

Psychoanalytic Psychotherapy as a Treatment for Depression in Adolescents: A Case Study

Global Journal of Social Sciences Studies

Vol. 4, No. 2, 91-101, 2018

e-ISSN: 2518-0614



Piliros-Dimitris Stavrou¹

¹Department of Psychology, University of Athens, Athens, Greece, 10679 Laboratory of Clinical Psychology, Psychopathology and Psychoanalysis (PCPP), University Paris Descartes – Sorbonne, Paris, France.

21 G. Papandreou Street, 15773, Zografos, Athens, Greece

Email: piliros.stavrou@gmail.com

ABSTRACT

The present article is an in-depth analysis of the use of psychoanalytic psychotherapy as a therapeutic tool for depression in an adolescent suffering from depressive symptoms. Drawing from psychoanalytic theories on object relations, transitional space and object, transference and countertransference, psychoanalytic psychotherapy is employed as a treatment for depression and the therapeutic relationship is examined as the space that allows for an improvement on the adolescent's emotional state and well-being. The effects of therapy are analysed using phenomenology as a theoretical approach and are demonstrated here through the use of thematic analysis, which provides a detailed examination of the adolescent's symptomatology prior and later the beginning of therapy.

Keywords: *Depression, Adolescence, Psychoanalytic psychotherapy, Phenomenology, Case study, Thematic analysis.*

DOI: 10.20448/807.4.2.91.101

Citation | Piliros-Dimitris Stavrou (2018). Psychoanalytic Psychotherapy as a Treatment for Depression in Adolescents: A Case Study. Global Journal of Social Sciences Studies, 4(2): 91-101.

Copyright: This work is licensed under a [Creative Commons Attribution 3.0 License](https://creativecommons.org/licenses/by/3.0/)

Funding: This study received no specific financial support.

Competing Interests: The author declares that there are no conflicts of interests regarding the publication of this paper.

History: Received: 27 June 2018/ Revised: 3 August 2018/ Accepted: 11 September 2018/ Published: 24 September 2018

Publisher: Online Science Publishing

1. INTRODUCTION

1.1. Classification

Depression is a mood disorder which manifests through a wide variety of symptoms, depending on the age of the patient and the type of depression they experience. Recent findings suggest that it is more common among adolescents in the past 20 years, as the number of adolescents who are being referred for depressive symptoms has been increasing gradually. In order to examine depression among adolescents, we employ the definition provided by the DSM, which identifies three categories of morbid depression, which apply to all ages. These are a major depressive disorder, dysthymic disorder, and atypical depressive disorder. Research in the field proposes that major depressive disorder is more common in childhood and adolescents (Fleming and Offord, 1990; Bernstein and Borchardt, 1991).

1.2. Aetiology of Depressive Disorders in Childhood

It is a shared belief among mental health professionals that the roots of depressive disorders are usually multifactorial, as its aetiology appears to be genetic, sociological and psychological antecedents. Regarding sociological factors, environmental studies which have taken place in the UK, America, Canada and New Zealand (Costello, 1989) suggest that low socioeconomic status, high life stress, low academic achievement and family dysfunction are all associated with the manifestation of psychiatric disorders. Current concepts of depressive disorders in childhood use criteria that are closely comparable to those in adults and, as with adult models, it is useful to consider what factors may make the child vulnerable to mood disturbance and what events can precipitate a depressive episode.

