# DEPRESSION AND CHILDHOOD BEREAVEMENT

By

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THIS work was originally started because attention had been drawn to the high suicide rate in Hampstead. Geffen and Warren (1) originally reported this high rate. During the last ten years it has varied between 20 and 30 per 100,000 inhabitants (see Table I). It also compares with the suicide death rate of 10 per 100,000 for the whole community.

TABLE I

*Suicides in Hampstead*

(Population 96,450 in 1958)

| Year | 1950 | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 | 1957 | 1958 | 1959 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of Suicides .. | 28 | 23 | 18 | 17 | 22 | 29 | 25 | 23 | 27 | 33 |

This compares with 21 deaths from carcinoma of the stomach, 18 from carcinoma of the breast, 10 from road accidents, 9 from pulmonary tuberculosis in 1958 in Hampstead.

Certain other boroughs, such as Kensington and Hammersmith, have almost as high a suicide rate. There are probably between 6 and 10 times as many suicidal attempts as suicides in the area, some of which are admitted as emergencies to the two Hampstead hospitals.

Sainsbury (2) has described the ecology of suicides in London and links the high incidence of suicide in certain areas with loose community structure, family instability, shifting population and loneliness.

Stengel (3) distinguishes between the type of people who commit suicide and those who only attempt it. The actual suicides seem to be most frequent in males in the general community and with the highest incidence in late middle age. The suicidal attempts, on the other hand, are preponderantly female, with the peak in the twenties and in the forties. Stengel particularly stresses the "appeal" element in suicidal attempts as they are often a form of calling out for help from those most nearly associated with the individual. Naturally, this person can sometimes fail to save the patient in time and death can ensue, so that obviously there is no hard and fast distinction between the conditions leading to actual suicide and suicidal attempts.

In reviewing the cases presented at Hampstead General Hospital it soon became apparent that it was necessary to study the whole subject of depressive illness, both sudden acute phases of depression in apparently healthy, normal people and the more persistent depressive states, as both of these can lead to suicide.

The incidence of depressive illness in the community is considerable. In 1955 the mental hospital population was 147,000 and there were 111,326 new out-patients at psychiatric departments and 2,608 patients in non-statutory



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beds, adding up to 260,934 (4). Of these about a third was suffering from depressive illness—say 87,000. This leaves out of consideration the old out-patients and the depressive patients attending their general practitioners and the cases treated by general hospitals which together far exceed this figure. It is also estimated that there are 22,000 new admissions a year to mental hospitals for severe depressive illness in this country.

In order to investigate the causation and incidence of depressive illness in Hampstead, I originally outlined a somewhat ambitious plan in which nationality, religion, family background, physique and the whole social situation were to be recorded and studied, but to facilitate statistical analysis the investigation was limited to one factor at a time.

For some years I have been particularly aware of the high incidence of childhood troubles, especially bereavement, in the previous histories of my depressive patients and of the intensity of these reactions in child patients. One can, however, be aware of something clinically without being able to measure or prove it. There is no such thing as a rejectometer, or coefficient of oedipal fixation; however the date of death of a patient's parents is a definite and accurately recorded factor which particularly lends itself to statistical analysis.

Freud (5) pointed out the similarity between mourning and melancholia and emphasized the loss of a "loved object" in depression but he did not specifically relate adult depression to childhood bereavement.

Abraham (6) developed a theory that children who have suffered some trauma or loss are subject to "primal parathymia" which makes them more liable to develop melancholia in later life. He alludes to difficulties caused by birth of a new baby and to Oedipal situations but, as Bowlby (7) points out, he fails to allude to definite grief and mourning in the child nor does he seem to appreciate the significance of actual bereavement. He came very near to appreciating this but, as Bowlby again points out, he was distracted by his theories of narcissism in the infant so that he vacillated in his theorizing.

Stengel says, "Parental loss is frequent in the histories of suicided individuals but it is difficult to evaluate these observations as suitable controls do not exist." Nevertheless, it seems that controls could be found to make an investigation of the childhood bereavement incidence in depressive patients statistically significant.

The hypothesis here is that a depressive illness in later years is often a reaction to a present loss or bereavement which is associated with a more serious loss or bereavement in childhood. The depressive illness is thus regarded as a kind of anaphylactic reaction which occurs in later life where there has been an early sensitization.

## Diagnosis and Definition

Aubrey Lewis (8) defines depressive illness as that in which the clinical picture is dominated by unpleasant affect, not transitory, without schizophrenia and without organic brain disease. This is essentially the criterion accepted here.

Depression is regarded as an excessive preponderance of a human emotion, a reaction type and not a disease entity. As Adolph Meyer (9) said, "We should not expect hard and fast demarcation between normal and pathological and between mental and non-mental. We recognize practical but not absolute lines of subdivision, spheres of emphasis rather than thorough-going and distinct partitions."

Various types of depressive illness have been described; endogenous,

manic depressive, involutional, psychoneurotic, reactive, psychotic, etc., and their differentiation from psychoneurosis has been described but none of this complicated differential diagnosis is attempted here.

During the last 30 years there has been considerable controversy over the classification of depressive illness and its differentiation from psychoneurosis. Though this controversy is extremely interesting it cannot be fully dealt with in this paper. T. A. Ross (10), Farquhar Buzzard (11), Yellowlees (12) and R. D. Gillespie (13) were in favour of a definite distinction between depressive illnesses and psychoneurosis while Mapother (14), Aubrey Lewis (8) and Curran (15) opposed any such distinction. Recently Garmany (16), in a study of 525 cases, came to the conclusion that there was no essential difference between the various types of depressive illness. It is, in fact, becoming more and more apparent that the sub-divisions of depressive illness have neither scientific basis nor practical use and for the present purpose they can be abandoned.

When a patient is unhappy and ill through his unhappiness he can be said to be suffering from a depressive state. In the present investigation the diagnosis of depressive illness was made when a patient was sufficiently depressed to be referred by his general practitioner to the out-patient department of Hampstead General Hospital for his depressive symptoms.

## The Investigation

During the last five years special attention has been paid to recording the ages at which any patient has lost his father or mother, whether they are alive or dead, or whether nothing was known about them. If there was no record of this information about the patient owing to inadequate history then the case was rejected from the series. Thus, there was no selection of cases but all depressive cases were included about which adequate records were available.

