‘Why me?’ – A depressive crisis at the age of nine in handicapped children

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For many years at the Habilitation Clinik at Danderyd Hospital we have noted that handicapped children seem to start becoming aware of their unfairly difficult circumstances and their future prospects just around the age of nine. Some question their parents and speak of their unhappiness. Parents often find it hard to come to terms with this. They generally try to give comfort in a way that makes children feel that they ought to show only their happiness. The result is that children keep their worries to themselves – but do not feel well. Teachers frequently report that children with handicaps begin to show signs of imbalance just around the age at nine.
In our treatment we are now bringing up these problems and trying to help parents and teachers to support their children through the crisis. We see a marked improvement in symptoms when children realize that the adults understand and agree with the fact that being different is unfair and difficult. Our clinical impression is therefore that a number of behavioural changes, and also psychosomatic symptoms, in the nine-year-old may be signs of a depressive crisis, and that these disappear when children and parents have learned to accept the situation.
In 1982 we carried out an investigation to find out how often newly appearing and transient behavioural symptoms occur in handicapped children during latency.

Investigation

We studied the medical records of all the children born between 1967 and 1972 who were registered at the Habilitation Clinic between the ages of 7 and 11 years.
The study coveted 209 children with varying degrees of physical handicap and varying levels of intellectual function. We grouped them according to the type of school they attended, which roughly reflects their level or intellectual function.

Distribution:

	Boys	Girls	Total
Comprehensive school (normal intelligence)	112	45	157
School for mentally deficient children (some retardation)	12	8	20
ADL school (considerable retardation)	7	9	16
Severaly retarded children	9	7	16
	140	69	209

From the records of these children we have extracted information on marked changes in behaviour, and on psychological and psychosomatic symptoms occurring during the period from 7 to 11 years. Parallel to this, members of the treatment team have made evaluations based on their contacts with the child and on their notes in the medical records.
Changes and symptoms have been registered under the following headings:

‘Depressive’ symptoms and behavioural changes

Aggressive behaviour at school
Aggressive behaviour in the home
Resistance to and refusal of treatment and aids
Motor restlessness
Tiredness
Passivity, reserve, refusal to attend school, tendency to isolation
Psychosomatic symptoms
Fear, dread, phobias
Confusion, withdrawal, stereotypy
Unhappiness
Talking unhappily about the handicap
Talking unhappily about problems with other children
Worsened performance at school
Bullying

Results:
No ‘depressive’ symptoms noted in children 7 to 11 years of age

in 25 comprehensive school children	= 16%
in 2 children from schools for the mentally deficient	= 10%
in 6 ADL school children	= 37%
in 12 severely retarded children	= 75%
total 45 children	= 21%

This means that marked changes had been noted in 4 children out of 5. Some had shown few symptoms; others, several symptoms in a process that often started with non-verbal, aggressive or psychosomatic symptoms at the age of 8. By the age of 9 the symptoms changed to unhappiness and sorrowful talks about handicaps and problems with other children. This is illustrated in the following list of different behavioural changes:

Symptoms in 84% of 157 children attending the comprehensive school

age	**7**	**8**	**9**	**10**
Aggressive behaviour at school, 19% number	1	16	10	3
Aggressive behaviour in the home, 22%	1	9	18	7
Resistance to treatment, 12%	1	8	7	3
Motor uneasiness, 11%	-	7	5	5
Tiredness, 16%	-	8	10	6
Passivity, reserve, 19%	1	8	17	4
Psychosomatic symptoms, 36%	2	18	25	12
Fear, dread, 11%	1	5	9	2
Unhappiness, 39%	3	14	32	12
Talking unhappily about the handicap, 29%	1	11	21	11
Talking urihappily about problems with other children, 28%	2	10	25	7
Worsened school performance, 24%	1	8	19	10

In children attending the comprehensive school the most usual symptoms are unhappiness (39%), psychosomatic symptoms (36%), talking unhappily about the handicap (29%) and talking unhappily about problems with other children (28%).

