DEPRESSION IN CHILDHOOD:

ISSUES IN DEFINITION, DIAGNOSIS AND TREATMENT

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of the requirements for the degree of
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My mother groand! my father wept.
Into the dangerous world I leapt:
Helpless, naked, piping loud:
Like a fiend hid in a cloud.

Struggling in my father's hands:
Striving against my swaddling bands:
Bound and weary I thought best
To sulk upon my mother's breast.

Blake, 'Infant Sorrow'

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Definition, diagnosis and treatment of childhood depression[1] is confused and controversial. Confusion relates to semantic ambiguity, definitional problems, methodological issues, and difficulties inherent in the study of depression in children.

To gain clarity on the meaning of depression, theoretical concepts were reviewed. Depressive syndrome was surveyed to delineate symptomatology, course, treatment and prognosis. Studies of childhood depression were collated to find common threads in descriptions and treatments of depressed children.

A perspective for diagnosing depression in children was formulated.

A pilot study of depression in children, illustrating issues discussed, was appended.

v/..............

[1]For 'depression' read 'depressive disorder' or 'depressive syndrome', unless otherwise stated.

The current status of 'Depression' as a nosological entity in psychiatrically disturbed children is confused and controversial. There is confusion in the semantics of depression, in criteria for the diagnosis of depression, and in the psychopathology of children, which may manifest differently at different maturational stages. Clinicians are divided over whether depression in children is relatively common or extremely rare; whether it is comparable to depression in adults, or whether it is qualitatively different; whether it is manifest or masked. The definition of depression is uncertain and criteria for diagnosis of depression in children are vague and controversial. Indications for different types of treatments are uncertain, and prognosis is unclear.

The general aim of this dissertation was to clarify the nature of depression in children; aetiological factors, clinical picture, criteria for diagnosis, course, treatment and prognosis.

Theoretical Concepts of Depression

Theoretical concepts of depression were reviewed for the purpose of reaching an understanding of what has been meant by depression.

Depression has been conceptualised from different frames of reference: from the psychoanalytic frame of reference, depression was associated with introjected anger following the loss of an ambivalently loved object; more recent ego-analytic approaches focussed on loss of self-esteem associated with the inability of the ego to achieve narcissistically significant goals; object relations theory stressed depressive vulnerability in relation to feelings of ambivalence associated with lack of an internalised 'good' object. The cognitive frame of reference associated depression with feelings of hopelessness due to negative views of the self, world and future. Learning theory approaches associated depression with reduction of response-contingent reinforcement. Learned helplessness equated depression with the expectation that desired outcomes were of low probability, and their occurrence independent of

responding. Adaptational approaches viewed depression as a biologically-rooted withdrawal response to stress. Biological theories associated depression with deficiency of functional norepinephrine and serotonin at central brain synapses.

Aparent differences between psychological concepts of depression elaborated from particular theoretical frameworks, might be related largely to points of focus, such as emotions or cognitions or behaviours, and to interpretations imposed on what had been observed. There was consensus between theories in viewing depression as being characterised by lowered mood and misery, cessation of active coping with the environment, withdrawal of emotional concern into the self, associated with themes of loss.

The majority of theories were not directed specifically towards depression in children. Classical psychoanalytic theory did not consider children to become depressed for theoretical reasons. However Klein (1935), Bowlby (1952) and Sandler and Joffe (1965) considered depression in children to be analogous to depression in adults.

Depression as a Clinical Syndrome

Depression as a clinical syndrome was surveyed for the purpose of delineating the implications of depressive disorder in terms of symptomatology, course, treatment and prognosis.

Depression was associated with lowered mood, and attitudinal, motivational, behavioural and vegetative changes (Beck, 1967). Symptomatology included depressive feelings or apathy, feelings of incompetence, worthlessness, guilt, hopelessness, anxiety, crying, suicidal tendencies, loss of interest in work and other activities, impaired capacity to function socially, appetite and weight loss, sleep disturbance, constipation, psychomotor retardation or agitation and physical complaints. Not all patients have all symptoms, and there is much individual variability.

Depression might occur in a severe form or a mild form with qualitatively and quantitatively different symptoms. It might present as a primary disorder, or secondary to another condition.

It might be unipolar with only depressive episodes, or bipolar with depressive and manic episodes.

Onset of depression was considered to be multifactorially determined by an interaction of biological, psychological, genetic and environmental factors.

Treatment might be in the form of medication, physical treatment, and/or psychotherapy, depending on the nature and severity of the disorder. Response of depressive episodes to treatment was usually good, but the condition tended to recur.

Depression as a clinical syndrome was characterised by miserable or apathetic mood, cessation of active coping with the environment, and withdrawal of emotional concern into the self. In this respect it corresponded with the picture of depression delineated from psychological concepts.

Depression in Children

Studies of depressed children at maturational levels of infancy, latency and adolescence were reviewed with the aim of elaborating a composite picture of depressed children. A variety of different symptoms were associated with childhood depression in particular studies, and this led to equivocal findings. Conclusions were based on trends rather than substantiated data.

Depression in infancy was described as manifesting with depressive appearance, apathy, withdrawal, feeding and sleeping disturbances, weight loss and developmental retardation. In latency-age children depression was associated with depressive mood change, somatic complaints, social withdrawal, relationship problems, sleep difficulties, weight and appetite change, self-depreciation, school problems including school refusal and problems with schoolwork, tiredness, lack of energy, apathy and running away from home. There was considered to be a progressive shift towards adult depressive symptomatology with adolescence, with symptoms being influenced by adolescent conflicts, manifesting in the activities with which the adolescent was involved, and being coloured by the subculture to which the adolescent belonged.

Depressive disorder in children, as in adults, was considered to be characterised by a cessation of active coping with the environment, withdrawal of emotional concern into the self, with misery and lowered mood, frequently accompanied by feelings of low self-esteem. Differences between depression in children and in adults appeared to lie in childhood depression being more transient, and more tied to specific situations, with greater somatic involvement and less evidence of cognitive factors, the younger the child. There did not appear to be evidence for associating angry, disruptive, antisocial behaviour with depressive disorder in children. Nor was the concept of 'masked' depression, in which it was inferred that depressive feelings were being defended against with behavioural or somatic symptoms, considered compatible with a depressive syndrome.

Criteria for the diagnosis of depression in children have not been established. Diagnosis was based most frequently on criteria used for diagnosing depression in adults.

Aetiology of depression in children was uncertain, but was associated with interaction of genetic, biological, psychological and environmental factors. At certain maturational levels, children appeared to be vulnerable to particular stresses.

Treatment of depression in children took the form of individual psychotherapy, group psychotherapy, parental counselling, family therapy, remediation of specific disorders associated with depression, treatment of possible associated organic pathology, and antidepressant medication. Treatment was directed towards helping the child to cope more adaptively with his needs and the demands of the environment, and modifying the environment to accommodate the child less stressfully and with more understanding. Because of uncertainty about the syndrome, the child rather than the depressive disorder was being treated.

Prognosis of childhood depression was uncertain. Studies suggested lack of continuity between childhood depression and depression in adults, however, definitional problems and lack of diagnostic criteria did not allow conclusive evaluations to be made.

Schemes for diagnosing depression in children in terms of symptoms associated with depression in children were advanced.

Discussion and Conclusions

A review of the literature of depression in children indicated childhood depression to be a vague, ill-defined area. There was no clear picture of symptomatology, no accepted criteria for diagnosis; understanding of aetiology was speculatory, and knowledge of course, treatment and prognosis, uncertain. As yet there was no agreement about the nature of depression in children, whether it was analogous to depression in adults, or different, whether depressive affect was overtly manifested or whether it was 'masked' by somatic or behavioural equivalents.

This confusion was attributed to ambiguity of depressive terminology, definitional problems, methodological issues, and difficulties inherent in the study of depression in children.

It was concluded that for clarification of the area, an accepted definition of depression in children was necessary, with clear criteria for diagnosis.

Schemes for diagnosing depression in terms of symptoms associated with depression in children have been advanced. However, it was considered that such schemes were unsatisfactory in that they had been a priori derived from study of children already considered to be depressed.

The author proposed that criteria for diagnosing depression in children should be based on the conceptual meaning of depression, derived from analysis of theoretical concepts of depression and the medical model: that depression implies cessation of active coping with the environment, withdrawal of emotional concern into the self, and lowered mood, misery and unhappiness that is disproportionate to environmental or physical events. With this perspective, conceptually consistent symptoms might be assembled to elaborate a description of depression in children.

Addendum

A study of depression in a sample of children referred to the University of Cape Town Child Guidance Clinic was appended for the purpose of illustrating the practical application of issues that had been discussed.

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1

AIMS OF DISSERTATION

The current status of 'Depression' as a nosological entity in psychiatrically disturbed children is confused and controversial. There is confusion in the semantics of depression, in criteria for the diagnosis of depression, and in the psychopathology of children, which may manifest differently at different maturational stages. Clinicians are divided over whether depression in children is relatively common or extremely rare; whether it is comparable to depression in adults, or whether it is qualitatively different; whether it is manifest or masked. The definition of depression is uncertain, and criteria for diagnosis of depression in children are vague and controversial. Indications for different types of treatments are uncertain, and prognosis is unclear.

The general aim of this dissertation is to clarify the nature of depression in children: aetiological factors, clinical picture, criteria for diagnosis, course, treatment and prognosis.

As a first step towards clarification, theoretical concepts of depression are reviewed for the purpose of reaching an understanding of what has been meant by depression. The question to be answered is whether what has been called depression in children conforms to what depression generally has been conceptualised to mean.

Secondly, depression as a clinical syndrome is surveyed for the purpose of delineating the implications of depressive disorder in terms of symptomatology, course, treatment and prognosis. The question here is whether what has been diagnosed depressive disorder in children conforms to what generally has been implied by the clinical syndrome of depression.

Thirdly, studies of childhood depression are collated for the purpose of finding common threads in descriptions and treatment of depressed children. Findings are evaluated in terms

of established theoretical and clinical concepts of depressive disorder, and in terms of behaviours of 'normal' and psychiatrically disturbed children at different maturational stages, with the aim of delineating the profile of the 'typically' depressed child, and formulating criteria for diagnosis.

Lastly, a study of depression in a sample of children referred to the University of Cape Town Child Guidance Clinic is appended with the aim of illustrating the practical application of issues that are discussed in the body of the dissertation.

CONCEPTS OF DEPRESSION

Depression and emotional states allied to it have a literary heritage going back to the Old Testament. Job, in his despair, was chronicled as saying:

> Oh that my grief were throughly weighed, and my calamity laid in the balances together!
> For now it would be heavier than the sand of the sea: therefore are my words swallowed up. (6,2-3)

Melancholia (what is now termed depression) was described by Hippocrates in the fourth century B.C. For it he prescribed a regimen of tranquility, sobriety, careful food intake, and abstinence from sexual activity.

Aretaeus of Cappadocia, a physician living in the first century A.D., described the melancholic patient as 'sad, dismayed, sleepless.. At a more advanced stage, they complain of a thousand futilities and desire death.'

Plutarch (2nd century A.D.) presented the following vivid account of melancholia:

> He looks on himself as a man whom the gods hate and pursue with their anger. A far worse lot is before him; he dares not employ any means of averting or of remedying the evil, lest he be found fighting against the gods. The physician, the consoling friend, are driven away. "Leave me," says the wretched man, "me, the impious, the accursed, hated of the gods, to suffer my punishment." He sits out of doors, wrapped in sackcloth or in filthy rags. Ever and anon he rolls himself, naked, in the dirt confessing about this and that sin. He has eaten or drunk something wrong; he has gone some way or other which the Divine Being did not approve of. The festivals in honour of the gods give no pleasure to him but fill him rather with fear and affright. (In Zilboorg, 1941, page 67)

Pinel (1801) described melancholia as follows:

> The symptoms generally comprehended by the term melancholia are taciturnity, a thoughtful pensive air, gloomy suspicions, and a love of solitude. These traits, indeed, appear to distinguish the characters of some men otherwise in good health, and frequently in prosperous circumstances. Nothing, however, can be more hideous than the figure of a melancholic, brooding over his imaginary misfortunes. (Ibid. page 136)

These accounts of melancholia resemble closely modern descriptions of depression, in which depression continues to be elaborated in terms of sad mood, feelings of futility, the wish to die, self denunciations, self-abasement, vegetative symptoms such as loss of appetite, weight and sleeplessness, feelings of guilt and expectations of punishment.

In spite of its long history and the consistency with which it has been described through the ages, the phenomena of depression have remained a mystery. Theorists entertain differing concepts of the nature of depression. From different frames of reference depression has been conceptualised as a disorder of mood, disorder of cognitions, disorder of behaviour and disorder of neurophysiological function, respectively.

From among the many existing theories of depression, selected psychoanalytic, adaptational, cognitive, learning theory, learned helplessness and biological concepts of depression are reviewed below.

2.1 PSYCHOANALYTIC CONCEPTS OF DEPRESSION

Contributions to psychoanalytic theory of depression have been diverse, and with varying emphases. Three main themes of conceptualization emerge: the classical Abraham-Freud position, emphasising object loss, the ego-analytic position emphasising loss of self esteem, and the object relations theory of Melanie Klein.

2.1.1 Classical Psychoanalytic Position

Central to the classical psychoanalytic view of depression is the analogy of depression to grief and mourning, following the loss of a loved person due to death or to the breaking of a relationship. However, whereas mourning is considered to be essentially a normal phanomenon, depression differs in that feelings of anger and hostility are harboured against the love object. When the reaction to the loss of the love object is charged with anger

(rage, unconscious hostility), the individual is likely to pass beyond the bounds of normal mourning (grief) into abnormal melancholia (depression) (Abraham, 1911).

Abraham (1911) considered ambivalence in relationships to derive from disappointments in the maternal relationship before resolution of oedipal conflicts. Particularly in individuals with a constitutional predisposition to oral eroticism, early disappointments in the maternal relationship were considered to lead to fixation at the oral-biting stage of psycho-sexual development. Abraham termed first disappointment in 'object-love' the 'primal parathymia', and theorised that its repetition in some form later in life might precipitate depression.

Freud (1917) elaborated Abraham's theory of depression. He proposed preconditions for melancholia to be object loss, ambivalence and regression of libido into the ego. Like mourning, it involved 'painful dejection', withdrawal of interest from the world, inhibition of activity and loss of ability to love. In contrast to mourning it involved loss of self-esteem, self-accusation and self-punishment. Furthermore, it could occur as a consequence of imagined or unconsciously perceived object loss.

Freud accounted for the symptoms of melancholia in terms of loss of love-object being followed by withdrawal of the libido into the ego, leading to identification of the ego with the abandomed object (introjection). Rage and hostility of the ambivalent relationship would then be turned in on the self (to punish the abandoning love object), leading to loss of self-esteem and self-accusations.

The classical position was further elaborated by Rado (1928). Rado considered the predisposition to depression to be an intense craving for narcisistic gratification, an intense need for love and approval, and a dependency on other people for self-esteem. The ego was considered to respond to loss of love-object with coercive rage, for which it would feel guilt. The superego would implement 'self-punishment - expiation' in the hope of obtaining forgiveness for the attack of rage. 'Guilt - atonement - forgiveness' was seen as the key dynamic in depression.

The Abraham - Freud - Rado formulation of depression emphasised oral fixation, narcissism, ambivalence, anger turned inwards, and object loss, real, fantasized or symbolic. Depression was considered to be due to loss of ambivalently loved object, with consequent loss of self-esteem, and anger turned against the self. This formulation is of dubious value in accounting for all depression, in that some depression does not seem to be associated with object loss. Furthermore, it is doubtful whether depression always involves anger turned inwards; mildly depressed individuals, for example, may blame circumstances or people for their misery. Nonetheless, the Abraham - Freud - Rado formulation possibly has been the most widely quoted psychological conceptualisation of depression.

2.1.2 Ego-Analytical Theories of Depression

Classical psychoanalytic theories of depression had in common the central analogy of grief due to real, imagined or symbolic object loss, with secondarily derived loss of self-esteem. With ego-analytic theories, inability to cope with associated loss of self-esteem became central.

Bibring (1953) proposed the basis of depression to be the 'ego's shocking awareness' of its helplessness to realise its aspirations. He defined depression as 'the emotional expression (indication) of the state of helplessness and powerlessness of the ego, irrespective of what may have caused the breakdown of the mechanism which established the self-esteem.' (page 163)

Bibring considered a characteristic of depression to be rigid adherence to certain 'narcissistically significant' (pertinent for self-esteem) goals including: the wish to be worthy and loved; the wish to be strong and superior; the wish to be good and loving. The ego's perception of its inability to reach these goals would precipitate depression. For example, depression might occur whenever an individual's fear of being weak and unfit to cope with dangers or attackers appeared to be confirmed. A blow would have been dealt to the individual's self-esteem, and depression would accompany a feeling of being doomed never to succeed in terms of

the ego's goals.

Bibring considered depression to be an ego phenomenon, conceptually similar to anxiety, that stemmed primarily from tensions within the ego itself, due to the ego not being able to cope with the aspirations it strongly maintained. In contrast to anxiety, which was considered to be a reaction to danger that prepared for fight or flight, depression was considered to reflect a state of paralysis due to the ego's incapacity for meeting danger. Depression was an affect associated with ego helplessness and inhibition of functioning.

Bibring did not relate depression exclusively to fixation at the oral stage, as he considered it possible for frustration at any of the psycho-sexual stages to bring about 'fixation to a state of helplessness and powerlessness'. Furthermore, he did not consider aggression against the self to be a primary feature of depression. Self-aggression and the use of oral mechanisms such as introjection, were considered to be secondary depressive features, related to collapse of self-esteem, regression to a state of helplessness, and submission of the ego to punishment from the super-ego.

Gaylin (1968) amended Bibring's formulation of depression in terms of a crisis in self-esteem to a 'crisis in self-confidence'. Gaylin proposed that depression might be precipitated by loss of anything that was overvalued in terms of existential security. The state of 'giving up' and 'paralysis of the will' was considered to give depression its unique quality, and to provide the individual with a 'fundamental defence', in the form of 'a plea for a solution to the problem of survival via dependency' (page 391)

Bibring advanced a credible theory of depression that could account for a variety of depressions, including those associated with death of a loved person or severing of a relationship, those following a failure in business, and those appearing for no apparent reason. The delineation of idiosyncratic areas of vulnerability offers the possibility of predicting future depressions in specific individuals.

2.1.3 Object Relations Theory of Depression

Klein (1935), like Abraham, Freud and Rado, associated depression with orality, ambivalence and regression to an earlier psycho-sexual stage. She deviated from the classical position in postulating a 'depressive position' as a normal stage of psycho-sexual development.

Klein theorised that at about four or five months of age, the infant, who had previously split objects into good and bad part-objects, became aware that the loved object was also the hated object, and that real and imaginary external and internal figures were bound up with each other. The stage began with the child coming to know the mother as a whole, real, loved person, identifying with her as a whole, yet experiencing with her 'loss of the loved object', each time the breast was taken away, reaching a climax during weaning. During this stage the infant 'experiences some of the feelings of guilt and remorse, some of the pain which results from the conflict between love and uncontrollable hatred, some of the anxieties of the impending death of the loved and hated internalised and external object - that is to say, in a lesser and milder degree the sufferings and feelings which we find fully developed in the melancholic.' (pages 219-220) If the infant failed to establish internally the 'good' object, then the situation of the 'loss of the loved object' would arise 'in the same sense as is found in the adult melancholic'. Furthermore 'this first and fundamental external loss of a real loved object, which is experienced through the loss of the breast before and during weaning, will only result in later life in a depressive state if at this early period of development the infant has failed to establish its loved object within its ego.'(ibid.)

Klein suggested that 'manic phantasies' of controlling first the breast, and then the internalised and external parents, might be used to combat the depressive position, and this could be triggered by the child finding the breast again after having lost it. Furthermore, as with introjection of the whole and real object the 'bad' and 'good' objects (breasts) come closer together, ambivalence occurs, leading to the mechanism of splitting of

objects into loved and hated objects. Klein considered ambivalence with splitting to be an important part of developing relations to objects, that diminishes in varying degrees as love and trust in real, internalised objects becomes established, and mastery is gained over aggressive impulses.

Klein is considered to have made a valuable contribution to psychoanalytic theory, in having conceptualised the growth of object relations to occur in an ambivalent setting, with the struggle between love and hate leading to depressive fears lest hating impulses should prove the stronger. It has been suggested that the 'depressive position' might have been more aptly named the 'position of depressive vulnerability' (Zetzel, 1953).

2.1.4 Bowlby's Position

Bowlby (1952, 1961, 1965) conformed to the classical psychoanalytic theory of depression in that he compared depression with mourning, attributed it to loss of object, related it to preoedipal maternal love disappointment, and associated it with grief and anger. He deviated markedly in his interpretation of these phenomena.

Bowlby considered mourning to be an adaptive phenomenon, involving withdrawal of emotional concern from a loved object in preparation for making a relationship with a new object. He proposed anger and grief to be emotional means of holding and recovering love objects (Bowlby, 1961). Bowlby considered pathological mourning (depression) to occur when defensive processes partially interfered with the mourning process, possibly resulting in fixation at the phase of striving to recover the lost object.

The impetus of Bowlby's work came from observations of infants and young children separated from the mother figure in the second half of their first year of life (after bonding had occurred). Bowlby claimed that the responses of these infants to loss of the mother were essentially the same as those of an adult to loss of a loved person, and he considered the underlying processes to be similar. Bowlby proposed mourning processes in the early years of life to be unfavourable to later personality development. He

considered it to predispose to psychiatric disorder, but he did not associate early mourning experiences with adult depression.

Bowlby has been criticised for not considering the differences in successive developmental stages and the affect they have on psychological processes in responding to object loss (Freud, 1960). While it was accepted that young children might grieve, that they mourn was considered doubtful in that mourning presupposed more elaborate psychological processes. Bereavement reactions of young children were considered, on the basis of psychoanalytic theory, to be governed primarily by the pleasure principle rather than by psychological processes which required more elaborate mental development.

2.1.5 Sandler and Joffe's Position

Sandler and Joffe (1965) considered depression to be a basic psychobiological affective response occurring in children where there had been a specific type of threat to the child's well-being: 'the feeling of having lost, or being unable to attain something which was essential to his narcissistic integrity. Coupled with this was the feeling of being helpless and unable to undo the loss' (page 91). Sandler and Joffe proposed that when a love object was lost, what had really been lost was 'the state of well-being implicit both psychologically and biologically, in the relationship with the object' (ibid.).

Sandler and Joffe believed that for a depressive reaction to occur, there should be an ideal state aspired to by the child, which he felt unable to attain because of frustrating circumstances. Under such conditions, regression to an earlier stage might occur, with more infantile, primitive ideal states and relationships being sought. This might manifest as daydreaming, thumbsucking, obsessional rituals, etc. Alternatively they considered that children might defend against conscious awareness of depressive feelings, for example by reversal of affect, but that depressive feelings would appear from time to time.

These authors considered that whereas manifestations characterising the depressive reactions of children were to be found in adults, the reverse was not true in that adults have at their

disposal further defensive and restitutional processes, such as identification and introjection, that were not considered to be available to children.

Sandler and Joffe's conceptualisation of the child grieving the loss of a state of well-being rather than the love object, appears to have been supported pragmatically. For example, children between six months and four years, who have entered institutions alone, have been reported to have suffered setbacks varying from behavioural disorders to depression (Bowlby 1952, 1965; Prugh et al., 1953). On the other hand, children who have lost a parent but have remained in their homes, have not appeared to have suffered similar setbacks, provided they have been well cared for by the remaining parent (Rutter, 1972; Wolff, 1973).

2.1.6 Psychoanalytic Theory of Depression and Children

The majority of psychoanalytical theorists have questioned the existence of depression in children. Partly this has been due to adult manifestations of depression not generally appearing in children, and partly because children have not been considered to have the personality structure necessary for the development of depression, in terms of classical psychoanalytical theory. Even where manifestations of depression have appeared in children, theorists such as Spitz (1945, 1946) have referred to the condition as 'depressive-type' rather than 'depression'. Children appeared to have been of interest mainly in relation to psycho-sexual developmental experiences leading to depressive vulnerability in adults.

2.1.7 Summary of Psychoanalytic Concepts of Depression

Psychoanalytic concepts of depression fall broadly into categories of classical psychoanalytic theory, represented by Abraham, Freud and Rado, ego-analytic theory, represented here by Bibring and Gaylin, and object relations theory represented by Klein. Classical analytic theory explained depression in terms of the loss of an ambivalently loved object by an individual fixated at the oral stage of psycho-sexual development, resulting in anger turned in against the self, feelings of guilt and loss of self-esteem.

Ego-analytic theory explained depression in terms of loss of self-esteem associated with the ego's inability to cope with its aspirations, leading to regression to a state of helplessness with consequent feelings of guilt. Object relations theory explained depression in terms of vulnerability due to lack of an internalised 'good' object, leading to regression after loss of loved object.

Psychoanalytic theories of depression share the viewpoint that depression is preceded by 'loss' of something of intrinsic importance to the individual, leading to cessation of active coping with the environment, passivity, and withdrawal of emotional concern into the self.

