Depressive Disorder in Highly Gifted Adolescents

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This article examines the nature and extent of depressive disorders in highly gifted adolescents based on current literature and data gathered from a phenomenological study, focus groups, and clinical records. Two case studies and clinical examples document the capacity of some highly gifted adolescents to mask even severe symptoms. Several factors appeared to contribute to this masking phenomenon, including shame for being incapacitated and unable to resolve their dilemma; depression's signature cognitive confusion, which disengaged their coping mechanisms; and fear of harming others with their toxic state. These findings raise questions about the efficacy of quantitative research instruments to determine actual cases of depressive disorder in this subgroup, as well as current research estimates of depression in the highly gifted population.

Depression is potentially debilitating, invasive, and toxic. It is feared, frequently misunderstood, and often peculiar in its course. Depression is also egalitarian in its manifestation, affecting people at any age, education or economic level, and ethnic background (American Psychiatric Association, 1994). It is a psychological state marked by feelings of sadness, worthlessness, impotence, and incapacity. Untreated major depression can have fatal consequences (Klein & Wender, 1993).

Highly gifted individuals are "those whose advancement is significantly beyond the norm of the gifted where advancement refers to aptitude or potential rather than performance" (Silverman, 1983, p. 16). Extraordinary ability is usually measured in psychometric terms, using scores on intelligence or aptitude tests. For instance, with the Wechsler Intelligence Scale for Children–III (Wechsler, 1991), individuals scoring at or above 145 are labeled "highly gifted," those scoring at or above 160 are "exceptionally gifted," and those scoring at or above 180 are "profoundly gifted." Individuals who show evidence of extremely high levels of creativity or unusual and profound talent are also usually included in this subcategory of gifted learners.

This paper explores major depression in the lives of highly gifted adolescents and synthesizes findings from a phenomenological study (Jackson, 1995), data from clinical records and interviews at the Daimon Institute for the Highly Gifted (White Rock, British Columbia, Canada), and research literature in gifted education and psychology. Poignant narratives illuminate the subjective experience of depression. This paper connects highly gifted adolescents' experience of depression, general information about depression, and depression-related phenomena peculiar to this population, arguing that highly gifted children are particularly capable of masking symptoms of this disorder.

Depressive Disorder: A Review of Literature

The degree, type, frequency, number, and duration of symptoms determine whether a particular episode/condition meets clinical diagnostic criteria. For example, a child who shows no signs of being comforted or of resuming normal functioning within a week after falling into a low mood or within 6 months of a major loss may be in a depressive state. Depressive states have been roughly categorized into two groups: mild (dysthymic) and major depression. The primary symptom for both disorders is disturbance of mood, and the distinction between the two is a matter of degree (American Psychiatric Association, 1994). Symptoms related to thinking
capacity, for instance, can range from mildly slowed to stuporous. Similarly, mood state may range from slightly downcast to unrelentingly bleak. In some cases, the mind may maintain reason; in the extreme, it can be delusional.

There is general agreement that the term depression can refer to the mood itself or to a combination of affective, cognitive, psychomotor, and vegetative manifestations that affect normal functioning. The condition of depression affects mental and emotional tone and capacity, as well as the physical body.

A sad or depressed mood and a loss of interest and pleasure in usual activities characterize major depression. There is often difficulty in falling or staying asleep or a desire to sleep much of the time. A person may also experience a shift in energy and activity levels, becoming lethargic or extremely agitated. Other physical signs include a poor appetite and weight loss or, in some cases, increased appetite and weight gain. Other characteristics of major depression include negative self-concept and self-blame, pessimism, and pervasive feelings of worthlessness, guilt, and despair. A seriously depressed person may have difficulty concentrating and may show evidence of slowed thinking, mental fuzziness, lack of cohesion in thought patterns, and indecisiveness. Those afflicted with major depression may report recurring thoughts and images of death and suicide (American Psychiatric Association, 1994).

According to recent research, as many as 3% of Americans—approximately 19 million—suffer from chronic depression. Of these, some two million are children (Solomon, 2001). Major depression is the leading cause of disability in the United States for those over the age of 5, second only to heart disease in causing premature death (American Psychiatric Association, 1994). Depression is linked to many other diseases, from alcoholism and drug abuse, to ulcers and eating disorders (Karp, 1996), and may coexist with conditions such as anxiety and conduct disorders (Cytryn & McKnew, 1998).

Despite the fact that treatments for depression are proliferating, it is estimated that only half of those suffering from major depression seek help. Of those 50%, some 90% visit their primary care physician, who may or may not be well versed in psychiatric profiles (Solomon, 2001) and biological psychiatry (Klein & Wender, 1993). It is also estimated that a depressive state in an American adult is recognized only 40% of the time. At the same time, as many as 1 in 10 Americans are on some form of antidepressant medication (Solomon). Optimal treatment for major depression usually involves psychiatric consultation and medication and psychotherapy (Klein & Wender). As many as 10% of American adults will be stricken with major depression, while current estimates of incidence in children and adolescents are 3% and 7%, respectively. There is evidence that incidence of depression is increasing in the developing world, particularly among children. An increase in reported suicide attempts in children (Cytryn & McKnew, 1998) dispels the long-held belief that, while suicidal ideation may occur in prepubertal children, suicide attempts are rare.