Symptoms in 62% of 52 Mentally Retarded Children

	age	**7**	**8**	**9**	**10**
Aggressive behaviour at school, 17%	number	-	3	-	6
Aggressive behaviour in the home, 27%		-	2	5	7
Resistance to treatment, 2%		-	-	1	-
Motor uneasiness, 17%		-	3	-	6
Tiredness, 6%		-	1	2	-
Passivity, reserve, 13%		-	2	1	4
Psychosomatic symptoms, 27%		-	2	5	7
Fear, dread, 8%		-	-	1	3
Unhappiness, 17%		-	2	3	4
Talking unhappily about the handicap, 6%		-	1	1	1
Talking urihappily about problems with other children, 6%		-	-	-	3
Worsened school performance, 10%		-	-	2	3

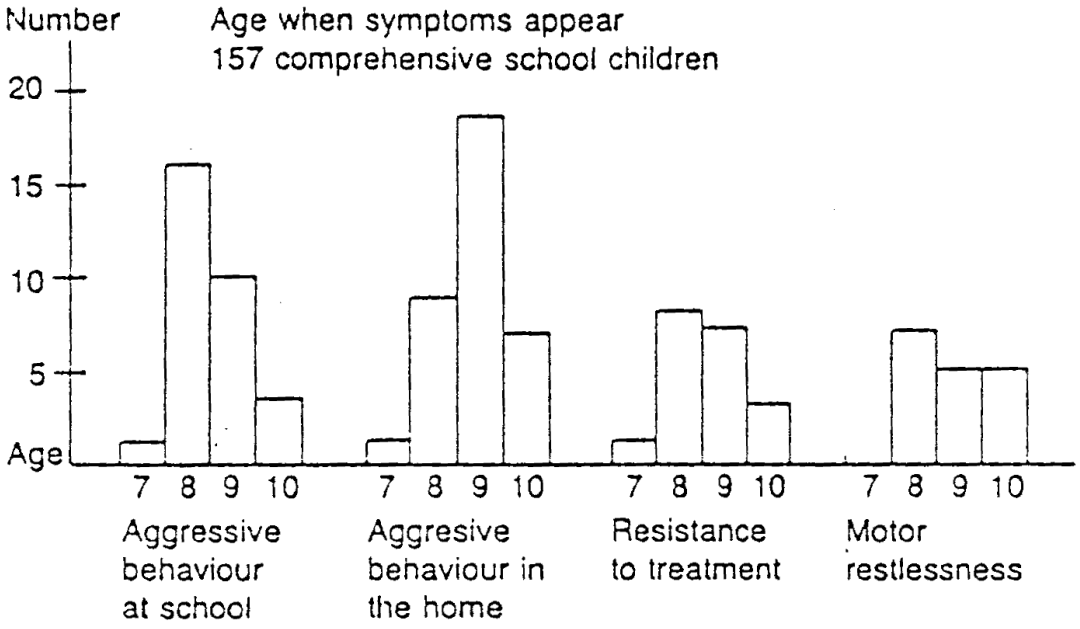
The tendency among the mentally retarded children is that symptoms of crisis appear later, between 10 and 11 years of age. The most frequent symptoms are aggressiveness in the home and psychosomatic symptoms (27%) and aggressiveness at school, unhappiness and motor restlessness (17%).
Psychotic symptoms with periods of withdrawal, stereotypy and, in one case, hallucinosis, appeared in 8 out of all 209 children (3,8%). Out of these, one attends the comprehensive school and the other 7 are in varying degree retarded, comprising 13,5% of the total of 52 mentally retarded children.
Bullying occurred only in 2 of the retarded children, but in one out of four children attending the comprehensive school.