1.3. The Psychoanalytic Perspective on Depression

Psychoanalytic theories on depression offered an explanation of depression rooted in loss, guilt and object relations theory. Based on theories formulated by Freud, Abraham, and Klein object refers to significant external figures (particularly parental), and to internal representations of those figures. These internal representations are developed on the basis of lived experiences (especially early in life) with parental figures, and through the individual's own internal processing of those lived experiences. In other words, internal objects both reflect directly the reality of external figures and are significantly shaped by the individual's own projective and introjective processes. The world of internal objects is a dynamic conception and, hence, forever in movement and subject to change. The outcome of such guilt was understood to be a sense of the self as worthless, bad, and potentially destructive, and the typical depressive symptoms, such as self-criticism and the wish to die, were understood as the behavioural manifestation of these underlying dynamics. Following the focus on object relations, there has been an increase in interest among psychoanalysts in what is termed "narcissistic depression." Kernberg and Chazan (1991) for example, write of a certain type of depression "which has more of the quality of impotent rage, or of helplessness-hopelessness in connection with the breakdown of an idealized self-concept." A chronic sense of emptiness, often as a result of failures in empathic parenting, was described by Kohut (1987) as the core depressive feature in some narcissistic patients. Alongside the emphasis on guilt owing to a sense of having damaged the object, in this type of depression, according to Kohut, there is a greater focus on the subject's own sense of narcissistic fragility, with subsequent feelings of shame and humiliation. The empirical research literature provides some support for the idea that these two formulations capture different subtypes of depression, at least for adults, each one describing a group of depressed individuals with differing presentations and differing vulnerabilities, and with potentially differing responses to therapy. In a similar vein, Spitz (1946) suggested that the most important

aetiological factor in childhood depression was the “loss of the love object” (1946). He developed the concept of ‘anaclitic depression’ to describe the reaction in children aged between 6 to 12 months to separation from their mothers, the ‘love object’, where features of misery, lack of expression and withdrawal were evident. The groundbreaking work of Mary Ainsworth with her ‘Strange Situation’ (Ainsworth, 1978) supports the findings of Spitz’s early work and served to demonstrate the significant link between patterns of attachment in infancy and later psychosocial functioning. The attachment theorist, Bowlby (1977; 1982) suggested that the experience of secure attachments in infancy fosters self-efficacy and makes it more likely that social functioning will be adaptive. He also hypothesised that insecure attachments in infancy are likely to predispose infants to react adversely to later stressful experiences and to become depressed. Van Eerdevegh *et al.* (1982) examined a sample of children who had lost a parent, recording their reactions to the parental death one-month and thirteen months after the event through a structured interview with the surviving parent. The results showed a persistent but minor form of depression, an increase in bed-wetting, and a significant degree of impairment in performance at school for older children. In addition, losing a same-sex parent appeared to be a significant risk factor for depression, particularly for boys. Given Rutter’s findings from the Isle of Wight Study (Rutter *et al.*, 1970) however, it is possible that depressive symptomatology in these children may have been higher if self-report rather than parental report had been used.

1.4. Familial Factors

More recently, research has looked at familial factors as risk factors for depression in children (Beardslee *et al.*, 1983; Weissman *et al.*, 1987; Harrington *et al.*, 1993). The available evidence highlights the following points. Firstly, that there is a familial or genetic component to depression; secondly that family studies of depressed children show a high rate of psychiatric disorders among their relatives and thirdly, that children of depressed parents have been shown to be at risk for a variety of psychiatric disorders, including depression. The finding that depression tends to run in families does not imply a purely genetic mechanism. Environmental as well as genetic factors are relevant here since psychosocial deprivation as well as depression tends to co-occur in families (McGuffin *et al.*, 1988). Differences have been found between uni and bipolar depression in terms of the pattern of familial transmission; with bi-polar depression showing a greater heritability. McGuffin and Katz (1986) estimated heritability for manic-depression as 86 percent based on data from a number of twin studies. For milder forms of unipolar depression, however, heritability was estimated at just 8 percent.

1.5. Parental Factors

It has been widely acknowledged in the research literature that parental mental disorder is a risk factor for psychopathology in children (Gershon *et al.*, 1982; Weissman *et al.*, 1988; Hammen *et al.*, 1990). In addition, longitudinal studies have shown that the adverse effects of growing up with an effectively ill parent, persists over time (Hammen, 1991). Research also indicates that early-onset depression, before the age of 20, is associated with an increased familial loading of depression. Weissman *et al.* (1988) found that children whose parents experienced a major depressive episode before the age of 20 years were at greater risk for developing major depression than children whose parents became ill later in life. Grigoriou-Serbanescu *et al.* (1991) found that for the most part, the younger the age of onset of parental depression, the greater the risk for psychopathology in their children. Parental affective disorder serves to identify a pattern of risk factors for their children, similarly, the severity and chronicity of parental psychopathology also determines the overall impact of the disorder on the child (Hammen *et al.*, 1990). In the same way that the children of alcoholic parents are more likely to become alcoholics, depressed parents are