Depression at any age may be the result of social or biological factors or both. Current research is attempting to shed light on the impact of environmental stressors that cause particular psychological reactions, leading to the biochemical changes that are at the core of a depressive disorder (Cytryn & McKnew, 1998).

Research on adults with mood disorders has revealed that many people afflicted with depression can date the early signs of their condition to either prepubertal or childhood years (Kendler, Kessler, Neale, Heath, & Eaves, 1993). A consideration of patterns of vulnerability reveals several trends. For example, children of parents with depressive disorder are found to have a significantly higher incidence of depression than does the general population (Cytryn & McKnew, 1998). In addition, children who have experienced difficulty with attachment and separation-individuation are more likely to develop emotional difficulties. Maternal rejection, in particular, has been found to contribute to later depressive states (Mahler, 1972). The growing child responds to rejection with anxiety and ambivalence and gradually shuts down innate, generative exploration and expression of capacity and purpose (Lewis, 1979). A well-established mother-infant attachment bond provides solid footing for the child’s further development. Children with well-established attachments are not prone to anxiety and depressive states (Mahler). In contrast, children who experience significant loss in the early years—of a loved one, for example—are at risk for a depressive episode later in life.

Temperament is also a factor. Temperament accounts for a child’s activity level, adaptability, threshold of responsiveness, intensity of reaction, mood quality, distractibility, attention span, and persistence. Those children who have difficulty with transitions and change or exhibit exceptionally intense emotional reactions are found to be at a higher risk for behavioral disorders in childhood (Lerner, 1984). Thomas and Chess’ (1977) concept of goodness of fit provides a common-sense framework for explaining the interactive effect of temperament and environment.

Depression and Highly Gifted Adolescents: A Review of Literature and Clinical Data

Common Traits of Highly Gifted Individuals

Lists of common traits of highly gifted children include a capacity and predilection for complex reasoning, need for precision, facility with abstract material and awareness of underlying patterns, ease with use of metaphors and symbols, and early grasp of the essential element of an issue (Hollingworth, 1942). Exceptional speed of processing and a capacity for intuitive
knowing mark an exceptional mind, as well. There is evidence of a demand for internal consistency and a need for all parts of a concept to relate to one another logically (Lovecky, 1994).

Personality traits of exceptionally bright adolescents include a strong tendency toward psychological introversion (Jackson, 1995; Silverman 1992, 1993). Highly gifted introverts are characterized by a rich inner life, embracing intellectual activity, emotions, sensations, and concept formation. They have a tendency to process information and sensations internally before presenting them to the outside world, therefore seeming inhibited. Introverts are a minority, and their less-immediate communicative style may contribute to social awkwardness and isolation (Dauber & Benbow, 1990).

Heightened sensitivity is another documented feature of highly gifted children (Dabrowski, 1967; Roedell, 1984; Silverman, 1983). Highly gifted adolescents may have stronger, deeper and more enduring reactions to stimuli than their age peers. Polish psychiatrist Kazimierz Dabrowski labeled these reactions "overexcitabilities"—enhanced and intensified mental activity, reactions, and expression that are beyond common and average. Dabrowski posited that, when enhanced reactivity is combined with particular talents, extraordinary development is possible. He noted a capacity for growth toward personal autonomy and a complex operative morality in children with these overexcitabilities. This development often places these children at odds with their various contexts. When they develop beyond the conventions and expectations of their family, classmates, and teachers, they may experience periods of great inner disequilibrium and feelings of being out of sync with their environment. Without appropriate support and creative outlets, anxiety states, depressive disorder, eating disorders, and obsessive-compulsive behaviors can result (Dabrowski, 1967; Jackson, 1995). Clinicians need to be aware of the effects of a complex cognitive and affective self-system on mood and behavior.

Clinical Depression in the Highly Gifted Population

There are conflicting opinions and evidence concerning the prevalence of depression in the gifted population (Neihart, 1999). Determining the nature and the incidence of this complex condition in the lives of highly gifted individuals is difficult. Issues related to defining giftedness, questions about research methodology, and the intrapsychic complexities of highly gifted individuals preclude easy fact finding.

Interest in the overall psychological characteristics and affective development of highly able individuals has been sustained and extensive. A substantial body of research in gifted education supports the view that gifted children are at least as well adjusted as their nongifted peers (e.g., Galluci, Middleton, & Kline, 1999). In this view, the gifted child's capacity for self-understanding, overall awareness, and complex problem-solving abilities ensure good social adjustment and emotional resiliency. A second antithetical view (e.g., Gross & Feldhusen, 1990; Roberts & Lovett, 1994; Roedell, 1984; Silverman, 1993) holds that gifted children are prone to emotional or social difficulties due to their differences from the norm and their heightened responses. In particular, super-sensitivity, perfectionism and differences across intellectual, emotional, and social domains contribute to unusual social and emotional challenges for gifted children.