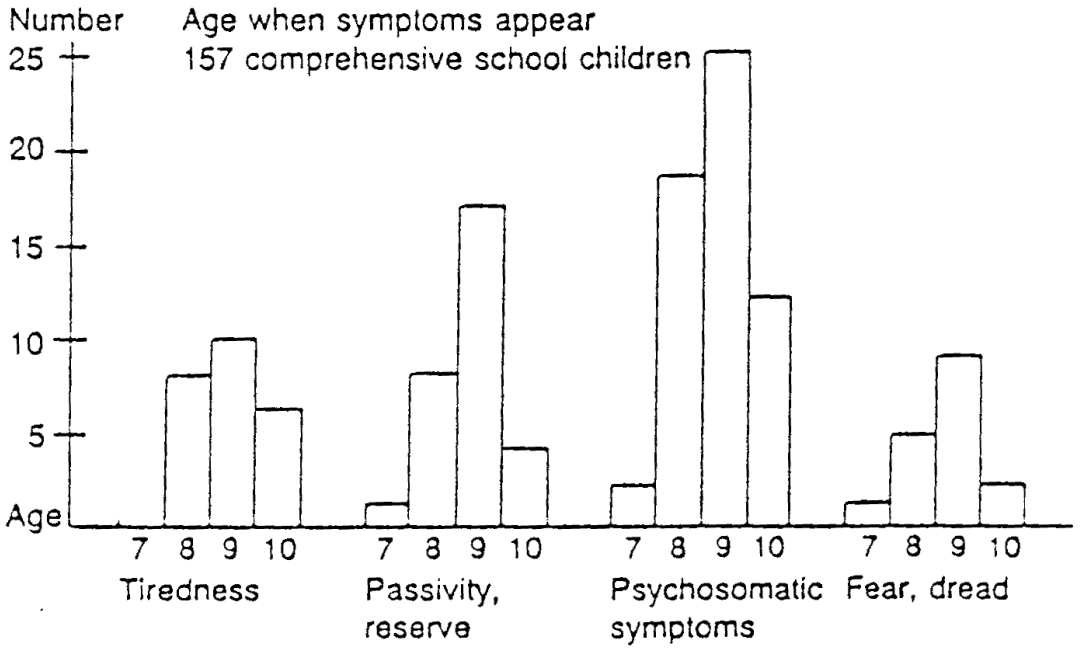
Bullying in Comprehensive School Children

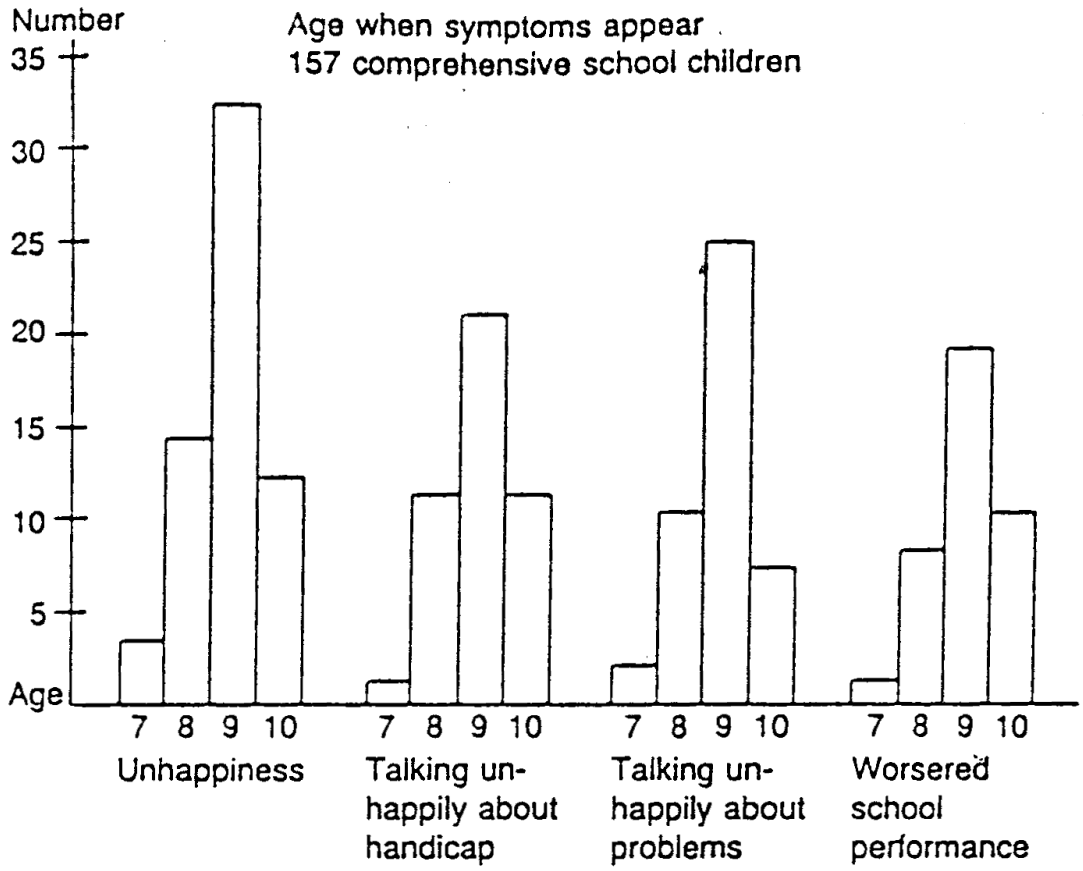
age	**7**	**8**	**9**	**10**
Suffered bullying, 24%	1	18	16	3
Bullied others, 3%	-	2	2	1