In general, psychoanalytic theory has not concerned itself with depressive states in children. Klein, however, considered infants and children who had not established a 'good' internal object to be vulnerable to depression in the same sense as adults. Bowlby considered separated infants to mourn the mother figure in essentially the same way that an adult mourns the loss of a loved person. And Sandler and Joffe considered separated infants to grieve the loss of a state of emotional and physiological well-being rather than the absent love-object.

2.2 DEPRESSION AS AN ADAPTIVE RESPONSE

The concept of affect serving an adaptive function derives from Darwin (1872), who considered a trait or behaviour, including emotional expression, to be adaptive from a phylogenetic point of view if it promoted the survival of the species, and to be adaptive from an ontogenetic point of view if it promoted the growth and survival of individual members of the species. For an affect to be adaptive it should be associated with physiological adaptation and/or communication of the need for help to other members of the species. Darwin surveyed the expression of emotions in animals, children and adults, claimed the presence of common features in emotional expression between species, and in adult expressions such as sadness, observed the vestiges of crying manifested by children, in terms of muscle contractions. Crying was interpreted

as an adaptive response for eliciting adult support.

Studies of infants, human and animal, that had been separated from their mothers, have yielded convergent findings (Spitz, 1945, 1946; Bowlby, 1952, 1965, 1968; McKinney, 1976, 1977; Kaufman, 1974): when the mammalian mother-infant bond is broken, a typical pattern of anxiety, agitation and protest, followed by withdrawal, decreased activity and depressive affect emerges. The depression was considered to alert the mother and/or other members of the social group, that the infant being in potential danger (Klerman, 1974). Alerted protectors could rally resources for nurturance, support and protection of the infant, thus promoting survival of the species and of the individual.

About fifty years ago, the biologist Hoagland observed that animals react in one of two ways to stimuli that tend to influence their behaviour: positively, by making appropriate adjustments such as attacking, manipulating or retreating, and negatively by ceasing all movement (Hoagland, 1928).

Hoagland's views were extended by Engel and Reichsman (1956). Their observations of an infant (Monica) with gastric fistulae led them to hypothesise that the central nervous system is organised to mediate two opposite patterns of response to a mounting need. Engel commented that:

> 'One of these is an active pattern in which the infant through crying and motor activity in effect achieves gratification of his needs through need-fulfilling (though to him yet unknown) external object. The other pattern is essentially a conservation one in which the infant reduces activity, heightens the barrier against stimulus and conserves energy, as, for example does a hibernating animal. Indeed, this may be considered a property of all living tissue and not of the central nervous system.' (Engel, 1962, cited in Friedman, 1974, page 284)

Engel thus proposed the presence of two biologically-rooted responses to stress: a state of mobilization for action and a conservation-withdrawal reaction.[1] The former was considered to be the anlage of anxiety, the latter to be the anlage of depression.

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[1]Conservation-withdrawal is considered to be a reaction involving detachment from the external environment when it becomes too stressful or too depriving for the organism. It is considered to be a basic biological process seen along the evolutionary ladder from

Engel and Schmale (1972) theorised that some infants, from the very beginning of life tended to show a disposition to conservation-withdrawal responses to stress. According to them, what started as a biological response might gradually be transformed during development into psychobiological (depressive) equivalents, and finally into a depressive response, all expressing the basic tendency to withdraw.

It has been suggested that during periods of life change, such as following the death of a loved person or after relinquishing a life goal, individuals might go through a period of disorganisation involving changes in self-concept, role or gratification. For such changes to be accomplished satisfactorily the loss requires to be recognised, accepted and then mastered. This process evokes feelings of helplessness and hopelessness, which constitute the essence of depression (Bowlby, 1968; Schmale, 1974). Such depression is considered by Bowlby and Schmale to be appropriate and submitting to it adaptive. These authors have suggested that when individuals are unable to tolerate feelings of hopelessness and helplessness, and defend against feelings of depression, depressive disorder might develop. Schmale (1974) considers depressive disorder to be associated with inability to bear feelings of depression.

Klerman (1974) proposed that depressive affect might have adaptive value in performing the following signalling functions:

1. Social communication of a need for help and support;
2. Physiological adjustment towards reduced psychomotor activity;
3. Subjective awareness, in terms of the James-Lange thesis of conscious awareness following physiological reaction;
4. Psychodynamic arousal of defences for maintaining psychic balance.

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paramecium to more complicated biological organisms, and represented at many levels of cellular, organic and systemic functioning. Such inactive or resting states are seen in hibernation, encyctment, and in the refractory periods that occur during the cyclical activities of many organs and functions. In man it is considered to be associated with reduced psychomotor activity, lowered metabolism and increased parasympathetic activity. Such states are typically time-limited. (Schmale, 1974)

In situations where active responding would not be adaptive, conservation-withdrawal or 'depression' might be indicated. However in many instances depression is too extreme in relation to environmental circumstances for it to be adaptive. For example, many of the hospitalised infants whom Spitz (1945) observed failed to thrive, and many of them died (See Section 4.1.1). Mothers who become depressed frequently neglect their children (Weissman and Paykel, 1974). People in happy circumstances may become severely depressed and commit suicide. In such circumstances depression is clearly maladaptive. Whether such depression can be viewed on a continuum with the depression discussed above is uncertain, and will be discussed in Section 3.2.

2.2.1 Summary of Depression as an Adaptive Response

It has been suggested that in situations where active coping is unlikely to succeed, conservation-withdrawal on a biological level and depression on a psychological level, might be an appropriate response. Whether such a depressive response can be viewed on a continuum with maladaptive depressive responses that are extreme in relation to environmental circumstances, is uncertain.

2.3 COGNITIVE CONCEPTS OF DEPRESSION

Beck (1967, 1974) formulated a theory of depression that derived depressive mood from cognitive factors.

Depressed individuals were considered to have pervasively negative attitudes towards themselves, their world and their future, - what Beck termed the 'cognitive triad' of depression:

1. The depressed person typically viewed himself as deficient, or unworthy, which he attributed to presumed physical, moral or mental defects within himself.
2. The depressed person typically saw his world as making tremendous demands on him, and he viewed his interactions with the environment in terms of failure or inadequacy.
3. The depressed person typically viewed the future as being a

continuation of the present with unchanging hardship, deprivation and frustration, because of which he felt hopeless.

Associated with depressive cognitions were illogical ways of thinking. For example, events might be exaggerated or misinterpreted; extreme judgements might be made in certain situations; overgeneralization from a single incident might occur; details might be focussed on selectively and out of context; inferences might be drawn in the absence of evidence or contrary to evidence; and personally relevent meanings might be drawn from unpleasant situations. Thought content would tend to revolve around themes of loss and deprivation. Sustained loss might be exaggerated, misinterpreted, overvalued and overgeneralised meaning attached to it. Hypothetical and 'pseudo' losses might be dwelled on.

Depressive symptoms, such as motivational, behavioural and mood changes were considered to stem from negative cognitions: indecisiveness, paralysis of the will, increased dependency, avoidance behaviour and suicidal ideation could understandably be related to the depressed persons view of himself, his world and his future.

The predisposition to experience negative, distorted cognitions centering around themes of loss and being a loser was tentatively related to particular kinds of unfavourable childhood experiences; for example, loss of a parent, chronic rejection by peers, the setting of rigid, perfectionistic goals early in life. It was proposed that when specific stresses impinged on the area of vulnerability of a predisposed individual, depression would be likely to occur.

Beck's theory is of interest in bringing to attention the role that disturbances of thinking might play in determining depressive mood. Furthermore, the cognitive formulation offers an intriguing explanation of how depression may develop, become more pervasive and be maintained. However, there is as yet no satisfactory explanation of why illogical cognitions leading to a negative view of the self, world and future, should arise independently of emotional factors.

2.3.1 Summary of Cognitive Concepts of Depression

It has been proposed that depressive mood, behaviour and motivational changes might be derived from a 'cognitive triad' of negative views of the self, world and future, that was related to illogical thinking. Depression was associated with a withdrawal from active coping with the environment, a tendency to dwell on real or imagined losses, and feelings of hopelessness.

2.4 LEARNING THEORY CONCEPTS OF DEPRESSION

The central thesis of learning, or behaviourally orientated theories of depression, is loss of, or reduction in, positive reinforcement. This might be a function of the loss of a significant provider of positive reinforcement (Lazarus, 1968), reduced frequency of emission of positively reinforced behaviours (Ferster, 1965, 1973; Lazarus, 1968; Lewinsohn, 1974, 1975), or decline in reinforcer effectiveness (Costello, 1972). Furthermore the lower level of activity with 'depressive behaviours' might be reinforced by sympathy or special dispensations from people who expected less from the depressed individual than before (Lewinsohn, 1974, 1975; Ullman and Krasner, 1969).

Ferster (1973) drew attention to the fact that many depressed individuals interacted with a limited range of people and frequently were dependent on only one person for reinforcement. Furthermore, their behaviour was passive, in that they tended to react to the prompts of others rather than spontaneously emitting activities themselves, with the result that reinforcers in their interactions were likely to be more appropriate to the repertoire of other people than to the repertoire of the depressed person. Ferster considered depressed individuals to have a 'limited' view of the world, a 'lousy' view of the world in that they suffered the aversive consequences of not dealing with, avoiding or escaping from aversive situations, and an 'unchanging' view of the world in that they tended to have a developmental history of not expanding or altering their world by exploring new avenues.

Lewinsohn (1974, 1975) proposed that people became depressed when their behaviour received little response-contingent reinforcement. The thin schedule of positive reinforcement would reduce activity further, with consequent further reduction of reinforcement. Lewinsohn considered the amount of reinforcement received by an individual to be related to the number of potential reinforcers available as a function of (a) personal characteristics, such as age, sex and attractiveness to others, (b) the environment, such as home as opposed to work, (c) repertoire of behaviours that could gain reinforcement, such as vocation and social skills. Lewinsohn drew attention to the importance of behaviour being followed by contigent reinforcement as opposed to noncontingent positive reinforcement, to the role played by the environment in maintaining depressive behaviours and to the relation between deficits in social skills and low rate of positive reinforcement. He considered negative attitudes, low self-esteem and hostility to be secondary to feelings of dysphoria, related to low rate of response-contingent positive reinforcement.

Learning theories of depression have contributed towards an awareness of behaviours associated with depression, in terms of repertoire of behaviours, lifestyle, interaction with the environment, and the potential of the environment for providing positive reinforcement. They have furthered understanding of the maintenance of depression and have drawn attention to behavioural deficits that could contribute towards depressive breakdown in predisposed individuals.

2.4.1 Summary of Learning Concepts of Depression

It has been proposed that depression might be associated with reduction of response-contingent positive reinforcement. This has been associated with the loss of a significant provider of positive reinforcement, deficits in social skills, passivity, lack of opportunity for reinforcement in the environment, and the reinforcement of 'depressive' behaviours by other people.

2.5 LEARNED HELPLESSNESS CONCEPTS OF DEPRESSION

Seligman (1974, 1975) advanced a theory of depression based on the assumption that the passive experience of uncontrollable trauma could interfere with later adaptive responding. He termed induced maladaptive responding 'learned helplessness', and proposed that it might provide a model for depression.

The concept of 'learned helplessness' was derived from laboratory experiments with dogs. It was observed that when dogs had been exposed to uncontrollable trauma, in the form of unavoidable shock, they became passive and helpless when they were exposed to shock again, and made no attempt to escape when given the opportunity to do so. Furthermore, the dogs were slow in learning that their responses could bring relief, they lacked aggressiveness and competitiveness, showed weight and appetite loss, and these phenomena diminished with time. Seligman theorised that animals developed learned helplessness when they were placed in a situation in which whatever they did had no bearing on what happened to them. The passive, helpless behaviour, weight and appetite loss, and the dissipation of the phenomena with time, led Seligman to conclude that learned helplessness might be analogous to the condition of clinical depression in man, and that clinical depression might be caused in a manner analogous to that in which learned helplessness was produced in animals.

In its most up-to-date form (Abramson, Seligman and Teasdale, 1978), the central and defining thesis of learned helplessness (depression) in man,was the expectation that highly desirable outcomes were of low probability and their occurrence was independent of the individual's actions. This expectation was considered to produce deficits in motivation, self-esteem, cognition and affect. 'Generality of depressive deficits', 'chronicity of depressive deficits' and 'lowering of self-esteem' were considered to depend on 'globality of attribution for helplessness', 'stability of attribution for helplessness' and 'whether attribution for helplessness (was) internal', respectively. Intensity of deficits was considered to depend on the 'extent of expectation of uncontrollability', and affective and self-esteem deficits were considered to

depend on the 'importance of outcome'.

Based on laboratory observations that street mongrels were less prone to learned helplessness than sheltered laboratory-bred dogs, and that by physically forcing helpless dogs to respond, recovery might be initiated, Seligman (1974) hypothesised that an important aspect of the theory could involve the prevention and cure of depression. He proposed that teaching children to connect responding with reinforcement might 'inoculate' against depression in later life, and that coercing depressed people to behave might initiate cure.

Theoretically the learned helplessness model of depression has inconsistencies. For example, one questions whether Seligman generalised from the concept of a conditioned response in dogs to the concept of a cognitive set in man, or whether he attributed dogs with having cognitive expectations, which would imply anthropomorphism. In terms of accounting for depression in man, the inference remains problematical.

Clinically, the validity of learned helplessness as a model of depression in man has yet to be confirmed (Depue and Monroe, 1978; Buchwald, Coyne and Cole, 1978). What is probable is that the tendency to react to adversity with attributions of helplessness might be a contributory factor in certain types of depression (Dweck, 1977; Depue and Monroe, 1978).

2.5.1 Summary of Learned Helplessness Concepts of Depression

A model of depression based on a laboratory paradigm of learned helplessness has been proposed. The central thesis of this model is the expectation that desired outcomes are of low probability, and their occurrence independent of the individual's actions.

It has been suggested that the model might be of use in terms of the prevention and cure of depression in man.

The usefulness of the learned helplessness model of depression in terms of depressive disorder in man has yet to be demonstrated.

2.6 BIOLOGICAL CONCEPTS OF DEPRESSION

Modern biological theories of depression are viewed as functioning on different levels of biological focus:
Firstly there is the biology of the predisposition to depression, that may or may not become manifest (Angst 1972, 1974; Shaw, 1977), representing a 'genetic biology'.
Secondly, there are the biological events associated with the triggering of depression in susceptible individuals, by stress, drugs or other factors.
Thirdly there is the biology concommitant with the depressive state.
Fourthly, there are the biological changes that accompany (and may account for) reversal of the depressive process, by drug or behavioural intervention, or by 'spontaneous remission'.
(Goodwin, 1974)

2.6.1 Genetic Information

Recent advances in genetic information have come from family studies extending over several years. These studies have differentiated between two types of primary affective disorders : unipolar depression (depression with depressive episodes only) and bipolar depression (depression with manic and depressive episodes, or a family history of mania)(Leonard, 1962; Angst, 1966; Perris, 1966; Winokur et al., 1969).It was observed that families with mania had high genetic loading for depressive illness in two consecutive generations, while families without mania had low genetic loading for depression with negligible incidence of two-generation positive history. This suggested that the former, bipolar depression, was a dominant trait., while the latter, unipolar depression, could not be so characterised.

Current genetic studies suggest that bipolar depression can be transmitted as either an X-linked dominant (Winokur et al.,1969; Mendlewicz et al.,1972), or as an autosomal dominant (Green et al., 1973). There is less uniformity of opinion on unipolar depression, although some studies favour polygenic inheritance (Gershon et al., 1971; Baker et al., 1972).

Angst (1974) argues that 'in every case of depressive disease a role is played by the patient's constitution itself as well as by environmental factors of varying specificity... With regard to their specificity, constitutional and environmental factors seem to be mutually complementary' (page 3). Although an individual might be genetically predisposed to depression, he is unlikely to suffer from a depressive disorder without an environmental precipitant, and the extent to which he is vulnerable to environmental precipitants will depend on the extent to which he is genetically predisposed. (ibid.)

2.6.2 Electrolyte Changes

Intracellular sodium appears to be elevated during depression, and even more elevated during mania, and to decrease upon recovery (Durell, 1974). There also appears to be a relative deficiency of intracellular potassium (ibid.). Water appears to shift from extra- to intracellular compartements, causing electrolyte redistribution, and possibly a change in action potentials in the cells.

2.6.3 Adrenocortical Activity

The diurnal curve of corticosteroid production in depression shows more peaks during the 24-hour cycle and a lower amplitude than normal, thus blurring the usual distinction between secretory phases. Plasma cortisol levels showed the secretion of substantially more cortisol, with more secretory episodes and more minutes of active secretion in severely depressed patients (Sachar, 1974).

Changes in adrenocortical activity reflect increased hypothalamic activity, and may be associated with apparent limbic system dysfunction.

Cortisol, and other corticosteroids, are important regulators of electrolyte metabolism, and most probably have a role in the electrolyte changes that accompany depressive disorder (ibid.).

2.6.4 Biogenic Amines

The major hypotheses relating to depression are considered to

be those involving the biogenic amines, norepinephrine and serotonin, which act as neurotransmitters.

Behavioural studies in animals and clinical evidence support the thesis of norepinephrine pathways being involved in mood, with deficiency in norephinephrine producing depression and overactivity resulting in euphoria, hypopomania or mania (Rosenblatt and Chanley, 1974). Similar observations of serotonin have suggested its role to lie in exerting reciprocal or, more probably, a stabilising or damping effect on synapses, including those that may be associated with mood (Coppen, 1974).

Clinical evidence suggests that there is a reduction of functional serotonin in the brains of many patients suffering from affective disorders, whether they be depressed, manic or in remission. Serotonin deficiency at central brain synapses may be a necessary genetic or constitutional requirement for affective disorder, permitting what might otherwise be normal and adaptive changes in norepinephrine activity and consequent mood to exceed the homeostatic bounds and progress in an undamped fashion to depression or excessive elation.

The symptomatic extremes of depression or mania would thus be attributable to high or low norepinephrine synaptic activity, and the predisposition to them or the extent to which those changes overrun their adaptive bounds would depend on a constitutional deficit in serotonin activity (Prange et al.,1974).

This theory has relevance for drug therapy, in that monoamine oxidase inhibiors (MAO inhibitors) appear to diminish presynaptic inactivation of norepinephrine and serotonin, and tricyclic antidepressants appear to block their re-uptake by presynaptic endings, thereby potentiating the effective amounts of norepinephrine and serotonin for synaptic activity in the brain. Electroconvulsive shock is also considered to increase levels of norepinephrine and serotonin in the brain. (Coppen, 1974).

2.6.5 Discussion of Biological Concepts of Depression

Recent genetic evidence strongly suggests that biochemical disturbance may play an important part in serious deppressions.

Significant alterations undoubtedly occur in electrolyte balance and in corticosteroid secretion. Although their role need not be secondary, no parsimonious concept has yet emerged relating these changes to the pathenogenesis of affective disorders. On the other hand, recent research into the biochemistry and pharmacology of biogenic amines, their localization and distribution in the brain, and their interrelationships with behaviour and clinical states suggests that further study of these areas should clarify underlying biological processes in depression.

Biological concepts of depression may provide a partial explanation of why some people become depressed, yet other people in similar situations do not become depressed. Furthermore, they contribute towards an understanding of pharmacological treatment, which is frequently effective in relieving depression. However, while an understanding of the biology of depression may cast light on defective neuronal structure and biochemical functioning, the notion of a direct one-to-one relationship between a specific biological event in the brain and a behavioural syndrome has been discarded in most areas of neurobiology (Akiskal and McKinney, 1975).

Investigations have not been made of possible biological concomitants of depression in children. Positive response to antidepressant medication by depressed children has been reported by some clinicians (Frommer, 1968), but this cannot be interpreted as conclusive evidence of biological correlates of depression.

2.6.6 Summary of Biological Concepts of Depression.

Recent genetic studies have differentiated between unipolar depression and bipolar depression. There is evidence that bipolar depression has a stronger genetic loading than unipolar depression, and is a dominant trait.

Alterations in electrolyte balance, corticosteroid secretion and biogenic amine activity have been associated with depression. Antidepressant medication has been implicated in potentiating effective levels of norepinephrine and serotonin at central brain synapses.

Biological concomitants of depression have not been found in children.

2.7 CONCLUSIONS CONCERNING CONCEPTS OF DEPRESSION

Depression has been conceptualised from different frames of reference. Eight different ways of conceptualising depression have been summarised in Table 1.

Framework	Model	Mechanism
Psychoanalytic	Object loss Self-esteem loss Depressive position	Aggression turned inwards Helplessness in attaining goals Remorse and guilt at loss of 'good' object
Cognitive	Negative cognitive set	Hopelessness
Learning Theory	Reinforcement loss	Decrease of positively reinforced behaviours
Learned Helplessness	Uncontrollable trauma	Reinforcement viewed as independent of responding
Adaptation	Conservation-withdrawal	Depressive withdrawal in response to stress
Biological	Biogenic amines	Serotonin and norepinephrine deficiency

Table 1: Summary of ways of conceptualising depression.

From the psychoanalytic frame of reference, depression has been associated with introjected anger following the loss of an ambivalently loved object; more recent ego-analytical approaches have focussed on loss of self-esteem associated with the inability of the ego to achieve narcissistically significant goals; object relations theory has stressed depressive vulnerability in relation to feelings of ambivalence before a 'good' internalised object has been established. The cognitive frame of reference has associated depression with feelings of hopelessness due to negative views of the self, world and future. Learning theory has associated depression with reduction of response-contingent positive reinforcement. Learned helplessness has equated depression with the

expectations that desired outcomes are of low probability and their occurrence independent of responding. Adaptational approaches have viewed depression as a biologically-rooted withdrawal response to stress. Biological theories have associated depression with deficiency of functional norepinephrine and serotonin at central brain synapses.

Children have been considered to be vulnerable to depression in the same sense as adults (Klein, 1935); it has been proposed that they may become vulnerable to depression after separation from the mother-figure (Bowlby, 1952); and it has been suggested that they might become depressed in relation to the loss of a state of physiological and emotional well-being, rather than in response to loss of the loved object (Sandler and Joffe, 1965). The majority of theories reviewed above have not been directed specifically towards depression in children.

Theories fall into psychological concepts of depression and biological concepts of depression. Psychological and biological concepts may be complementary, in that constitutional factors, early learning and life stresses may contribute towards the development of depression (Akiskal and McKinney, 1975).

Apparent differences between psychological concepts of depression elaborated from particular theoretical frameworks, may be related largely to points of focus, such as emotions or cognitions or behaviours, and to the interpretations imposed on what has been observed. There is general consensus between psychological theories of depression in having viewed depression as a peculiarly joyless condition, characterised by cessation of active coping with the environment, withdrawal of emotional concern into the self, associated with themes of loss.

3

DEPRESSION AS A CLINICAL DISORDER

The concept that mental disorders were illnesses dated from Hippocrates, often regarded as the father of modern medicine. Hippocrates considered the brain to be the organ of the intellect, and if thinking and behaviour were deviant, brain pathology were inferred. Physical disturbance might affect thought and behaviour, likewise, environmental and emotional stress could damage mind and body.

Depression is surveyed below within the framework of the medical model. The aim is to delineate its symptomatology, treatment, course and prognosis as a clinical syndrome.

3.1 SEMANTICS OF DEPRESSION

It is important for the term 'depression' to be clarified. Depression may have at least three clinical meanings that overlap, but do not necessarily coincide.

3.1.1 Depression as an Affective State

Depression may denote an affective state, characterised by feelings of dejection, dysphoria or melancholy, that may be of low or high intensity, short or long duration. It may be an appropriate response to life events or it may occur for no apparent reason. It may be a trait giving depressive colouring to an individual's personality. It may occur as a symptom of many clinical disorders.

An individual with depressive feelings could be described as being depressed, but would not necessarily be suffering from depression as a clinical disorder.

3.1.2 Depression as a Clinical Syndrome

Depression may denote a clinical syndrome, consisting of a characteristic cluster of signs and symptoms. The syndrome predictably implies a reduction in ability to experience pleasure,

loss of interest and diminution of a sense of competence, in the context of dysphoria or psychic pain. These psychic events cannot be related realistically, in terms of intensity or duration, to environmental events or physical changes in the individual.

Beck (1967) elaborated five affective, cognitive, motivational, vegetative and motor disturbances that are usually associated with depression. These were:

1. Mood change, with sadness, apathy and loneliness;
2. Negative self-concept, with self-reproach and self-blame;
3. Regressive and self-punitive wishes with the desire to escape, hide or die;
4. Vegetative changes with anorexia, insomnia and loss of libido;
5. Activity level change, with retardation or agitation.

The changes were considered to range in pathological intensity, or degree of abnormality, from mild to severe (See Table 2).