There is indeed clinical evidence that depression can be an insidious and often fatal influence in the lives of some gifted people (Barkett, 2002; Claridge, Pryor, & Watkins, 1998; Jackson, 1998; Tolan, 1998). There is evidence, as well, that many highly gifted and talented people throughout history have suffered from various forms of clinical depression. (Dabrowski, 1967, 1972; Jamison 1995, 1993; Styron, 1990). A critical mass of anecdotal evidence in the form of clinical reports, reports from parents, and reports of depression survivors themselves attest to the fact that some highly gifted teens experience depression (e.g., Piechowski, 2002; Tolan) and that they are capable of disguising even the most severe symptoms (Jackson, 1995, 1998). Clinical records, among the data serving as the foundation for this paper, confirmed that some highly gifted children—especially those in undifferentiated school programs with no access to like-minded peers and appropriate learning experiences—may exhibit signs of depressive disorder as early as age 7. Signs of depression at young ages in this population may be subtle: social withdrawal, acting out behaviors (often labeled "immature"), acute intellectualization of all phenomena, and highly focused pursuits that preclude engaging in a broader social context. These behaviors may in fact be elaborate defense mechanisms meant to protect the highly gifted learner from perceived disregard, derision, or misunderstanding.

In a recent review of pertinent literature, Neihart (2002) concluded that gifted children and adolescents do not show higher or lower prevalence of depression than those in the general population. However, the editors of the volume in which that review appeared cautioned against unquestioned adoption of their findings, based on several mitigating factors. The lack of a clear and consistently applied definition of giftedness (Peterson, 1997b; Robinson, 2002) ensures that there will be variance in research sampling. It is difficult to make meaningful comparisons when research teams have studied differing populations of children. Also confounding the research results is a sampling bias in favor of academically adjusted students. The bulk of research findings are gleaned from samples where students are identified as academic achievers, successful enough to be selected for special programming (Meckstroth, 2002). Other subpopulations, such as nonmainstream cultural or socioeconomic groups (Peterson, 1999), profoundly or cre-
atively gifted students, or gifted learning-disabled students, are likely underrepresented. Students who are emotionally at risk or behaviorally "maladjusted" (Peterson, 1997a) and highly gifted students whose learning needs are not met in programs designed for moderately gifted students may also be underrepresented.

In addition, the instruments used to investigate the occurrence of depression in gifted children and adolescents, such as self-report questionnaires, may not be appropriate, since these may not generate accurate reporting. In particular, two issues contribute to this potential mismatch of subjects and methodology: the association of perfectionism with giftedness (Greenspoon, Parker, & Schuler, 2000) and the sense of shame reported by those who have experienced depression (Jackson, 1995). Given the potential for obfuscation, research of depressive disorders should take into account the complex defense mechanisms operative in the highly gifted psyche. If questionnaires are used, information should be supplemented by qualitative methods or corroborated by direct observation of behavior.

The Experience of Depression in Highly Gifted Adolescents

Susceptibility. Poorness of fit, mentioned earlier, may characterize many areas of an exceptionally gifted child's life. Often, a highly gifted child spends large portions of time in inappropriate educational environments where they do not have access to "true peers," people whose intellect and social-emotional needs mirror theirs. Perhaps their introverted nature precludes easy social exchange, and super-sensitivities ensure that their reactions to "ordinary" stimuli seem exaggerated (Gross, 1993).

Highly gifted children perceive the world complexly, with access to a reality that is usually not reflected in the perceptions of those around them. They often lack access to an understanding or appreciative audience and are unlikely to be able to exchange perceptions with others. Extreme sensitivity to both obvious and subtle environmental stressors can subject them to psychic overload and may precipitate a depressive state (Roedell, 1986). Poorness of fit as a precursor to depressive states was a central theme in the language of all participants in the phenomenological study of interest here (Jackson, 1995). A 17-year-old exceptionally gifted male expressed the effects of a poor fit:

I do not believe that gifted people have any higher innate tendency toward depression than does any other group. But, you have to remember that, if every second word you utter, every concept you put forth is mocked or belittled, you start to shut down pretty fast. You are forced into reducing your vocabulary, which effectively jettisons your communicative capacities; you learn to translate according to what seems to be the "common kid code." By and large, I realized pretty quickly that I would never fit into their accepted activities, which predominantly focused on establishing a hierarchy of social and physical power—survival of the fittest, if you will. It just did not interest me to participate.

As young children, the highly gifted are often unaware of how different their thoughts and feelings are from even their less-gifted peers. There is evidence, however, that a dawning realization of differences may bring with it a sense of desolation and loneliness. A mother of an exceptionally gifted 8-year-old boy reported the following conversation:

James: Mom, I am different. I am not normal.
Mother: Yes, James, you are different and so is everyone, but you are also like me in some ways and like your father in others.
James: No, I am not normal, and I cannot begin to explain to you the ways that I am unlike you. I simply cannot begin to explain that.

At the time of this conversation, the mother had felt trepidation about her son's diminishing emotional responsiveness. James had experienced rejection by his age peers and little appropriate educational programming. He was often angry, recalcitrant, moody, and unresponsive. In therapy, James revealed many symptoms of a depressive state, including sleep disturbance, "fuzzy-headedness," and dark thoughts. His mother was concerned about his increasing sullenness, withdrawal, and violent outbursts. She had cultivated a warm, responsive relationship with him, but admitted to not knowing how to keep up with his rapid mental processing, emotional sensitivity, mercurial mood shifts, and extreme sense of justice.