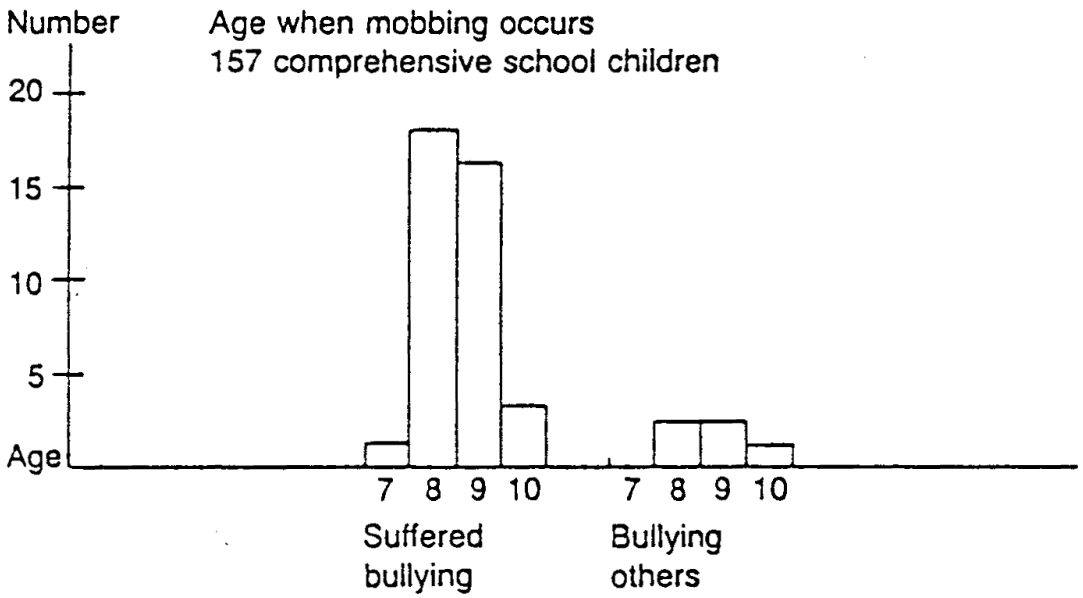
Girl, MBD + mental deficiency

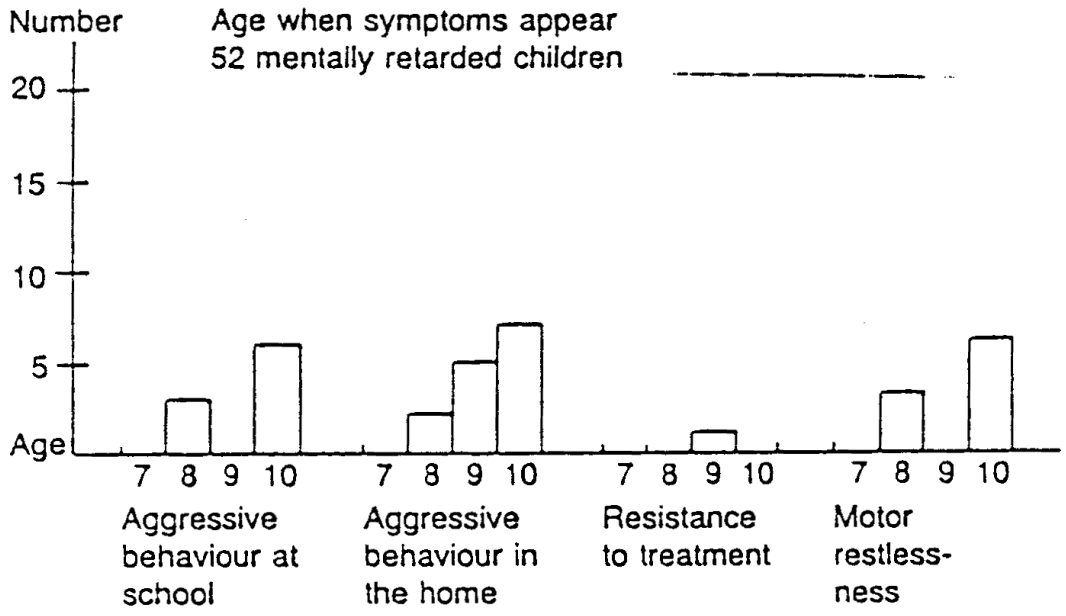
Age	
8	Aggresive and defiant at school, tired motor restless
8 3/4	Talks unhappily about her handicap
9	Unhappy. Parents come to see childpsychiatrist.
10	Happy again. Better school performance.