	Depth of depression			
Clinical feature	*None* (%)	*Mild* (%)	*Moderate* (%)	*Severe* (%)
Sad facies	18	72	94	98
Stooped posture	6	32	70	87
Crying in interview	3	11	29	28
Speech: slow, etc.	25	53	72	75
Low mood	16	72	94	94
Diurnal variation of mood	6	13	37	37
Suicidal wishes	13	47	73	94
Indecisiveness	18	42	68	83
Hopelessness	14	58	85	86
Feeling inadequate	25	56	75	90
Conscious guilt	27	46	64	60
Loss of interest	14	56	83	92
Loss of motivation	23	54	88	88
Fatigability	39	62	89	84
Sleep disturbance	31	55	73	88
Loss of appetite	17	33	61	88
Constipation	19	26	38	52

Table 2: Frequency of Clinical Features of Patients Varying in Depth of Depression (n = 486) (Beck, 1967, page 40)

Depressive disorders are considered to have usually a well-defined onset, a progression in symptom severity until a bottom level has been reached, and then a steady improvement until the episode is over; remissions are typically spontaneous and free of depressive symptoms; and there is a tendency for the disorder to

recur (Beck, 1967).

Depression may occur as a primary disorder in a healthy individual, or in one whose previous episodes of psychiatric illness have been depression or mania, irrespective of the presence or apparent absence of life stress. Depression may occur secondarily to other psychiatric disorders such as schizophrenia, neurosis and personality disorder, and to a wide range of non-psychiatric illnesses such as viral infections, nutritional deficiencies, endocrine disorders, anaemias, central nervous disorders such as multiple sclerosis, tumours and cerebral vascular disease. Depression may in addition be secondarily induced by drugs such as reserpine (See Table 3).

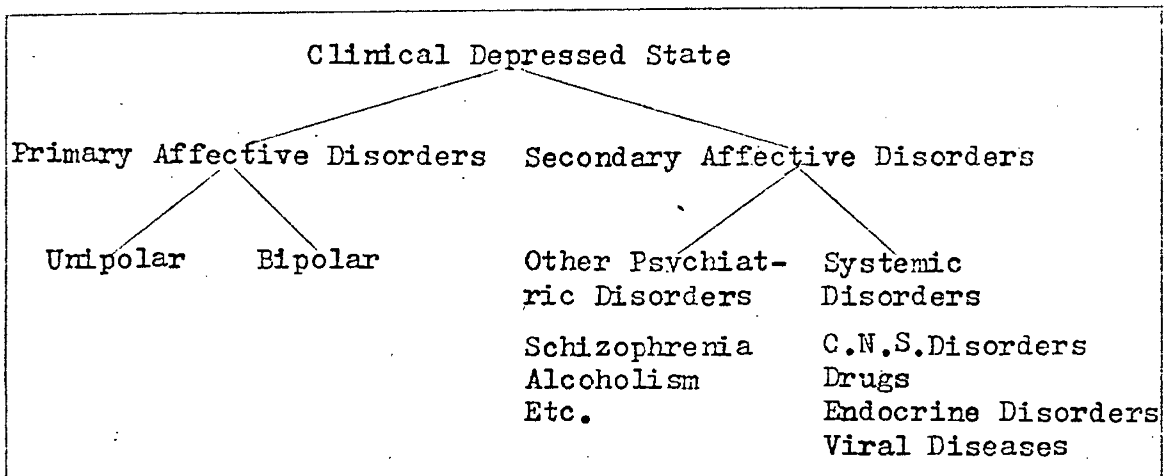

Table 3: Nosology of Depression (From Robins and Guze, 1972)

3.1.3 Depression as a Disease Entity

Depression may be a discrete nosological entity, which, in addition to having a characteristic cluster of signs and symptoms, has a specifiable type of onset, course and prognosis. Whether depressive disorder may be a disease entity is controversial. At present, depression tends to be viewed as a heterogenous group of symptom complexes that are classified as syndromes, rather than as a single disease entity (Freedman, Kaplan and Sadock, 1976).

3.1.4 Summary of Semantics of Depression

The term 'depression may have at least three different but overlapping clinical meanings:

1. Depression may denote an affective state characterised by feelings of unhappiness, dejection or dysphoria.
2. Depression may denote a syndrome, consisting of a characteristic cluster of signs and symptoms, that exists as a primary disorder, or is secondary to another psychiatric or physical disorder.
3. Depression may denote a discrete nosological entity which, in addition to consisting of a characteristic cluster of signs and symptoms, has a specifiable type of onset, course and prognosis.

The validity of considering depressive disorder to be a disease entity has been questioned, and the tendency at present is to classify it as a syndrome.

3.2 NORMAL DEPRESSION VERSUS DEPRESSIVE ILLNESS

Although there is reasonable agreement about what constitutes depressive disorder, there is no clear dividing line between so-called normal depression and pathological depression. Because of this phenomenon, different views have been advanced regarding the nature of depressive disorder in relation to normal depression.

The continuity hypothesis proposed clinical depression to be an exaggeration of normal low mood. This view, favoured by the psychobiological school of Adolph Meyer, was based on the observation that clinically depressed individuals resembled normal people who had suffered a major setback or a bereavement. Both groups looked sad, spoke in low voices, used the same words to describe how they felt, and might experience sleeplessness, appetite loss and fatigability. Furthermore, individuals who had never been depressed, might suffer the type of mood fluctuations, seemingly independent of environmental stimuli, that were usually associated with clinical depression (Wessman and Rick, 1966).

In contrast to the concept of continuity between normal mood and depressive disorder, Kraepelin and his followers proposed clinical depression to be a disease that was distinct from normal mood. It was argued that although depressive disorder might appear

to be on a continuum withnormal depressive mood, deviations in mood were produced by underlying disease processes in a manner analogous to high body temperature (which is on a continuum with normal temperature) being produced by underlying disease factors (that are not on a continuum with normal health). Associated with the concept of depressive disorder being a disease was the assumption of associated biochemical pathology.

Although there is considerable evidence that biochemical changes are associated with depressive disorder (see Section 2.6), there is as yet no conclusive evidence relating such changes to clinical depression. The relationship between so-called normal depression and depressive disorder remains unresolved.

3.2.1 Summary of Normal Depression versus Depressive Illness

There is uncertainty as to whether depressive disorder is an exaggeration of so-called normal depression or whether it is qualitatively different. Similarities between people who are grieving and people who are clinically depressed support the former view. More intensive investigations have suggested depressive mood to be qualitatively different from depressive disorder.

3.3 DIMENSIONS OF DEPRESSION

The manifestation of depressive disorder in several reasonably distinctive patterns has led clinicians to attempt to sub-classify it in different ways. Manic depressive - Psychogenic, Neurotic - Psychotic, Endogenous - Reactive and Unipolar - Bipolar dichotomies of depression have been proposed.

3.3.1 Manic Depressive Depression - Psychogenic Depression

The Kraepelinian formulation stipulated two types of depression: manic-depressive depression and psychogenic depression. The former assumed psychotic proportions, seemed to be unrelated to environment, and was thought to be rooted in heredity, constitution

or metabolism. Psychogenic depression was an extreme reaction, in terms of intensity and duration, to events in the patient's life, and usually remained on a neurotic level. The current trend is towards relabelling manic-depressive depression, that has been associated with manic episodes, bipolar depression.

3.3.2 Psychotic Depression - Neurotic Depression

The psychotic - neurotic dichotomy of depression, for many years a major issue, has recently lost its importance since Kendell (1968), in a carefully controlled study, failed to separate the psychotic group of depressed patients from the neurotic group of depressed patients. Kendell (1976) proposed a psychotic - neurotic continuum to be a convenient mode of conceptualising the apparent lack of boundary between psychotic and neurotic depressions. Foulds (1973) proposed the relationship between psychotic depression and neurotic depression to be hierarchical, with psychotic depression including neurotic depressive symptoms, and neurotic depression diagnosed by exclusion of psychotic depressive symptoms. The designations 'psychotic depression' and 'neurotic depression' continue to be used in a descriptive capacity, and are generally synonymous with the designations of 'severe depression' and 'mild depression' (Kendell, 1976).

3.3.3 Endogenous Depression - Reactive Depression

The endogenous - reactive dichotomy of depression, originally considered to represent distinct groups of constitutionally and environmentally caused depression, has become blurred. The majority of depressive illnesses have been preceded by stressful events of some kind, with little relationship between the kind or severity of preceding stresses and the symptomatology of the illness. The aetiological role of stressful events seems to be one of degree rather than of presence or absence of stress (Angst, 1966, 1974; Perris, 1967; Paykel, 1974). Angst suggested the endogenous-reactive differentiation to represent a continuum rather than a dichotomy dividing patients into relatively clear-cut groups, with

most patients near the middle of the continuum and few at the extremes.

3.3.4 Unipolar Depression - Bipolar Depression

The unipolar - bipolar dimension of depression, proposed by Leonard (1962) and supported by the research of Perris (1966), Angst (1966) and Winokur et al. (1969), has gained rapid acceptance. This dimension separates patients with depressive episodes associated with manic episodes, or with a family history of mania, from those patients who have had only depressive episodes. The unipolar-bipolar dimension has been supported by genetic studies and pharmocological studies of responses to psychotropic drugs, especially lithium. At present there is controversy whether all depressions that are not associated with mania should be regarded as unipolar depressions (Kendell, 1976).

3.3.5 Current Status of Depression

Depression is generally regarded as being a heterogenous group of syndromes resulting from interaction of biological, genetic, psychological and cultural factors (Lewis, 1938; Perris, 1966; d'Elia and Perris, 1972; Angst, 1974; Akiskal and McKinney, 1975; Kendell, 1976; Depue and Monroe, 1978). The multifactorial causation is considered to have implications for symptomatology, in that some depressions may present with predominantly depressed mood, or a high level of anxiety, or prominently apathetic mood and diminished drive (Kielholtz, 1972).

Depressions are considered to present in varying degrees of mild, moderate and severe depression. Severe depressions characteristically have diurnal variations of mood, feelings of guilt, retardation or agitation, suicidal ideation, insomnia, loss of weight and possibly loss of contact with reality, whereas mild mild depressions are prone to fluctuate from day to day and lack the characteristic features of severe depressions (Kendell, 1976; see Table 4). While severity of depression has implications for treatment, suicide risk and possibly prognosis, the distinction between mild, moderate and severe depressions remain far from

clear-cut. In general severe depressions include those depressions previously designated 'endogenous', 'psychotic' and 'manic-depressive, regardless of whether there is a precipitating factor, whereas mild depressions are associated with depressions previously designated 'reactive', 'neurotic' and 'psychogenic'.

Symptom	Severe Depression	Mild Depression
Mood	Shift to depression is marked, usually worse in the morning.	Mood is less severely depressed, fluctuates, worsens, if at all, in the evenings and when alone.
Psychomotor Retardation	Marked; expresses itself by general slowing of thinking and activity.	Not marked at all.
Agitation, Anxiety, Irritation.	Agitation is usually present.	Anxiety and irritability are often present. Fears are common.
Feelings of Inferiority, Uselessness, Hopelessness.	Markedly present but disappear with lifting of depression.	Not so pronounced but often other variations in the personality after recovery.
Delusions of Self-reproach and Guilt.	May be marked.	Usually not present. May blame other people.
Insomnia	Marked, characterised by early morning awakening.	Marked, characterised by difficulty falling asleep and disturbances.
Appetite and Weight	Severely affected.	Usually little change.
Libido	Can be lost completely or partially.	Usually little affected.
Energy	Markedly reduced.	Variably reduced.
Bodily pain	Present - clears up with lifting of depression.	Present - may clear up or persist.

Table 4: Characteristics of Depression. (cf. Table 2, page 28)

3.3.6 Summary of Dimensions of Depression

Based on the clinical observation of patients, clinicians have attempted to sub-classify depression into dichotomies of:

1. Manic-depressive depression - psychogenic depression;
2. Psychotic depression - neurotic depression;
3. Endogenous depression - reactive depression;
4. Unipolar depression - bipolar depression.

Recent research has cast doubt on the validity of all but the unipolar - bipolar depressive dichotomies. There has been a trend towards using the categories in the capacity of descriptive dimensions of depression.

Depressions designated mild, severe and depressed, tend to manifest qualitative in addition to quantitative differences. Whether mild and severe depressions may most approriately be conceptualised as forming a continuum (Kendell, 1976), or whether they are more approriately conceptualised in a hierarchical fashion with severe depression including the features of mild depression (Foulds, 1973), is uncertain. In general severe depressions include depressions previously designated manic depressive, psychotic or endogenous, and mild depressions include depressions previously designated psychogenic, neourotic or reactive.

3.4 CLASSIFICATION OF DEPRESSION

Classification of depressive disorder is problematic in that the major classificatory systems do not provide categories that correspond with the findings of recent research.

Diagnostic and Statistical Manual (DSM-2) of the American Psychiatric Association (1968), provided the following categories for classification of depression: Involutional Melancholia; Manic-depressive illness, depressed; Manic-depressive illness, circular; Manic-depressive illness, circular, depressed; Other major affective disorder; Psychotic depressive reaction; Depressive neuroses; and Cyclothymic personality disorder. There is no provision for classification of depression in children.

International Classification of Diseases (ICD-9) of the World Health Organization (1975) provided for the clasiffication of depression in the following categories: Depressive-type affective disorder; Cyclical depressive affective disorder; Cyclical mixed affective disorder; Depressive type non-organic reaction; Neurotic depression; Affective (cyclothymic) personality disorder; Acute depressive reaction (grief); Prolonged depressive reaction; Depressive disorder unspecified; and Disturbance of emotions in childhood/adolescence with misery.

Tri-axial Classification of Mental Disorders in Childhood (Rutter et al., 1969), provided for depressive disorder to be classified under Neurotic disorder, depressive states.

Clearly the listed categories do not correspond with research findings. The findings of recent research indicated tentative validity for the unipolar - bipolar depressive distinction, but failed to differentiate significantly between psychotic - neurotic and endogenous - reactive depressive dichotomies.

3.4.1 Summary of Classification of Depression

Research has cast doubt on the validity of categories for the classification of depressive disorders offered by the DSM-2, ICD-9 and Tri-axial classificatory systems.

3.5 EPIDEMIOLOGY OF DEPRESSION

Epidemiology of depression is confusing in that surveys of depression have not studied the same thing in the same way: some surveys have included mixed anxiety-depression states, some have not; some have used clinical diagnoses, some have used rating scales; some have surveyed only patients in treatment, some have been community surveys with considerable variation in the intensity of the search for cases.

The prevalence of depressive disorders (the proportion of cases in a given population on a given date) has been estimated to range between 0,4 and 10,4 per thousand for psychotic depression,

and to range between 1,4 and 26,5 per 1000 for neurotic depression (Silverman, 1968).

The incidence of depression (number of new cases) has been assessed from community incidence surveys and admission for treatment. Surveys of the incidence of depression in Sweden (Essen-Möller, 1961; Hagnell, 1966) estimated an incidence of depressive disorder in 1 percent of men and 3 percent of women. Translated into individual risk, the probability for a person to develop depressive disorder at least once, provided he or she lived to a certain age, was estimated as 7,8 percent for males and 20 percent for females (ibid.). In terms of admission for treatment, depressive disorder was diagnosed in 15 percent of psychiatric referrals in the United States of America (Redick, 1974).

3.5.1 Summary of Epidemiology of Depression

Information concerning the epidemiology of depression is uncertain. However, depressive disorder appears to manifest in a mild form (neurotic) more frequently than in a severe form (psychotic), and it has been found to present more frequently in women than in men. In the United States, 15 percent of psychiatric referrals were diagnosed to be suffering from depressive disorder (Rednick, 1974).

3.6 AETIOLOGY OF DEPRESSION

Although there is uncertainty regarding the causation of depression, depression is generally considered to result from an interaction of predisposing and precipitating factors:

1. Genetic factors may predispose an individual to depression. Genetic vulnerability has been associated strongly with bipolar depression, and to a lesser extent with unipolar depression. (See Section 2.6.1)
2. Biological factors may predispose an individual to depression. (See Sections 2.2 and 2.6) Such factors may or may not be associated with genetic factors.

3. Developmental events, for example, in the mother-child relationship during infancy, have theoretically been associated with vulnerability to depressive disorder (See Section 2.1). Loss of a parent during childhood, although not strongly associated with contingent depression, has been associated significantly with depression in later life (Brown, 1966; Beck, 1967).
4. Physiological stressors, such as viral infections, childbirth, reserpine and hypothyroidism may contribute to the precipitation of depressive disorder (Slater and Roth, 1969).
5. Psychosocial events, such as bereavement, economic upheavals and life changes that overwhelm the coping mechanisms of the individual, may precipitate depressive disorder in predisposed individuals. (Schmale, 1974; See Chapter 2)
6. Personality traits may determine or modify the reactivity of the organism to stress, including the stress of being depressed (Akiskal and McKinney, 1975).

Akiskal and McKinney (1975) have proposed that 'depressive illness, as a final common pathway, is the culmination of various processes that conceivably converge in those areas of the diencephalon that modulate arousal, mood, motivation, and psychomotor function.' (page, 290) The specific form that the syndrome would take was considered to depend on the interaction of predisposing and precipitating factors in a given individual.

3.6.1 Summary of Aetiology of Depression

The aetiology of depression is uncertain. However, it is considered to result from an interaction of genetic, biological, developmental physiological, psychosocial and personality factors. The specific form of the syndrome is considered to depend on the interaction of predisposing and precipitating factors in a given individual.

3.7 DIAGNOSIS OF DEPRESSION

There are no clear criteria for differentiating between normal mood and abnormal depression; the boundary between the two states is undefined. (See Section 3.2)

In clinical practice criteria of intensity, duration, precipitating event, previous episodes of depression, and the quality of psychopathological features are used in the diagnosis of depression. Symptoms of depressive feelings or apathy, feelings of worthlessness, guilt, hopelessness, helplessness, anxiety, crying, suicidal tendencies, loss of interest in work and other activities, impaired concentration, impaired capacity to function socially, appetite and weight loss, sleep disturbance, constipation, psychomotor retardation or agitation, headache, and other complaints may be presented. Not all patients have all the symptoms and there is much individual variability.

Certain symptoms, such as early morning awakening, diurnal mood fluctuation with feeling worse in the morning, weight loss, feelings of guilt, rumination and suicidal tendencies, hallucinations and delusions, are associated with severe depression, while symptoms such as difficulty in falling asleep at night, feeling worse in the evenings and blaming others, are associated with mild depression. (See Table 4, page 34)

Rating scales, such as the Hamilton Rating Scale and the Zung Self-Rating Depression Scale, have been designed for evaluating depression more precisely. The Beck Depressive Inventory (Beck, 1967) employs twenty-one categories of symptoms and attitudes for assessing severity of depression. The categories are Mood, Pessimism, Sense of failure, Lack of satisfaction, Guilty feeling, Sense of punishment, Self-dislike, Self-accusations, Suicidal wishes, Crying spells, Irritability, Social withdrawal, Indecisiveness, Distortion of body image, Work inhibition, Sleep disturbance, Fatigability, Loss of appetite, Weight loss, Somatic preoccupation, and Loss of libido.

Feighner and associates (1972) proposed the following criteria for diagnosing depression, all of which should be fulfilled for a diagnosis of depression to be made (page 58):

"A. Dysphoric mood characterised by symptoms such as the following: depressed, sad, blue, despondent, hopeless, 'down in the dumps', irritable, fearful, worried or discouraged.

B. At least five of the following criteria are required for 'definite' depression; four are required for 'probable' depression.
(1) Poor appetite or weight loss (positive if 2 lb a week or 10 lb or more a year when not dieting).
(2) Sleep difficulty (including insomnia or hypersomnia).
(3) Loss of energy, eg, fatigability, tiredness.
(4) Agitation or retardation.
(5) Loss of interest in usual activities, or decrease in sexual drive.
(6) Feelings of self-reproach or guilt (either may be delusional).
(7) Complaints of or actual diminished ability to think or concentrate, such as slow thinking or mixed up thoughts.
(8) Recurrent thoughts of death or suicide, including thoughts of wishing to be dead.

C. A psychiatric illness lasting at least a month with no preexisting psychiatric conditions such as schizophrenia, anxiety neurosis, phobic neurosis, obsessive compulsive neurosis, hysteria, alcoholism, drug dependency, anti-social personality, homosexuality and other sexual deviations, mental retardation, or organic brain syndrome. (Patients with life-threatening or incapacitating medical illness preceding and paralleling the depression do not receive the diagnosis of primary depression).

.....

Secondary depression 'definite' or 'probable' is defined in the same way as primary depression, except that it occurs with one of the following:
(1) A preexisting non-affective psychiatric illness which may or may not still be present.
(2) A life-long threatening or incapacitating medical illness which precedes and parallels the symptoms of depression."

While Feighner and associate's scheme has the advantage of providing unambiguous criteria for the diagnosis of depression, its usefulness will depend on it being incorporated into an accepted classification scheme; this has not as yet taken place. (cf. Research Diagnostic Criteria of Spitzer, Endicott and Robins, 1975.)

3.7.1 Summary of Diagnosis of Depression

There are at present no defining criteria for the diagnosis of depression. In clinical practice, diagnosis of depression is usually based on the presence of characteristic symptom patterns and the history of the patient. Rating Scales have been designed for more precise diagnosis of depression and assessment of severity of

depression. Schemes listing criteria for diagnosis of depression have been formulated.

3.8 MASKED DEPRESSION

Depression may present first at a surgeon's or internist's office for 'the relief of bodily ailments'(Ziegler, 1939). Slater and Roth (1969) advised that if somatic ailments 'occur periodically and have an effect on the patient's well-being exceeding by far the objective findings, affective disorder should be suspected as the underlying cause of the physical disability and psychiatric treatment instituted' (page 219). It seems that most depressive patients have physical complaints (Kenyon, 1978), and it has been suggested that whereas in normal emotional states bodily feelings may be relatively unimportant, in morbid emotional states bodily feelings may so predominate that they become the sole manifestation of mood change (Tyrer, 1973).

In addition to underlying hypochondriacal and psychosomatic disorders, it has been proposed that depression may underly various behaviour patterns such as alcoholism, drug addiction, learning disorders, bulimia, accident-pronenessm, sexual problems and rage responses (Lesse, 1974).

Atypical depressions, in which depressive affect is not immediately apparent have been termed 'masked depression', 'hidden depression', 'missed depression', 'depression sine depressione', 'latent depression', 'underground depression', 'depressive equivalent' and 'affective equivalent', by various writers (López Ibor, 1972). The depressive or affective 'mask' usually refers to the predominand symptom that precipitated referral. While certain clinicians have considered such depressive states to constitute qualitatively different entities from more overtly depressive states (Kielholtz, 1973; Lesse, 1974), other clinicians have argued that the concept of 'masked depression' as a depressive entity has little validity (Werry, 1976; Kovacs and Beck, 1977); Pearce (1977) pointed out that the term is confusing in that it implies depressive symptomatology in the absence of depressive affect, whereas evidence of

lowered mood may invariably be elicited.

It has been proposed that defence mechanisms may be used as an unconscious means of overcoming the passive experience of helplessness in the face of frustration or disappointment (Anthony, 1975). For depression, 'with its core feelings of unworthiness and helplessness', regression was considered to be the defence mechanism of choice; obsessive-compulsive reaction was thought to be able to compensate marginally for loss of self-esteem; other defence mechanisms suggested were reversal of affect, characterised by excitement, clowning and aggressive behaviour, identification with the idealised object, acting out in the form of delinquency, and hypochondriasis (ibid.).

While it is accepted that unconscious defences may be used against depressive feelings in a manner analogous to that in which unconscious defences are used against feelings of anxiety, it is considered that parsimony should be used in interpreting behaviour: aggressive behaviour and delinquency are more likely to be related to aggressive affect, or feelings of anger and resentment than to feelings of depression; angry people, or people who have been contravening social mores,are more likely to be depressed as a consequence of alienating other people, than their behaviour is likely to be a consequence of inferred underlying depression.

Regardless of how depression may present, it is considered that for depressive disorder to be diagnosed, evidence of lowered mood, with associated signs and symptoms should be present. (See Section 3.7)

3.8.1 Summary of Masked Depression

It has been proposed that depressive disorders may be masked by somatic symptoms, hypochondriasis or behavioural problems; that such depressions might constitute different entities from overtly depressed states. Because so-called 'masked' depressions invariably manifest lowered mood and depressive symptomatology, and overt depressions are frequently associated with physical complaints, the distinction is considered to be invalid.

3.9 TREATMENT OF DEPRESSION

Treatment of depression is related to the nature of the signs and symptoms, the severity of the disorder, and physical, psychological and environmental factors that might have been associated with the aetiology of the depressive disorder. Consequently, treatment commences with a physical examination and the taking of a psychiatric history. In cases of severe or moderate depression, where there is a risk of the patient committing suicide, or where the patient does not have a supportive home environment, hospitalization may be indicated.

Moderate depressions usually respond fairly rapidly to tricyclic or monoamine oxidase inhibitor antidepressant medication. In cases of severe depression, particularly where there is a risk of suicide, some authorities consider electroconvulsant therapy to be the treatment of choice (Shaw, 1977). In the case of mild depression, where response to antidepressant medication frequently does not occur, psychotherapy may be the only useful form of treatment.

Initial psychotherapy with severely or moderately depressed patients, should generally be of a supportive nature. With recovery, or in the case of mildly depressed patients, psychotherapy requires to be directed towards resolving psychological conflicts, modifying problematic ways of behaving or rectifying faulty cognitions that might be associated with maintaining or predisposing the patient to depressive disorder.