It is rare for highly gifted children to escape the effects of their differences from age peers. Their developmental asynchrony places them at risk for social isolation or misunderstanding; inappropriate educational response; and emotional, intellectual, or social void. This lack of meaningful, positive social interaction is the most important variable in the etiology of depressive disorder for the highly gifted adolescent (Jackson, 1995). Several authors point to social isolation and lack of authentic interaction as particularly troublesome for highly gifted children (e.g., Gross & Feldhusen, 1990; Little, 2002; Roedell, 1984). According to the data supporting this paper, highly gifted teens who were unable to experience meaningful spiritual, emotional, and intellectual exchange in their family, social and educational environments, or both are more susceptible to a depressive state than those who had more pos-
Depressive Disorder

You wouldn't ever want to admit that you were that—*depressed*, I mean. People think of it as a really shameful thing, maybe even something contagious, certainly something dangerous—that is, if they really know what clinical depression is. Other people think that having a sad moment or a momentary loss is big-time depression, and when your experience is so vastly different from that, you just keep your mouth shut.

Greg, also 17 and exceptionally gifted, described his reticence:

Why is it so hard to admit that I have this problem—depression? I am really comfortable with you. I have survived some enormously hard things, but I have such a tough time telling you that I am unable to control this aspect of my emotional life. That was one of the hardest things I have ever said to anyone.

Exceptionally gifted Akleta, 17, described the shame she felt:

It is very definitely a sense of failure, being so incredibly messed up that you can't think your way out. I mean, there is a tremendous amount of shame attached to that. It is a very uncomfortable place to be.

In all cases presented here and in clinical records at the Daimon Institute, highly gifted teens reported that they needed to feel very comfortable with anyone who questioned them, verbally or on paper, if they were to reveal their inner worlds. An interesting irony emerges as to the willingness and capacity of highly gifted teens to report accurately on their emotional world. Based on this author’s clinical experience, highly gifted teens appear to demand honest self-scrutiny and highly moral action in themselves, and this conflicts with the sense of failure, toxicity and impotence experienced in a depressive state. Some highly gifted teens reported being unable to talk about an intense depressive state without fear of harming the person they were talking to. They also feared that there were few people who could understand the complexity of a deep state of depression. In the phenomenological study (Jackson, 1995), students admitted in the focus groups at the Institute and in clinical interviews to denying, hiding, or obfuscating their experience of depression to protect their fragile sense of self-efficacy and to protect the well-being of those around them. Kieran, 15 and exceptionally gifted, compared his experience of depression with his usual self-presentation:

I act like nothing's wrong. On some subconscious level it seems like some sort of weakness, some sort of vulnerability, and it hurts to share weaknesses. When you

An exceptionally gifted male, 17, in combat boots and black clothes, echoed John:

I have taken a rather unconventional route; it is more efficacious for me. I first felt extreme isolation in grade 3. I remember my best friend moved, and I was alone—I mean really alone. I basically lived that way until the last 2 years in high school, where I began to run into people like me. I walk in a certain way; and I have a certain reputation. People stay out of my way; I don’t get bothered much.

I am capable of empathy, certainly, but I usually save it for a very few people, a very few, and very definitely for animals. . . . When I experience dark moods, depressive states, I simply ignore it. I don’t deal with it. I go into the “don’t think, don’t feel, just act” mode. Shooting is really helpful; my sniper practice. It is a singular activity which focuses my attention wholly and completely. You have to be right there right now. It is a singular activity that is absolute. It is not tentative. It provides an absolute and precise measure of reality. This is really clean. I feel really peaceful and content, without the stress of multiple interpretations and expectations.

*Masking, as related to research.* It is important for researchers to understand the subjective experience of depression and concurrently or subsequently being a research subject. In a focus group on affective disorders' held at the Daimon Institute, several highly gifted adolescents captured the interaction of these two realities. Shara, 17 and exceptionally gifted, explained as follows:
are gifted, you feel what other people feel; if someone else is depressed, you pick up on it, and it makes you feel depressed so you become afraid that your depression, when it happens, will evoke that feeling in someone else.

This capacity for sensitive, capable children to deny or mask the depressive state, especially in early stages, is documented in the literature on affective disorders. Two leading researcher/clinicians (Cytryn & McKnew, 1998) in the field of childhood affective disorders described the difference between the inner world of the depressed children and their overt behavioral expression:

Children often... do not wear it on their sleeves as adults do. Children tend to be depressed in an extremely quiet way. They often creep into their rooms or other secluded places and cry while appearing cheerful in public settings. Usually they don’t look as sad, tearful, or as slowed down as depressed adults. By the time a child exhibits signs of depression for all to see, he or she is usually severely depressed. (p. 32)

At the Daimon Institute, adolescent subjects were asked to respond to this statement: “Current research determines that gifted adolescents are no more or less susceptible to clinical depression than their nongifted peers.” Kieran, who had survived major depression, responded as follows:

Hogwash. That is absolute hogwash, at least for highly gifted kids! It doesn’t take a genius to know that the inner world of the highly gifted person is complex and often conflictual. I mean, how easy is it to disguise what you are thinking and feeling? It is second nature to any highly gifted kid: hiding things that are dangerous, unformed, problematic. Where do we get a chance to express things, to have them understood, to make light of them, to air them out? That doesn’t happen too often, and, when it doesn’t, it builds up and builds up and you’re often drawn into some very deep and dark places.