more likely to have depressed offspring, therefore supporting the assumption that there is an interaction between common risk factors and the specific parental illness. Nevertheless, there is a proportion of 'resilient' children who manage in the face of adversity and exhibit the ability to adapt successfully despite their family circumstances. For example, a number of studies have identified that an ability to work and engage in supportive and intimate interpersonal relationships contributes to resilient outcomes in children (Garmezy, 1985; Rutter, 1987). In this case, our participants' parents, here named Matilda and Craig, played a vital role in the process of their daughter's therapeutic progress. The parents who were both employed in a consulting company and had hired a nanny for Anna's first five years of life, since they both worked approximately 11 hours per day. They both agreed to attend a session at the beginning of Anna's therapy in order for the researcher to assess Anna's family framework. Indeed, it was considered essential for her parents to engage to psychotherapeutic work themselves, as they demonstrated a dysfunctional communication pattern during the first meeting. In detail, Matilda seemed to carry a lot of guilt for being successful in her field and working long hours, for Anna did not get to spend a lot of time with her family and was practically raised by her nanny. Through painful for Matilda examination of her own childhood, we discovered that she had previously experienced feelings of abandonment and rejection by her parents and had dealt with this experience by behaving the same way towards her daughter. Through this, Anna had been left to feel rejected, helpless and emotionally unstable. Graig also manifested problematic patterns in regards to the way he communicates with his family, as his initial reaction was to be absent and unwilling to engage in emotional work that would promote communication between them. Eventually, though, he committed to the work being done in our practice, and through the joint work he and his wife strengthened the positive aspects of their relationship and brought awareness to the ways they could improve their family life and take measures to support their daughter in a more holistic way.

2. METHODOLOGY

2.1. Participant

Anna, aged 14 years old, who visited our practice as she exhibited depressive symptoms and her parents found it necessary for her to receive professional help. The sessions were held weekly over a period of two years until Anna and her parents deemed it necessary. Anna herself explained she was struggling with everyday activities and suggested that 'something is done because she couldn't take it anymore'. Anna lived with her parents and had exhibited depressive symptoms such as social withdrawal, an abrupt drop in grades, isolation from her group of friends, loss of appetite and weight loss, and finally disrupted sleep patterns. At the time of the referral, Anna met the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria for Major Depression (moderate). She was said by her parents to have gone from being a girl with a full life with plans for her future to lying on her bed, tearful and apathetic. As well as assessing her symptoms, the therapist was interested to get a picture of Anna's "internal world" and to develop some initial hypotheses about her condition.

2.2. Method

Our study considered two methods of analysis: one phenomenological and one stemming from the psychoanalytic perspective.

The first allowed us to open a contact with the other, to establish a contact, a common sense to the phenomena experienced. The fact of receiving and then conceiving of a therapeutic process, which aims at renewing a vital contact with reality, will allow us to access the phenomenon of realization of which Tatossian (1991) speaks. In fact, the latter says: start by receiving the data of the real to end up conceiving them and thus be able to create a reality

The initial clinical understanding based on a phenomenological approach focuses on the how, before being interested, in the way of the occurrence of the situations. The objective of our research was to be able to elaborate, initially, what has occurred in this child's story.

The phenomenological approach has been widely used to explore the experience of illness and disease (see for instance (Senior *et al.*, 2002; Barr and McConkey, 2007; Taïeb *et al.*, 2010)). It was used here not so much to subscribe to a particular conceptualization, or a diagnostic procedure based on preconceived ideas, but rather in a non-restrictive manner, seeking to describe the facets of experience with the patients themselves so as to pinpoint the most prominent and specific elements. The narrative stage as such required us to set aside our own representations of the depressive experience, our beliefs and our theories, so as to collect material that was as close as possible to the experience of our participants, distancing ourselves from preconceived clinical and research positions and allowing the underlying themes to emerge (Glaser and Strauss, 1967). The present case study is based on psychoanalytic psychotherapy sessions conducted with a patient over the course of two years, whose narrative during the first two months and during the last two months of therapy is used as a material for the analysis of her experience of depression.

