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CASE REPORTS

Shattered maternal identity and early childhood depression

Perturbação da identidade materna e depressão na primeira infância

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ABSTRACT

Introduction: Depression in early childhood was first described by Spitz in 1940. The literature reports an association between depressive symptoms in infants and early affective deprivation, pinpointing maternal depression as a major risk factor. However, there is little evidence on the impact of maternal comorbid depression and gender dysphoria on the risk of depression in early childhood.

Case report: A 25-month-old toddler was referred to the Child and Adolescent Psychiatry Outpatient Department for persistent irritability and sleep disturbances. His mother had persistent depressive disorder and had never felt comfortable in her role as a mother, struggling with caregiving and responding to the child's emotional needs. During follow-up, maternal symptoms of gender dysphoria were identified.

Discussion: Mother-infant bonding and responsive caregiving are essential for adequate socioemotional development.

Keywords: child neglect; depressive disorder; gender dysphoria

RESUMO

Introdução: A depressão na primeira infância foi descrita pela primeira vez por Spitz em 1940. A literatura relata a associação entre sintomas depressivos na criança e privação afetiva precoce, sendo a depressão materna um fator de risco amplamente reconhecido. No entanto, há pouca evidência sobre o impacto da disforia de género materna no desenvolvimento de depressão na primeira infância.

Caso clínico: Uma criança de 25 meses foi referenciada para a consulta de Psiquiatria da Infância e da Adolescência por irritabilidade persistente e perturbações do sono. A mãe apresentava perturbação depressiva persistente e manifestava grande dificuldade na resposta às necessidades emocionais da criança. Durante o seguimento, foi identificada sintomatologia materna de disforia de género.

Discussão: A qualidade da relação mãe-bebé e dos primeiros cuidados são requisitos fundamentais para o normal desenvolvimento psicoafetivo infantil.

Palavras-chave: disforia de género; negligência infantil; perturbação depressiva

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INTRODUCTION

The first description of depression in babies dates back to the 1940s, when the Austrian-American psychoanalyst René Spitz described symptoms of apathy, withdrawal, depressive mood, and developmental delay in institutionalized children.[1] In his post-World War II studies, Spitz observed several children who had lost their parents prematurely and how this early separation from primary caregivers was profoundly damaging. In 1946, he conceptualized this unnatural state of grief in babies as anaclitic depression, reporting massive apathy or irritability, depleted interest in affection, and generally low interest in the outside world, as well as severe developmental deterioration. Anaclitic stems from the Greek anáklitos, or "reclining" – symbolizing a lack of affection derived from an unfulfilled emotional dependency. Thus, in addition to tangible physical absence, emotional unavailability plays a key role in early childhood depression. Regarding this mediation, maternal depression is a major risk factor for childhood vulnerability. In fact, dyads involving depressed mothers enhance lower resilience in children and insecure infant attachment, favoring later psychopathology in offspring.[2]

Comorbid with depressive disorder, psychological distress occurs in other psychiatric conditions as a result of frustrated essential psychological needs.[3] Among these conditions, gender dysphoria stands out as particularly distressing because of its deleterious effects on self-perception and emotional regulation.[4] Higher prevalence rates of internalizing problems and self-injury have also been reported in gender dysphoric individuals, particularly women.[5] Therefore, emotional unavailability may be heightened in depressed mothers with gender dysphoria, with a significant impact on the dyad.

Despite the clinical relevance of depressive disorders, diagnostic tools for depressive states in young children are scarce. According to the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood - DC:0-5™, the diagnosis of depressive disorder of early childhood requires the presence of persistent depressed mood or irritability, anhedonia, and at least two of the criteria included in **Table 1** for at least two weeks. Toddlers are more likely to manifest this myriad of symptoms in their behavior or play than in their speech.[6]

Table 1 - Diagnostic criteria for depressive disorder of early childhood according to the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood - DC:0-5™.*

I.	Substantial change in appetite or developmental delay
II.	Insomnia or hypersomnia
III.	Psychomotor agitation or retardation
IV.	Fatigue, lack of energy or interest in activities
V.	Feelings of guilt or worthlessness
VI.	Lack of concentration or decisiveness in tasks
VII.	Worrying about death or suicide, or self-harming episodes

CASE REPORT

A 25-month-old toddler was referred to the Child and Adolescent Psychiatry Outpatient Department after routine pediatric observation for speech delay and concerns regarding social interaction. The referral also mentioned maternal depressive symptoms, emotional liability, and a subjective sense of incompetence in caregiving.

In the first Child and Adolescent Psychiatry appointment, the mother mentioned persistent irritability and speech delay as main concerns. She described periods of prolonged crying before sleep since birth and aggravating difficulties of the child in expressing needs, despite understanding instructions and requests at home, not only due to speech delay but also to his state of constant distress, which the mother felt unable to alleviate. The child had never attended kindergarten due to the family's financial difficulties. The mother had always been his primary caregiver, with occasional support from his elderly paternal grandmother. During the COVID-19 pandemic and subsequent epidemiological measures, the lockdown required both parents and siblings to stay at home. Months later, the mother noticed that the child seemed significantly more interactive and responsive than before. There was no mention of sensory processing complaints or bizarre interests in play, nor concerns about mealtimes. The child had no other relevant medical history or previous therapeutic interventions.

The child lived in a household of four, including the parents and a five-year-old sister. According to the mother, the pregnancy was

unplanned and was not noticed until late in the second trimester. Despite the unexpectedness, it had been "welcome and peaceful" until the 31st week of pregnancy, when a sudden episode of bleeding led to the diagnosis of placenta previa. Hospital admission and complete rest were required in the weeks leading up to the birth, which occurred prematurely at 35 weeks.