However, Sean, an exceptionally gifted boy of 12, expressed a different view: “I think it is not easy to disguise true depression. It is simply too intense. It spills out of you. There seems to be no sense in it and no way to contain it.” At the time of his comment, Sean had been in therapy for 2 years. His original clinical presentation was extreme noncompliance at school and at home, social isolation, and episodes of explosive anger. His depressive state dated back to age 4. Sean had not deliberately masked his initial depressive state; rather, he had not been conscious of it as he lashed out in vicious verbal attacks. Because of the conscious and unconscious masking and concomitant problems with validity of research instruments, the actual extent of depressive disorder in the highly gifted population is difficult to determine.

The inner experience. The nature and the course of the depressive experience for the highly gifted adolescent is multifaceted and idiosyncratic. Deep experience is always highly personal, and the vast capacities and vagaries of the highly gifted psyche ensure a particular and unique depressive disorder trajectory (Jackson, 1995; Styron, 1990). Kieran, quoted earlier, described his:

The nature of depression for highly gifted people has to be relevant to their unusual abilities... For me it’s like—boom! A thousand horrible scenarios play out so vividly in your mind’s eye, like some great horror movie. It seems that the mind amplifies the depressive state, and this can happen very, very quickly. It can get very frightening incredibly quickly.

Specific indicators of depression in the highly gifted population include a strong physical component. In the phenomenological study (Jackson, 1995), a female participant, 17, articulated how her conflicitual feelings were manifested in her body. Because of her ill health, she was often absent from school and was often coping with several physical diseases at once, some of unknown etiology. Another highly gifted boy, 13, described the onset of a major depressive episode following the death of his pet canary:

I felt like something irreparable happened when my bird Merlin died. I was so sick, I mean physically sick, day after day. I had the flu constantly. I felt that I had the flu; when you think about that, it is “funny,” ironic. I had the flu and Merlin “flew” away. I mean, the stress of that made me sick. I made myself sick with that—I know that I did.

When it gets really bad, when the kids at school are calling me gay—can you tell me why they call me gay? I try to cope, I try to say “no troubles, just one more year here.” But, then something happens, and it happens very, very quickly.

I leave my body. I leave my mind... I don’t know if I am here. And then I know that I am dying. I mean my actual brain is here, but my soul has left my body. I am screaming inside: “It is all so stupid, stupid, stupid!” I am dying here.

This young man’s physical manifestation of distress became so severe that he could no longer leave the house. He lost his appetite and became emaciated. However, a comprehensive series of physical exams revealed no irregularities:
These tests—I feel badly about the cost and bother to the medical system. I mean, there is nothing wrong with me; nothing physically wrong with me. It is my soul that is dying here. I keep telling them that is what is wrong, and they keep searching for clues in my body. That is not what the problem is.

A 17-year-old boy from the original study reported depression welling up in him like black bile, cutting off his breath, reducing his capacity to digest food, causing his chest to compress with pain. Heaviness in the eyes, pressure in the head, shakiness throughout the body, compulsive behaviors, and disordered eating patterns were other physical symptoms reported by the highly gifted adolescent subjects in a state of major depression. Yet, even with the cognitive impairment of major depression, some of these highly gifted teens maintained stellar academic performance. Almost all of the subjects reported compartmentalization of various aspects of the self: “I shut that part of myself off,” “I cannot afford to entertain those thoughts,” “I discipline myself to not feel those things,” and “I let myself sink deep into my imaginative world” were common remarks.

There was also evidence of extreme emotions, from being overwhelmed, to being explosive and aggressive. The psychomotor overexcitability common to highly gifted teens may have contributed to heightened and unusual responses to even subtle stimuli. These depressed teens reported deadened emotions, a void, or potent emotions “beyond description.” Finely tuned imaginative capacities came into play during major depression, with reports of vivid visual images and fantasies and even more troublesome delusions and hallucinations for some individuals.

As with any clinical symptom, it is important to note the degree to which the highly gifted teen feels control over these inner images and their duration and frequency. An enduring state of delusion and a felt incapacity to control undesirable imaginative responses may be signs of psychoses or other psychiatric difficulties. Neihart (1999) cautioned, however, that “observations from psychiatric studies suggest that disturbance of mood, certain types of thinking processes, and tolerance for irrationality are three characteristics common to both highly creative production and psychiatric problems” (p. 13). One young boy, exceptionally gifted and deeply depressed, had honed his ability to “alter reality.” He reported that his classroom teacher was insensitive and hard-hearted and that his schoolwork was meaningless and redundant. His response was to turn his teacher into a television screen, and he spent hours “turning the channels” with his imaginary remote control device. He was referred to counseling for attention-deficit disorder, defiance, and isolationist social tendencies.