There were a number of cases in which the patient himself did not know anything about his father or his mother or did not know if they had died. These cases were included in the series under the headings of "Father unknown" or "Mother unknown".

This fact of the patient not knowing whether his mother or his father is alive or dead is, in itself, a very positive potential factor in depressive illness as it implies, to say the least of it, a serious break-up of the family structure or breach in relationship between the patient and his parents.

The age, sex, marital state and other data were noted on the card but the only items to be analysed are the age and sex of the patient when his father or mother died.

Two hundred and sixteen depressive patients were studied in this way—61 males and 155 females.

It is realized that every out-patients department has its own special clientele. This particular out-patients department probably has a higher proportion of minor depressive illness and transitory acute depressions than the out-patients departments which are primarily attached to a mental hospital where there is probably a higher proportion of severe depression requiring mental hospital treatment.

## Controls

In order to evaluate the figures for childhood bereavement among the depressive patients obviously some control referring to the incidence of childhood bereavement in the general community is necessary for comparison. Some Hampstead general practitioners very kindly collected the information

TABLE II

*Incidence of Orphanhood from 1921 Census*

| Age of Child | Total Both Sexes | Not Known | Per cent. Not Known | Total Known | Father Only Dead | Mother Only Dead | Both Dead | Number Fatherless Including Both Dead | Per cent. of Known Father-less | Number Motherless Including Both Dead | Per cent. of Known Mother-less | Number Either Parent Dead | Per cent. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | 610,982 | 7,672 | 1·25 | 603,310 | 34,517 | 11,361 | 1,607 | 36,124 | 6·00 | 12,968 | 2·16 | 47,485 | 7·86 |
| 9 | 710,630 | 8,203 | 1·15 | 702,427 | 61,377 | 21,495 | 4,543 | 65,920 | 9·40 | 26,038 | 3·71 | 87,415 | 12·40 |
| 14 | 727,875 | 18,087 | 2·47 | 709,788 | 76,090 | 31,898 | 8,390 | 84,480 | 11·90 | 40,288 | 5·75 | 116,378 | 16·60 |

from unselected patients who attended their surgeries; in addition, such information was obtained by the house physicians at Hampstead General Hospital from a number of patients in general wards suffering from medical or surgical disorders. These cases are not, perhaps, a perfect control as they were ill in some respect or, at least, were attending their doctors. However it has been estimated that 80 per cent. of the patients on a doctor's list attend him in any year. As, therefore, each doctor only took these records for a short time, there would tend to be a somewhat higher incidence in the controls of regular attenders. It was, in fact, found that a number of the controls were attending their doctors for psychiatric complaints. However, as this was an attempt to compare the incidence of childhood bereavement among depressive patients attending the hospital with that in the general community, it is assumed that those attending the general practitioner are a sample of the general community and these patients must be included among the controls, and this has, in fact, been done.

It was also felt that there must be some way of correlating the incidence of childhood bereavement from the Registrar General's figures giving the death rate, the birth rate, actuarial figures for the expectation of life and marriage rate and for the size of the family, but the mathematics would be somewhat complicated.

The table on orphanhood of the 1921 census, however (17), provides an invaluable set of figures with direct bearing on this particular problem. Table II shows the most relevant aspects of these figures and is an analysis of the figures from the 1921 census for the ages of children of both sexes from 4 to 5, 9 to 10 and 14 to 15. For instance, the percentage of children aged 4 to 5, fatherless (including those lacking both parents) from this table is 6 per cent. and one can, therefore, assume that 6 per cent. of the age group who are now 38 to 42 years of age lost their fathers in the first 5 years of life. From Table II, 9·4 per cent. of the 9 plus children were fatherless but of those children 6 per cent. had lost their fathers before the age of 5, thus 9·40—6 per cent.=3·40 per cent. who lost their fathers when they were between 5 and 9 plus years of age.

According to this method Table III has been produced to give the bereavement indices of the three age groups, figures which can be compared with the bereavement indices for the depressive patients and for the Hampstead controls.

TABLE III

*Age Incidence of Bereavement Calculated from 1921 Census*

| Age at Bereavement | Loss of Father (Per cent.) | Loss of Mother (Per cent.) | Loss of Either Parent (Per cent.) |
|---|---|---|---|
| 0– 4 .. .. .. .. | 6·00 | 2·16 | 7·86 |
| 5– 9 .. .. .. .. | 3·40 | 1·55 | 4·54 |
| 10–14 .. .. .. .. | 2·50 | 2·04 | 4·20 |
| 0–14 .. .. .. .. | 11·90 | 5·75 | 16·60 |

These figures are probably higher than those for other ages because there was the heavy loss of fathers 1914–18 during the war and of both parents in the influenza epidemic of 1918. There is no reason to suppose that the survivors until 1959 have a higher bereavement index than those who died between 1921 and 1959; in fact, we would expect the orphans to have a higher mortality. Thus the orphanhood figures of the 1921 census can be taken as a fair estimate of orphanhood among the middle-aged people of today. Moreover, if these