In cases of recurrent bipolar and unipolar depressions, maintenance lithium medication may be indicated, and in the case of unipolar recurrent depressions, antidepressant maintenance medication may be effective in reducing attacks (Angst et al., 1970; Shaw, 1977).

3.9.1 Summary of Treatment of Depression

Treatment of depressive disorder includes psychotherapy, antidepressant medication and electroconvulsant therapy, depending on the nature and severity of the disorder. Precautions require to be taken against the danger of suicide by depressed patients.

3.10 PROGNOSIS OF DEPRESSION

The following conclusions concerning the prognosis of depressive disorder were reached by Beck (1967) after an extensive survey of the literature:

1. Complete recovery from an episode of depressive illness occurred in 70 - 95 percent of cases. About 95 percent of the younger patients recovered completely.
2. The median duration of an episode was approximately 6,3 months among inpatients, and approximately 3 months among outpatients, the latter group generally comprising milder cases.
3. Initial episodes in patients under the age of 30 tended to be shorter than initial episodes occurring after age 30. Acute onset favoured shorter duration.
4. After an initial attack of depression, 47 - 79 percent of patients tended to have a recurrence at some time in their lives.
5. The probability of frequent recurrences were greater in bipolar depressive disorders than in unipolar depressive disorders.
6. After the first attack of depression, most patients had a symptom-free interval for more than three years.
7. Although the duration of particular episodes remained approximately the same, the symptom-free interval tended to decrease with each successive attack.
8. About 5 percent of hospitalised patients subsequently committed suicide. Suicide risk was greatest during weekend leaves from the hospital, during the month following hospitalization, and remained high for six months after discharge.
9. A proportion of patients (1/6 - 1/3) gained very little relief from their symptoms. The clinical course might be characterised by continuing social and psychological disability, punctuated by frequent and prolonged admissions to hospital (Toone and Ron, 1977).

3.10.1 Summary of Prognosis of Depression

Complete recovery from depressive disorder occurs in the majority of cases. Depressive disorder tends to recur, and in

certain predisposed individuals, intervals between successive attacks diminish with increasing age. In a minority of cases there is a poor prognosis, with minimal relief from symptoms, and frequent, prolonged hospitalizations. Suicide occurs in about 5 percent of hospitalised patients.

3.11 CONCLUSIONS CONCERNING DEPRESSION AS A CLINICAL DISORDER

Depression has been delineated as a clinical syndrome, associated with lowered mood, and manifesting attitudinal, motivational, behavioural and vegetative changes. Symptomatology includes depressive feelings or apathy, feelings of incompetence, worthlessness, guilt, hopelessness, helplessness, anxiety, crying, suicidal tendencies, loss of interest in work and other activities, impaired capacity to function socially, appetite and weight loss, sleep disturbance, constipation, psychomotor retardation or agitation and physical complaints. Not all patients have all the symptoms, and there is much individual variability.

Depressive disorder may present in a severe form or in a mild form. Symptoms such as early morning awakening, diurnal mood fluctuation with exacerbation of mood in the morning, weight loss, feelings of guilt, ruminations, suicidal tendencies, hallucinations and delusions may colour the severely depressive picture, whereas symptoms such as difficulty in falling asleep at night, exacerbation of mood in the evening, and lifting of mood in some situations, are more likely to be associated with mild depressions. Differences between severe and mild depressions are qualitative and quantitative. Mild depression may appear to merge with 'normal' depressive mood, but differs in not being able to be related realistically to environmental events or physical changes in the individual.

Depression may be a primary disorder, or it may be secondary to another psychiatric or physical disorder.

If depression is a primary disorder, it may be unipolar, with only depressive episodes, or it may be bipolar with depressive and manic episodes.

Onset of depression is considered to be multifactorially

determined by an interaction of genetic, biological, psychological, and environmental factors, which colour the depressive picture in a particular individual.

Treatment may be in the form of medication, physical treatment, and/or psychotherapy, depending on the nature and severity of the depression.

Response to treatment of depressive episodes is usually good. However the disorder, particularly bipolar depression, tends to recur. Furthermore, a percentage of depressed patients commit suicide.

Depression as a clinical syndrome is characterised by dysphoric or apathetic mood, cessation of active coping with the environment and withdrawal of emotional concern into the self. In this respect it corresponds with the picture of depression delineated from psychological concepts of depression in the previous chapter. But this consensually accepted depressive core has considerable diversification.

Depression is clearly a heterogenous disorder. Aside from the unipolar - bipolar dichotomy, depressive severity is associated with qualitatively different symptomatologies, with implications for treatment and prognosis. Depressive disorder is frequently described in terms of the severe or moderate condition, yet mild depression occurs far more frequently (Silverman, 1968). Mild depression cannot be considered as a discrete condition in that it frequently develops into moderate or severe depression.

Because of these factors, precise delineation of the symptomatology, course, treatment and prognosis of clinical depression as a unitary disorder, is not possible.

4

DESCRIPTION OF CHILDHOOD DEPRESSION

Depression in childhood has been a controversial subject in clinical and theoretical circles. Clinicians who looked for the adult condition in children did not find it. Psychoanalysts disclaimed the possibility of depression in children on theoretical grounds. During the past decade a substantial body of clinicians have testified convincingly to the existence of a syndromal depressive disorder in children.

The area of childhood depression has not been satisfactorily elaborated, and there is little agreement on what constitutes the condition. In this chapter an examination will be made of literature covering empirical and clinical investigations of depression in children with the aim of finding recurring signs and symptoms that can be grouped together so as to delineate a composite picture of childhood depressive disorder.

Because depression is inferred largely from behaviour, and behaviour changes with developmental stage, depression in children will be surveyed in maturational stages of infancy, latency and adolescence. Case studies illustrating depression in childhood are included in the Appendix.

4.1 DEPRESSION IN INFANT CHILDREN

The infant is characterised by his self-centeredness. The younger he is, the more he is aware only of his own needs and wants. He has a strong need to be nurtured. In the first two years the mother provides the adaptive, regulating activities for the child that the child's own ego provides at a later age (Solnit, 1960). If during the first two years the mother is absent, the main ego support is removed and the child feels overwhelmed by anxiety and depression at being abandomed. The most important predisposing factor to the development of depressive disorder in the infant is therefore, separation from the mother.

Seminal work in the area of infant depressive reactions subsequent to maternal separation was performed by René Spitz and John Bowlby.

4.1.1 <u>The Work of Spitz</u>

Spitz (1946) documented a syndrome which he had observed in a long term study of 123 unselected infants, aged 14 days - 18 months, in a state nursery. Nineteen of the infants had developed the full syndrome and 26 had developed, to a lesser extent, some of the symptoms. Spitz described the syndrome, which he called Anaclitic Depression, in the following way (page 229):

> 'Apprehension, sadness, weepiness.
> Lack of contact, rejection of environment, withdrawal.
> Retardation of development, retardation of reaction to stimuli, slowness of movement, dejection, stupor.
> Loss of appetite, refusal to eat, loss of weight.
> Insomnia.
> To this symptomatology should be added the psysiognomic expression in these cases, which is difficult to describe. This expression would in an adult be described as depression.'

Anaclitic depression was observed in some children who had been separated from their mothers during the second half of their first year. The syndrome did not appear to be associated with race, sex, intelligence, developmental level or chronological age, provided the child was over six months of age. The syndrome appeared to be associated with the mother-child relationship, in that where the relationship had been good, it occurred more readily and more severely, and where poor or bad, it was less likely to occur, and to occur in a weaker form. Occurrence of the syndrome and its intensity, also appeared to be related to the personality of the mother-surrogate that the child received in the nursery, and the quality of her relationship with the child, as compared with the quality of the relationship it had with its mother.

Development of anaclitic depression was described in three stages:

1. Children who had previously been happy would become apprehensive, sad and weepy. The child would seek to attract attention and to make contact. This contact would lead to clinging, and disappointment when contact was terminated.

2. Weepiness would give way to withdrawal, with the child lying in its cot with averted face. Approach by an observer would be ignored, and contact would provoke weeping or screaming. The children tended to lose weight, and some suffered from insomnia. There would be greater susceptibility to colds ro eczema. A gradual decline would take place in their developmental quotients. This stage lasted about three months.

3. The children would withdraw further. It would become difficult to provoke any reaction, even weeping. They would have a 'sort of frozen rigidity of expression' and would be out of contact with the environment. In some cases there would be 'autoerotic activities in the oral, anal and genital zones'.

The syndrome could be 'dramatically reversed' by returning the mother to the child within three months of separation.

After a certain length of separation from the mother, beyond a certain level of deterioration, what Spitz considered to be a 'critical point of development', the condition became irreversible.

In foundling home infants, where permanent separation from the mother took place, usually during the infant's sixth month of life, no intervention was eventually effective in reversing the syndrome. Moreover, in addition to stuperous withdrawal, the foundling children became inordinately vulnerable to death. Although conditions in the Foundling Home were satisfactorily hygienic and aseptic, 34 of the 91 infants observed during the course of two years died of illnesses varying from respiratory and intestinal infections to measles and otitis media (Spitz, 1945).

Spitz attributed onset of Anaclitic Depression to loss of the infant's 'love object' in the person of the mother. He considered a secondary, interactory factor to lie in confining the infant to its cot, which inhibited it from actively seeking a substitute 'love object'. Prophylaxis and treatment was considered to lie in not separating the child from its mother. Where separation was inevitable, it was proposed that a suitable mother-substitute should be provided, and that the child should not be confined to its cot, but should be allowed to move around freely.

Spitz (1946) did not consider Anaclitic Depression to be

identical to adult depression in that in terms of classical psychoanalytic theory, depression presupposes a certain level of personality development (See Section 2.1.1).

4.1.2 The Work of Bowlby

John Bowlby (1952, 1965) made an extensive, world-wide survey of 'children who are orphaned or separated from their families for other reasons and need care in foster-homes, institutions or other type of group care, for the World Health Organization. Bowlby studied the reaction to separation by young children. He described the reaction as occurring in three consecutive phases, which he termed 'protest', 'despair', and 'detachment'. Bowlby considered this process to constitute mourning the mother-figure, after the child had bonded with her during the middle of the first year of life.

1. During the phase of protest, lasting about three days, the child would cry for its mother and search for her. It would cling to toys it might have brought from home.

2. During the phase of despair, the child's active behaviour would diminish and it might cry monotonously or intermittently. It would be withdrawn, inactive, and appeared to be mourning. It would resist being dressed, fed, toileted, and refuse comfort from the nurses.

3. During the phase of detachment, the child's resistance to its new caretakers would begin to decrease. Help would be accepted, and the child would begin to smile and be sociable. It would lose interest in the toy brought from home and might discard it. Aggressiveness might increase towards the toy brought from home or towards other children. Detachment would be most evident when the child was visited by his family, or when he returned home. He might act as if he hardly knew his parents. After briefer separations, detachment would give way after a few hours or a few days, and would frequently be followed by a phase during which the child would show ambivalence towards his parents, demanding their presence and crying if left, but behaving aggressively towards them.

Bowlby considered that once the third stage had been reached,

the child would have become vulnerable, in that he would be likely to react abnormally to future disappointments or loss of a loved person.

Bowlby considered the period of 'protest' to coincide with yearning, and angry efforts to recover the 'love object'; and he considered the stage of 'despair' to conincide with withdrawal of emotional concern from the 'loved object' in preparation for establishing a relationship with a new one. 'Loss of loved object gives rise not only to an intensified desire for reunion but to hatred of the object, and, later, to detachment from it; it gives rise not only to a cry for help but to a rejection of those who respond to it.' (1968, page 278)

Bowlby (1965) proposed that reaction to separation was 'a form of depression having many of the hallmarks of the typical adult depressive patient in a mental hospital. The emotional tone is one of apprehension and sadness. The child withdraws himself from all that is around him, there is no attempt to contact a stranger and no brightening if this stranger contacts him. Activities are retarded and the child often sits or lies inert in a dazed stupor. Lack of sleep is common and lack of appetite universal. Weight is lost and the child easily catches infection. There is a sharp drop in general development.'(Page 27)

Like Spitz, Bowlby associated this disorder with the infant having previously had a good relationship with its mother, and separation taking place after about six months of age, without the provision of an adequately nurturant mother-substitute.

In a sample of ninety-five children who had been separated from their mothers during the second half of the first year of life, without the provision of an adequately nurturant mother -substitute, twenty percent were found to have reacted to separation with severe depression, twenty-seven percent with mild depression, and the remainder of the infants were apparently unaffected.

Bowlby considered a depressive response to separation from the mother-figure to be a 'normal response' for infants in the second half of the first year of life. (cf. Section 2.1.4)

4.1.3 Other Work in the Area of Infant Depression

The observations of Spitz and Bowlby regarding the occurrence of depressive-like states in many infants over six months of age, who had been placed in institutions such as nurseries or hospitals, have been supported by the research of Heinicke (1956), Heinicke and Westheimer (1966) and Schaffer (1959, 1971), among others. Whether similar states may occur in infants for reasons other than in response to separation from their families, has not to the knowledge of the author been investigated.

The age-related nature of the syndrome has been confirmed by the work of Schaffer (1959, 1971), who found that although babies under seven months of age might show disturbance when hospitalised, they did not fret, and they responded to both the nurses who cared for them and to their mothers at visiting times.

Prugh et al.(1953) demonstrated that no matter how excellent the medical and nursing care of children under four years of age in hospital and no matter how sensitive their handling from an emotional point of view, many of the children showed behavioural and emotional disturbances. However, there was less evidence of depression, withdrawal, eating and sleep disturbances, rocking and thumbsucking, when children were allowed to move about in the ward and were given a great deal of individual attention. When mothers were admitted to hospital with their children, there was evidence that the children could tolerate sickness, pain and frightening medical procedures without suffering the disturbances of children who were admitted alone (Wolff, 1973).

Wolff (1973) proposed that the age-linked nature of sensitivity to separation might be accounted for in the following way: At about six months of age children are considered to move from a state of 'adualism', in which they cannot distinguish between their inner and outer worlds, to a state of 'dualism', in which they become aware of people as objects, distinct from themselves. Memory traces are laid down, and they react to separation from their mothers and to reunion with them. However, because of their limited capacity to anticipate the future, and their almost non-existent understanding of verbal explanations until about four

years of age, temporary separation might evoke the same responses as permanent loss.

There has been controversy over the nature of the reaction of young children to separation: some authors have considered the reaction to represent depressive disorder (Bowlby, 1965, 1968), whereas other authors have argued, on theoretical grounds, that young children have not sufficiently elaborate psychological structures to mourn (Freud, 1960), or to suffer true depression (Spitz, 1946).

Pragmatically the condition satisfies the criteria for diagnosis of depressive disorder in adults (See Section 3.11). It is considered parsimonious to interpret the reaction of separated infants as being a manifestation of depressive disorder.

4.1.4 Summary of Depression in Infant Children

A depressive type of syndrome has been found to occur in some infants who were separated from their mothers[1] during the second half of the first year of life, and placed in institutions or hospitalised for extended lengths of time.

Stages of protest, characterised by weeping and searching for mother, followed by apathy, withdrawal, inward grief and despair, followed by a stage in which the child once more became responsive to others, appeared to have forgotton his mother, and no longer seemed to care, were described (Bowlby, 1952, 1965). An alternative outcome, consisting of intensified withdrawal, and exacerbation of symptoms such as depressive affect, weeping, apathy, retardation, loss of appetite, loss of weight, insomnia, and decrease in general development was also proposed (Spitz, 1945, 1946; Bowlby, 1952, 1965).

It was concluded that this syndrome in infants was analogous to depressive disorder in adults.

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[1] Discussion of what constitutes infant separation and maternal deprivation is beyond the scope of this dissertation. For a comprehensive survey of the area, see Rutter, 1972.

4.2 DEPRESSION IN LATENCY-AGE CHILDREN

Descriptions of depression in latency-age children can be divided arbitrarily into those in which depression is considered to be overt and similar to depression in adults, but with differences related to the developmental level of the child, those in which depression in children is considered to be overt but qualitatively different from depression in adults, and those in which depression in children is considered to be hidden or masked, and qualitatively different from depression in adults.

A selection of studies of depression in children, in which the manifestation of depression has been described, are reviewed below. Case Studies of depressed children are included in the Appendix.

5.2.1 Studies of Depression in Latency-Age Children

1. Harrington and Hassan (1958) described the signs and symptoms of a sample of seven girls, aged 8 - 11 years, whom they considered to be suffering from depression. Common characteristics were weeping, flatness of affect, loss of appetite and energy, somatic complaints, various problems in school adjustment, fears of death for self and parents, and self-depreciation. Associated with self-depreciation were excessively ingratiating behaviour and striving for recognition. Relationships with mothers were reported to have deteriorated, and to be characterised by clinging, alternating with unreasonable hostility; in some cases relationships with siblings, peers and school teachers were reported to have deteriorated too. Depressions had been preceded by disturbing events such as accidents or physical illness.

2. Agras (1959) studied a group of seven children, aged 6 - 12 years, who had presented with school phobia at the out-patient department of a Canadian children's hospital. All the children expressed fears of going to school. Six of the children had weeping bouts for no apparent reason, and manifested unhappy, miserable whiney behaviour. Three of the children were concerned with death, and one made suicidal gestures. The seventh child was

described as being inappropriately cheerful, hyperactive, and at times 'destructively hypermanic'. Five of the children had somatic symptoms such as stomach-ache, nausea, vomiting and headaches, typically occurring during the morning before school, and not over the weekend.

Agras considered the school phobia syndrome to have features in common with adult depressive disorder. This led Agras to theorise that school phobia might be one of the modes in which depression presented in children, and that such modes might be part of the development of depressive disorders in relation to maturation.

3. Toolan (1962, 1974) claimed that overt manifestations of depression, such as retardation of mental and physical activities, insomnia, feelings of depression, worthlessness and nihilism, and suicidal preoccupations, were rarely to be found in children. Instead, he proposed that depressed children manifested with 'depressive equivalents', related to the developmental level of the child. He considered the following symptoms to be expressions of depression at different age levels:
Infants: sleep and eating disorders, colic, crying, head-banging;
Pre-school children: withdrawal, apathy, regression;
Latency-age children: behavioural symptoms such as temper tantrums, disobedience, truancy, running away from home, accident proneness, masochism, self-destructive behaviour, boredom, restlessness, low self-esteem, inferiority feelings.

Toolan considered depressive feelings in children to be displaced into behavioural problems; feelings of being bad, evil and unacceptable' led to antisocial acts. He argued that behavioural symptoms 'should be considered as evidence of depression', and that underlying depressive themes would be reflected in themes of fantasies, dreams and responses to projective tests.

4. Sandler and Joffe (1965) studied the case histories of 100 children seen at a British child-therapy clinic. They found that a significant number of children of all ages had suffered a depressive reaction to a wide range of internal and external events

involving loss of a state of well-being. (See Section 2.1.5) They described the children as looking sad or depressed, being withdrawn, apathetic, uninterested in anything, disatisfied, discontented, appearing to feel unloved but not accepting comfort, having insomnia, and performing autoerotic and other repetitive activities.

Sandler and Joffe considered depressive reactions in children to show some of the qualities, such as helplessness, passively resigned behaviour and inhibition of functions, seen in most adult depressive reactions, and mingled with it attempts, such as clowning, to deal with the existence of depressive affect, or to prevent its emergence.

5. Glaser (1967) considered depressive disorder in children to be qualitatively different from depression in adults, and to be 'masked' by symptoms not usually associated with depression. Underlying 'masking' symptoms would be depressive elements such as feelings of inadequacy, low self-esteem, helplessness, hopelessness, isolation and rejection by others, that did not correspond with the child's life situation. Such feelings might be expressed by the child, or assessed by the clinician during an interview with the child.

Glaser held a developmental view of depression, considering that manifestation would be related to the maturational level of the child. In infants and small children he considered depression to present in the form described by Spitz (1946) and Bowlby (1952). In latency-age children and adolescents he considered underlying depression to be masked by:

1. Behavioural problems and delinquent behaviour such as temper tantrums, disobedience, truancy, running away from home;
2. Learning difficulties, such as reading problems and school failure;
3. Psychophysiological reactions such as abdominal pains, vomiting and nausea, headache, and various other psychosomatic complaints.

Glaser considered the underlying depressive elements to differ from the 'classic' entity of depression, and from the self-limited depressive episodes found in adults, but he did not specify the nature of the difference.

6. Frommer (1968) performed a retrospective clinical study of the case histories of child psychiatric outpatients of a British general teaching hospital, over a five year period. She compared 74 children, who had been diagnosed as suffering from a neurotic disorder (including some depressive features), to a group of 190 children who had been diagnosed depressed. According to Frommer, symptoms of irritability, weepiness, complaints of depression, tension and explosiveness, and moodiness significantly differentiated the depressed children from the neurotic children.

On the basis of differing 'clinical patterns' and 'treatment needs', Frommer divided the total sample of depressed children, aged 3 - 16 years, into the following groups:

1. Depressed children with enuresis and/or encopresis or late toilet training success, in whom moodiness, weepiness, hostile and antisocial behaviour, and depressive disorder of long standing were the most common symptoms. These children tended to be immature for their age, to have poor peer interrelationships, and to have learning disorders. Onset of depression was usually insidious, and prognosis was poorer than in the other groups.

2. Children with uncomplicated depression, who typically, were weepy, with recurrent explosions of temper and misery for no apparent reason, with sleep problems such as falling asleep, nightmares, sleepwalking, talking in sleep, and waking in the night or unusually early. These children frequently had good social adjustment, and were not usually anxious or lacking in self-confidence.

3. Children with depressive phobic anxiety state, who tended to be quiet and withdrawn with 'typical depressive symptoms, such as weepiness, tension, and irritability', apathy, explosiveness, anxiety, clinging behaviour, abdominal pain, sleep difficulties, and less moodiness than was manifested by the other depressive children. This group frequently presented with abdominal pain, headache, nausea, vomiting and fainting, following on an illness, trauma or environmental stress that had occurred earlier.

Frommer associated the different clinical patterns with premorbid personality traits, family factors and response to treatment.

Frommer concluded that depression in children was most commonly a non-specific mailaise, with abdominal pain, headache or enuresis frequently serving as reasons for referral, and psychological symptoms, such as undue anxiety, nervousness, fears (notably school phobia), obsessional behaviour, rituals, tics, depressive feelings and suicidal ideas, less frequently serving as reasons for referral. Furthermore, she concluded that systematic enquiry would invariably disclose symptoms characteristic of depression, in children as in adults, and in many cases there would be precipitating events, from which time personality change could be dated.

7. Poznanski and Zrull (1970) reviewed the case records of 1,788 referrals to a United States children's psychiatric out-patient clinic, in an endevour to find clinical correlates of overt depressive symptomatology in children. Using criteria of the child being described as sad, unhappy or depressed, with established depressive symptomatology such as excessive self-criticism, feelings of inadequacy, difficulties with sleeping and concerns about death, fourteen of the referrals (four under 6 years of age and ten aged 7 - 12 years) were considered suitable for further study.

In the sample of fourteen children, negative self-image was found to be the most frequent correlate of depression, with the child describing himself as 'mean' or 'stupid' or 'punk kid'. Other symptoms significantly associated with depression were excessive crying, withdrawal and problems in handling aggression. Parents of these children showed a high incidence of depression, and had difficulties in handling aggression, with hostility and overt parental rejection.

8. Ling, Oftedal and Winberg (1970) used a combination of well-established clinical criteria of depression in adults, together with factors more readily observable in children, in assessing for depression children who presented with headaches at a neurological department. A child was considered to be depressed if he manifested any four of the following features: significant

mood change, social withdrawal, deteriorating school performance, sleep disturbances, aggressive behaviour not previously present, self-depreciation and beliefs of persecution, lack of energy, somatic complaints other than headaches, school phobia, anorexia and weight loss, with emphasis on recent changes of behaviour.

In a sample of twenty-five children, aged 4 - 16 years, who had presented for neurological investigation with severe headaches, ten were considered to be depressed in terms of these criteria. Mood change, social withdrawal and self-depreciation were found to be the most common symptoms, and sleep disturbance, deteriorating school performance and various somatic complaints were present in most of the children.

9. Arajärvi and Huttunen (1972) studied a sample of 44 Finish psychiatric in-patients aged 5 - 12 years, all with symptoms of enuresis and/or encopresis. In addition to enuresis and encopresis, depressed children showed social withdrawal, inhibition, lack of spontaneous activity, passivity, and poor self-confidence.

10. Kuhn and Kuhn (1972), in a study of the imipramine treatment of 100 depressed children, proposed 'morning tiredness' to be the 'cardinal symptom' of depression in children. Among other signs and symptoms of depression in children were considered to be underachievement at school, anxiety, sleep disturbances, inhibition, tiredness, diminished activity, disturbances in concentration and mental ability, enuresis, disatisfaction, apathy, weepiness, irritability and aggressiveness.

Kuhn and Kuhn considered about 12 percent of child psychiatric referrals to suffer from some form of depression.

1 . Vranješević, Radojičić, Bumbaširević and Todorović (1972) in Belgrade, described depression in children with interchranial tumours. The children looked sad and unhappy, and were apt to cry; they seemed to feel rejected and unloved; they lost interest in activities that had previously interested them, and withdrew; some were preoccupied with death; some older children manifested

disobedience, antisocial behaviour and delinquency as defences against feelings of inferiority and inadequacy; they had neuro-vegetative disorders, insomnia and loss of appetite.