Defense mechanisms. Highly gifted adolescents may develop complex defense mechanisms. For example, 13-year-old Anna always carried a book with her. Her vocabulary was prodigious and she could recount passages from many Shakespearean plays. Her understanding of the themes and questions inherent in the text was outstanding. She longed to be an actress and could, upon request, assume any role with an astonishing command of body, emotion, and intellect. In her daily life, however, Anna was difficult, recalcitrant, and distant. A deeply spiritual child, Anna sought communion with nature. Her favorite moments at the private school she attended were her lunch-hour walk in a grove of trees. “I walk and I talk to the trees. There is so much I can say to them. They are always there to listen.” Anna had not revealed this inner world to family members or schoolmates. She was brought to counseling because of noncompliance and belligerence. In counseling sessions, she revealed a complex sense of morality and a gentle, generous, nuanced, and open nature. Elsewhere, she experienced an extreme sense of isolation. Anna was intensely private, exceptionally bright, and dangerously depressed.

A Phenomenological Approach to Studying Highly Gifted Adolescents

Highly gifted adolescents are capable of establishing complex emotional and intellectual defenses. In accessing these individuals for research purposes, qualitative methods allow for collaborative, context-based personal inquiry, which engages the participant as a “coresearcher.” When individuals are invited to make meaning of the multifaceted experience of depression, for instance, the sense that they are not being objectified and reduced to an already established framework can override the intricate defenses normally operative. Coleman and Cross (2000) summarized this approach: “In phenomenology the connection between reality and the person is actively co-created such that there is no real distance between the two. Phenomenology provides a means for entering parts of a person’s life” (p. 211). Ary, Jacobs, and Razavieh (1990) explained further:

Qualitative inquirers argue that human behavior . . . cannot be reduced to variables in the same matter as physical reality, and that what is most important in the social disciplines is understanding and portraying the meaning that is constructed by the participants involved in particular social settings or events. . . . It is an intensely personal kind of research. (p. 445)

Phenomenological researchers ask participants to describe their lived experience of phenomena, with the investigator making no attempt to shape the experience. Subjects are invited to “tell their story” without intervention and interpretation. Taped interviews are transcribed into protocols, and, through a rigorous process of reduction, central themes
emerge. Approached with due rigor, qualitative research can produce penetrating insights into the human condition.

The first of the following case studies is drawn from the study referred to previously (Jackson 1995), which used the methodology just described. The purposive sampling method sought students who had been identified as highly gifted (a score of at least 145 on a test of intelligence) and had self-identified as having experienced a “less than positive” emotional state. Jared was one of 10 participants. Half of the subjects were exceptionally gifted, all had experienced major depression, and all reported masking their depressive experience. Two of the exceptionally gifted were in the throes of major depression during the time of the interviews, including Jared. The presentation of Jared here is based on interview protocols, research notes, and his personal journal during his depressive state. The information presented in the second case study, of David, is drawn from case notes, audiotape recordings, and writings during the time he was in therapy for major depression.

**Two Case Studies**

**Jared: Major Depression and an Ethic of Silence**

Jared recounted 8 months of battling the demon mood:

I would try to sleep, and there was this physical sensation, this huge surge as if I would have to vomit. It would build up in my stomach and right up in my throat, and it would not be any physical material, just feeling. My face would be red and my neck bulging with feeling. And my mind would be rolling over all this very dark material, something I could not control, something so powerful.

He described a flattened mood that eclipsed other feelings—and thoughts of suicide:

I felt as if I had absolutely nothing to hold me here, nothing at all that keeps me here. I almost yearn for that. I feel as if I am debasing myself by my being. And I haven’t decided whether you don’t [commit suicide] because you are weak and you are afraid or whether you don’t because you still have something to do here. I think that I do not do it because I think about it too much. It would probably be fairly easy for me to do, but since it is constantly on my mind and a part of me asking why, why, why—then how am I going to burst into action?

He had sometimes been unable to remember or compute even simple things, and “at other times . . . the act of breath-

ing seems a labor and it is just, it is just really, really dark and that is incredibly frightening.”

He talked about the effort of will required to maintain equilibrium, to assume the posture of everyday living, to keep up, to produce. He referred to terrifying mental and emotional decay: “I am often too concerned with what’s happening inside.” For the faculty at his prestigious magnet school for highly able learners, he was one of the finest minds they had had in their classrooms, and he was actually class valedictorian. The student that earned honors in physics, mathematics, music, literature, and art articulated depression images in graphic detail in the interview—and, nonverbally, a deep, underlying fatigue.

Shockingly, he revealed that no one—his teachers, his friends, or his family—was aware of his depressive state. Just the week before, his father, a highly successful entrepreneur, had spoken with him, concerned that Jared might be studying too hard. He advised Jared to pace himself in light of approaching final exams. Jared reported that his father questioned his diminished energy and suggested some exercise, a healthy diet, and “down time.” Jared was quick to assure his father that he would attend to pace and explained his fatigue in terms of senior-year pressures: predictable, undesirable, and easily dealt with. He offered nothing more, and his father did not press him further.