The postpartum period had additional maternal complications, particularly depressive symptoms. The mother recalled feelings of increased vulnerability during this time, combined with loneliness at home. The father had just started a new job. The mother-in-law was ill and unable to help. The baby had recurrent periods of prolonged crying and distress that the mother was unable to alleviate. Nights were particularly difficult for the mother to cope with because of sleeplessness and growing despair. During the day, she felt unable to play with the baby, placing him on the playground, where he would be entertained by television shows or simply play by himself while the mother rested. The father played with the baby for a while at the end of each workday, a period he described as "pure joy" for the child. Notably, the lockdown period during which the father was required to stay home coincided with significant improvements in the child's social interaction.

A review of the family medical history elicited increasing defensiveness from the mother. She reported depressive symptoms and chronic pain since the age of 22, with associated functional disability. Despite financial difficulties, she had been unemployed since the birth of her first daughter. This five-year-old daughter was initially described as healthy, but was eventually referred to outpatient Child and Adolescent Psychiatry because of changes in eating behavior.

On observation, the baby was a good-looking, affectionate toddler. At first, he denoted apathy and marked reluctance to engage in play. Instead, he chose to engage in isolated, mainly functional play, which did not seem to be a source of particular enjoyment for him, as evidenced by facial expressions of dullness. However, when exposed to consistent stimuli and attempts at reciprocal communication, he gradually showed interest in exploring the environment and interacting with others. Although he did not vocalize intelligible words, he would make eye contact with doctors and approach them to play or ask for a hug.

The mother typically dressed in an androgynous manner and was recurrently mistaken for the father. Her discomfort was palpable when moments of play were suggested, and she had difficulty initiating and sustaining interaction - whether in vocalizations or actions. She even kept physical distance from her son when he was interacting with doctors.

During follow-up, maternal symptoms of gender dysphoria were reported. Although the parents had never disclosed any information on the subject, the mother's medical records included several therapy sessions following a medical abortion months before the son's first medical appointment. Her therapist's observations confirmed a long history of depression and revealed high levels of neuroticism and self-image issues. In addition, she had always felt strongly about having her birth-assigned sex changed and had undergone masculinizing hormone therapy in her twenties - just before she learned she was pregnant for the first time, interrupting the process.

The baby's symptomatology was interpreted as affective dysregulation in early childhood associated with global developmental delay. A multidisciplinary treatment plan was designed, including individual speech and occupational therapy, kindergarten enrollment, and mother-child psychotherapy. In addition, social support was activated and psychiatric follow-up of the mother was requested. Unfortunately, she was not available to participate in the dyad treatment plan or to engage in her own treatment. It was the father who replaced her in sessions aimed at improving the dynamics of the parent-child relationship – specifically, training appropriate and consistent emotional responses and promoting appropriate stimulation during play.

Father-child psychotherapy sessions and a newly acquired kindergarten routine resulted in substantial improvements in emotional regulation. However, long-term follow-up brought additional periods of lockdown and subsequent periods of symptom worsening, markedly influenced by the mother's own affective dysregulation.

DISCUSSION

Early childhood encompasses a critical period of socio-emotional development. It is in the mother-infant dyad that the newborn first absorbs the surrounding world and acknowledges oneself as an individual. As the British pediatrician Donald Winnicott famously said, *"There is no such thing as a baby - there is a baby and someone"*.[7] In this context, learning to appropriately regulate emotions – both positive and negative – is a key early developmental process that depends heavily on this primary attachment. In times of discomfort or pain, a baby will return to his/her caregiver, whose comforting responses will alleviate distress and gradually allow the child to grasp the skill of managing emerging emotions.[6,8]

The literature highlights the association between persistent negative emotions and emotional dysregulation in the mother with depression in the offspring.[9] According to current evidence, the prevalence of depressive disorders in children aged three to five years ranges from 0.5% to 2%. Recurrence rates and prognosis are similar to those of adult depressive disorders, with an identical chronic course and significant comorbidity rates.[6]

The present study highlights the role of comorbid maternal depression and gender dysphoria in early childhood depression. Maternal depression is a well-known risk factor for offspring psychopathology. However, reports on the role of maternal gender dysphoria are rare. Gender dysphoria encompasses the individual experience of an incongruence between one's expressed gender and

one's assigned gender at birth and is strikingly associated with an increased prevalence of depressive disorders.[4,5] Most importantly, it is correlated with high psychological distress, which appears to contribute to emotional unavailability. However, there is little evidence on how comorbid gender dysphoria may interact with depressive symptoms in motherhood. Therefore, it is not possible to conclude which disorder predominates in the baby's symptomatology.

In the present case, both parents acknowledged how much affect deprivation had affected their child's development. Nevertheless, they still struggled to find appropriate emotional responses. While the mother's psychopathology seemed to play a significant role in the baby's symptomatology, the father's presence seemed to be protective. It is critical to raise clinicians' awareness of depressive states in young children and the importance of identifying risk factors in the dyad. Screening for maternal depression and comorbid psychopathology should be a priority.

AUTHORSHIP

Sara Gomes Rodrigues - Conceptualization; Data curation; Methodology; Project administration; Visualization; Writing – original draft

Pedro Samuel Pinto - Conceptualization; Visualization; Writing – review & editing

Vânia Miranda Martins - Supervision; Validation; Writing – review & editing

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