood. These authors reviewed 6,000 patients and found that in only four cases an affective psychosis began before age sixteen and never before age fourteen.

Despite this somewhat uncertain position on the possibility of manic-depressive illness in childhood, some cases have been reported, especially since the discovery of the effectiveness of lithium for treating this disorder. Anthony and Scott (1960) reported the case of a twelve-year-old boy who was seen with symptoms of acute mania which subsided and then returned. This boy's history was recorded up to the time he was twenty-two years old. By then he had been hospitalized four times with a clear-cut manic-

depressive disorder. The authors emphasized that the illness began before puberty. They concluded that although manic-depressive disorders are clinically rare in childhood, they are psychodynamically possible because children may utilize grandiose fantasies as a defense against feelings of sadness or disappointment.

Since the appearance of this paper, other authors have presented single case histories of manic attacks in young adolescents (Warneke, 1975; Berg, Hullin, and Allsopp, 1974). Although it is of clinical interest as well as therapeutic importance that lithium was successfully used in these cases, the articles merely call attention to a few rare cases of manic-depressive illness which began in adolescence. However, two articles have reported manic episodes in very young children, therefore tending to justify this disorder as a bona fide pediatric illness. The first article by Feinstein and Wolpert (1973) speculates that certain children may show precursors of later manic-depressive behavior. They report the case of a three-and-one-half-year-old girl with a strong family history of this disorder who began to show rapid mood alterations from the age of two. She eventually was seen because of hyperactivity and distractibility. Later she is described as reacting to an alleged disappointment with prolonged agitation and destructive behavior. (Her sister had accompanied her to the psychiatric appointment, although simply to see another psychiatrist who shared the same waiting room.) Due to the child's extreme aggressive behavior, she was tried on lithium at age five

and one-half, with good effect. There was no recurrence of her agitation or destructiveness. On the basis of her family history, the episodes of hyperactivity, and her response to lithium, the authors conclude that their patient is an example of juvenile manic-depressive illness. They doubt that the hyperactivity was the consequence of minimal brain dysfunction since this form of hyperactivity is unresponsive to lithium.

Thompson and Schindler (1976) describe a five-year-old boy who was seen because of a short attention span, wandering thoughts, and disruptive classroom behavior. Past history was significant in that the child had been abandoned by his parents and spent a deprived infancy, possibly with nutritional deficiency, in an orphanage. At age three he was adopted by loving parents who showered the boy with care and attention. On evaluation there were no neurological findings, despite his distractibility. He was jovial and showed a constantly elevated mood. The authors speculate that the boy's exuberant behavior may have resulted from his sudden favorable circumstances—being placed in a loving and giving environment after having been raised in the deprivation of a poorly run orphanage. His separation from this all-rewarding environment when he started school may have set off fears of loss and a return to deprivation which, according to the authors, led to his increasing manic behavior.

These two reports are certainly provocative but they leave crucial

questions unanswered. There was no alternation of so-called manic behavior with states of depression, which would have truly confirmed the diagnosis. Furthermore, the manic behavior itself consisted of hyperactivity, distractibility, grandiose fantasies, and in one case aggressive behavior. A difficulty not mentioned is that such behavior is common in many children who have variations of minimal brain dysfunction. Grandiose fantasies also are a fairly normal method of defense in all young children who confuse fantasy and reality in their attempts to compensate for being small and socially powerless. The same argument can be leveled at Anthony and Scott's claim that the psychodynamics of manic depression may be found in children. This is certainly true, for children are realistically dependent on others, have difficulty resolving ambivalence, and are prone to an omnipotent denial of reality. These psychodynamic characteristics are found in normal children who do not show features of affective disorders. Therefore the presence of such psychodynamics may be a necessary but not sufficient cause for the expression of manic-depressive behavior. The point is that these authors do not demonstrate, either on a clinical or psychodynamic basis, the specificity needed to make this diagnosis. The child who improved on lithium may be cited as showing some form of specificity in terms of drug response. However, lithium has been tried in a variety of childhood disorders, especially aggressive behavior, with reportedly good effects (Annell, 1969) so that its effects may not be that specific for manic-depressive disorders. The

speculation that a childhood predisposition to manic-depressive disorders does exist nevertheless is an extremely intriguing proposition. This predisposition may take the form of excessive affective lability or impulsivity which, given a sufficiently pathological home environment and a precipitating trauma, may ultimately result in a cyclical illness. Proving the existence of such susceptibility, however, must await comparison studies of children from highly affected families, who are either raised with their natural parents or have been adopted in early infancy by normal parents so that they do not grow up subjected to their parents' cyclical moods.

Conclusion

This chapter has reviewed the clinical syndromes that have been called depression in children. There is still much controversy whether true depression can exist prior to late childhood. The reaction of infants to separation may be better conceived of as a grief reaction, and the transient unhappy moods of the young child may be considered a direct, behavioral reaction to momentary disappointments. Even when states similar to adult depression are manifested in later childhood, the symptoms are influenced by the appropriate cognitive and affective developmental level. The pendulum of psychiatric opinion has swung back and forth as to whether depression in childhood exists, but this continuing argument may ultimately center on a semantic difference: the question is not whether depression exists in

childhood, but rather how the developmental process allows or limits the experience or expression of varying pathological moods and affects.

Notes

[1] Malmquist also includes “depressive equivalents.”

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