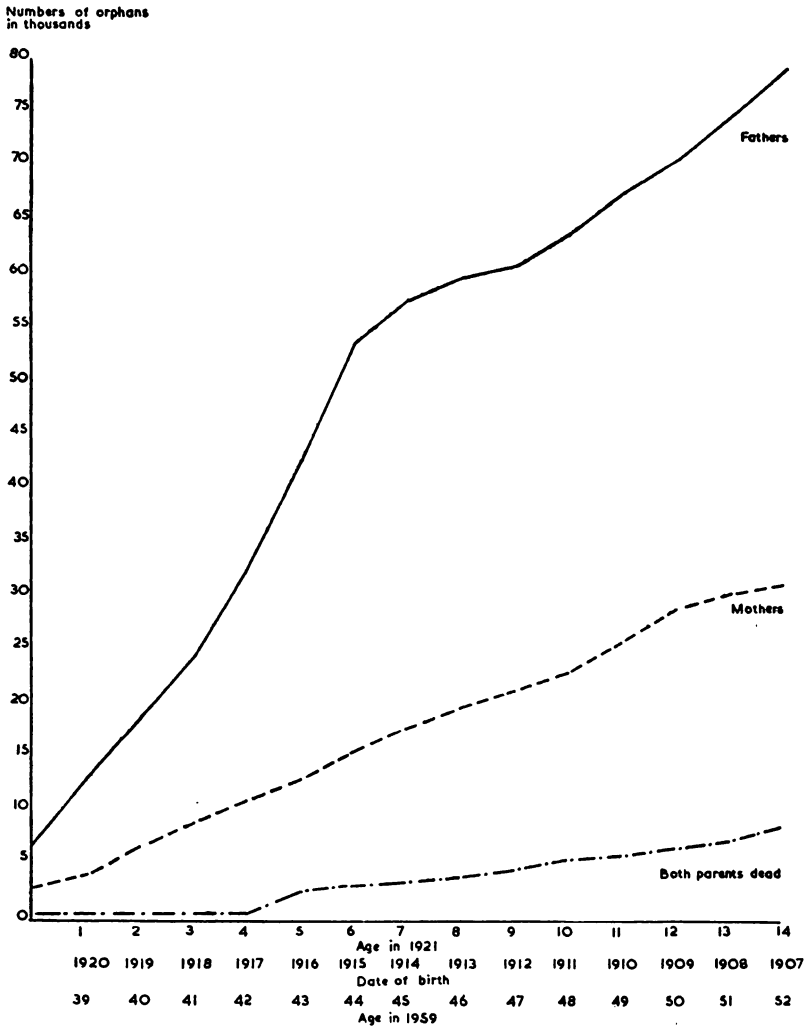
figures are used as controls for younger people, the controls are likely to err on the high side, especially in the 5–9 period for fathers as there has not recently been a slaughter of fathers equal to that of the 1914–18 war in this country. The comparable figures for the 1939–45 war were not, in this country, as high as in the 1914–18 war. Thus it appears that these figures for bereavement, calculated from the 1921 census, are quite fair controls for comparison with the incidence of childhood bereavement in patients suffering from depression now.

The sexes of the children have not been treated separately as it is obvious from the Registrar General's figures that there is no significant difference between the bereavement rate of boys and girls. There may, however, be a significant difference in depressive cases between the sexes.

The Registrar General's figures are worth examining in a little more detail especially to observe the impact of the 1914–18 war on orphanhood.

Chart 1 shows the numbers of orphans, plotted to the year of birth, present age and age in in 1921. This shows the high paternal mortality during the war

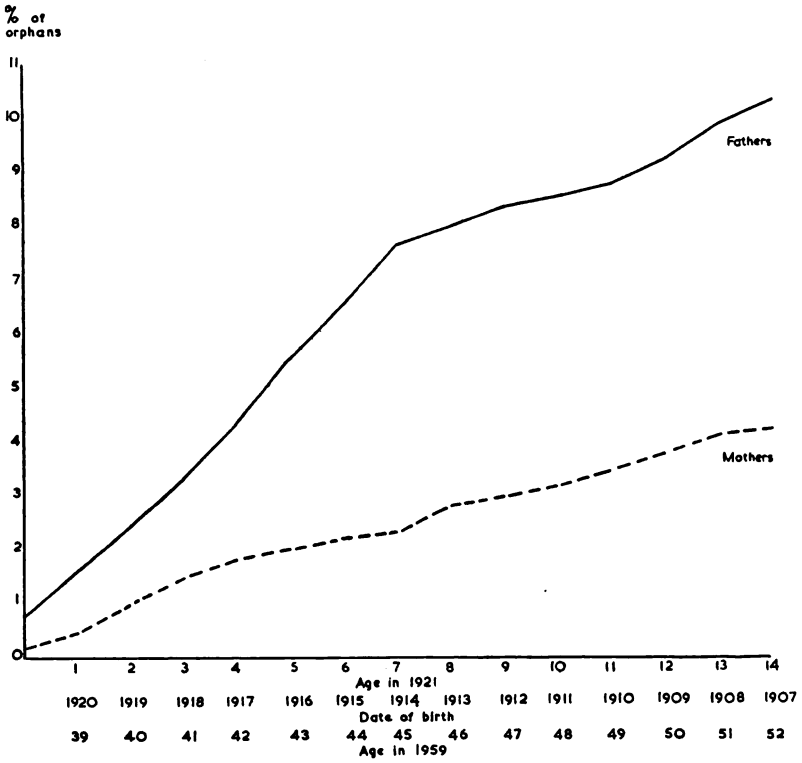
CHART I.—Showing numbers of orphans at ages 0—14 in 1921.



and this also shows in Chart 2 where the percentage of orphans at each age is shown. Chart 3 shows the increase in percentage per year, and particularly stresses the paternal mortality in the 1914–18 war.

The initial figure is fairly high, both for fathers and mothers, probably because it includes fathers who died in the nine months before the birth of the child, and it also includes the maternal mortality rate, which at this time was about 2 per 1,000 live births. It appears from these figures that about 1 per cent. of those who are now between 40 and 45 lost their fathers in the 1914–18 war.

CHART II.—Showing percentage of orphans in children of ages 0—14 in 1921.




If orphanhood in childhood is proved to be a significant factor in depressive illness, it would follow that the 1914–18 war is also a factor in present depressive illness; probably the 1939–45 war has not yet had its full effect in this respect.

## RESULTS

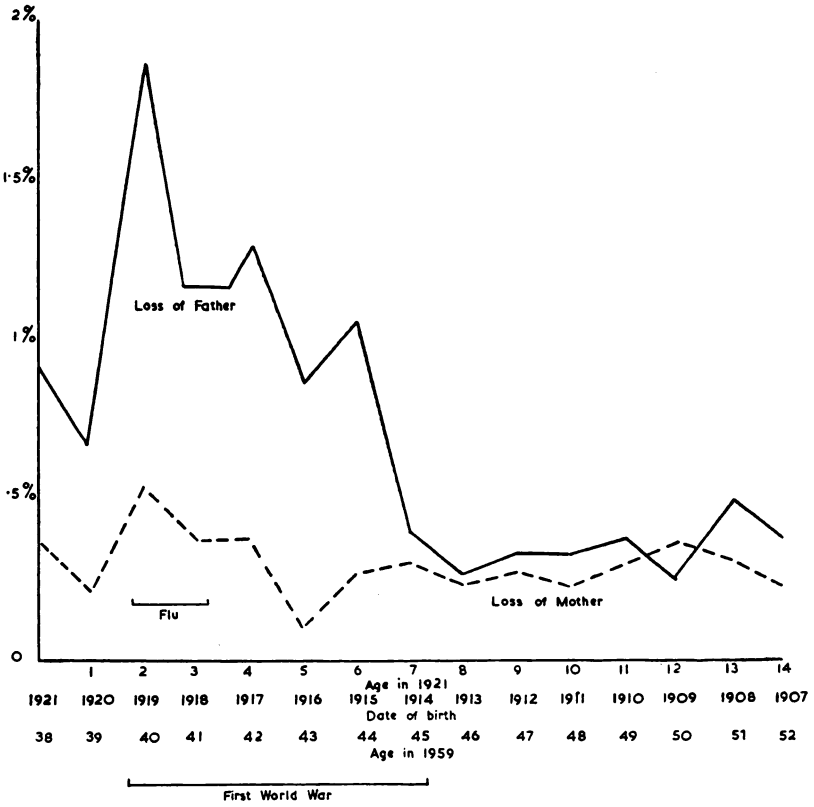
The standard error has been calculated to the formula:

$$e=\frac{P_1Q_1}{n_1}+\frac{P_2Q_2}{n_2}$$

Where E is standard error $P_1$ is the proportion showing the attribute in the sample, in this case, say, the proportion bereaved of a father in the years 0–14. $Q=1-P_1$; $n_1$ is the number in the sample (in this case, 201 cases known). $P_2$, $Q_2$ and $n_2$ are the corresponding figures for the controls using the Registrar General's figures. $n_2$ is 727,875 and the standard error in the Registrar General's controls is thus negligible.

The results of the collected statistics on childhood bereavement are

CHART III.—Showing annual increase in percentage of orphans according to date of birth and age in 1959 (from 1921 census).




summarized in Tables IV, A–F, the percentages are stated as a percentage of known cases, after deduction of the cases with unknown parents. Table IVD shows the most significant results. From this it appears that the bereavement

TABLE IVA

*Tables Comparing Incidence of Childhood Bereavement in 216 Depressive Patients compared with*

(*a*) Incidence of Orphanhood from 1921 Census

(*b*) Incidence of Childhood Bereavement in Controls from Hampstead general practice.

Male Patients—Loss of Father—57 Known Cases

| Age at Loss | Per cent. Depressive Cases | Per cent. from 1921 Census | Difference | Standard Error | Hampstead G.P. Controls | Difference G.P. Depressives | Standard Error |
|---|---|---|---|---|---|---|---|
| 0–14 | 26·3 | 11·90 | *14·4* | ±5·84 | 15·5 | 10·8 | ±6·87 |
| 0– 4 | 12·3 | 6·00 | 6·3 | ±4·35 | 6·8 | 5·5 | $>\frac{d}{2}$ |
| 5– 9 | 7·0 | 3·40 | 3·6 | ±3·25 | 4·9 | 2·1 | $>\frac{d}{2}$ |
| 10–14 | 7·0 | 2·50 | 4·5 | ±3·25 | 3·9 | 3·1 | $\pm\frac{d}{2}$ |

TABLE IVB

*Incidence of Loss of Father in Female Patients and Controls*
(144 known cases)

| Age at Loss | Per cent. Depressive Cases | Per cent. from 1921 Census | Difference | Standard Error | Hampstead G.P. Controls | Difference G.P. Controls | Standard Error |
|---|---|---|---|---|---|---|---|
| 0–14 | 28·50 | 11·90 | *16·6* | ±3·8 | 11·95 | *16·55* | ±4·6 |
| 0– 4 | 4·86 | 6·00 | −1·14 | $> \frac{d}{2}$ | 5·00 | Not significant | |
| 5– 9 | 9·03 | 3·40 | *5·63* | ±2·4 | 3·77 | 5·26 | ±2·83 |
| 10–14 | 14·60 | 2·52 | *12·1* | ±2·94 | 3·2 | *11·4* | ±3·3 |

TABLE IVC

*Incidence of Loss of Mother in Female Depressive Patients*
(146 known cases)

| Age at Loss | Per cent. Depressive Cases | Per cent. from 1921 Census | Difference | Standard Error | Hampstead G.P. Controls | Difference G.P. Controls | Standard Error |
|---|---|---|---|---|---|---|---|
| 0–14 | 23·30 | 5·75 | *17·55* | ±3·5 | 9·36 | *13·94* | ±3·932 |
| 0– 4 | 9·60 | 2·16 | *7·44* | ±2·44 | 3·12 | 6·48 | ±2·663 |
| 5– 9 | 6·85 | 1·55 | *5·30* | ±2·088 | 3·12 | 3·73 | ±2·35 |
| 10–14 | 6·85 | 2·04 | *4·81* | ±2·088 | 3·12 | 3·73 | ±2·35 |

TABLE IVD

*Incidence of Various Childhood Situations of Loss Before the Age of 15, in 216 Adult Patients of Both Sexes, Suffering from Depression Compared with:*
(*a*) The Incidence from the 1921 Census, and
(*b*) The Incidence in 267 Patients Attending Hampstead General Practitioners' Surgeries

| | Per cent. in Depressives | Per cent. in 1921 Census | Difference and Standard Error | Per cent. in G.P. Controls | Difference and Standard Error |
|---|---|---|---|---|---|
| Loss of father .. | 27·8 | 11·9 | 15·9±3·16 | 13·4 | 11·4±3·8 |
| Loss of mother .. | 20·5 | 5·8 | 14·7±2·82 | 8·8 | 11·7±3·32 |
| Loss of both .. | 9·2 | 1·2 | 8 ±2·8 | 0·2 | 9 ±3 |
| Loss of either .. | 41·0 | 16·6 | 24·4±3·56 | 19·6 | 21·4±4·35 |
| A parent unknown | 12·0 | 2·5 | 9·5±2·24 | 3·7 | 8·3±2·5 |

index from 0–14, of either parents, for both sexes of depressive patients, is 41, comparing with 16·6 from the 1921 census and 19·6 from the controls collected in Hampstead general practice. These figures are highly significant.

The loss of fathers is more frequent than the loss of mothers in all these tables, but the loss of either parent, during each of the phases of childhood, 0–4, 5–9, and 10–14 is significantly higher in those patients suffering from depressive illness than in the general population.

There are not as many significant results for the male depressives as for the females, as the number of male depressives was only 61, as compared with 155 females; the ratio of male depressives to female depressives appearing at the out-patients department being 1 : 2·54. It is interesting that the incidence of loss of parent of the same sex is just as significant as the loss of parent of the opposite sex.