3. DATA ANALYSIS

A thematic qualitative analysis was conducted. The principles of Grounded Theory (Glaser and Strauss, 1967; Corbin and Strauss, 2008) were used to perform this analysis, including the identification of initial content elements (Zwaigenbaum *et al.*, 1999). Then keywords and phrases were organized into a preliminary model, with themes grouped under broad categories. The goal of a thematic analysis is to identify themes, i.e. patterns in the data that are important or interesting and use these themes to address the research or say something about an issue. This is much more than simply summarising the data; a good thematic analysis interprets and makes sense of it. A common pitfall is to use the main interview questions as the themes (Glaser and Strauss, 1967; Clarke *et al.*, 2006). Typically, this reflects the fact that the data have been summarised and organised, rather than analysed. Clarke *et al.* (2006) distinguish between two levels of themes: semantic and latent. Semantic themes ‘...within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written’. The analysis in this worked example identifies themes at the semantic level and is representative of much learning and teaching work. The analysis moves beyond describing what is said to focus on interpreting and explaining it. In contrast, the latent level looks beyond what has been said and ‘...starts to identify or examine the underlying ideas, assumptions, and conceptualisations – and ideologies - that are theorised as shaping or informing the semantic content of the data’.

4. CASE ANALYSIS

4.1. Establishing a Psychoanalytic Frame for the Therapy

The techniques of psychoanalytic psychotherapy are primarily based on close and detailed observation of the relationship the young person makes with the therapist and the theoretical assumption that the young person's free play, drawings, and conversation can be seen as equivalent to "free association." The therapist introduces the context to the young person as one for understanding feelings and difficulties in his or her life. Much of Anna's early therapy was conducted in silence. She chose to draw, her drawings being dark and forbidding. There were disturbing scenes of death: decaying cadavers, bloody skulls transfixed by daggers, and wounded bodies with bleeding gashes. Anna seemed absorbed in these images as well as in the process of image making. She seemed to “attack” the paper with pencil and black pens. Her therapist found herself watching and thinking intently, mirroring

the intensity of Josie's preoccupation. The ending of sessions was difficult. Anna found it hard to leave, often weeping, saying she couldn't face going. The therapist found herself terribly afraid that Josie would die before they met again, so she found herself extending the length of sessions—but they were never long enough. With the help of supervision, the therapist realized that Anna was allowing the therapist to get a sense of what Bion called a "nameless dread" that Anna, herself, was protecting against through "projective identification." Once the therapist was aware of this it was possible to manage her own anxiety, help Anna to feel that her anxieties could be thought about, and so end the sessions on time rather than "acting out in the countertransference" by prolonging the sessions.

4.2. Working With the Transference and the Countertransference

A central source of information to the therapist in expanding his or her understanding is the emotional responses evoked in him or her by the young person. These responses are broadly referred to as countertransference phenomena. Such phenomena can include personal factors that intrude and distort the therapist's capacity for objective understanding, but also many responses arising from primitive nonverbal forms of communication, projective identifications, which the therapist becomes aware of. These are similar to the ways in which infants can communicate with their caretakers before the development of language, and depend on emotional availability and space for "reverie" in the therapist. These primitive modes of relationship can be used to control anxiety by ridding oneself of it and pushing it outside rather than using it for communicative purposes. The distinction between benign (communicative) and malignant (destructive, eg, to cause confusion) forms of projection is vital in clinical work. At times, for example, the anxiety that Anna's therapist felt about her safety was an important way that she could become alert to fragile states of mind that Anna herself was denied. At other times, in a more destructive way, the therapist would be left feeling so stupid and worthless at the end of a meeting with Anna that she just "couldn't think," and in those cases supervision became vital in helping her to see what painful feelings Anna herself was defending herself against by means of such malignant projections.

With all adolescents, most particularly those with environmentally compromised early experiences, there is a need for the therapist to be in a state of mind characterized by availability to the reception of projected contents (anxieties, effects, uncertainties) of the adolescent's mind. These contents are often of a primitive nature and are not always known to the adolescents themselves. The patient's experience of the therapist receiving, holding in mind, and thinking about this projected material is a central feature of the work. Bion describes how the placement and residence of toxic, primitive states of mind in the therapist's mind can lead to their detoxification. Previously unthinkable anxieties and emotions can then become thinkable, and in due course "returned" to the patient. Patients thereby gain ownership of a previously disowned part of themselves and are strengthened by identification with an object experienced in this way.