12. Frommer, Wallace, Mendelson and Reid (1972) analysed the presenting complaints, symptoms, behaviour and family circumstances of 300 children under 5 years of age, who had been referred to a British child psychiatric unit over a six year period. They divided the referrals into groups of 122 depressed children, 93 aggressive children and 129 anxious children.

Appetite loss, complaints of abdominal pain, enuresis after 3 years of age and sleep problems were significantly associated with depression. Depressed children frequently had accompanying anxiety, a significant number of their mothers were depressed, and possible precipitating factors could often be identified.

13. Nissen (1973) used a combination of retrospective and prospective methods in the investigation of depression in children. From a sample of 6000 children seen as inpatients at a children's hospital in Germany, he selected a group of 105 children with relatively 'hard' features of depression, such as weeping, with-drawal, sleep difficulties and problems with aggression, in order to form a 'homologous nucleus-group of depressive children and adolescents'.

Nissen observed that these children did not have 'typically adult symptoms' such as guilt, self-reproach, ideas of sinfulness or impoverishment. They manifested aggressiveness, enuresis, sleep disorders, weeping, unsociability, anxiety, inhibition of play and learning, school phobia and truanting, running away from home, isolation and gastrointestinal disorders. The majority of the children had been referred because of school and upbringing problems (51%), behavioural disorders (26%), psychosomatic disorders (9%); only 14% had been referred for depression.

On the basis of his observations, Nissen proposed depressive symptomatology to be age-related, and to undergo a 'metamorphosis' through the developmental stages that man passes:

Small and preschool children: inhibition of play, agitation, paroxysms of weeping and screaming, encopresis after the third year, sleep disorders, jactation and appetite disorders;
Younger schoolchildren: irritability, insecurity, inhibition of play, unsociability, inhibition of learning, enuresis after the fifth year, pavor nocturnus, genital manipulation, paroxysms of weeping and screaming;
Older schoolchildren and adolescents: brooding, suicidal impulses, feelings of inferiority, dejection and headache.

Nissen considered this picture to be consonant with developmental stages, and of the nature of '"genuine" primary depressions'.

14. Weinberg, Rutman, Sullivan, Penick and Dietz (1973) diagnosed depression in 42 of 72 children (50 boys and 22 girls) aged 6 - 12 years, who had been referred to an educational diagnostic centre with school performance or behaviour problems. Criteria used for diagnosis were dysphoric mood and self-depreciatory ideas, with two or more of the following symptoms: aggressive behaviour, sleep disturbances, change in school performance, diminished socialization, change in attitude towards school, somatic complaints, loss of energy, unusual change in appetite and/or weight; symptoms were to represent a change from the child's usual behaviour, and were to have been present for more than a month.

These authors found the most common manifestations of depression to be agitated behaviour, crying, moodiness, sleep disturbances, somatic complaints and exacerbation of previous behaviour such as aggression or withdrawal. They found a high incidence of hyperactivity, school phobia, enuresis, temper tantrums, poor social judgement and destructive behaviour. Fifteen children had reported death wishes, and three had attempted suicide. Forty of the depressed children had a family history of depression.

Weinberg and associates suggested that depression might be a common feature of children who were doing poorly at school, in contrast to previous school performance.

15. Cytryn and McKnew (1974) proposed depression to occur in

in children in chronic, acute and masked forms, of which masked was considered to be the most common form. They considered depression to manifest on fantasy, verbal and behavioural levels, with depressive fantasy themes occurring in all depressed children, depressive verbalisations of hopelessness, helplessness, guilt, worthlessness, unattractivness, being unloved and suicide preoccupations occurring in some children, and depressive mood and behaviour such as psychomotor retardation, sadness, crying, appetite disturbance and sleep disturbance manifesting in very few children. Hyperactivity, aggressiveness, school failure, delinquency and psychosomatic symptoms were considered to be defences against underlying depression in masked depression.

Acute depression was related to traumatic precipitating events such as death, divorce or birth of a sibling, involving object loss. Chronic depression was associated with a history of many separations and object losses, and with parental depression. Masked depression was found most frequently in disorganised and psychopathological families, frequently with histories of character disorder, but not affective disorder.

Cytryn and McKnew proposed a developmental view of depression, with depressive verbalisations and behaviour becoming more common with advancing age, and manifesting in certain latency-age children. These authors considered childhood depression to be a qualitatively different entity from adult depression.

16. Lesse (1974) considered depression in children frequently to go unrecognized, because it tended to be 'hidden' in symptoms not generally associated with the manifestations of depression in adults. From the 'standpoint of depressive symptomology as seen in adults, all depressive reactions seen in infants and in most children would fall into the category of masked depression.' Disorders that might hide underlying depression were considered to include school phobia, underachievement at school, isolation, relationship problems, 'acting out' behaviour such as disobedience, temper tantrums, truancy, running away, hypochondriasis,and psychosomatic disorders such as headaches, tics, abdominal complaints, nausea, vomiting, asthma and migraine.

17. Mosse (1974) discussed the symptomatology of 49 depressed children (40 boys and 9 girls) aged from infancy to 12 years, who had been treated by her in clinical practice. Of these children, only four boys had been referred because of depressive feelings. The children had been referred for a variety of reasons, and their depressions had only become apparent during psychiatric examination and through the use of projective tests. Underlying feelings of depression were masked by complaints including poor concentration, social withdrawal, morbid fears, school phobia, learning disorders, feelings of inferiority, retardation of reactions, fluctuating moods, excessive anger, violent or disruptive behaviour, defiance, disobedience, restlessness, hyperactivity, delinquency, running away from home, masturbation, overeating, headaches, stomach-aches, tiredness, suicidal ideation and attempted suicide.

Mosse considered about 7 percent of child psychiatric referrals to suffer from depression.

18. Anthony (1975), on the basis of his clinical experience, described the depressed child, aged 8 - 11 years, as looking sad and depressed, talking in a low weak voice, crying frequently, and constantly iterating his loneliness: 'nothing appears to cheer him up, and he seems to have all the energy drained out of him'. Weeping bouts, flatness of affect, fears of death for self or parents, irritability, somatic complaints, loss of appetite and energy, various problems in school adjustment, clinging to parents alternating with unreasonable hostility towards them, were considered to be characteristic symptoms of depression.

Alternately, depression might present with depressive equivalents, such as eating and sleeping disturbances, antisocial behaviour, accident proneness, running away from home, boredom, restlessness, fatigue, poor concentration and sexual acting out; which might serve as defences against feelings of depression, isolation, loneliness and emptiness.

Precipitating factors were considered to be specific events such as accidents and physical illnesses,rather than the loss of a parent.

19. Schechtman, Gilpin and Worland (1976) performed a retrospective controlled study on 18 children (11 boys and 7 girls) aged 9 - 14 years. Their aim was to delineate the symptomatology of depression in children. Variables that statistically differentiated depressed subjects from controls matched for age and sex, were feelings of depression, loneliness, poor self-esteem, failing in school, aggression turned inwards, friendlessness, sleep problems, and feelings of guilt.

The majority of depressed children were referred because of failing in school, friendlessness and sleep problems.

20. Pearce (1977), in a recent study of 547 children, aged 1 - 17 years, who were attending a British child psychiatric department (Pearce, 1974 cited in Pearce, 1977), found 23 percent of the children to have the symptom of depression associated significantly with symptoms of anxiety, sleep disturbances, school refusal, phobias, alimentary disorders, obsessions and hypochondriasis. Pearce concluded that a reasonable definition of depression in children would be the association of depression, sadness, misery, unhappiness or tearfulness with at least two of the above symptoms, with symptoms of sufficient severity to interfere with the child's social or cognitive functioning, and that this should represent a change from normality that had been present for at least four weeks.

Pearce considered depressed children to look miserable, to manifest depressive feelings in behaviour such as crying, lethargy, social withdrawal and listlessness, but not necessarily to complain of such feelings. He proposed that depression might additionally feature complaints of aches and pains, that were possibly hypochondriacal in nature, sleeping and eating disturbances, irritability, low frustration tolerance, possible anxiety, but not physical aggression. Ideas of being unwanted, or unloved might be present, accompanied by low self-esteem and morbid thoughts, including suicidal ideation. He commented that although depressive mood might invariably be found by careful interview or projective tests, in small children with fluctuating moods it could on occasion be missed.

4.2.2 Symptomatology of Depression in Latency-Age Children

Summaries of the signs and symptoms associated with depression in latency-age children are listed in Table 5, below.

1. Harrington and Hassan, 1958.
   - Weeping
   - Flatness of affect
   - Loss of energy
   - Somatic complaints
   - School adjustment problems
   - Fears of death
   - Self-depreciation
   - Relationship problems

2. Agras, 1959.
   - School phobia
   - Weeping bouts
   - Miserable whiney behaviour
   - Concern about death
   - Stomach-ache
   - Nausea and vomiting
   - Headache
   - Hypermania

3. Toolan, 1962.
   - Temper tantrums
   - Disobedience
   - Truancy
   - Running away from home
   - Accident proneness
   - Masochism
   - Self-destructive behaviour
   - Boredom
   - Restlessness
   - Low self-esteem
   - Inferiority feelings

4. Sandler and Joffe, 1965
   - Sad, depressive appearance
   - Withdrawal
   - Apathy
   - Disatisfaction
   - Relationship problems
   - Insomnia
   - Passivity
   - Helplessness
   - Inhibition of functions

5. Glaser, 1967
   - Inadequacy
   - Low self-esteem
   - Helplessness
   - Hopelessness
   - Isolation
   - Feelings of rejection
   - Temper tantrums
   - Truancy
   - Running away from home
   - Learning difficulties
   - Abdominal pains
   - Nausea and vomiting
   - Headache

6. Frommer, 1968.
   - Irritability
   - Weepiness
   - Complaints of depression
   - Tension and explosiveness
   - Moodiness
   - Enuresis
   - Encopresis
   - Hostile/antisocial behaviour
   - Sleep problems
   - Apathy
   - Abdominal pain
   - Nausea and vomiting
   - Headache

7. Poznanski and Zrull, 1970.
   - Sadness/unhappiness/depression
   - Self-criticism
   - Feelings of inadequacy
   - Sleep difficulties
   - Concern about death
   - Crying
   - Withdrawal
   - Problems with aggression

8. Ling, Oftedal and Winberg, 1970.
   - Significant mood change
   - Social withdrawal
   - Deteriorating school perform.
   - Sleep disturbances
   - Aggressive behaviour
   - Self-depreciation
   - Beliefs of persecution
   - Lack of energy
   - Somatic complaints

School phobia
Anorexia and weight loss
Note: symptoms were to represent change from usual behaviour.

9. Arajärvi and Huttunen, 1972.
Social withdrawal
Inhibition
Lack of spontaneous activity
Passivity
Poor self-confidence
Encopresis
Enuresis

10. Kuhn and Kuhn, 1972.
Morning tiredness
Underachievement at school
Anxiety
Sleep disturbance
Inhibition
Tiredness
Poor Concentration
Diminished Activity
Enuresis
Disatisfaction
Apathy
Weepiness
Irritability
Aggression

11. Vranješević, Radojičić, Bumbaširević and Todorović, 1972.
Sad and unhappy
Apt to cry
Feeling of being rejected/unloved
Loss of interest in activities
Withdrawal
Preoccupation with death
Disobedience and delinquency
Feelings of inferiority
Feelings of inadequacy
Neurovegetative disorders
Insomnia
Loss of appetite

12. Frommer, Wallace, Mendelson, Reid, 1972.
Appetite loss
Abdominal pain
Enuresis
Sleep problems
Depression

13. Nissen, 1973.
Weeping
Withdrawal
Sleep difficulties
Problems with aggression
Inhibition of play
Inhibition of learning
School phobia and truanting
Running away from home
Enuresis
Unsociability
Self-isolation
Gastrointestinal disorders

14. Weinberg, Rutman, Sullivan, Penick and Dietz, 1973.
Dysphoric mood
Self-depreciatory ideation
Aggressive behaviour
Sleep disturbances
Change in school performance
Diminished socialization
Changed attitude towards school
Somatic complaints
Loss of energy
Change in appetite and/or weight
Note: symptoms were to represent change from usual behaviour, to have lasted four weeks, and to be of concern to child or parent.

15. Cytryn and McKnew, 1974.
Depressive and fantasy themes
Hopelessness
Helplessness
Guilt
Worthlessness
Feeling of being unattractive
Feeling of being unloved
Suicidal preoccupations
Depressive mood
Psychomotor retardation
Sadness
Crying
Appetite disturbance
Sleep disturbance
Hyperactivity
Aggressiveness
School failure
Delinquency
Psychosomatic symptoms

16. Lesse, 1974.
School phobia
Underachievement at school
Isolation
Relationship problems
Disobedience
Temper tantrums
Truancy
Running away
Hypochondriasis
Headache
Abdominal complaints
Nausea and vomiting
Tics
Asthma
Migraine

17. Mosse, 1974.
Depressive feelings
Poor concentration
Withdrawal
Morbid fears
School phobia
Learning disorders
Inferiority feelings
Retardation of reactions
Fluctuating moods
Excessive anger
Violent/disruptive behaviour
Defiance or disobedience
Restlessness or hyperactivity
Running away from home
Overeating
Headache
Stomach-ache
Tiredness
Suicidal ideation and attempts

18. Anthony, 1975.
Sad/depressed appearance
Talking in low, weak voice
Crying frequently
Loneliness/relationship problems
Loss of energy
Flatness of affect
Concern about death
Irritability
Somatic complaints
Loss of appetite
School problems

19. Schechtman, Gilpin, Worland, 1976.
Feeling of depression
Loneliness / friendlessness
Poor self-esteem
Failing in school
Aggression turned inwards
Friendlessness
Sleep problems
Feelings of guilt

20. Pearce, 1977.
Depression/misery/tearfulness
Anxiety
Sleep disturbances
School refusal
Phobias
Alimentary disorders
Obsessions
Hypochondriasis
Note: symptoms were to represent change from usual behaviour, to have lasted four weeks, to affect child's social or cognitive functioning.

Table 5: Summary of studies of depression in latency-age children.

Inspection of the summaries of characteristics associated with depression in children reveals that different clinicians have associated a variety of behavioural, attitudinal, motivational, emotional and somatic symptoms with depressive mood change that may be overt, hidden or fluctuating. Comparison between studies is problematic because of differing terminology. What were considered to be identical or overlapping symptoms have been grouped together, and the frequency with which they appeared in the twenty studies is presented in Table 6.

Symptom	Studies in Numerical Order:																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Depressive, sad affect, misery		•		•		•	•	•			•	•		•	•		•	•	•	•
Weeping	•	•				•	•			•	•		•		•			•		•
Apathy, affective flatness	•			•		•				•								•		
Anxiety, fearfulness										•							•			•
Irritability, tension						•				•						•		•		
Anger, temper tantrums			•		•												•			
Aggression problems							•	•		•			•	•	•					
Moodiness						•											•		•	
Self-depreciation, inadequacy, lack of confidence.	•		•		•		•	•	•		•			•	•		•		•	
Guilt															•				•	
Hopelessness, helplessness				•	•										•					
Passivity, inhibition, lack of spontaneity				•					•	•			•							
Boredom, disatisfaction, loss of interest			•	•						•	•									
Poor concentration										•							•			
Tiredness, lack of energy	•							•		•	•			•			•	•		
Psychomotor retardation											•				•					
Hyperactivity, hypomania, restlessness		•	•														•			
Running away from home			•		•								•			•	•			
Self-destructiveness, accident-proneness			•																	
Preoccupation with death	•	•					•				•							•		
Suicidal ideation															•		•			
Social withdrawal, isolation, relationship problems	•			•	•		•	•	•		•		•	•	•	•	•	•	•	
Defiance, disobedience, disruptive behaviour.			•		•						•					•	•			
Antisocial behaviour, delinquency						•					•				•		•			
School refusal, school adjustment problems	•	•	•		•			•					•	•		•	•	•		•
Schoolwork problems								•					•	•	•	•		•	•	
Sleep problems				•		•	•	•		•	•	•	•	•	•				•	•
Appetite / weight disturbance	•							•			•	•		•	•		•	•		
Somatic complaints	•	•			•	•		•	•			•	•	•	•	•	•	•		•
Enuresis, encopresis						•				•		•	•							

Table 6: Symptoms associated with depression in latency-age children

Symptoms most frequently associated with depression in children were somatic complaints, particularly of a gastro-intestinal nature, social withdrawal and relationship problems, sad, depressive appearance, problems with sleeping, self-depreciation with feelings of inadequcy and worthlessness, school refusal and school adjustment problems, problems with schoolwork, tiredness and lack of energy, and appetite and weight disturbances, particularly loss of appetite. To a lesser extent apathy and affective flatness, problems with aggression, passivity and inhibition, running away from home, preoccupation with death, and disobedience were associated with depression in children. There was a low frequency of irritability, boredom, loss of interest, and antisocial behaviour; and irritability, moodiness, boredom, loss of interest, feelings of guilt, hopelessness and helplessness, anger, poor concentration, psychomotor retardation, hyperactivity and restlessness, self-destructive behaviour and suicidal ideation were minimally recorded.

From the data recorded, the depressed child emerges as one who looks miserable, cries, withdraws socially, is lethargic and listless, complains of aches and pains, has disturbed sleep and possibly eating disturbance, is reluctant to attend school and may have difficulty with schoolwork, has low self-esteem and may have perceptions of being isolated, rejected and unloved.

Toolan (1962, 1974), Glaser (1967), Nissen (1973), Cytryn and McKnew (1974) advanced a developmental view of depression, with younger children presenting slightly differently from older children.

Symptoms of misery and depression, social withdrawal, lethargy, disturbed sleep, appetite disturbance and low self-esteem listed above are consistent with criteria for diagnosis of depression in adults. (See Section 3.7) Differences appear to lie in greater somatic involvement in children, and a low incidence of feelings of guilt, self-reproach or suicide.

Disparate symptoms, such as overt aggression, hostility, anti-social behaviour, defiance, violent or disruptive behaviour, anger and delinquency, fit less easily into the depressive picture. It is

conceivable that such behaviours might be situation specific in particular children, for example, coercion to play sport might provoke aggression, hostility, anger and defiance in a depressed child. Alternately, some children diagnosed depressed might be unhappy children or angry children with feelings of depression. Rutter and associates (1970), in a careful, epidemiological study of Isle of Wight children, found many children with conduct disorders to have secondary feelings of depression.

The desire to be dead, including self-destructive thoughts and behaviour, accident-proneness and attempted suicide has been associated with depression in children in a few of the studies cited above. Epidemiological surveys have found 'diagnosed' suicide to be rare in children under fifteen years of age (Kanner, 1972; Shaffer, 1974), and not significantly related to depression (Despert, 1952; Shaffer, 1974; Anthony, 1975). Barker (1976) suggested that running away from home in latency-age children might be motivated in ways comparable to suicide in adults. Children frequently express the wish to be dead when very upset or angry, but it is unlikely that they appreciate the finality of death (Wolff, 1973). While it has been suggested by some authors that young children do not possess the knowledge to accomplish suicide, other authors have suggested that they might kill themselves by running in front of cars[1] or falling from buildings, and that such deaths have not been recognized as suicides (Mosse, 1974). The association of suicide with depression in latency-age children remains inconclusive.

The concept of 'masked depression' in children who do not manifest overt depression is controversial. (See Toolan 1962, 1974; Glaser, 1967; Cytryn and McKnew, 1974; Lesse, 1974) It has been supported by observations that children tend to defend against depressive feelings by 'acting-out' at times when they could be expected to experience grief, for example, after bereavement (Wolff, 1973; Solnit,1974; Mosse, 1974), and by associations between antisocial behaviour, parental loss, parental depression and suicide in children (Shaffer, 1974). Furthermore, children with depressive symptoms may have a wide range of other difficulties, ranging from

[1] See the case of Shane in the Appendix.

delinquency to hypochondriasis (Hersov, 1976). However, there is inadequate evidence for considering that depression in children might take a diametrically different form in addition to a similar or analogous form to that which is generally denoted by depression. While it is accepted that children might defend against feelings of depression, this is not considered to be in any way analogous to suffering from depression. (See Section 3.1)

The majority of studies that used the concept of 'masked depression', considered feelings of depression to be a necessary prerequisite for diagnosis of depression. What was termed the 'mask' or 'depressive equivalent' in these studies was regarded as the reason for referral in other studies, and part of the depressive symptom-complex. The term 'mask' is therefore considered to be confusing and to serve no purpose. (See Section 3.8) This is particularly relevant where so-called 'masks' take the form of somatic complaints. While somatic complaints have been associated with depression in the majority of the studies reviewed, somatic complaints may be manifested by a variety of disturbed children, and may also be manifested by psychiatrically healthy children who are upset (Pinkerton, 1965).

4.2.3 Summary of Depression in Latency-Age Children

Depression in latency-age children has been associated with depressive mood change that might be overt, fluctuating or hidden. It has been associated with somatic complaints, social withdrawal, relationship problems, sleep difficulties, weight and appetite change, self-depreciation, feelings of inadequacy, feelings of worthlessness, school refusal, school adjustment problems, school-work difficulties, tiredness and lack of energy, apathy, passivity and running away from home.

The presence of overt aggression, destructiveness and anti-social behaviour associated with depression in some studies reviewed, was queried on the grounds that depression is conventionally associated with lowered mood and lack of active environmental involvement; furthermore, depressive feelings in children have not been associated only with depressive disorder (Rutter et al.,1970).

The association of suicide with depression in children remains uncertain.

The concept of 'masked depression' in children was criticised in that so-called 'masks' were considered to be more appropriately regarded as reasons for referral.

Symptoms of lowered, depressed mood, social withdrawal, lethargy, sleep and appetite disturbances and low self-esteem, in the 'typically' depressed child were considered to be consistent with the adult depressive picture. Differences appeared to lie in greater somatic involvement in children, and a low incidence of feelings of guilt, self-reproach or suicide.

4.3 DEPRESSION IN ADOLESCENCE

Depression has been found to occur more frequently in adolescent than in latency-age children, and there is generally a progressive shift towards adult symptomatology (Nissen, 1973; Rutter, Graham, Chadwick and Yule, 1976). Some clinicians have claimed that depression in adolescence may present with symptom patterns not found in other age groups (Mastropaola, 1972; Toolan, 1974; Lesse, 1974).

A selection of studies of depression in adolescence, in which the manifestation of depression has been described, are reviewed below.

4.3.1 Studies of Depression in Adolescence

1. Mastropaola (1972) considered depression in adolescence to present with 'subtleties and dimensions' that could not easily be grouped into typical syndromes, and only partially resembled those seen in adults. He considered adolescent mood fluctuations to be more rapid, and without the sadness, inhibition, guilt or feelings of impending doom that frequently characterise the adult state. Depression was considered to present in adolescents with a single dominant symptom or chain of symptoms of the following types:

1. Neurasthenic-cenesthopathic (psychophysiological) type,

characterised by asthma, irritability, fatigability and aches and pains often of a bizarre nature, that were not accompanied by an adequate emotional reaction;

2. Phobic-obsessive type, characterised by phobias and compulsions, with diurnal mood variation and anxiety;

3. Conduct disorder type, characterised by 'mutations' of mood and behaviour ranging from capriciousness to irritability and aggression, with episodic 'excesses of instincts' in which masturbation or homosexuality gave way to guilt and depression.

Mastropaolo differentiated between early adolescence, ages 12 - 15 years, and late adolescence, ages 15 - 18 years.

Early adolescence was associated with rapid change in interests, desire for activity fluctuating with extreme fatigue, inability to concentrate, feelings of insecurity and inferiority especially associated with appearance, incoherence, inability to communicate and express pain, emotional lability, crying, vomiting, headache and abdominal pain, psychomotor retardation, sleep disturbance, appetite variations, obedience, conformity, flight, tantrums, social maladjustment and poor scholastic achievement.

Depression in late adolescence was considered to present most frequently with neurasthenic-cenesthopathic, phobic-obsessive and conduct disorder type equivalents described above. When not expressed in equivalents, depression was associated with slothfulness, fantasy, apathy and inhibition. Symptoms accompanying depression were social maladjustment, feelings of inadequacy, lack of initiative, loss of self-esteem, cynicism, antisocial acts, suicide, incompetence, loss of affection and feelings of guilt.

For diagnosis to be made, it was considered necessary to understand the underlying psychopathological mechanisms, as well as social and cultural influences in the context of the 'adolescent crisis'. Problems capable of triggering depression were often connected with parental relationships, and usually associated with study and work difficulties, economic dependence or immigration. Emotional events such as bereavement were less frequent precipitators of depression. Features of adolescence predisposing to depression were considered to be (1) the necessity to destroy the 'primitive

love object' so as to obtain emancipation, (2) lack of identity, and (3) alteration of the feeling of body integrity.

2. Nissen (1973) described depression in adolescence as being characterised by depressive mood, brooding, suicidal impulses, feelings of dejection, headaches, unsociability, loneliness and feelings of guilt. Psychosomatic symptoms such as asthma, or behavioural symptoms such as drug abuse might be manifested.