It will be noticed in Table IVE that the loss of the father does not appear

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TABLE IVE. (See also Chart 4)

*Table Showing Age at Loss of Fathers in Depressive Patients (both Sexes), Compared with Census Controls and Patients Attending General Practices*

| Age at Loss of Father | Age Groups of Patients | | | | | | | Total | * Percentage of Known Cases | Percentage in 1921 Census | Difference and Standard Error | Percentage in General Practice | Difference and Standard Error |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 15–19 | 20–29 | 30–39 | 40–49 | 50–59 | 60–69 | 70+ | | | | | | |
| 0– 4 .. .. | | 1 | 3 | 4 | 6 | | | 14 | 7·0 | 6·0 | 1 ±1·8 | 5·7 | 1·3±2·3 |
| 5– 9 .. .. | | 3 | 4 | 4 | 4 | 2 | | 17 | 8·5 | 3·4 | 5·1±1·97 | 4·2 | 4·3±2·33 |
| 10–14 .. .. | 1 | 4 | 6 | 2 | 8 | 4 | | 25 | 12·4 | 2·5 | 9·9±2·32 | 3·5 | 9 ±2·58 |
| 15–19 .. .. | 1 | 4 | 6 | 3 | 3 | 1 | 1 | 19 | 9·5 | | | 4·2 | 5·3±2·41 |
| 20–29 .. .. | | 3 | 10 | 4 | 10 | 3 | | 30 | 14·9 | | | 11·5 | 3·4±3·19 |
| 30–39 .. .. | | | 2 | 5 | 5 | 4 | 1 | 17 | 8·5 | | | 8·4 | Nil |
| 40+ .. .. | | | | 3 | 10 | 7 | 4 | 24 | 11·9 | | | 17·6 | −5·7±3·33 |
| Not known .. | 1 | 6 | 4 | 1 | 2 | | 1 | 15 | 7·0† | | | 1·9 | 5·1±1·91 |
| Alive .. .. | 3 | 20 | 22 | 10 | | | | 55 | 27·4 | | | 45 | −17·6±4·4 |
| Totals .. | 6 | 41 | 57 | 36 | 48 | 21 | 7 | 216 | | | | | |

No figures available from Census over 15

Total known—201 Average age of patients—43 Average age of controls—43·5

* Percentage of total known, i.e., 216−15=201.

† Percentage of total, i.e., 216.

TABLE IVF. (See also Chart 5)

*Incidence of Loss of Mothers at Various Ages of 216 Depressive Patients Compared with 1921 Census and 267 Controls from General Practice*

| Age at Loss of Mother | Age Groups of Patients | | | | | | | Total | Percentage of Known Cases | Percentage in 1921 Census | Difference and Standard Error | Percentage in General Practice | Difference and Standard Error |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 15–19 | 20–29 | 30–39 | 40–49 | 50–59 | 60–69 | 70+ | | | | | | |
| 0– 4 .. .. | | 4 | 2 | 3 | 3 | 1 | 2 | 15 | 7·3 | 2·2 | *5·1*±1·82 | 3 | *4·3*±2·11 |
| 5– 9 .. .. | | 4 | 3 | 4 | 1 | 1 | 1 | 14 | 6·8 | 1·6 | *5·2*±1·76 | 3·4 | 3·4±2·1 |
| 10–14 .. .. | 1 | | 5 | 2 | 3 | 2 | | 13 | 6·3 | 2·0 | *4·3*±1·7 | 2·3 | *4* ±1·9 |
| 15–19 .. .. | | 1 | 3 | 2 | 3 | | 1 | 10 | 4·9 | | | 3·1 | 1·8±1·84 |
| 20–29 .. .. | | | 7 | 1 | 3 | 2 | | 13 | 6·4 | | | 5·8 | 0·6±1·77 |
| 30–39 .. .. | | | 4 | 6 | 7 | 5 | 1 | 23 | 11·2 | | | 10 | 1·2±2·69 |
| 40+ .. .. | | | | 2 | 14 | 8 | 2 | 26 | 12·7 | | | 19·8 | *−7·1*±3·4 |
| Alive .. .. | 4 | 29 | 30 | 15 | 11 | 2 | | 91 | 44·5 | | | 52·5 | 8 ±4·65 |
| Unknown .. | 1 | 3 | 3 | 1 | 3 | | | 11 | 5·1 | | | 1·9 | 3·2±1·7 |
| Totals .. | 6 | 41 | 57 | 36 | 48 | 21 | 7 | 216 | | | | | |

Total known—205

statistically significant between the ages 0–4. This is, perhaps, due to the comparatively high figure for father loss from the 1921 census, namely 6 per cent., which was the result of the 1914–18 war.

The incidence of bereavement of the depressive patients is compared with patients attending Hampstead general practices; there are not so many significant results because the standard error of the control is added to that of the depressive cases, and also the incidence of bereavement in Hampstead controls was higher than that from the 1921 census.

The incidence of childhood bereavement in depressives in the general population and in Hampstead is more graphically shown in Charts 4 and 5.

CHART IV. (see Table IVE).—Incidence of death of fathers at various age groups in