As Jared recounted this exchange with his father, he revealed profound shame for his calculated and easy deceit. He was ashamed about the ease with which he could dupe his father and confused by the fear and guilt that fed and accompanied his duplicity.

It was clear that Jared was acutely ill with depression, but he also despaired for another reason: He blamed himself for his lack of control and for not being able to “figure it out.” He had always had a sense of interdependence, with a concern for the welfare of others. He therefore worried about how revealing his depressive state would affect his parents, concerned that they would feel responsible for his distress and, an even greater fear, that they would then castigate themselves for being ignorant of his condition.

Late in the interview, he revealed that depression robbed him of what he had assumed was his birthright: his ability to intuit answers with little effort. He admitted that, for the first time, he could not easily see the whole of a thing, and he could not predict the next part of the pattern. He was a vital young man rendered weak. His genius had been eviscerated.

Jared was suffering from major depression, a condition unimaginable to those who have not experienced it. He struggled to explain its tempo, rhythms, and power:

But, the thing that bothers me most isn’t the mood swings or the polarization I do feel with my true emo-
tions. It's that in-between—that detached state, that not caring for and not being able to be touched by anything. This makes me feel sick at heart—deadened. Sometimes, it is a feeling of deep, deep anguish, and this is truly almost inexpressible.

During the interview, he opened his personal journal to writings at the height of his depression. He read as follows:

I feel hopelessness, a lot of hopelessness, no anger—no anger at anyone other than myself, I guess you could say almost a self-hate—very, very critical. The self-criticism reigns unchecked. I seem unable to prevent this.

He had had little psychic fuel left and could not ask for help; he conserved what little he had and pretended that he was well. He reflected on his experience: "Going through it was really, really hard. Thinking back on it, I can say, now, now, it wasn't that rough, but going through it, I think it was."

Themes in the transcribed interview included his intense need to be understood, his hope for validation of his experience, and insight. The transcripts also revealed his ethic of silence. The depressive state had, until the research interview, robbed him of his voice and his uncommon capacity to express. He felt his terrors were unspeakable and that no person could receive the intricacies and felt horror of the depressive state. His response had been to mask the symptoms. He described his feelings as large and ominous, unexplainable, amorphous, distressingly intangible, conflictual, and often paradoxical:

It is so hard for me to do this, to tell you, to bring it out in any kind of coherent manner. It is going to be so very hard to do this, to talk to you about this, and I am not sure even want to do it. It leaves you feeling completely overwhelmed. It is not just about bringing things out. You have to deal with them, and, last week, it was really, really, really bad.

Most importantly, this undesirable state also felt dangerous:

Right now, I am even debating deciding how deep I should go, and if you want to talk nightmares, we can do that, but I am really not sure if I want to do that. If you want to talk suicide, we can do that, too. All of that exists in me. It is dark, and it is there, but I just do not know if I should do that.

The anonymity of the interview had provided an unusual window of opportunity:

The reason why I still sit here, with you, and do not go home, which I could, and this might be kind of disturbing, but it is because you are almost faceless, in the way that I am not going to have to live with you the rest of my life like I would with my mom and my dad. I am not going to have to deal with the repercussions of what I say at my school, and it is easier. I get to be a little detached and impersonal.

Ironically, his profound abilities allowed him to deceive all who interacted with him. His sensitivity, perfectionism, and high energy all assisted his duplicity. His sensitivity to the needs of others contributed to his faulty logic and to his incapacity to ask for help. One irony of the depressive state for Jared was the fact that his capacity to analyze—to take a thing apart and view its components—remained powerful, while the capacity to put it together in a meaningful gestalt—to synthesize—became dormant (Dabrowski, 1967; Jackson 1995). However, while his inner world was full of horror and incapacity, his outer world was marked by competence, carefully maintained. At the time of the interview, exhaustion was the only telling sign of his deep malaise.

Breaking his silence seemed to be at once cathartic and exhausting. He suggested that the depressed state could not go on forever and that his resources were running low. The interviewer wondered how much longer he could pretend. She mentally sketched a program of intervention as the interview concluded. It would have to be carefully and skillfully administered. Jared's intellectual and emotional defenses were extensive, and his innate emotional framework was complex and fluid. He would have to be supported caringly over time. He was highly gifted and greatly at risk.

David

The following recollections of the mother of David, a highly gifted, learning-disabled adolescent, described major depression:

He was very sad. I could see the sadness, but couldn't reach him, and he was distant all the time. When he was really depressed, he would sleep until at least noon and was awake most of the night. He buried himself in his computer, learning everything he could about repairing and networking. He would not meet to talk to anyone. He would not even leave the house. Our family took a holiday; he brought his laptop computer. I don't think he left the cabin once. He didn't even see the beach or go out for a walk, not even once. His appetite was poor; he only wanted to eat junk food. He would not look after himself properly: he did not go to the dentist, did not shower, his hair was long and often dirty. I hurt inside all the time watching
him. We tried everything to get him to eat better, to get involved, and to be a part of our family life and the world outside. There was constant tension and horrible fights. We were desperate and terribly concerned.