3. Toolan (1974) associated the following symptoms with depression in adolescence: tiredness, pervasive boredom, restlessness, frantic seeking of new activities, feelings of emptiness, isolation and alienation, escape into drugs or sexual promiscuity, difficulty in concentrating, dropping out of college, illegitimate pregnancies, suicidal ideas, delinquency and acting-out behaviour, hypochondriasis. Toolan considered feelings of unworthiness and of being unlovable, loneliness, helplessness and depression to underly these symptoms or 'masks' of depression. Toolan claimed that the symptoms usually disappeared once the overt picture of depression was manifested.

4. Lesse (1974) associated school refusal, underachievement and study problems, automobile accidents, excessive drinking and drug abuse, suicide attempts, psychosomatic disorders, hypochondriasis, delinquent behaviour, feelings of inadequacy, hopelessness and depression, with depression in adolescence.

5. Malmquist (1976) considered depression in adolescence to present with mixed symptomatology: fluctuations between apathy and overactive garrulousness, somatization, hypochondriasis, hostile attacks on parents, anger, rage, impulsiveness, acting-out, ambivalence, feelings of being unable to satisfy the self in terms of personal ideals, ambitions or self-concept, feelings of guilt, low self-esteem, behavioural problems including sexual promiscuity, theft, violence, alcoholism, drug abuse, and taking risks.

6. Rutter (1975) considered adolescent depressive disorders,

like adult depressive disorder, to manifest with misery and unhappiness together with loss of appetite, sleep disturbance, social withdrawal, irritability, loss of interest, difficulty in concentrating and frequently a preoccupation with physical complaints.

4.3.2 Symptomatology of Depression in Adolescence

Summaries of the signs and symptoms associated with depression in adolescence are listed in Table 7, below.

1. Mastropaola, 1972.
   - Changing interests
   - Restlessness
   - Fatigue
   - Poor concentration
   - Insecurity
   - Inferiority feelings
   - Communication problems
   - Emotional lability
   - Crying
   - Vomiting
   - Headache
   - Abdominal pain
   - Psychomotor retardation
   - Sleep disturbance
   - Appetite disturbance
   - Obedience
   - Conformity
   - Flight
   - Tantrums
   - Social maladjustment
   - Scholastic problems
   - neurasthenic-cenesthopathic equivalents
   - Phobic-obsessive equivalents
   - Conduct disorder
   - Slothfulness
   - Fantasy
   - Apathy
   - Inhibition
   - Social maladjustment
   - Inadequacy
   - Lack of initiative
   - Cynicism
   - Antisocial acts
   - Suicide
   - Affectionlessness
   - Guilt

2. Nissen, 1973.
   - Depressive mood
   - Brooding
   - Suicidal Impulses
   - Dejection
   - Headaches
   - Unsociability
   - Loneliness
   - Guilt
   - Psychosomatic symptoms
   - Drug abuse

3. Toolan, 1974.
   - Tiredness
   - Boredom
   - Restlessness
   - Isolation
   - Drug abuse
   - Sexual promiscuity
   - Poor concentration
   - Leaving college
   - Illegitimate pregnancies
   - Suicidal ideation
   - Delinquency
   - Acting-out
   - Hypochondriasis

4. Lesse, 1974.
   - School refusal
   - Study problems
   - Automobile accidents
   - Alcohol abuse
   - Drug abuse
   - Suicide attempts
   - Psychosomatic problems
   - Hypochondriasis
   - Delinquency
   - Inadequacy

hopelessness	Low self-esteem
helplessness	Behavioural problems
depression	Sexual promiscuity
	Theft
5. Malmquist, 1976.	Violence
Fluctuating moods	Alcoholism
Apathy	Drug abuse
Overactivity	Risk taking
Psychosomatic complaints	
Hypochondriasis	6. Rutter, 1975.
Parental relationship problems	Misery
Anger	Appetite loss
Rage	Sleep disturbance
Impulsiveness	Social withdrawal
Acting-out	Irritability
Ambivalence	Loss of interest
Inadequacy	Poor concentration
Guilt	Aches and pains

Table 7: Summary of studies of depression in adolescence

Inspection of the summaries of characteristics associated with depression in adolescence reveals that different clinicians have associated a variety of behavioural, attitudinal, motivational, emotional and somatic symptoms with depressive mood change that may be overt, hidden or fluctuating. Comparison between studies is problematic because of differing terminology. What were considered to be identical or overlapping symptoms have been grouped together, and the frequency with which they appeared in the six studies is presented in Table 8.

Symptoms most frequently associated with depression in adolescence were social withdrawal, psychosomatic complaints and hypochondriasis. Four of the studies cited drug abuse, and four of the studies cited antisocial behaviour. Depressive mood, low self-esteem and feelings of inadequacy, and restless acting-out, were each cited in three of the studies. Suicidal ideation was cited in four of the studies. In general there was little overlap between studies, possibly due to selective attention to different symptoms in particular studies. Alternately, there might have been differences in the samples that were studied.

Rutter, Graham, Chadwick and Yule (1976) drew attention to anomalies involved in psychiatric diagnosis of adolescents. In a

SYMPTOM	STUDIES IN NUMERICAL ORDER					
	1	2	3	4	5	6
Depressive Mood		●		●		●
Apathy	●				●	
Crying	●					
Fluctuating moods	●				●	
Irritability						●
Anger, rage					●	
Cynicism	●					
Brooding	●					
Ambiguity					●	
Guilt	●	●			●	
Fantasy	●					
Boredom			●			
Loss of interest	●					●
Hopelessness/ Helplessness				●		
Low self esteem, feelings of inadequacy	●			●	●	
Insecurity					●	
Inhibition / conformity	●					
Fatiguability	●		●			
Poor concentration			●			●
Social withdrawal / relationship problems	●	●	●		●	●
Suicide	●	●	●	●		
Phobias / Obsessions	●					
Sleep disturbance	●					●
Appetite disturbance	●					●
Slothfulness	●					
Hypochondriasis	●		●	●	●	●
Psychosomatic complaint	●		●	●	●	●
Alcohol abuse				●	●	
Drug Abuse		●	●	●	●	
Sexual promiscuity	●		●		●	
Illegitimate pregnancies			●			
Scholastic problems / dropping out			●	●		
Restlessness / acting out	●		●		●	
Antisocial behaviour	●		●	●	●	

TABLE 8: Symptoms associated with depression in adolescence

randomly chosen sample of 96 Isle of Wight boys and 87 Isle of Wight girls, Rutter and associates found that 20,8 percent of the boys and 23 percent of the girls often felt miserable and depressed, 20,8 percent of the boys and 17,2 percent of the girls usually had difficulty in falling asleep or staying asleep, and 22,9 percent of the boys and 24,1 percent of the girls usually awakened unnecessarily early in the morning. Furthermore, these features were frequently accompanied by feelings of self-depreciation, ideas of reference, and occasionally by suicidal thoughts. In the cases of these children the authors considered the marked symptoms of affective disturbance to reflect 'inner turmoil' rather than depressive disorder. It is possible that 'inner turmoil', associated with transition from childhood to being an adult, involving uncertainty and loss as well as gain, may be a complicating factor in psychiatrically disordered as well as mentally healthy adolescents, and may confuse the diagnosis of psychiatric syndromes such as psycho-physiological disorders, neurotic disorders and conduct disorders. (See Mastropaolo, 1972, Section 4.3.1 ; cf. the case of Chiara in the Appendix.)

The six studies examined above rendered an inconclusive picture of depression in adolescence. In all probability depression in adolescence is associated to some extent with conflicts involving resolution of the adolescent identity crisis (Erikson, 1950). Symptomatology is likely to be manifested in the activities with which the adolescent is involved, and coloured by the sub-culture to which he or she belongs. For example, depression may be associated with school underachievement and school refusal (Rutter et al., 1976), or it may be associated with drug or alcohol abuse (Nissen, 1973; Lesse, 1974). It is unlikely to be associated with rage and delinquency, as proposed by Malmquist (1976) above.

The view that there is a progressive shift towards adult symptomatology in adolescence, including a rise in the incidence of completed suicide (Nissen, 1973; Rutter et al., 1976), is tentatively accepted in the absence of evidence to the contrary. Interaction of teenage concerns and activities with depressive symptomatology might lead to an impression of distinctive adolescent depressive symptom patterns.

4.3.3 Summary of Depression in Adolescence

Studies of depression in adolescence surveyed above failed to yield a conclusive picture of depression in adolescence. It was tentatively accepted that there might be a progressive shift towards adult symptomatology in adolescence, with symptoms being influenced by adolescent conflicts, manifesting in the activities with which the adolescent was involved, and being coloured by the subculture to which the adolescent belonged. The association of completed suicide with depression was considered to be an important feature of depression in adolescence.

It was noted that caution should be used in differentiating features associated with adolescent 'inner turmoil' from depressive symptomatology.

4.4 BIPOLAR (MANIC DEPRESSIVE) DEPRESSION IN CHILDREN

Bipolar depressions do not as a rule appear before adolescence, although single cases at an earler age have been observed and reported in the literature. Kraepelin (1913) reported that 0,4 percent of his manic-depressive patients had suffered mania before the age of 10 years. Slater and Roth (1969) cited the British Registrar General's tabulation for the period 1952 - 1960 as giving an incidence of manic-depressive illness in children aged 10 - 15 years as 3 boys and 3 girls, and in adolescents aged 15 - 20 years as 71 males and 138 females, per million.

Barton Hall (1952) found two cases of manic-depressive disorder, aged 14½ and 15½ years, among 1000 children aged 5 - 16 years, seen by her in general psychiatric practice over a five year period. A retrospective study of the childhood of adult manic depressives suggested the presence of early cyclothymic temperament, hypomanic states with hyperactive, impulsive, erratic and uncontrolled behaviour, with associated accident-proneness. Childhood mania, with elation and flight of ideas was rarely described, and then only in older adolescents.

Anthony and Scott (1960) formulated criteria for the diagnosis

of childhood manic-depressive disorder:

1. Abnormal psychiatric state similar to the classical description;
2. A family history of manic-depressive illness;
3. Early onset of cyclothymic mood of increasing severity and length of mood swings, with delirious mania or depressive outbursts occurring during febrile illness;
4. Recurrent or periodic mood disorder (at least two episodes);
5. Diphasic moods showing swings of pathological dimension;
6. Minimal influence of environment on symptoms;
7. Severe symptoms requiring inpatient treatment;
8. An extravert personality;
9. Absence of features of schizophrenogenic or organic states;
10. Evidence of current as opposed to retrospective assessments.

Anthony and Scott described the case history of a 12 year old boy who met most of their criteria for diagnosis of manic-depressive disorder. In his premorbid state the boy had manifested a cycloid disposition from an early age, and his fantasy life was reported to shown evidence of manic and depressive themes. Breakdown first occurred after adoption of a brother. The authors interpreted the boy's breakdown as having been a depressive reaction to loss of being central to the family, which he defended against with manic defences. (See Section 2.1.3) Ten year follow-up of the patient suggested continuity between childhood and adult conditions.

White and O'Shanick (1977) presented the case history of a 15 year old boy who was admitted to hospital with grandiose delusions, flight of ideas, loose associations and general agitation. There was a strong family history of affective disorders and cyclothymia. The boy had been diagnosed hyperactive at 6 years, but had not responded to treatment with stimulant drugs. Throughout his childhood he had manifested extreme hyperactivity, impulsiveness and mood-swings, and had problems at school. With lithium carbonate treatment the presenting symptoms disappeared, and his mood stabilised. (See Section 3.9)

White and O'Shanick proposed that manic-depressive illness might be seen very early in life and often resembled the hyperactive child syndrome. With adolescence the symptoms more closely resembled

the adult form of manic-depressive illness. These authors advised that when a child manifested increased psychomotor activity, marked mood swings, and there was a positive family history of affective disorders, manic-depressive illness should always be considered.

4.4.1 Summary of Bipolar (Manic-Depressive) Depression

In rare instances manic-depressive disorder may occur in children. Symptomatology is likely to include increased psychomotor activity with marked mood swings. Where there is a family history of affective disorder, manic-depressive illness should be considered.

There is a slightly higher incidence of manic-depressive disorder in adolescence. In adolescence symptoms resemble more closely the adult condition, with distinct manic and depressive episodes.

4.5 EPIDEMIOLOGY OF DEPRESSION IN CHILDREN

Epidemiology of depression in children is confusing in that surveys have not studied the same thing in the same way: different researchers have not meant the same thing by depression (Annell, 1972), different populations have been used, for example psychiatric inpatients as opposed to referrals to a school clinic, and the ages of children studied have varied from population to population.

The prevalence of depression among 2000 ten and eleven year old Isle of Wight children was estimated by Rutter and associates (1970) to be three girls and no boys. Among 2303 Isle of Wight adolescents, these authors diagnosed 9 as having depressive disorder, and a further 26 as having an affective disorder involving both anxiety and depression.

Poznanski and Zrull (1970) recorded an incidence of depressive disorder in 0,8 percent of 1788 United States child psychiatric referrals. Nissen (1973) recorded an incidence of 1,8 percent of severe and moderately severe depressive states among 6000 German child inpatients. Kuhn and Kuhn (1972) claimed that about 12 percent of an average child psychiatric series suffered from some form of

X

depression. Weinberg and associates (1973) reported that 58 percent of referrals to a school clinic were depressed. Pearce (1977) estimated an incidence of depression in 23 percent of 547 child psychiatric outpatients at a British hospital. Annell (1972) found the incidence of depression reported by participants of the Fourth Congress of European Pedopsychiatrists to range between 1,8 percent and 25 percent of particular child populations studied.

4.5.1 Summary of Epidemiology of Depression in Children

Studies of depression in children have reflected a wide range of incidence. The epidemiology of depressive disorder in children is uncertain.

4.6 AETIOLOGY OF DEPRESSION IN CHILDREN

Although there is uncertainty regarding the causation of depression in children, depression is generally considered to result from an interaction of predisposing and precipitating genetic, biological, psychological and environmental factors. (See Section 3.6) Certain children might be genetically predisposed to be more sensitive to environmental stress than other children (d'Elia and Perris, 1972; Angst, 1974). Other children might have psychological vulnerability to particular forms of loss (Bibring, 1968). At specific maturational stages children may be sensitive to a particular form of stress, such as removal from home with separation from the mother (Spitz, 1946; Bowlby, 1952). Whereas young latency-age children do not often become depressed after the death of a parent, older latency-age children and adolescents may become depressed for the same reason (Wolff, 1973).

Rutter (1975) suggested that depression in children might be more tied to specific situations than depression in adults. He proposed that the breaking of a close bond or relationship might be a particularly important precipitant of depression, but could also act later when anniversaries or like events served to revive memories of the loss.

Maternal depression has been associated frequently with childhood depression (Frommer, 1968; Poznanski and Zrull, 1970; Cytryn and McKnew, 1972; Weisman and Paykel, 1974; Malmquist,1976; Schechtman et al., 1976). The association might be understood in terms of genetic factors, in terms of the child identifying with the depressed person, and through the 'psychic abandonment of the child that depression produces'(Anthony, 1976).

Anthony (1976) considered 10 - 15 percent of children to be high risks for depressive disorder during their childhood, adolescence and later life.

> 'These individuals can be identified from fairly early on through a configuarion of qualities that includes moodiness, self-centeredness, hypersensitivity to small losses or frustrations, a tendency to withdraw when conditions are not perfectly suited to the child, clinging and demanding relationships of an ambivalent kind. In the presence of inadequate mothering, early spoiling followed by later rejection, promises frequently made and not kept and frequent preparations for which the child is not at all prepared, coupled with the dispositional characteristics make future clinical depressions almost predictable ' (Page, 170).

Anthony's viewpoint, while intriguing, has not been confirmed.

4.6.1 Summary of Aetiology of Depression in Children

The aetiology of depression in children is uncertain. It is generally considered to result from an interaction of genetic, biological, psychological and environmental factors. Certain children might be genetically predisposed to be sensitive to environmental stress and to respond to it with depression, other children might be psychologically vulnerable to certain events, or there might be a combination of variables. At certain maturational levels children might tend to react to specific types of environmental stress with depression.

In infants, separation from the mother under certain conditions has been significantly associated with depression. In older children the breaking of a bond has been associated with depression. Maternal depression has been associated frequently with depression in children.

4.7 DIAGNOSIS OF DEPRESSION IN CHILDREN

Children have rarely presented at clinics with complaints of depression or lowered mood. Generally they find it difficult to verbalise their emotions (Mosse, 1974; Pearce, 1977). Non-specific somatic maillaise, abdominal pain, persistent headache, enureses, have been frequent reasons for referral of depressed children. Less frequently they have been referred with more obviously psychological complaints such as anxiety, phobia, especially school phobia, and obsessional behaviour (Frommer,1968). Poznanski and Zrull (1970) found difficulty in handling aggression to have been the most frequent reason for referral of depressed children to their clinic. Weinberg and associates (1973) drew all their cases of depression from scholastic referrals to an educational diagnostic centre.

Because of the complex manner in which depressive symptomatology may be interwoven with a variety of major or minor complaints, to which it may not necessarily be causally related (Mosse, 1974), and because of the general lack of criteria for making a diagnosis of depression (Rie, 1966; Gittelman-Klein,1977), diagnosis of depression in children may be difficult.

Clinicians have advanced criteria and formulated schemes for diagnosing depression in children. Pearce (1977) proposed that for depression to be diagnosed in children, there should be evidence of lowered mood, representing a change from the child's normal mood, of sufficient severity to interfere with the child's social and cognitive functioning, that had been present for at least four weeks. Associated with the lowered mood should be at least two of the following symptoms: anxiety, sleep disturbance, irritability, suicidal thoughts, eating disturbance, school refusal, phobias, alimentary disorders, obsessions and hypochondriasis. Similar schemes had been proposed by Ling, Oftedal and Weinberg (1970), Weinberg and associates (1973) and Conners (1976).

Pearce (1977) pointed out that the moods of young children often fluctuate, which might result in the depressive mood being missed. In such cases, where underlying lowered mood was suspected,

it was proposed that diagnosis of depression might be based on the presence of depressive themes, containing elements of mistreatment, thwarting, blame, loss, abondonment, personal injury, death or suicide in fantasy material such as dreams, paintings, spontaneous play and projective tests (Toolan, 1962; Poznanski and Zrull, 1970; Cytryn and KcKnew, 1974; Mosse, 1974; Pearce, 1977).

A scheme for the diagnosis of depression in children was developed by the National Institute of Mental Health (Dweck, Gittelman-Klein, McKinney and Watson, 1977). The following criteria were advanced, of which items 1 and 2 were necessary for a diagnosis of depression to be made:

> '1. Dysphoria.
> 2. Generalised impairment in response to previously reinforcing experiences, without the concomitant introduction of new sources of reinforcement. This impairment is manifested by a reduction in instrumental, self-initiated activities across broad classes of behaviour. Previously pleasurable activities are no longer effective in regulating behaviour.
>
> The above has to be generalised across settings and not be specific to isolated areas of functioning.
>
> Associated Features
>
> Characteristics of dysphoria and reduced response to reinforcements are probably associated with different secondary symptoms at various ages. Empirical investigations are necessary to determine what aspects of behaviour and cognitive function are altered at various developmental levels. These would consist of changes in self-esteem, guilt (i.e.,notions of personal responsibility), personal and general pessimism (i.e.,negative expectations about oneself or life in general), or blaming others.
>
> Duration
>
> A minimum duration of 4 weeks is stipulated for the diagnosis to be made.
>
> Interview observations and reports by significant others would be necessary for the determination of the clinical syndrome. No single source of information would be deemed adequate for a formulation of the diagnosis.' (Pages 153 - 154)

No scheme for diagnosing depression in children has been consensually implemented. Nor has the validity of any of the proposed schemes for diagnosing depression in children been established.

Diagnosis of depression in children has been based generally on the criteria for diagnosing depression in adults (Frommer,1968).

(See Section 4.6) While this practice has been criticised by clinicians who consider depression in children to be qualitatively different from depression in adults (for example, Conners, 1976), there is, as yet, no other starting point from which to proceed (Gittelman-Klein, 1977).

A diagnosis of depression in a child has been considered to have been supported by a family history of depression, particularly if a parent were suffering from depression. Positive response to antidepressant medication has been considered to provide tentative diagnostic confirmation (Frommer, 1968; Annell, 1972).

Criteria for diagnosing depression in children are uncertain. A scheme for diagnosis, such as was advanced by Pearce (1977) or Dweck and associates (1977) would have the advantage of providing clear criteria for diagnosis of depression in children. However, the value of such a scheme would depend on verification that the criteria differentiate depression from other states, such as unhappiness, or prolonged grief or adjustment reaction, that criteria can be interpreted unambiguously by all clinicians, and that the scheme be incorporated into an accepted psychiatric classificatory scheme.

4.7.1 Summary of Diagnosis of Depression in Children

Criteria for diagnosis of depression in children are uncertain. Schemes listing criteria for diagnosis of depression in children have been proposed. In clinical practice diagnosis of depression in children has been based most frequently on the criteria used for diagnosing depression in adults.

4.8 CLASSIFICATION OF DEPRESSION IN CHILDREN

Depressive disorder in children may be classified in the Tri-axial Classification of Mental Disorders in Childhood (Rutter et al., 1969) under Neurotic disorders, depressive states. Depressive disorder in children may be classified in the ninth revision of the International Classification of Diseases of the

World Health Organization (ICD-9, 1975) under Disturbance of emotions in childhood/adolescence with misery. The second revision of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-2, 1968) has not provided a separate category for classification of depression in children.

The classification of depressive disorders in children presents difficulties in that categories provided by the classificatory schemes do not correspond with findings of recent research. (See Section 3.4) Furthermore, it is doubtful whether childhood depression may be classified validly in the same categories as adult depression, in that depression in children is not commonly seen in its adult form (Solnit, 1974; Anthony, 1976; Hersov, 1976; Malmquist, 1976). Cf. Table 9 in the Appendix.

Clinicians such as Graham (1974) and Werry (1976) have argued that 'true' depressive disorder, either unipolar or bipolar, is extremely rare in prepubital children; that what have frequently been called 'depressive disorders' in children by other clinicians, would more appropriately be designated 'Adjustment Reactions' in terms of the DSM-2, and 'Adaptation Reactions' in terms of the Tri-axial classificatory system.

The consensus of clinical opinion tends towards accepting that depressive reactions of children may be categorised as depression, although possibly differing from the adult form in being more transient and more tied to specific situations (Rutter, 1975). The issue whether depression in children should be classified with, or apart from adult depression remains unresolved.

4.8.1 Summary of Classification of Depression in Children

The classification of childhood depression is problematic. It is doubtful whether categories provided by Tri-axial, ICD-9 and DSM-2 classificatory systems for the classification of childhood depression have validity in terms of recent research. The classification of childhood depression in relation to adult depression is uncertain.

4.9 METHODOLOGICAL ISSUES CONCERNING THE STUDY OF DEPRESSION IN CHILDREN

The study of depression in children has been problematic because of ambiguity of depressive terminology, and because of confusion about the definition of depression in children. In addition there have been problems related to selection of subjects and designs of study.

Semantic ambiguity of terms such as 'depression' (See Section 3.1), 'reactive depression' and manic-depressive psychosis' (See Section 3.3) has created problems in communication that has made it difficult to select populations of depressive patients for specific investigations, and has hampered comparison of research findings.

The diagnosis of depression in children has been handicapped by lack of definitional criteria. Definitional criteria have not been provided by major classificatory systems (See Section 4.8), nor has the literature of depression in children arrived at a conclusive syndromal description of childhood depression. Further confusion relates to depression having been inferred, in some instances, from disparate behavioural problems and somatic complaints, sometimes in the absence of lowered mood under the rubric of 'masked' depression. Few of the studies reviewed specified minimal criteria for diagnosis of depression in children.

The majority of studies of depression in latency-age children and adolescence were based on retrospective analyses of clinical records or uncontrolled clinical studies of patients, with obvious drawbacks in terms of objectivity and reliability. Controlled prospective studies, with the exception of that of Nissen (1973), were based on very small samples, or selected populations, such as children presenting with school problems. None of the studies was compared with epidemiological studies of behaviours manifested by 'normal' children at particular maturational levels, or children suffering from other physical or psychiatric disorders. This is considered to be a serious omission. For example, a comparison of psychiatric clinical interview ratings given blind to normal and child psychiatric patients found that ratings of depression were significantly greater in patients than among normals, but were not

different among patients with neurotic, antisocial and mixed diagnoses (Rutter and Graham, 1968).

The study of depression in children is intrinsically problematic. Depressive feelings in children are inferred from behaviours that might represent emotions other than depression, such as unhappiness or anger. Behaviour patterns change with development, leading to children expressing their feelings or defending against them differently at various maturational levels (Solnit, 1974). Furthermore, children might experience certain events, such as death or separation, differently from adults (Wolff, 1973), leading to emotional responses that do not correspond to the responses that adults would have made to the same events. For example, if a young child acts-out after a bereavement, this might reflect uncertainty rather than grief, and it might be erroneous to interpret the acting-out response as being an equivalent of grief or depression.