4.3. Object Relations in Psychoanalytic Psychotherapy

In the field of therapy, the concept of object relations was introduced by Klein (1946) who worked with adults and observed that the therapeutic relationship can contain, organize, and mirror internal object relations and the interplay between therapist and client. The observation and facilitation of expression in a therapeutic context helps to amplify unresolved interpersonal issues that may need to be resolved for the improvement of one's emotional well-being. Henley (1991; 1992) who has applied an object relations approach to his work with children with developmental and emotional disabilities, has noted that individuals with disabilities can be benefited from psychoanalytic therapy, as it aids them in the development of the reconstruction of early attachment bonds, which

can be impaired or underdeveloped. Since the introduction of object relations facilitates the sequence of attachment, the therapeutic process which is based on these principles encourages sensory stimulation, object formation, and interaction with both the therapist and the psychic product. In other words, psychoanalytic therapy in its many forms can add a different dimension to the therapeutic relationship, since it allows for the processes of individuation and separation to be witnessed, practiced, and mastered through creative exploration.

4.4. Transitional Space and Transitional Objects

Moving further into psychoanalytic concepts directly related to psychoanalytic psychotherapy, two concepts in object relations theory that are of particular interest to therapy are Winnicott (1953) concepts of “transitional space” and “transitional objects.” According to Winnicott, transitional space is defined as an intermediate area of experience where there is no clear distinction between inner and outer reality. Based on the above, it can be understood that the therapeutic relationship can be considered transitional space since it functions as a way for clients to bridge subjective and objective realities and practice relating to others around them. Thus, a therapeutic setting where the therapist provides the client with time and space facilitates creative expression, can be experienced as a holding environment within which object relations can develop. In line with the above, “transitional object” is defined by Winnicott as an actual object, such as a blanket or a toy which represents something different than what it is. In a psychoanalytic therapy framework, art products can become transitional objects, and their use may diffuse or symbolically diffuse unresolved issues. Anna seemed hesitant at first to connect with the therapist and utilize the transitional space provided in the therapy room and was fixated on the transitional object she carried with her during every session; a water bottle. Indeed, she would visit the practice holding the bottle in her arms and wouldn't even let it from her arms for the first two months of the sessions. As time went by and Anna felt more comfortable in the therapeutic relationship, she started becoming detached from her transitional object and invested more in communicating psychic material with the therapist in the transitional space.

4.5. Emotional States at the Beginning of the Psychotherapeutic Sessions

4.5.1. Irritability

Irritability is central in the emotional state of adolescents experiencing depression. It takes the form of marked reactivity in exchanges. It does not conflict that generates irritability, but rather a state of irritability that generates conflict with others (peers, family, teachers), so that relationships are stormy and exhausting. This irritability may be perceived by the subjects, or only by those around them. It may affect all areas of activity, or at first, only show up at home. Anna seemed to struggle to put up with anything. Initially, she was unable to realize she was irritable but described bouts of anger towards people around her, and this gradually made relationships more and more difficult to sustain.

"I felt as if everything was making me explode, well that's a bit strong... I don't know... I couldn't stop myself" "To begin with, I could see that I was getting angry all the time, except with my best friend, but even with her I was shouting, everything got at me."

4.5.2. The Overwhelming Depressive Experience

Depressed adolescents usually talk about feelings of disquiet or malaise that they have difficulty pinpointing. These were states that caused people around them to say they were unhappy, depressed or miserable. It in fact appears that depressed adolescents cannot always identify what they are feeling. They do not spontaneously describe it as sadness, fear or dread, but what they do say is that they are afraid of losing control in the face of the

overwhelmingly painful, unbearable feelings that they are experiencing. Anna talked of being bored, down in the dumps, saying that *"It was unbearable, it would suddenly start to swell up, I felt overpowered, something really odd, it hurt, it sometimes made me cry, but more than anything it hurt. I remember when it started it was like I was stifling, not all at once, but like a weight on my chest, building up until I couldn't bear it anymore."*

Here, we can see that Anna feels threatened by the depressive experience, but it is not yet spilling over; then the feeling of being overtaken by the depressive experience; and finally, overwhelming, unbearable, invasive feelings that confront her with her inability to cope with what is happening.