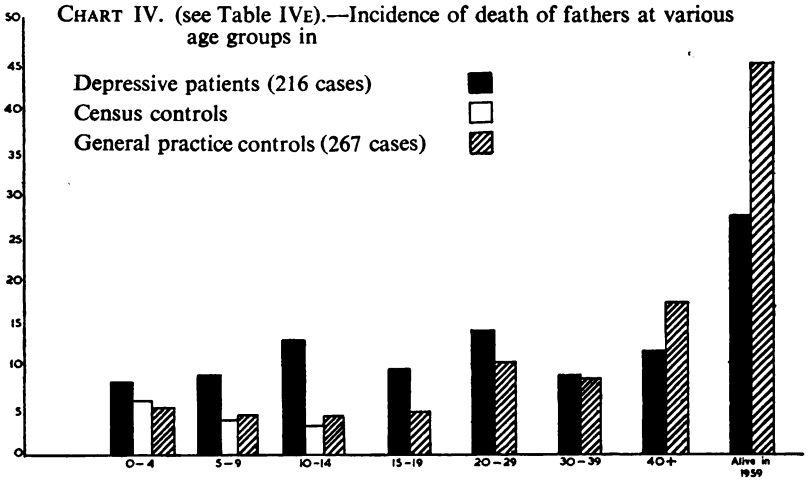
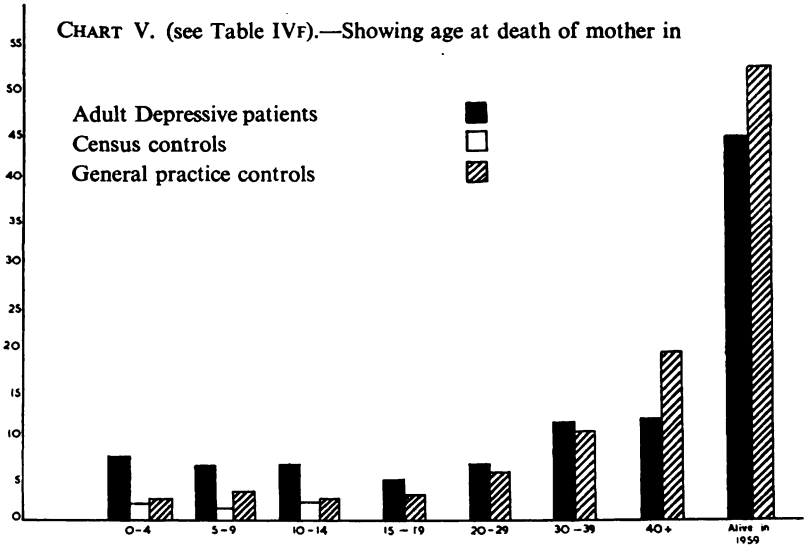



CHART V. (see Table IVF).—Showing age at death of mother in

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From Table V it will be seen that the age groups of the Hampstead controls do not exactly coincide with the age groups of the depressive patients, However. the average ages are remarkably similar; for instance, the average age for male depressive patients was 42·7 and for male controls 43·4; for female depressives 43·1 and for female controls 43·7. Thus, the higher paternal mortality due to the 1914–18 war is likely to have affected the figures for the depressive patients and for the Hampstead controls about equally.

TABLE V

*Age Groups of Depressives and Control Patients*

| | 15–19 | 20–29 | 30–39 | 40–49 | 50–59 | 60–69 | 70+ | Average Age | Total |
|---|---|---|---|---|---|---|---|---|---|
| Male depressives .. | 1 | 11 | 14 | 15 | 15 | 4 | 1 | 42·7 | 61 |
| Female depressives .. | 5 | 30 | 43 | 21 | 33 | 17 | 6 | 43·1 | 155 |
| Male controls .. | 3 | 30 | 17 | 17 | 14 | 14 | 9 | 43·4 | 104 |
| Female controls | 10 | 43 | 27 | 25 | 17 | 20 | 21 | 43·7 | 163 |

The average ages of the controls and depressive patients correspond, but the age groups do not entirely correspond.

## THE INCIDENCE OF "PARENTS UNKNOWN" IN DEPRESSIVE PATIENTS AND CONTROLS

Table IVD compares these figures. It will be seen that of the depressive patients 12 per cent. did not know whether one or other parent was alive or dead. In the 1921 census (0–14 age group) 2·5 per cent. only have unknown parents although this section includes also the unrecorded ones who may have been known to the individual. Thus there seems to be a significantly high incidence of unknown parents among depressive patients.

When one considers what a severe trauma or at least evidence of family disruption is a situation in which a person knows no significant facts about his father or his mother, this is not surprising. The incidence of an unknown parent is significantly higher in depressives also when compared with the Hampstead controls.

These statistics, in fact, support the original hypothesis that both bereavement in childhood and family disruption are important factors in the development of depressive illness in later life.

## SITUATIONS IMMEDIATELY PRECIPITATING THE DEPRESSIVE ILLNESS IN ADULTS

No attempts has been made to analyse statistically the immediate provoking situation. In only very few cases did there appear to be no provoking situation. The common situations were broken love affairs, loneliness, marital difficulties, death of spouse or relative, loss of job and trivial quarrels or rejections. On the physical side there were a few precipitated by influenza or operations such as hysterectomy. No cases of puerperal depression were in this series, probably because there is no obstetric department at Hampstead General Hospital.

The main factor present in most of these provoking situations was some degree of loss or rejection. This was, of course, most obvious in the broken love affair. The commonness of this rejection factor, especially when there is a

suicidal attempt, would suggest the term "Dido" reaction for this type of illness.* In fact, it seems that the "Dido complex" is much more important in the psychopathology of depressive illness in England than the "Oedipus complex" which only seemed obviously important in one case in the series.

In many of the cases the obvious provoking episode was trivial, though of a rejecting nature. In this class would be a slight reproach from an employer, or a failure to achieve some desired end.

Loss of a job in which most of the life has been spent in men in their fifties proved to be a particularly dire situation, resulting in one case in suicide and in another in chronic depression.

Of particular interest, in view of the main hypothesis of this paper, were two cases of women who had had their illegitimate babies adopted at about a year. This broken maternal bond seemed to give these mothers a very intractable sense of loss and guilt which was very difficult to modify. These cases had not themselves been bereaved in childhood and this situation is, in fact, the converse of the situation of childhood bereavement which has been the main concern of this paper. In fact, the prematurely broken parental relationship seems to be a severe trauma both to the child and the mother. Such a broken bond is obviously biologically unsound, as it is not conducive to the survival of the child and it seems natural, just as physical pain is felt when a damaging trauma is applied to the body, that emotional pain or depression is suffered when a damaging trauma is endured by the family.

## Discussion

Depression is the unpleasant affect which occurs when things are going wrong, when there is a persistent frustration of instinctual and biological needs, and it certainly occurs in children.

If one considers that crying is the normal somatic response to depression, depression can be said to be the first emotion felt by a human infant when he leaves his mother's womb and enters a cold and uncomfortable world with a midwife smacking his bottom. Warmth, suckling and food relieves this state and during infancy the satisfaction of warmth, food and physical handling becomes closely associated with the person of his mother. This can be interpreted in the psychoanalytic terms, but it can also be stated in organic or Pavlovian terms. It does not matter particularly what system of terminology is used. The appearance and whole person of the mother is the most important conditioned reflex associated with the instinctual satisfaction of the human child. A break in this association over a long period produces depression in the child, as has been shown by Spitz (18) and many others. If there has never been any regular pleasurable association with the mother then the satisfaction of feeding and comfort become much more diffusely associated, and no particular relationship with any one person is established; separation then does not seem to involve much depression, although such a situation without any close personal relationship probably involves much impoverishment and retardation in the child's intellectual and emotional development. This absence of "trauma" or "grief reaction" has been observed by Spitz where there was no previous satisfactory relationship with the mother.