Depressive feelings may accompany primary child psychiatric disorders other than depression (Rutter et al., 1970).

Lastly, what have been diagnosed depressive disorders in particular children, might have been appropriate responses, in terms of duration and intensity, to home situations that the children found intolerable, but had not the insight to assess, or the verbal fluency to describe, or they may not have felt free to talk about their home situations. None of the studies reviewed above described adequately the home circumstances of their child subjects.

In order to achieve clarity in the area of childhood depression, it is essential to establish clinical criteria for diagnosis. Associated with diagnosis is the need for reliable evaluations of home circumstances and psychosocial history, against which the clinical condition might be assessed.

4.9.1 Summary of Methodological Issues Concerning the Study of Depression in Children

Semantic ambiguity, lack of definitional criteria and unsatisfactory study designs have been associated with the study of depression in children, which is in itself intrinsically difficult.

4.10 CONCLUSIONS CONCERNING THE DESCRIPTION OF CHILDHOOD DEPRESSION

Studies of depressed children at maturational levels of infancy, latency and adolescence were reviewed with the aim of elaborating a composite picture of depressive disorder in children. A variety of different symptoms were associated with childhood depression in particular studies, and this led to equivocal findings. The following conclusions, based on trends rather than on substantiated data, are tentatively advanced.

Depression, analogous to depression in adults, was described in children over six months of age. Aetiology of depression was uncertain, but it was associated with genetic, biological, psychological and environmental factors. At particular developmental stages children appeared to be vulnerable to certain stresses as precipitants of depression. For example, infants were considered to be most vulnerable to separation from the mother-figure, whereas older children were particularly sensitive to maternal depression, and at a later stage they became vulnerable to bereavement.

Depression in infancy was described as manifesting with depressive appearance, apathy, withdrawal, feeding and sleeping disturbances, weight loss and developmental retardation. In latency age children depression was associated with depressive mood change, somatic complaints, social withdrawal, relationship problems, sleep difficulties, weight and appetite change, self-depreciation, school problems including school refusal and problems with schoolwork, tiredness, lack of energy, apathy and running away from home. It was considered that there might be a progressive shift towards adult depressive symptomatology with adolescence, with symptoms being influenced by adolescent conflicts, manifesting in the activities with which the adolescent was involved, and being coloured by the subculture to which the adolescent belonged. The association of completed suicide with depression was considered to be an important feature of depression in adolescence.

The concept of 'masked' depression, in which inferred depression was apparently defended against with behavioural or somatic symptoms, was not considered to be compatible with

depressive disorder. Nor was there considered to be evidence for associating angry, disruptive, antisocial behaviour with depressive disorder in children.

Depressive disorder in children, as in adults, was considered to be characterised by a cessation of active coping with the environment, withdrawal of emotional concern into the self, with misery, frequently accompanied by feelings of low self-esteem. Differences between depression in children and in adults appeared to lie in childhood depression being more transient and more tied to specific situations, greater somatic involvement, and less evidence of suicide and cognitive factors, the younger the child.

The epidemiology of depressive disorder in children is uncertain.

Criteria for the diagnosis of depression in children have not been established. Diagnosis of depression in children has been based most frequently on the criteria used for diagnosing depression in adults.

The classification of childhood depressive disorder is problematic. Categories provided by classificatory systems are unsatisfactory in terms of research findings. Furthermore, it is uncertain whether childhood depression should be classified with, or apart from adult depression.

In rare instances bipolar depression may be found in older children. This has been reported to manifest with mood swings, increased psychomotor activity, and may on occasion have been mistaken for hyperactive syndrome. Bipolar depression has been found in children with strong family histories of affective disorder.

The study of depression in children has been handicapped by ambiguity of depressive terminology, lack of defining criteria, and methodological problems in studies of depression. Until such time as greater precision in research is possible, the picture is likely to remain blurred.

X

5

TREATMENT OF CHILDHOOD DEPRESSION

The treatment of depressed children is related to the nature of the signs and symptoms, the severity of the disorder, and physical, psychological and environmental factors that might have been associated with the aetiology of the depressive disorder. Most important is the child himself, his maturational level, his personality with its strengths and weaknesses, his place in the family, and his place in the greater community.

Treatment may involve any or several of the following procedures: individual psychotherapy with the child, group therapy, parental counselling, family therapy, counselling or collaborating with the school teacher, remediation of specific disorders that might be associated with depression, treatment of possible associated organic pathology, and antidepressant medication. Its goal is symptom removal, helping the child to cope more adaptively with his needs and the demands of the environment, and where indicated, modification of the environment to accommodate the child less stressfully and with more understanding.

Treatment of the depressed child commences with a physical examination and the taking of a psychiatric history.

5.1 ASSESSMENT OF DEPRESSION IN CHILDREN

Assessment is based on the assumption that genetic, biological, psychological and environmental factors have interacted to have predisposed and precipitated depression in the child. (See Sections 3.6 and 4.6) Consequently, assessment aims at identifying presumptive aetiological factors.

Assessmemt may begin with a psychiatric history of the child, taken from one or both of the child's parents, or from the person in whose care the child has been placed. It is directed towards gathering the following information:

1. Whether there has been a family history of affective disorder, from which the parents might suffer, and to which the child might have inherited a predisposition;
2. The family's ethnic origin, religious persuasion and socio-economic level, for establishing whether the family is functioning as an integrated member of the community; if not, this could be a source of stress to a school-going child who might have difficulty reconciling his life outside the family with his life within the family;
3. Size of family, relationships between members and home atmosphere, with the aim of locating stressful factors in the home, and establishing the extent to which the child has reason to feel unhappy;
4. Collating significant events such as the death, injury or illness of a family member, move of house, or removal of the child from home for a period, about which the child might have unresolved conflicts;
5. The child's personal history, including his very early development, temperament, ways of responding to stress, interpersonal relationships and behaviour at home and at school; such information would delineate the child's premorbid personality and level of functioning, and the extent to which it has changed;
6. Birth injuries, head injuries and serious illnesses, which might have left stigmata that have bearing on the child's condition;
7. School record, including scholastic competence, possible learning problems, classroom adjustment and relationship with peers and teachers;
8. Extramural activities, including friendships and hobbies.

The psychiatric history clarifies the nature of the child's condition, that is, whether it is appropriate to the home or school situation, whether it is fairly recent, and whether it conforms to a pattern of family illness. It should cast light on ways of responding that might predispose to depression, areas of psychological vulnerability, areas of conflict, and stressful factors.

Secondary valuable sources of information are the child's school teacher and the family doctor, who may contribute additional

important material that has bearing on the child's condition, and provide perspective for the material already gained. For example, a perceptive teacher would be able to discern whether a child with the symptom of poor school adjustment had problems with his peers, his lessons, or in leaving home.

A family diagnostic interview is of value in identifying family beliefs, attitudes and ways of relating that might have bearing on the child's psychiatric disorder, and on his potential for recovery: the child's condition might be associated primarily with family dynamics.

Psychological testing, particularly intelligence testing, is always necessary with child patients. For example, a child of low intelligence or a child who has a learning disorder, might not be able to keep up with the academic level of the class, or might not be able to satisfy parental expectations, leading to the child giving up or withdrawing. Projective tests can illuminate intra-psychic and interpsychic areas of conflict.

A medical examination is performed to exclude organic conditions which might underly apparent depression, or which might be associated with secondary depression. (See Section 3.I.2)

When the nature of the depression has been assessed, and the clinician has arrived at an understanding of the child and the child's problems in the child's environment, treatment procedures may be formulated: if the depression were strongly associated with family dynamics, family therapy might be the treatment of choice; if the depression were related to intrapsychic conflicts or peer relationships, individual therapy might be a more useful starting point; if the depression were severe, particularly if there were a family history of depressive disorder, antidepressant medication may be indicated. Problems in all areas of functioning, home, school, personal problems and specific symptoms require therapeutic attention.

5.1.1 Summary of Assessment of Depression in Children

Treatment of the depressed child commences with assessment of the child, his family and his greater social environment. Optimally assessment involves a psychiatric history taken from the parents,

a report from the school, a report from the family doctor, interview with the child, psychological testing, medical examination, and a family diagnostic interview. Assessment confirms diagnosis, casts light on issues which might have precipitated depression, might be maintaining it, and might predispose to future psychiatric disorder.

Treatment procedures are formulated on the basis of understanding gained from assessment.

5.2 INDIVIDUAL PSYCHOTHERAPY OF DEPRESSED CHILDREN

Psychotherapy, directed towards facilitating insight, has been considered by some clinicians to be the treatment of choice for depressed children (Anthony, 1975). It has been suggested that with intensive psychotherapy the child's ego might be strengthened 'so that he can overcome his depression and learn how to cope with conflicts, tensions and painful events with his own inner resources', and by so doing, future depressions might be prevented (Mosse, 1974, page 107).

With young children, psychotherapy most appropriately takes the form of play therapy, with the child 'playing out' conflicts and gaining insight through the medium of play, possibly with the assistance of the therapist communicating to the child her perception of what he is feeling at particular points in time (Axline, 1969), in the context of a warm, empathetic, accepting relationship (Axline, 1969; Moustakas, 1953). Play therapy has been found effective with anaclitic depression (Bødtker, 1972). Mosse (1974) suggested that with older children the very act of talking about depressed feelings, giving names to mysterious emotions and discussing intimate concerns that have not been spoken of before, might be sufficient to lift depression.

Solnit (1974) and Toolan (1962, 1974), believed that depressed children and adolescents might be resistant to treatment because they feared experiencing depressive feelings, and that they defended against experiencing such feelings in their daily lives.

'In the course of the treatment, the underlying depression becomes uncovered, and with the support and interpretive assistance of the therapist the child is able to feel and cope with the depressive reactions. The interpretation of the defences against these sad feelings and sense of loss and helplessness will gradually enable the child to reexperience his depressive reactions and work them through.' (Solnit, 1974, page 113)

Toolan (1975) and Gilpin (1976) emphasised that while it was necessary for the child to trust the therapist and have a close therapeutic relationship in order for the child to find the strength to face the painful feelings of loss and diminished self, the danger of the child becoming overdependent on the therapist should not be overlooked. Gilpin considered termination of therapy to be highly significant in assisting the child to accept aggressive feelings over impending loss of the therapist without guilt, and to understand that termination of therapy is not rejection. Psychotherapy of depressed children was described as taking place in three phases: firstly giving support, secondly facilitating insight, and thirdly preparing for a more healthy acceptance of loss.

In addition to lack of insight into unconsious conflicts and maladaptive coping with loss, it has been suggested that there are children whose depressions might be associated to some extent with not having learned to cope adaptively with their environments. Where a child is unable to stand up for his rights among other children, where he lacks social skills that are necessary for peer acceptance, and where his life is circumscribed by phobic fears, the child is likely to feel lonely, depressed and have low self-esteem. With such children, a learning theory approach of training them in behaviours necessary for successful social functioning, or desensitizing them to phobic fears, is considered to be a valuable adjunct to intensive psychotherapy. (cf. Wolpe, 1973; Lewinsohn, 1974; See Section 2.4)

In cases of severe depression, where the child presented a suicidal risk, an interim period of hospitalization, during which time a supportive relationship might be formed with the therapist, was considered to be advisable (Frommer, 1968; Mosse, 1974; Anthony, 1975).

5.2.1 Summary of Psychotherapy of Depressed Children

Psychotherapy of depressed children may be directed towards supporting the child, facilitating insight into concerns and conflicts, and strengthening the child's ego so as to help the child cope more adaptively with frustration and loss.

Where the child has deficits in social skills or has phobias, behavioural training or behaviour therapy may be indicated.

In cases of severe depression, hospitalization may be indicated.

5.3 GROUP THERAPY OF DEPRESSED CHILDREN

Depressed children may be treated with group psychotherapy in place of, or together with, individual psychotherapy.

Mosse (1974) reported that all her depressed child patients were initially treated with individual psychotherapy, after which many were placed in groups. Group patients were treated with individual psychotherapy during crises.

Frommer (1968) employed a form of group treatment for depressed children based on the work of Steiner. Children met weekly for periods of 1½ - 2 hours in groups of approximately the same age. A prepared story, relevant to the problems of the group, or certain of its members would be told in weekly installments. The story would be reconstructed by the group, first in retelling, then in some artistic medium on the next occasion, before the following installment would be told. Frommer reported particular success using this method with immature and socially inadequate children.

Van de Lande (1972) reported success with depressed adolescents in a Dutch therapeutic community. Groups provided opportunity for the mourning process to be shared by others in the same phase. The expression of aggression was facilitated in adolescents coming from 'aggression-deprivation' families in which aggression was considered to have been associated with 'object loss', and therefore turned inwards against the self. (See Section 2.1.1)

5.3.1 Summary of Group Psychotherapy of Depressed Children

Group psychotherapy has been found to benefit depressed children, particularly where the children were immature or socially inadequate. Group interaction was considered to elicit socially adaptive behaviours that militated against depression in adolescents.

5.4 FAMILY MANAGEMENT OF DEPRESSED CHILDREN

Depressed children were frequently found to be experiencing considerable stress in their homes. Factors such as unrealistic parental demands, marital disharmony, threatened loss of a parent, parental illness, particularly depression, were considered to be factors that might lead to depression in children. (Mosse, 1974; Barker, 1976; See Section 4.2.1)

In some instances parental counselling on child management might be sufficient to effect change in the home. In others, where pathological modes of interacting were associated with the child's depressive disorder, family therapy might be indicated (Dare and Leared, 1972). Where a parent was psychiatrically ill, parental treatment was considered to be necessary, in certain cases, for recovery of the child (Frommer, 1968).

In instances where inadequate or destructive home environments were anticipated to perpetuate depression in a child, removal of the child from home might be indicated (Frommer, 1968; Mosse, 1974).

Frommer (1968) emphasised that family management could not be a substitute for treatment of the child; the child required to be treated independently.

5.4.1 Summary of Family Management of Depressed Children

Family management in the form of counselling, parental psychotherapy or family therapy might be necessary for recovery of the child. Family management was not considered to be a substitute for treatment of the child (Frommer, 1968). In certain instances removal of the child from the home might be indicated.

5.5 REMEDIATION OF SYMPTOMS OF DEPRESSED CHILDREN

Symptoms such as enuresis, encopresis, tics, learning disorders and other symptoms associated with depression, frequently require to be actively treated. Without treatment, they might linger on for months or years, independently of the depression, upsetting and embarassing the child.

Where depression has been associated with scholastic problems, it was considered to be important to remediate the child in the specific problems, and to help him to catch up with the other children so that once more he was able to function normally in the classroom (Frommer, 1968; Moss, 1974). Frommer argued that neglect of remediation could lead to an

> 'intractable series of relapses. Children depend even more on their capacity to function normally in the school situation in order to find their feet in life than an adult does on being able to do his work. Schooling influences their total growth and development, and handicap in learning means a handicap for life if it is not relieved.'
> (Frommer, 1968, page 133)

5.5.1 Summary of Remediation of Symptoms of Depressed Children

Where children have specific symptoms such as enuresis, encopresis, tics and learning disorders associated with depression, it is frequently necessary for the symptoms to receive specific treatment.

5.6 PHARMACOLOGICAL TREATMENT OF DEPRESSED CHILDREN

Although there have been few adequately controlled studies of the use of pharmaceuticals in the treatment of depressed children (Hersov, 1976), there has been growing recognition that in cases of severe and persistent depression, medication may be of benefit (Pearce, 1977). In cases of clearcut depressive disorder leading to impaired functioning, several clinicians considered a trial of of anti-depressant medication to be indicated (Frommer, 1967,1972; Stack,1972; Weinberg et al.,1973; Anthony,1975; Hersov,1976; Pearce,1977). Furthermore, it has been proposed that regardless

of whether depressive symptoms were primary, or secondary to another condition, antidepressant medication might help a depressed child function more effectively at home and at school (Kuhn and Kuhn, 1972; Polvan and Cebiroǵlu, 1972; Weinberg et al., 1973).

The majority of clinicians advocating pharmacological treatment of depressed children, considered tricyclic antidepressants to be the medication of choice, because of their greater safety and freedom from side effects (Hersov, 1976). Certain clinicians used a wider range of medication, and considered specific preparations to be more suited to different types of depressive disorders. Frommer (1976,1968,1972) and Stack (1972) considered monoamine oxidase inhibitors to be the most suitable treatment for children with 'phobic depressive states'. Frommer and Stack emphasised that what the drug could achieve as well as its side effects should be considered before prescribing it for a particular depressed child. Furthermore, they advised that where one type of antidepressant drug was not effective, another type of antidepressant should be given a trial. In some intransigent cases of depression, Frommer reported therapeutic success with combinations of monoamine oxidase inhibitors and tricyclic antidepressants. In cases of excessive anxiety, addition of a tranquilisor to the antidepressant medication was reported to have been beneficial.

Antidepressant medication usually has a lag of ten days to three weeks before becoming effective. Medication requires to be maintained while improvement continues, until the child has enjoyed a state of stable well-being for three to four weeks (Frommer, 1968).

Children with severe mood swings, possibly early manifestations of bi-polar depression, are considered to have been helped by lithium preparations (Frommer, 1968; Annell, 1969; Stack, 1972; Gram and Rafaelson, 1972; White and O'Shanick, 1977).

Electroconvulsive therapy (E.C.T.) has been used for the treatment of depressed children in rare instances. Frommer (1968) reported having used it in the treatment of two girls, aged 12 and 15 years, who were actively suicidal, and where the risk of E.C.T. was considered to have been warranted.

Clinicians advocating the use of medication for depressed children have generally empasised the importance of treating the underlying psychogenic cause of the depression. The value of drug therapy was considered to lie in accelerating the healing process, and in making severely depressed children receptive to active psychotherapy (Frommer, 1968; Weinberg et al., 1973). Polvan and Cebiroğlu (1972) pointed out that while theoretically the treatment of childhood depression should lie in helping the child in his family and greater environment, in cases where it was not possible to win the cooperation of the parents, medication might be the only avenue of treatment that was available.

5.6.1 Summary of Pharmacological Treatment of Depressed Children

Tricyclic antidepressants and monoamine oxidase inhibitors have been used in the treatment of depressed children. Their value was considered to lie in accelerating recovery, and making depressed children accessible to psychotherapy. Medication was not considered to be a substitute for resolving conflicts associated with childhood depressive disorder. Medication was advocated most strongly in cases of severe depression associated with impaired functioning.

Lithium has been used in the treatment of mood swings that were considered to be early manifestations of bipolar depression.

The use of pharmacological treatment of depressed children has not been substantiated by adequately controlled studies.

5.7 PROGNOSIS OF DEPRESSION IN CHILDREN

Depression in children has been considered to be a serious disorder that should not be regarded as a transient phase of normal experience and development. Frommer (1968) observed that untreated children might remain ill for protracted periods, often being subjected to intensive organic investigations of associated somatic symptoms. Pearce (1977) proposed that depressive disorder might lead to the development of unhealthy patterns of behaviour.

Anthony (1975) claimed that unless the neurotic conflict underlying depression were resolved, and some measure of insight attained by the child, the child would be likely to respond to all future frustrations and deprivations with depression. These clinicians considered that when it was possible to treat the child in his environment, the prognosis for a depressed child would be good.

Other clinicians have been less optimistic about the outcome of childhood depression. It has been suggested that children who were depressed as infants frequently manifested disturbances in affectional relationships and conduct disorders at later developmental stages (Bowlby, 1952; Goldfarb, 1955). Bowlby (1965) described the typical features of such children as including:[1]

> 'superficial relationships;
> no real feeling - no capacity to care for people or to make friends;
> an inaccessibility, exasperating to those trying to help;
> no emotional response to situations where it is normal - a curious lack of concern;
> deceit and evasion, often pointless;
> stealing;
> lack of concentration at school.' (Bowlby, 1965, page 37)

Infant depression was not considered by these authors to be continuous with depressions in later life.

Nissen (1973) performed a ten year follow-up study of 105 depressed children. (See Section 4.2.1) Of the 105 subjects, 47 percent developed 'neurotic depressions', 7 percent developed 'symptomatic depressions', and 5 percent developed 'psychopathic depressions'. The remaining 41 percent of the sample included one case of endocrine disorder, two cases of seizures, two cases of non-depressive neurosis, eight cases of self-neglect syndrome, nine cases of schizophrenia and fifteen with no psychiatric disorder. Nissen considered there to be no specific correlation between childhood depression and subsequent adult pathology. However, he concluded that depressed children were at high risk for developing a variety of psychiatric disorders.

Pritchard and Graham (1966) performed a survey of patients who had attended both the child and adult departments of the same psychiatric hospital. Their investigation failed to show a significant relationship between depression in childhood and

[1] Cf. the case of Amanda in the Appendix.

depressions in later life.

A follow-up study of child psychiatric patients by Dahl (1972) indicated lack of continuity between childhood symptoms and adult depression.

Present information suggested that childhood depression is not continuous with adult depression. However, definitional problems and lack of diagnostic criteria for depression have not permitted conclusive evaluations to be made. Furthermore, the majority of mildly depressed children, probably forming the bulk of depressed children, have possibly tended to be regarded as 'good' children, who have not required psychiatric attention.

In contrast to depression in childhood, single case studies of early onset bipolar depressions have suggested the condition to be continuous with adult bipolar depression (Anthony and Scott, 1960; d'Elia and Perris, 1972; Carlson, 1977; White and O'Shanick, 1977).

5.7.1 Summary of Prognosis of Depression in Children

Information about the prognosis of childhood depression is uncertain. Some clinicians consider the prognosis to be good provided that it is treated, and others consider it to predispose to a variety of psychiatric disorders. Significant indications of continuity between childhood depression and depression in adults have not been found. Definitional problems and lack of diagnostic criteria do not allow conclusive evaluations to be made.

Isolated studies have suggested early onset bipolar depression to be continuous with adult bipolar depression.

5.8 CONCLUSIONS CONCERNING THE TREATMENT OF CHILDHOOD DEPRESSION

Treatment of the depressed child is related to the nature of the signs and symptoms, the severity of the disorder, and physical, psychological and environmental factors that might have been associated with the aetiology of the depressive disorder. Most important is the child himself, his maturational level, his

personality with its strengths and weaknesses, his place in the family and his place in the greater community.

Treatment of the depressed child commences with assessment, optimally involving a psychiatric history taken from the parents, a report from the school, a report from the family doctor, interview with the child, psychological testing, medical examination, and a family diagnostic interview. Treatment procedures are formulated in accordance with information gained from assessment.

Treatment may involve any or several of the following procedures: individual psychotherapy with the child, group psychotherapy, parental counselling, family therapy, remediation of specific disorders that might be associated with depression, treatment of possible associated organic pathology, and anti-depressant medication. In cases of severe depression, particularly where the child presents a suicide risk, hospitalization may be indicated. In the case of an inadequate or destructive home environment, removal of the child from the home might be advisable.

The aim of treatment is symptom removal, helping the child to cope more adaptively with his needs and the demands of the environment, and modifying the environment to accommodate the child less stressfully and with more understanding.

Prognosis of childhood depression is uncertain. Although studies have suggested lack of continuity between childhood depression and depression in adults, definitional problems and lack of diagnostic criteria do not allow conclusive evaluations to be made.

There is at present uncertainty about the treatment of depressed children and their prognosis. Isolated theorists, for example Frommer (1968) and Mosse (1974) have written comprehensively about the treatment of depressed children, but their work has not been supported by controlled studies. Studies of pharmacological treatment of depressed children have not yielded evidence as to which children benefit from medication and at what maturational stages. To a great extent uncertainty about treatment relates to uncertainty about the syndrome itself. It is not yet possible to talk of treating depression in children: it is the child who is depressed that is being treated.

6

CONCLUSIONS CONCERNING DEPRESSION IN CHILDREN

A review of the literature of depression in children has indicated childhood depression to be a vague, ill-defined area. There is no clear picture of symptomatology, no accepted criteria for diagnosis, understanding of aetiology is speculatory, and knowledge of course, treatment and prognosis is uncertain. As yet there has been no agreement about the nature of depression in children: whether it is analogous to depression in adults, or different, whether depressive affect is overtly manifested, or whether it is 'masked' by somatic or behavioural equivalents.

To a certain extent this confusion may be attributed to ambiguity of the terminology of depression, which has contributed towards definitional difficulties, both of which have been associated with methodological problems in studies of depression. These factors have inhibited assembling a common body of information about depression that could be tested and validated.

There are difficulties inherent in the study of depression in children, in that clinicians are largely dependent for information on parents and teachers, who might give selective attention to differing symptoms, describe what they observe in idiosyncratic ways, and interpret it according to varying assumptions. Further difficulties stem from depression being inferred from behaviours that might reflect disturbances other than depression. Children's behaviours change with development, and different behaviours might represent different feelings at different ages. Stimuli too might affect children in varying ways at changing maturational levels.

Clinicians have recently proposed guidelines for diagnosing depression in children, and so arriving at a common definition. Some clinicians, for example, Pearce 1977), have proposed criteria for diagnosis of depression in terms of the presence of certain symptoms. Gittelman-Klein (1977), who considered anhedonia to be the common feature of children suffering from depression, proposed that a large-scale analysis should be made of children with

anhedonia as a starting point for the definition of depression in children. The Committee of the Center for Studies of Child and Family Health of the National Institute of Mental Health proposed basic criteria of dysphoria with 'generalised impairment in response to previously reinforcing experiences without concomitant introduction of new sources of reinforcement that is generalised across settings, and of duration for at least four weeks' (Dweck et al., page 153). These proposals may be criticized in having been a priori derived from children already considered to be depressed.