4.5.3. Negative Perceptions of Self

These are usually expressed in a variety of ways among depressed adolescents. The subject feels he or she cannot live up to parental or school demands. Anna felt useless and incapable of doing or being, bogged down in negative views the life she is living and the things she does. This disqualification might be expressed verbally to the people around her, but most often the experience of depreciation took the form of incessant rumination that gets in the way of any form of activity.

"To begin with, I tried to get on with my work, even so, I really tried, but it was no use. I felt so completely useless; it's a horrible feeling, everything about me made me look like a loser."

"My friends did everything better than me, so I told myself, why bother trying"

"I could see I wasn't getting things done, my marks were useless, there was no way, I just couldn't do any better, I wasn't even trying anymore"

4.6. Emotional States at the End of the Psychotherapeutic Sessions

4.6.1. Development of Emotional Stability

At the end of the sessions, Anna demonstrated a different approach to issues that previously irritated her and caused her to behave in problematic ways according to her parents. When confronted with a problem in her everyday life, instead of expressing distress and have tantrums that cause problems to her and her immediate environment as she did before, at this point she has a calmer approach and seems to rationalize situations that would previously cause a much stronger reaction.

'My teacher pointed out something I did wrong in front of the whole class... it was a bit embarrassing to have my mistakes pointed out in front of everyone. But I took it pretty well I think, it wasn't so bad after all I think...'

'It is easier for me now to have a normal conversation with my parents, and things they say don't piss me off as much as they used to.'

It is evident that Anna experiences potential conflicts in a different way now, and most importantly she is able to acknowledge this difference and understand she has made progress in comparison to her previous emotional state.

4.6.2. Positive Perception of the Self

When Anna first came to our practice, she was struggling with the image of herself on many levels; she felt unattractive, she thought that boys were not only uninterested in her but also made fun of her looks, and she would use words such as *'ugly, gross, blunt'* to refer to the way she looked. Apart from that, she saw herself as incompetent, unable to fulfill even simple tasks and from time to time even *'useless'*. After twenty-four months of therapy, the first thing that became apparent was the shift in the adjectives she was using to describe herself.

'and I tried this dress on and I think I looked nice, like, this colour looks good on me I think...'

'I bought this new eyeliner and tried it on and made my eyes pop, I had only seen that on tutorials online, didn't know I could do it myself, made my eyes look so pretty.'

Furthermore, she started giving credits to herself for managing tasks that had seemed unbearable before:

'I went to the mall today, and met the girls... it wasn't as bad as I thought, I mean, it felt good to leave the house for a change, didn't think I would enjoy it but I'm glad I went...'

'So they gave us the test back, turns out I didn't do as bad as I thought, I actually did better than Steph and she always gets the highest grades out of all of us, I'm actually kind a proud for this grade, I like history more than I thought I did.'

Anna has not only re-introduced social activities in her everyday life and has started paying more attention in school, but she seems to recognize the change in her behaviour and general mood as well. Besides this, she acknowledges the importance these changes have for her self-esteem, as she associates her performance in school with an increase in self-esteem. Therefore, we can observe that the therapeutic process has had an extremely positive effect on her perception of herself.

5. CONCLUSION

As the authors have tried to illustrate in this article, psychodynamic psychotherapy can be a powerful intervention for depressed young people, especially those for whom depression is a marker of broader difficulties in negotiating the adolescent process. Although outcomes research in child and adolescent psychodynamic psychotherapy is still in its infancy, there is a growing body of empirical evidence to show the effectiveness of such an approach, and there are several ongoing studies that also aim to throw more light on the elements of psychodynamic therapy with adolescents that may promote change. The work by Blatt *et al.* (1996) on adult depression is important because it not only begins to provide empirical support for certain subtypes of depression related to key psychodynamic features, it also relates these to therapeutic mechanisms that may help us as clinicians to know what kind of help is needed by different people with different kinds of psychological vulnerability to depression. There is still a great deal to learn about adolescent depression, and much that can be learned about what are the most effective interventions to promote long-term recovery. We need to understand in more complex terms the multifaceted nature of adolescent depression, so as to unravel how those complex dynamics interact with particular therapeutic interactions and techniques.