Bowlby (19) has outlined three stages in the separation reaction of an

* NAM QUIA NEC FATA MERITU NEC MORTE PERIBAT
SED MISERA ANTE DIEM SUBITOQUE FURORE.
—(Virgil: *Aeneid*, Book 4, Line 696)
"So she perished, not by a deserved fate, but in misery and before her time, in a frenzy of mad passion."

infant. Firstly, the separation anxiety with crying; secondly, despair with apathy, and thirdly, at the end of several weeks, a stage of acceptance of the present situation with some impoverishment of affect and fracture of the maternal bond. It may well be that this type of trauma is likely to produce a nucleus of depressive affect which can be re-stimulated by subsequent rejections in much later life.

In the series of cases studied here, however, it was not only in infancy that the trauma of bereavement seems to have effect but throughout childhood and the loss of a father is significant as well as the loss of a mother and is certainly commoner.

It may be that in its milder forms depression serves a biological purpose as it involves inhibition and withdrawal from an intolerable situation. It also sometimes involves varying degrees of calling out for help which can be effective. People able to feel depression are aware of lack of love, affection or success and when not depressed are usually able to show positive emotions. People subject to depression are among the most valuable people in the community. But when severe depression, in various rejection situations, has occurred in childhood it, as it were, sensitizes the person so that a later similar situation brings up all the forgotten force and misery of the childhood situation, energy for the most part untapped, but when released by stimuli similar to the original trauma, the affective energy is released in all its primitive intensity resulting in the complete incapacitation of the patient.

In this paper I am stressing the rejection and bereavement factors in depressive illness because this is the special subject here, but this emphasis on the "nurture" factor in no way implies a denial of the importance of "nature" or heredity. It seems possible, though it is by no means proved, that whether or not a breakdown occurs is often dependent on the early environment; which type of breakdown is more determined by the constitution and heredity. It is worth pointing out, however, that these results emphasizing the significance of early bereavement are as valid as those stressing the significance of heredity in depressive illness. The death of a parent is a purely environmental influence on a child, and most unlikely to be associated with any possible heredity factor linked with depressive illness (unless the death is by suicide). In heredity research, however, it is not possible to separate the influence of heredity from environment. For example, the rearing of two identical twins separately necessitates an odd if not dire situation likely to be traumatic to both of them. Also if a parent develops a depressive illness, that in itself is traumatic and involves a rejection of the child. In this series depressive illnesses occurred in two siblings, who had endured the same childhood loss of their mother. The actual picture of the depression was almost identical in this pair and one can question whether the illness was more determined by their common heredity or by their common early environment.

It is by no means implied here that childhood bereavement is the only factor in depression, or that it operates in every case but that it is one of the factors which are significant. Many other factors are obviously also important, such as physique and heredity, organic factors such as after-effects of virus infections, and head injuries, endocrine factors, especially in women (as shown by McKinnon and Thomson (20) who found that suicides usually occurred in the luteal phase of the ovarian cycle). Other levels of emphasis are the biochemistry and electro-physiology in the mechanism of depression. The importance of these physical factors is in no way diminished by the emphasis here on the biological factor of bereavement and loss.

The severity of the actual immediate situation is also important as already mentioned—but as Lewis asks, "What is an adequate situation to precipitate a mental disorder?" and he adds, "The personality often makes the situation and then is appalled by it." And the question that follows is, naturally, "What makes personality?" This is the question we are all struggling to answer.

## Prophylactic and Therapeutic Implications

One of the main conclusions from this work is that a special attention should be paid to children who have lost a parent or whose families are in some way disrupted.

If, as the statistics imply, 41 per cent. of people suffering from depressive illness now lost a parent in the first 15 years of their life, compared with 16 per cent. in the general population, then it would seem that something could be done to prevent depressive illness by increased care of these orphans. Also when one appreciates that, in addition, 12 per cent. of depressive patients have no knowledge of one of their parents, it seems that this prophylactic care should include those whose families are disrupted for other reasons than death.

Exactly how to prevent subsequent depressive illness in a bereaved child we do not know, but it seems reasonable to suppose that solicitude from surviving relatives and an adequate parent substitute, provide the environment most conducive to recovery from childhood bereavement. The fact that the child at the time shows no obvious emotional disturbance is no evidence that he or she is not deeply affected, rather the reverse. In many cases of bereaved children, or children parentless for some other reason, definite psychiatric treatment is needed. This point was, in fact, stressed by Sylvia Anthony (21) in 1940. She considers that 8 to 12 is the most traumatic time for the loss of parents, but this is not borne out by the present figures where the loss of mother appears equally significant in each 5-year cycle of childhood and the loss of father seemed more significant in later childhood. The object of prophylactic therapy is to help the child to face the fact of his loss and to be aware of his feelings towards the dead parent. especially to compensate him for the loss with adequate emotional attachment. The histories of patients who have done best usually show some such re-establishment of an emotional relationship and adequate compensation.

It is necessary to point out that these results of bereavement apply particularly to the incidence of depressive illness in an English community. In some primitive communities when the child is orphaned, there is immediate and effective adoption by the nearest relatives or neighbours, with powerful maternal instincts. Schweitzer (22) speaking of a West African community says, "Among these nature peoples there are no widows unprovided for and no neglected orphans. The nearest male relative inherits the widow and her children." It is possible that in these communities the child is protected from some of the worst consequences of orphanhood which one observes in some highly organized communities. In the more developed and civilized communities there is more of a tendency to leave the care of the orphan to the State or County Council or to charitable institutions, with not always satisfactory results. The conclusions, therefore, about the influence of childhood bereavement on later depressive illness, though perhaps of general significance about the type of situations producing depression, may not be equally significant in communities of altogether different family and social structure.

Finally, though childhood bereavement has been shown to be a significant

factor in depressive illness, it is not, of course, suggested that childhood bereavement is always followed by depressive illness or that depressive illness cannot occur without it. What is stated is that about 40 per cent. of the depressive patients were orphaned before the age of fifteen and that about a half of depressive patients were so orphaned or have no knowledge of one or other parent and that orphanhood as a child more than doubles the chances of a human being developing depressive illness.