She was writing about her son’s 14th year. When David first entered therapy, he was under psychiatric care, heavily medicated with antidepressants, violent, and emotionally explosive. His parents lived in fear—for their own safety and for David’s. He was morbidly depressed and suicidal. He showed signs of extreme agitation and poor impulse control. At the time this article was written, David was 18 and had been in weekly therapy for 2 years. He had finished high school, no longer took antidepressive medication, was involved in his family and social life again, held down a full-time job, and was about to enter a technical program.

In contrast to Jared, there was ample external evidence that David was seriously disturbed. Schoolwork was rarely completed, teachers’ instructions were disregarded, and he did not participate in classes. Unlike Jared, David’s overall academic achievement was poor, although he outstripped teachers and curricula in all areas of technology and secured the role of key computer troubleshooter for the faculty. However, school officials reported feeling uneasy in his presence, frustrated, and concerned. They found him difficult to deal with in everyday matters—uncooperative, shut down, derisive. He was a social isolate, guarded and defensive, and his volcanic anger was barely under control.

Despite grudging acknowledgement of his complex intelligence and extraordinary facility with technology, school personnel saw him as an academic failure, a disturbed troublemaker, and a malcontent. Administrators blamed the family and constructed a behavioral intervention when he was thought to have violent tendencies. Although counselors attempted interventions, there was no consistent academic or emotional support in place for him, nor any psychoeducational analysis. The latter would have detected his fine problem-solving and visual-spatial abilities; however, the difference between his written expressive capabilities and his computational genius would have pointed to a severe learning disability. Without this essential information and these insights, school faculty treated his lack of production as noncompliance and insubordination and disregarded him.

Lacking knowledge of the disability, teachers demanded what David could never produce. His inability to understand his own functioning and his incompatibility with an educational system demanding written expression of acquired knowledge ensured frustration and self-repudiation. David knew he could not perform as demanded. He was often overwhelmed with his incapacities and was unable to find a conduit for his profound abilities except in computer studies. His complex and sensitive nature and his need to belong and to contribute in meaningful ways were subverted.

The roots of David’s depression—incompatibility with the demands of the educational system and lack of support for his gifts and understanding of his learning disabilities—seem, in comparison to Jared’s, straightforward. In an in-depth interview, however, David quickly asserted that the suppression of his feelings and the beginnings of the depressive state occurred very early in his school experience:

I know when it started: the first day of playschool—yes, playschool, not kindergarten. I remember it clearly. I would have been, hmm, just 3, just turned 3 years old. I remember how high the ceiling was and the color of the little mats we had to sleep on. That was the first day I came face to face with evil—with how others kids could be. I remember the boy’s face; I can still see it. It was then I knew what the word bully meant. I mean, I really knew what it meant. He shoved me around; he was very physical; I was very frightened. And then it hit me; this is the way that people could be, they were not all loving and kind. There was evil in the world. I remember that so clearly as the first day I started to shut down parts of myself. . . . I started hiding who I was. I could never fit in. I did not know how to be mean, and I always wanted other people to be fair, to care, to work together. It was very definitely the beginning of my despair.

When it became obvious, in grade 8, that I was depressed, I had been emotionally locked up for a very, very long time. By the time they noticed what was wrong, it was almost too late.

**Conclusion**

A phenomenological research study (Jackson, 1995) and comments from extensive clinical files and focus groups of highly gifted adolescents revealed several trends, most importantly the capacity to mask various aspects of a depressive disorder. Gifted adolescents’ profound sensitivity and their shame and sense of failure for their inability to figure out the source and cure for their toxic state formed the motivational substrate of the masking phenomena. Their reduced capacity for synthesis, slowed cognitive functions, and delayed reactivity disengaged their usually exceptional problem-solving capacities. A need to protect others from the potency of their state and a fear that it would not be easily communicated or understood further alienated them.

For highly able individuals like these, early intervention and insightful and informed diagnosis are essential. During
depressive episodes, emotional extremes, unusual mental images, and spiraling thoughts are common in this population. Atypical physical manifestations of depression may occur, and somatic distress must be carefully considered as to its etiology and possible relationship to the psychological distress.

Appropriate and thorough psychological support must take into account the complex defense mechanisms inherent in the depressed highly gifted adolescent. Clinicians who are familiar with the complicated and unusual innate functioning of highly gifted teens are more likely than those who are unfamiliar to assess accurately the severity of depressive states for this subgroup of the gifted population. Sensitivity to the shame and vulnerability reported by all subjects here is essential for best outcomes.

Finally, there is a need for more qualitative research on the nature of depressive disorders for highly gifted adolescents. It is clear that vulnerability to depression depends on a number of interactive factors. Poorness of fit with educational programming and lack of intellectual and emotional communion were factors for these students. The need for community in terms of a meaningful and vital exchange was apparent in this group of exceptional students. Without this communion and informed, perceptive response, some highly gifted depressed adolescents are gravely at risk.

References


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**End Notes**

1. No claim can be made for the representativeness of this sample. These in-depth interviews were conducted with the intent of providing a nondirective, sensitive environment in which questions about depressive states could be asked in a private, nonjudgmental environment with likeminded peers. All participants were highly, exceptionally and profoundly gifted adolescents who had been referred for either developmental or therapeutic clinical support.