The author considers that it would be more substantive to formulate criteria for diagnosis of depression in children from first principles; that is, from a consideration of what is conceptually meant by depression. Theorists of different theoretical orientations have explicitly, or implicitly, conceptualised depression in terms of cessation of active coping with the environment, withdrawal of emotional concern into the self, and lowered mood, misery and unhappiness. (See Chapter 2) This view of depression is consistent with the medical model of depressive disorder. (See Chapter 3) Furthermore, a review of studies of depression in childhood yielded an analogous picture of depression in children. (See Chapter 3)

Based on the assumption that depression has conceptual implications of a specific nature, the perspective of diagnosis of depression in children changes. Symptoms such as anhedonia. poor concentration, school refusal, disturbed peer relationships, early morning fatigue, loss of interest in play and bordom are no longer random symptoms that have been associated with depression in children by different clinicians. They become conceptually understandable as a withdrawal of psychic energy from the environment. Together with lowered mood and sadness, they point to depression. When withdrawing behaviour and depressive mood are generalised to many situations, and represent a change from previous behaviour and mood, that is in excess of, or of longer duration than could be justified in terms of environmental or physical events, a diagnosis of depression in in children, as in adults, would be appropriate. With this perspective, specific symptoms may be assembled as a second step in the description of depression in children. (See Appendix).

With this perspective, depression in children is considered to be analogous to depression in adults, but consonant with the maturational level of the child, coloured by the child's interests, and manifested in the activities with which the child is involved.

Energetic behaviours demonstrating active environmental involvement, such as defiance, angry, disruptive behaviour, and delinquency, are not considered to be consistent with what is conventionally denoted by depressive disorder. Such behaviours are not considered to be masks of depression, even when accompanied by depressive feelings.

The concept of 'masked' depression is considered to be irrelevant, in that diagnosis of depression is based on a pattern of symptoms that essentually include lowered mood and misery. It is accepted that the moods of depressed children may fluctuate, in the same way that mildly depressed adults may be distracted at times, but the overwhelming affect is that of depression.

In the literature attention has not been given to possible differences between mild depression and severe depression in children, such as occurs in adults. (See Section 3.3) This may represent an important avenue for future research.

Issues such as aetiology, course, treatment and prognosis of depression in children must await a clearer definition of the syndrome before clarification will be possible.

APPENDIX

PILOT STUDY OF DEPRESSION IN CHILDREN

Abstract: Manifestations of depression were investigated in a sample of 18 children aged 3½ - 16 years, referred to a university child guidance clinic. Aetiology, symptomatology, treatment and prognosis were analysed. Incidence was discused. Guidelines for diagnosis of depression in children were tentatively advanced. Sample size was considered too small for generalization.

The manifestation of clinical depression in children is controversial. In spite of a growing body of literature on the subject, there is limited agreement between clinicians regarding the nature of the syndrome. By some it is considered to be analogous to depression in adults. By others it is considered to be qualitatively different. Certain clinicians, such as Graham (1974) and Werry (1976) have expressed doubt that depressive disorder occurs in children in any but very rare instances. At present there is no clear syndromal picture of depression in children and no accepted criteria for its diagnosis.

Associated with lack of definitional data on depression in children is uncertainty regarding its aetiology, epidemiology, treatment and prognosis. Aetiology has been considered to involve the interaction of genetic, biological, psychological and environmental factors (Anthony, 1976). Reported incidence has ranged between 1,8 - 25 percent of child psychiatric referrals (Annell, 1972). Treatment has included psychotherapy, family and environmental management, symptomatic treatment and antidepressant medication (Frommer, 1968). Prognosis has been considered good by some authors (Pearce, 1977), guarded by others (Nissen, 1973).

Aim of Study

The aim of the study was to investigate the manifestation of depression in children. Conventionally depression has been described as a syndrome characterised by lowered, unhappy mood, cessation of active coping with the environment, and withdrawal of

emotional concern into the self, with associated signs and symptoms that cannot be related realistically to environmental or physical events, in terms of intensity or duration. While some descriptions of depressed children have been consistent with this picture (eg. Pearce, 1977), other descriptions have included disparate behaviours such as anger, defiance, disruptiveness and antisocial behaviour; in some cases, under the rubric of 'masked depression', depression has been diagnosed in the absence of lowered mood (eg. Toolan, 1974). The intention here was to assess whether there was justification for accepting in children a view of depression that did not correspond with what traditionally was meant by depressive disorder.

Subjects

The subjects included 18 of 182 children who had presented at the University of Cape Town Child Guidance Clinic in 1977, and had been allocated to the author in a random manner. There were 9 boys and 9 girls aged 3½ - 16 years. Three of the children had been referred for school readiness assessment, four for assessment for giftedness, four for scholastic problems, three for behavioural problems, two for emotional problems, one for stuttering, and one for bizarre behaviour. Five of the children had feelings of unhappiness, misery and depression. The clinical histories of these five children are summarised below.

Clinical Histories

Case 1: Ruth, aged 3¾ was referred by her father because of increasing tearfulness, often for no apparent reason. Family and personal history: Ruth had been a planned baby, conceived to replace a sister who had died of leuchaemia. She was described as a happy healthy baby with advanced milestones. When Ruth was 14 months old, mother was killed in a motor accident. Maternal aunt moved into the home to look after Ruth and her sister Cloë. An intimate relationship developed between maternal aunt and father, and she moved away 10 months later when the relationship ended. Father cared for the children himself, until three months later he remarried a divorcee with a daughter, Brigitta. Stepmother replaced father as Ruth's main caretaker, and weaned and toilet-trained

Ruth, then $2\frac{1}{4}$. Ruth became sickly, ran high temperatures, and was subjected to stressful medical tests for several months. She had her tonsils out immediately after the birth of a baby brother, and a month later she was referred to the Child Guidance Clinic. The family constellation at the time of presentation consisted of father, aged 39, stepmother, aged 34, Cloë, 13, Brigitta, 11, Ruth, $3\frac{3}{4}$ and Justin, 6 weeks. At clinic interview stepmother complained of Ruth lacking spirit, withdrawing to her room, not enjoying playing, responding with tears to instructions such as to have a bath, waking up crying, picking at her food, not being able to relate to other children or stand up for her rights with them, and causing serious marital disharmony in that father tended to protect Ruth against stepmother. Ruth presented as a thin, frail child who remained immobile, mute and withdrawn as stepmother openly expressed hostility for her. Dynamics: Clearly Ruth was a child who had sustained traumatic emotional losses, had received a rejecting mother surrogate at a delicate maturational stage, and probably competed with her for father. She had experienced stressful medical attention, had lost her position as 'baby', had an operation, and was exposed at home to hostility from mother, and mother's criticism of father when he gave Ruth attention. Treatment: Ruth was given play therapy and stepmother supportive therapy, with the aim of starting family therapy once mother had attained insight into the needs of children and her responses to Ruth. With play therapy Ruth became animated, directing tremendous aggression against dolls in a manner reminiscent of stepmother. At home she became less tearful and more assertive, and mother found it easier to respond positively to her.

Case 2: Amanda, aged $4\frac{1}{2}$ was referred to the Child Guidance Clinic with the following emotional and behavioural problems: 1.mutism with her foster parents and other adults, 2.inability to laugh, 3.not eating unless fed, 4.enuresis, 5.messing and smearing faeces, 6.rejecting cuddling and not showing affection, 7.sleep disturbance, 8.autoerotic behaviour and stuffing things up her nose, 9.smacking another child when smacked herself, 10.staring vacantly, and not answering when spoken to. Full neurological and developmental examination revealed developmental retardation; her intelligence was estimated as low normal. Family and personal history: Amanda, aged $2\frac{1}{4}$ and her sister, Carol, aged $3\frac{1}{2}$ had been placed in Tenterden Place of Safety as 'children in need of care' when their father was sent to an alcoholic rehabilitation centre. Mother was of low intelligence, had never been employed, and was inadequate. The family had no fixed abode. Amanda and Carol were fostered to the same family, but Carol was returned after two months because it was claimed that she engaged in bizarre behaviour. Foster family had previously adopted a girl Kim, aged 8 and a boy Marthinus, aged $4\frac{3}{4}$; they had been eager to adopt Amanda but adoption had been blocked by Amanda's father. At clinic interview the foster parents presented as grossly obese people, and in their presence Amanda was mute, withdrawn,

and stared vacantly into space. However, in a subsequent play situation with foster mother and foster siblings in the clinic on the same day, Amanda played vigorously, and with the children she was not mute. Dynamics: Amanda might have become anaclitically depressed (Spitz, 1946) after placement in the institution; she might not have regained her trust in adults. Treatment: antidepressant medication was prescribed for Amanda, but it was not administered. With play therapy Amanda became animated and talkative, playing out domestic activities such as making coffee, telephoning, and 'bossing' the therapist. Conflicts emerged in connection with her foster sibs attending school and she being left at home, and she appeared to be competing with foster mother for foster father. At home she was reported to be chattering to her foster parents and her symptoms were reported to have disappeared.

Case 3: Caroline, aged 7, was referred to the Child Guidance Clinic by her mother because of misery, crying and mood swings. For no apparent reason, anytime, anywhere, Caroline's mood would change from equanimity to unhappiness and withdrawal. She disliked school, complained of being bored, and was isolated from her peers. She was fearful of going into crowded places such as resturants. She had no real friends of her own, but liked being with her sister and with adults. She also enjoyed ballet and art. Family history: Father was a 39 year old man who was suffering from Ankylosing Spondylitis that affected his spine and eyes. About four years ago he had become severely ill, lost an eye, and was in and out of hospital for six months. Recently his other eye had bled. Illness had caused father to give up driving, and he had retired from working in the motor business to keeping an antique shop. His illness was being held in check with high dosages of drugs with depressive effects. Mother was a 33 year old university graduate, whose work as a successful estate agent frequently took her from her family at odd hours. Susan, aged 9½ in Std.II, was a popular, competent, successful child. There was a history of depressive illness in father's family. Personal history: Caroline had been an adaptable, healthy, sociable child with normal milestones. In her first year at nursery-school, aged 3½, she had been involved, creative and well-adjusted, mixing with her peers. Thereafter she became progressively less interested until in her third nursery-school year she moved in the group without participating. In the teacher's words 'Caroline was almost a non-child: irritating, not bothering and achieving poorly. She was admitted to an intellectually undemanding primary school, aged 6½, where her work was rated A+, but she was not able to read. At clinic interview the family presented as concerned but relaxed, with the parents being supportive of each other, and Susan tending to 'parent' Caroline. Caroline presented as a coy, selfconscious child, unassertively permitting her sister to speak for her and correct her. Her I.Q. was reflected as 142+ on the Wechsler Intelligence Scales, placing her in the 'gifted child' range. Dynamics: Fear and inability to make sense of her father's illness, and inability to fit in with the other

schoolgirls because of her extraordinarily high intelligence, might have precipitated loss of self-esteem and misery in a child with high aspirations and a predisposition to mood disorder. Low mood might have been maintained by Susan's contrasting success and parenting tendencies. Treatment: In playtherapy Caroline expressed aggression, repeatedly enacting a scene in which she first shot the therapist and then revived her.. Arrangements were made for her to be moved to an intellectually demanding school. In the home Caroline responded by becoming more assertive, and mood swings disappeared. At follow-up three months later she was reported to be making a good adjustment at her new school.

Case 4: Shane, aged 12½ was referred to the Child Guidance Clinic by his housemother at St.John's Hostel because of recurrent 'black' moods with aggressive acting-out behaviour, of many years duration. Family and Personal History: Father had been jailed as an habitual criminal and Shane had never known him. Mother, who had been married three times, had five children, all of whom had been declared in need of care. A.C.V.V. records described her as being 'irresponsible' and a 'blatant liar'. Shane, and his younger brother Baudrie, had spent their infancy in an environment of drunken debauchery and violence. After complaints of neglect and child abuse, the boys had been placed in foster care, moved to Tenterden Place of Safety, transferred to East London Children's Home, brought back to Cape Town to St.Michael's Home, to be nearer mother, then moved to St.John's Hostel. The boys seldom saw mother, and most of their week-ends and holidays had been spent in the hostel. Mother blatently favoured Baudrie, and repeatedly let Shane down. For several months Shane had refused to have contact with her. Shane's relationship with Baudrie was ambivalent in that he was fond and protective of him and hostile and aggressive at times. Shane made friends easily but his friendships were transitory and peers tended to tease him. Shane was a Special Class child with a reading disorder, and he could not yet read. During his 'black' moods Shane behaved badly at school as in the hostel, was defiant, disruptive and resisted discipline. Shane was also afraid of the dark. At clinic interview Shane presented as a likeable child with insight into his problems, but lonely, unhappy and angry. Treatment included counselling St.John's Hostel staff and Shane's teacher on managing his behaviour and helping him with his problems, psychotherpay with Shane, and cojoint meetings with Shane and Baudrie with the aim of improving sibling communication. Shane responded positively for some time. Then mother promised to make arrangements for him to leave the hostel and live with her, and let him down. Shane ran away from the hostel, and told the therapist afterwards that he had tried to be knocked down and killed by a car on several occasions. He also tried to kill himself by riding down a steep hill on a bicycle without brakes. He began carrying a knife and would remark that if anyone made him angry 'they would get it.' Dynamics: Shane may have inherited a predisposition to psychiatric problems from his unstable parents, and this is likely to have been strengthened by early experiences

of neglect, abuse and parental violence, followed by a succession of caretakers. Shane's learning difficulty may have lowered his tolerance of frustration. Lifelong institutionalism, even over holidays, evoked anger, depressive feelings, and probably feelings of worthlessness. Such feelings are likely to have been exacerbated by being let down by his mother and having his brother favoured. Shane is likely to have interacted with and modelled the aggression of other hostel boys. Finally, during the course of his life, Shane may have learned that black moods and tempers can be effective in manipulating the environment and in gaining recognition. Shanes parasuicides were viewed as gestures of despair, but were considered to be angry punitive acts directed against the adults in his life rather than acts of final withdrawal.

Case 5: Chiara, aged 16½, was referred to the Child Guidance Clinic by her mother for staying away from home without permission. Family History: Father was an advocate /part-time lecturer; a cynical man of Afrikaans origin. Mother was a bank personnel officer, of Italian descent and Roman Catholic religion. After divorcing father, she had remarried and divorced again. She had emeshed relationships with the maternal grandparents who lived close by, and with her children, Chiara, Tanya, aged 14½, and half brother Jevon, aged 3½. Family interaction consisted largely of tantrums, emotional blackmail, inconsistent discipline and frequent comparisons between the girls, with Chiara being more highly valued by her mother. Personal History: Chiara had been an unplanned baby, demanding and willful, with advanced milestones; she cried until she vomited. As a young child she resisted going to bed, was wakeful, had frequent nightmares that resulted in her going to her parent's bed. From 2 years Chiara had tonsillitus and sinusitis, and had continued to have trouble after tonsillectomy at 7 years and antrostomy at 9 years. She had a history of frequent vague illnesses, colds that lasted too long, and attacks of dizziness and billiousness in her early teens, which after organic investigations were attributed to emotional problems. She had many headaches, and had to be stopped from taking aspirins. As a child she was afraid of many things; temperamentally she was volatile, throwing tantrums and banging doors. Chiara had enjoyed primary school at Springfield Convent, but disliked the 'regimentation and conformity' of Rustenberg, found classes boring, and frequently 'bunked'. Chiara was socially skilled, but she had no long-standing friendships. Her friends fell into different subcultures, and she found coping with their different expectations of her taxing. Her boyfriend was a married pop star band musician, and she was under considerable pressure to give him up. She had tried alcohol and drugs, but did not use them regularly. Before Chiara presented, she had run away from her mother's home, had changed schools and had been given into her father's custody. At clinic interview Chiara presented as an attractive, plump girl, intelligent but emotionally immature, who enjoyed generating a reaction of 'what are we going to do about Chiara', but felt lost and uncertain of what to do about her life. Projective testing revealed themes of ambivalence, inadequacy, alienation, depression,

violence, death and suicidal ideation, with a rigidly controlling superego, suggesting that she could become a suicide risk. Dynamics: Chiara might have been temperamentally vulnerable as a baby (Rutter et al., 1964), grew up in an unstable home with an inconsistent, emotionally intrusive mother. Chiara's dizziness/nausea syndrome might have been related to insecurity engendered by domestic unpredictability. It is probable that she never learned to control impulses or to resolve problems constructively. Acting-out and running away from home might have been related to a 'need' to break away from an emeshed family and find her own identity (Erikson, 1954). Treatment: with individual psychotherapy Chiara became emotionally congruent, resolved conflicts relating to her relationships with her parents and peers, and assumed responsibility for her life.

Discussion

The five children whose case histories have been summarised above were all unhappy, and could have been inferred to have had depressive feelings. However, only two of the children were considered to have been suffering from depressive disorder, and a third was considered to have manifested the stigmata of a previous serious depressive condition (Spitz, 1946; Bowlby, 1965). The remaining children were considered to have been suffering from a conduct disorder and an adjustment disturbance, respectively. (See Table 9)

Ruth, aged 3½, was diagnosed to be suffering from mild depressive disorder (Kendell, 1976), in that she was excessively tearful, withdrawn, anorexic, anhedonic, unable to express aggression, in that symptoms affected her play and peer relationships, and represented change from how she had been at an earler age. Although Ruth's unhappiness might have been proportionate to her home situation, her constellation of symptoms suggested her manner of handling her unhappiness to constitute cessation of active coping with the environment and withdrawal of emotional concern into herself. For this reason she was considered to be depressed rather than just unhappy. Furthermore, with therapy, Ruth was able to reverse the process, in spite of her home circumstances remaining fairly unchanged.

Amanda, aged 4½, was considered to manifest, in certain situations the signs of an earlier anaclitic depression (Spitz, 1946), probably associated with severe deprivation. Why she related to children and not adults was uncertain, but one might speculate that

Subject	Diagnosis	Classification	
Ruth	Depression	ICD-9: Tri-axial,	Disturbance of emotions in childhood with misery. Axis I: Neurotic disorder, depressive Axis II: Normal intelligence Axis III: Major environmental factor of emotional or attitudinal nature.
Amanda	Depression	ICD-9: Tri-axial,	Psychosis, origin specific to childhood, other (apsychotic). Axis I: Psychosis, other Axis II: Normal intelligence Axis III: Major environmental factor of social or material nature.
Caroline	Depression	ICD-9: Tri-axial,	Disturbance of emotions in childhood with misery Axis I: Neurotic disorder, depressive Axis II: Normal intelligence Axis III: No known associated or clinical factors.
Shane	1. Conduct disorder with misery. 2. Learning disorder	ICD-9 Tri-axial, Tri-axial,	Disturbance of conduct, mixed disturbance of conduct and emotions. Reading retardation. Axis I: Conduct disorder. Other specific learning disorder. Axis II: Normal intelligence. Axis III: Any major environmental factor of social or material nature. Any major environmental factor of emotional or attitudinal nature. Developmental disorder.
Chiara	Adjustment	ICD-9 Tri-axial,	Adjustment reactions with mixed disturbance of emotions and conduct. Axis I: Adaptation reaction. Axis II: Normal intelligence Axis III: No known associated or clinical factor.

Table 9: Summary of diagnoses and classifications of cases with depressive features.

as a young infant she had learned to be wary of adults and that her foster parents might not have been sufficiently skilled to break through her defences and make emotional contact, and because of this she had retained many regressive behaviours. Certainly Amanda formed a therapeutic relationship quickly and easily, and from that point she advanced to responding to her foster parents, with accompanying remission of other referral symptoms. Amanda was considered to be either recovering from,or to bear residual stigmata of depression, in that, in spite of initial mute, non-responding behaviour with adults, she had played in an assertive and involved manner with her foster siblings, manifesting active coping and emotional involvement with the children.

Caroline, aged 7, was considered to have been suffering from mild depression (Kendell, 1976), because although there were times when she was reasonably happy, her prevailing mood was one of unhappiness; her mood would abruptly change to one of unhappiness with weeping and withdrawal in any situation, at any time, and for no apparent reason. She was maladjusted at school, isolated from her peers, and had no friends of her own. She was unassertive and unable to show aggression. Her misery could not be related to circumstances in her home realistically, and represented a change from previous behaviour. The family history of depression and Carolin's mood swings suggested that she might have been manifesting early bi-polar depression (White and O'Shanick, 1977).

Shane, aged 12½, was not considered to be suffering from depressive disorder. Although he was frequently miserable and had feelings of worthlessness, the feelings were of long-standing, and could be related to his upbringing, his relationship with his mother, and his inability to achieve at school. Furthermore, he responded to these feelings with aggressive behaviour towards objects and people. Shane's parasuicides appeared to be angry actions aimed at punishing the people who were in control of him, rather than gestures of withdrawal from life. Shane's interactions manifested intense involvement with events and people, as opposed to cessation of active coping and withdrawal of emotional concern. It was considered that to describe Shane's symptomatology as 'masked depression' would have extended the meaning of depression

beyond that which is useful.

Chiara, aged 16½, was not considered to be depressed. Her feelings of depression, isolation, alienation and ambivalence could be related understandably to the emotional stress of breaking away from her mother, and the conflicts generated by contravening social norms. Her ajustment reaction with disturbance of emotions and conduct could possibly be understood in terms of adolescent 'inner turmoil' (Rutter, Chadwick and Yule, 1976).

Subject	Referring Complaint	Symptom
Ruth	increasing tearfulness	lack of spirit, withdrawing, not enjoying play, tearfulness on waking, disturbed peer relationships, inability to show aggression, feeding problems.
Amanda	multiple emotional and behavioural problems	staring vacantly, selective mutism with adults, inability to laugh, rejecting cuddling, smacking other children when smacked, feeding problems, enuresis, disturbed sleep, autoerotic behaviour, stuffing things up her nose, messing and smearing faeces.
Caroline	misery, crying and mood swings.	misery, crying, mood swings, disturbed peer relations, maladjustment at school, boredom, fear of crowded places.

Table 10: Summary of symptoms of depressed children.

Clearly symptomatology of the depressed children was not identical (See Table 10). However, symptomatology had been reported by the children's caretakers. In the clinic, Ruth and Caroline presented in a similar manner. Could 'tearfulness for no apparent reason' be equated with 'mood swings'? Could different parents attach significance to different behaviours? Such factors could account for the diversity of symptoms associated with depression in children. Amanda presented a qualitatively different picture from Ruth and Caroline. She was considered to have experienced a serious anaclitic depression, and it was possible thather regressive symptoms, such as faeces smearing might

have been associated with developmental retardation found in anaclitic depression (Spitz, 1946). None of these children presented with aches and pains associated with depression in children by some clinicians, for example, Frommer (1968) and Nissen (1973).

Treatment was restricted to psychotherapy, and response in each case was rapid in terms of remission of symptoms. Estimated longterm prognosis of these children was guarded. Unless Ruth's family should enter family therapy, it was considered that she would continue to be exposed to stressful family interactions. Amanda was considered to be at high risk for developing the affectionless, antisocial personality associated with infantile deprivation and depression by Bowlby (1965). Caroline was considered to be likely to respond to stress at a future date with misery, mood swings and withdrawal. Prognosis might have been more optimistic were these children to have received extended intensive psychotherapy.

The incidence of depression in the sample of 18 children seen by the author was 17 percent. This was a conservative estimate, in that 40 percent of the sample had been referred for assessment of school readiness or giftedness, and 60 percent had been referred with emotional, behavioural of scholastic problems. Of the children referred with problems, 27 percent were diagnosed to be suffering from depressive disorder. (cf. incidence of depression found by participants of the Fourth Congress of European Pedopsychiatrists varying between 1,8 - 25 percent, Annell, 1972).

The children were considered to be suffering from overtly manifested depressive disorder, analogous to adult depression, but consonent with younger, less mature personalities.

Conclusion

In a sample of 18 children referred to the University of Cape Town Child Guidance Clinic, three cases of depressive disorder were diagnosed. The children manifested lowered mood, withdrawal, anhedonia, appeared to be unable to cope with their environments, and had associated symptoms that could not be realistically related to environmental or physical events, in terms of intensity or duration.

Conceptually their conditions were consistent with the view of depression being characterised by lowered, unhappy mood, cessation of active coping with the environment and withdrawal of emotional concern into the self. The disorders of the children were considered to be analogous with depression in adults, but differed in being consonent with the developmental levels of the children.

Depressive feelings were found in association with other primary child psychiatric disorders. These disorders were not considered to be 'masked' depressions. (cf. Rutter and Graham, 1968)

Parents used differing terms to describe what were considered to be similar symptoms. Because of such factors, it was considered that symptoms suggesting generalised withdrawal of energy from the environment (including symptoms such as social withdrawal, poor coping, problems with schoolwork, inhibition of play), representing change from previous behaviour, might provide a more reliable guide to the diagnosis of depression, than specific symptoms.

Size of sample was considered to be too small for generalization.

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