REFERENCES

- Ainsworth, M.D.S., 1978. The bowlby-ainsworth attachment theory. *Behavioral and Brain Sciences*, 1(3): 436-438. Available at: <https://doi.org/10.1017/s0140525x00075828>.
- Barr, O. and R. McConkey, 2007. A different type of appointment: The experiences of parents who have children with intellectual disabilities referred for genetic investigation. *Journal of Research in Nursing*, 12(6): 637-652. Available at: <https://doi.org/10.1177/1744987107083516>.
- Beardslee, W., J. Bemporad, M. Keller and G. Klerman, 1983. Children of parents with major depressive disorder: A review. *American Journal of Psychiatry*, 54: 1254-1268.
- Bernstein, G.A. and C.M. Borchardt, 1991. Anxiety disorders of childhood and adolescence: A critical review. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30(4): 519-532.
- Blatt, S.J., C.A. Sanislow III, D.C. Zuroff and P.A. Pilkonis, 1996. Characteristics of effective therapists: Further analyses of data from the national institute of mental health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology*, 64(6): 1276-1284. Available at: <https://doi.org/10.1037/0022-006x.64.6.1276>.

- Bowlby, J., 1977. The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. *The British Journal of Psychiatry*, 130(3): 201-210. Available at: <https://doi.org/10.1192/bjp.130.3.201>.
- Bowlby, J., 1982. Attachment and loss: Retrospect and prospect. *American Journal of Orthopsychiatry*, 52(4): 664-678. Available at: <https://doi.org/10.1111/j.1939-0025.1982.tb01456.x>.
- Clarke, D.M., K.E. Cook, K.J. Coleman and G.C. Smith, 2006. A qualitative examination of the experience of 'depression' in hospitalized medically ill patients. *Psychopathology*, 39(6): 303-312. Available at: <https://doi.org/10.1159/000095778>.
- Corbin, J.M. and A.L. Strauss, 2008. *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications.
- Costello, E.J., 1989. Child psychiatric disorders and their correlates: A primary care pediatric sample. *Journal of the American Academy of Child & Adolescent Psychiatry*, 28(6): 851-855. Available at: <https://doi.org/10.1097/00004583-198911000-00007>.
- Fleming, J.E. and D.R. Offord, 1990. Epidemiology of childhood depressive disorders: A critical review. *Journal of the American Academy of Child & Adolescent Psychiatry*, 29(4): 571-580. Available at: <https://doi.org/10.1097/00004583-199007000-00010>.
- Garmez, N., 1985. Stress-resistant children: The search for protective factors. *Recent Research in Developmental Psychopathology*, 4: 213-233.
- Gershon, E.S., J. Hamovit, J.J. Guroff, E. Dibble, J.F. Leckman, W. Sceery, S.D. Targum, J.I. Nurnberger, L.R. Goldin and W.E. Bunney, 1982. A family study of schizoaffective, bipolar I, bipolar II, unipolar, and normal control probands. *Archives of General Psychiatry*, 39(10): 1157-1167. Available at: <https://doi.org/10.1001/archpsyc.1982.04290100031006>.
- Glaser, B. and A. Strauss, 1967. *The discovery of grounded theory: Strategies for qualitative research*. Piscataway, NJ: Aldine Transaction.
- Grigoriu-Serbanescu, M., D. Christodorescu, A. Totoescu and I. Jipescu, 1991. Depressive disorders and depressive personality traits in offspring aged 10-17 of bipolar and of normal parents. *Journal of Youth and Adolescence*, 20(2): 135-148. Available at: <https://doi.org/10.1007/bf01537605>.
- Hammen, C., 1991. Depression runs in families. In *the social context of risk and resilience in children of depressed mothers*. New York: Springer-Verlag.
- Hammen, C., D. Burge, E. Burney and C. Adrian, 1990. Longitudinal study of diagnoses in children of women with unipolar and bipolar affective disorder. *Archives of General Psychiatry*, 47(12): 1112-1117. Available at: <https://doi.org/10.1001/archpsyc.1990.01810240032006>.
- Hammen, C., D. Burge and K. Stansbury, 1990. Relationship of mother and child variables to child outcomes in a high-risk sample: A causal modeling analysis. *Developmental Psychology*, 26(1): 24-30. Available at: <https://doi.org/10.1037/0012-1649.26.1.24>.
- Harrington, R., H. Fudge, M.L. Rutter, D. Bredenkamp, C. Groothues and J. Pridham, 1993. Child and adult depression: A test of continuities with data from a family study. *The British Journal of Psychiatry*, 162(5): 627-633. Available at: <https://doi.org/10.1192/bjp.162.5.627>.
- Henley, D., 1991. Facilitating the development of object relations through the use of clay in art-therapy. *American Journal of Art Therapy*, 29(3): 69-76.
- Henley, D., 1992. *Exceptional children, exceptional art*. Worcester, MA: Davis.
- Kernberg, P.F. and S.E. Chazan, 1991. *Children with conduct disorders: A psychotherapy manual*. Basic Books.
- Klein, M., 1946. Notes on some schizoid mechanisms. *The International Journal of Psycho-Analysis*, 27: 99.
- Kohut, H., 1987. *Building psychic structure that regulates self-esteem*. The Kohut Seminars. New York: WW Norton & Company.