Number
Age when symptoms appear
157 comprehensive school children
20
15
10
5
Age
7 8 9 10
Aggressive behaviour at school
Aggresive behaviour in the home
Resistance to treatment
Motor restlessness


Number
Age when symptoms appear
157 comprehensive school children
25
20
15
10
5
Age
7 8 9 10
Tiredness
Passivity, reserve
Psychosomatic symptoms
Fear, dread


Number
Age when symptoms appear
157 comprehensive school children
35
30
25
20
15
10
5
Age
7 8 9 10
Unhappiness
7 8 9 10
Talking unhappily about handicap
7 8 9 10
Talking unhappily about problems
7 8 9 10
Worsered school performance


Number
Age when mobbing occurs
157 comprehensive school children
20
15
10
5
Age
7 8 9 10
Suffered bullying
7 8 9 10
Bullying others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Aggressive behaviour in the home
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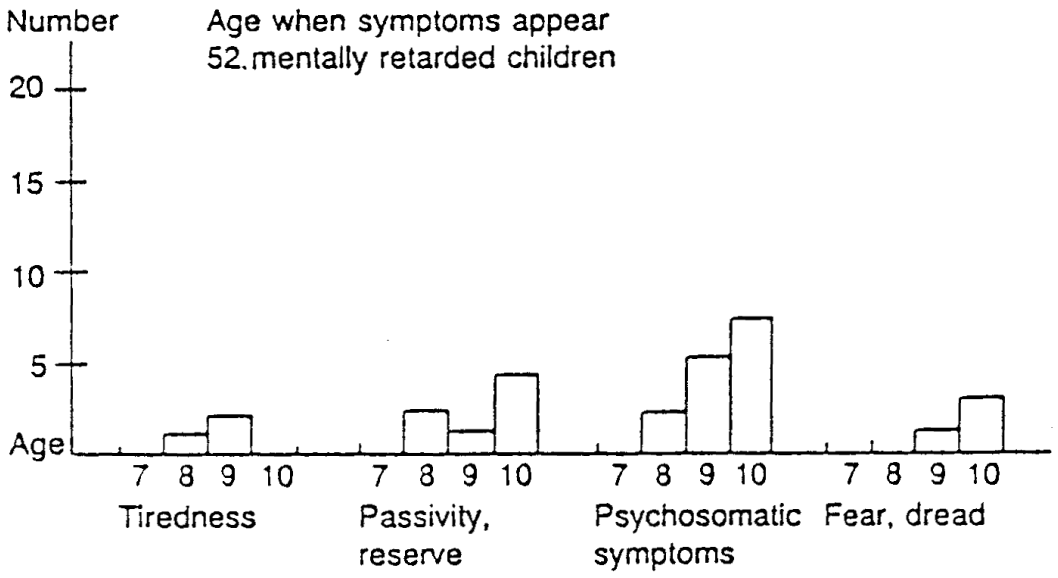
Motor restlessness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Age when symptoms appear
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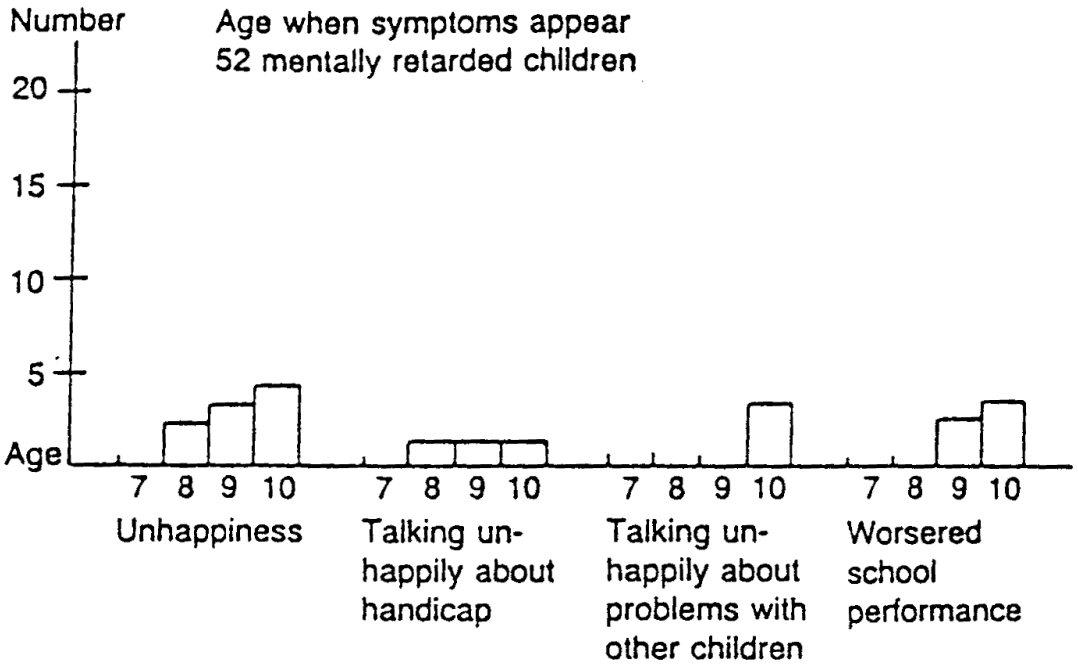
Tiredness
Passivity, reserve
Psychosomatic symptoms
Fear, dread