- McGuffin, P. and R. Katz, 1986. Nature, nurture and affective disorder. *The Biology of Depression*: 26-52.
- McGuffin, P., R. Katz and P. Bebbington, 1988. The Camberwell collaborative depression study III. Depression and adversity in the relatives of depressed probands. *The British Journal of Psychiatry*, 152(6): 775-782. Available at: <https://doi.org/10.1192/bjp.152.6.775>.
- Rutter, M., 1987. Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57(3): 316-331. Available at: <https://doi.org/10.1111/j.1939-0025.1987.tb03541.x>.
- Rutter, M., J. Tizard and K. Whitmore, 1970. *Education, health and behaviour*. Longman Publishing Group.
- Senior, V., J.A. Smith, S. Michie and T.M. Marteau, 2002. Making sense of risk: An interpretative phenomenological analysis of vulnerability to heart disease. *Journal of Health Psychology*, 7(2): 157-168. Available at: <https://doi.org/10.1177/1359105302007002455>.
- Spitz, R.A., 1946. The smiling response: A contribution to the ontogenesis of social relations. *Genetic Psychology Monographs*.
- Taïeb, O., O. Bricou, T. Baubet, V. Gaboulaud, B. Gal, L. Mouthon, R. Dhote, L. Guillevin and M.M. Rose, 2010. Patients' beliefs about the causes of systemic lupus erythematosus. *Rheumatology*, 49(3): 592-599. Available at: <https://doi.org/10.1093/rheumatology/kep430>.
- Tatossian, A., 1991. Eugène Minkowski ou l'occasion perdue. In P. Fedida & J. Schotte (Eds.), *Psychiatrie et existence*. Grenoble: Million. pp: 11-22.
- Van Eerdewegh, M.M., M.D. Bieri, R.H. Parrilla and P.J. Clayton, 1982. The bereaved child. *The British Journal of Psychiatry*, 140(1): 23-29.
- Weissman, M.M., G.D. Gammon, K. John, K.R. Merikangas, V. Warner, B.A. Prusoff and D. Sholomskas, 1987. Children of depressed parents: Increased psychopathology and early onset of major depression. *Archives of General Psychiatry*, 44(10): 847-853. Available at: <https://doi.org/10.1001/archpsyc.1987.01800220009002>.
- Weissman, M.M., P.J. Leaf, G.L. Tischler, D.G. Blazer, M. Karno, M.L. Bruce and L.P. Florio, 1988. Affective disorders in five United States communities. *Psychological Medicine*, 18(1): 141-153. Available at: <https://doi.org/10.1017/s0033291700001975>.
- Winnicott, D.W., 1953. Psychoses and child care. *British Journal of Medical Psychology*, 26(1): 68-74. Available at: <https://doi.org/10.1111/j.2044-8341.1953.tb00810.x>.
- Zwaigenbaum, L., P. Szatmari, M.H. Boyle and D.R. Offord, 1999. Highly somatizing young adolescents and the risk of depression. *Pediatrics*, 103(6): 1203-1209. Available at: <https://doi.org/10.1542/peds.103.6.1203>.

Online Science Publishing is not responsible or answerable for any loss, damage or liability, etc. caused in relation to/arising out of the use of the content. Any queries should be directed to the corresponding author of the article.