Number
Age when symptoms appear
52 mentally retarded children
20
15
10
5
Age
7 8 9 10
Unhappiness
Talking unhappily about handicap
Talking unhappily about problems with other children
Worsered school performance

Psychosomatic symptoms in 71 children (1)

Headache	5
Dizziness	3
Convulsions	17
Fainting-fits	3
Dleepingdisorders	2
Tics	4

Psychosomatic symptoms in 71 children (2)

Obesity	5
Discomfort at eating, nausea, vomiting, obstipation, flattulens	9
Ache (stomach-, heart-, back-, etc.)	9
Urethritis, enuresis	6

Psychosomatic symptoms in 71 children (3)

Transient visual disorder	2
Stuttering	1
Transient speech-difficulties	1
Psoriasis	1
Muscular hypertension	2

DISCUSSION

Our investigation has shown that the majority of chi1dren who are somewhat different on account of handicaps, show symptoms of a depressive crisis during the age period 8 to 11 years. In children attending the comprehensive school the symptoms are concentrated around the age of nine; for children attending schools for the mentally deficient and ADL schools, around the age of 10. It is possible that in the later groups we might have observed more symptoms if the study had also included 11 to 12-year-old children.

In severely retarded children who hardly register their symptoms and communicate with their surroundings, no such crisis is noted.

It is probable, that we have found relatively high figures for 'talking unhappily about the handicap' and '... problems with other children' since we all the time made it particularly important to be receptive to children’s unhappiness and to give the unhappiness appropriate consideration. In addition some children might have had other reasons than their handicap for being unhappy.

From the point of view of development psychology we interpret the results to show that the increasing realism of children during latency enables them to understand their situation and to compare it with the one of others. They can now feel that they are different, and unfairly affected.

If children receive help from individuals close to them to endure and to process their unhappiness, they learn for the future to deal with difficult and negative feelings. It is our impression that parents and other adults find it difficult to accept that handicapped children are also unhappy. The adults need support and guidance themselves and perhaps crisis treatment.

It is natural for a nine-year-old child to go to his parents and teachers with his unhappiness. If the adults are unable to receive his feelings in the right way, and to confirm them, the child becomes infinitely lonely.

In our work we have found that handicapped teenagers with serious thoughts of suicide have not, as a rule, shown any unhappiness at the age of nine or ten.

We believe that active, outreaching crisis work with 9 year old children and their parents with relatively small investment might prevent serious and intractable depressions in the teens in children with handicaps. In most cases a short term crisis work will be enough, but, some families may have a structural pathology needing family treatment.