The theory of depressive illness here outlined is simply psychobiology based on the reactions of different human beings to various stressful situations both in childhood and adult life and provides an additional reason for diminishing the distinction which seems to have grown up between adult and child psychiatry.

## Summary

1. The incidence of loss of parents during childhood has been investigated in 216 unselected patients suffering from depressive illness attending the Hampstead General Hospital Psychiatric Department.

2. Control figures were taken from the 1921 orphanhood tables from the 1921 census.

A second series of controls were taken from 267 patients attending Hampstead general practice surgeries.

3. The incidence of childhood bereavement was significantly higher in the depressive patients than in both the general population and Hampstead general practice patients. For instance 41 per cent. of depressive patients lost either parent before the age of 15, compared with 12 per cent. from the Census, and 19·6 per cent. from Hampstead general practice.

The loss of fathers was more significant in later childhood in the age groups 5–9 and 10–14. The loss of mothers was equally significant in each five-year period of childhood.

4. From this it is concluded that bereavement in childhood is one of the most significant factors in the development of depressive illness in later life.

5. There was a significantly higher proportion of depressive patients who had no knowledge of their parents than in the general population.

6. The theory is put forward that depression in later life often occurs through the re-activation by possibly minor rejection situations of an apparently recovered depression in childhood.

7. The therapeutic and prophylactic implications of this theory are discussed.

## Examples of Patients in Present Series

The patients in the present series were, as already mentioned, extremely varied, but a clear picture of the types of patients can really only be obtained from a few case histories.

There were certainly a number showing self-reproach, early waking and with depression worse in the mornings but there were also many which could not be regarded as typical of any syndrome in any existing system of classification.

*Case No. 1*

*Diagnosis:* Typical recurrent depression of "endogenous" type. Loss of mother when patient was 11.

A 53-year-old married woman complaining of depression, difficulty in concentrating, loss of interest and loss of appetite. She also had suicidal thoughts and fear of death.

Depression was worse in the mornings and was associated with early waking.

The present attack of depression dated from 6 months previously and was associated with anxiety about her daughter-in-law's pregnancy.

There had been four previous depressions all starting in November and lasting from 3 to 6 months.

Her mother died when she was 11 and her father when she was 24. One of her 3 sisters also suffered from depressive illness.

She had a difficult early life as her father re-married when she was 12 and the stepmother was unkind. The patient ran away from home when she was 15 and worked in a store and later in the Civil Service.

She is reasonably happily married and has 5 grown up children. She recovered from the present depression with supportive drug therapy.

*Case No. 2*

*Diagnosis:* Agitated depression in Irish orphan incapacitated by poliomyelitis.

A 25-year old domestic servant. She was seen in out-patients department in November, 1954, complaining of depression. She was agitated and totally incapacitated. The condition had persisted for several months, increasing in intensity.

She had been referred to a convalescent home for menorrhagia for which no organic cause was found and while there she became very agitated.

Her mother died when she was 7; her father took little responsibility for her and is said to have died when she was 12. She was cared for by an aunt. She took various domestic jobs in Ireland and, at the age of 23, came to England where she worked in a nursing home. She is said to have been a conscientious worker in spite of her incapacity which affects her left arm and leg. This illness occurred at the age of 7, coinciding with the death of her mother and was followed by considerable hospitalization for a year or two.

At the time when seen in hospital she had been living alone in a bed-sitting room and was quite unable to manage. She was wringing her hands and saying, "I do feel so depressed I do not know what to do."

She was considered to be suicidal and admission to a mental hospital was arranged as a voluntary patient at once.

*Case No. 3*

*Diagnosis:* Chronic depression "endogenous" in type. Severe infantile bereavement.

A 45-year-old unmarried woman, housekeeper for her adoptive sister, complaining of depression, agitation, pre-occupation with bodily symptoms. "I feel as if I cannot pick up, terrible pains across the head." The depression is worse in the mornings. It is also associated with broken sleep.

The onset has been gradual and increasing in severity in a chronically obsessional personality.

Her mother died at her birth. Her father committed suicide when she was 5 and she was then sent to an orphanage until she was 10 when she was adopted by a Jewish family who treated her fairly well. Her adoptive father died 3 years ago and much of her breakdown dated mainly from this.

She had no friends and no love affairs and no outside interests apart from her adoptive family.

She had been managing precariously in the out-patients department for four years. Occupational therapy has now been arranged for her and her admission for electric convulsive therapy is being considered.

Cases Nos. 4, 5 and 6 are much more diffused and psychopathic examples of depression. As follows:

*Case No. 4*

*Diagnosis:* Recurrent agitated depression.

A 63-year-old single canteen worker complaining of depression with agitated and broken sleep. She has been off work for four weeks.

She has been suffering from depression, with about six attacks, since 1948 when she was admitted to a mental hospital for electric convulsive therapy. She has many times had E.C.T. for this condition with relief of symptoms.

She is living with her sister and working in a canteen. Both her parents died when she was 14 and there were thirteen siblings. She has worked all her life in domestic work. Has been a steady and conscientious worker. When seen in 1959 re-admission to a mental hospital was arranged for a further course of E.C.T. and she will probably recover from this attack.

*Case No. 5*

*Diagnosis:* Depression based on long-standing character disorder and lack of relation to parents. Psychopathic personality.

A 30-year-old single shorthand-typist complaining of exhaustion and depression for many years.

She had been able to work until recently but had an unhappy love affair with a married man and an unsatisfactory homosexual attachment.

She had some analytic psychotherapy without much improvement. She was an orphan

adopted at the age of 5 years and brought up abroad. Came to this country as a refugee before the war.

Her admission to a rehabilitation unit was arranged but she did not react very well to the treatment there.

*Case No. 6*

*Diagnosis:* Depression with paranoid and hysterical features. This patient was able to form relationships with people and to function in outside life. A case which defies any precise labelling.

A 29-year-old single clerical worker complaining of depression and various bodily symptoms with some ideas that her symptoms were due to previous bad treatment.

She had previously been treated with E.C.T. at a mental hospital and had somewhat improved.

Her father died when this patient was 10. Her mother is alive. She was brought up in India. She was able to be maintained outside mental hospital and was supported there while in the out-patients department. She continued at work.

There seems to be a group of patients whose depressive symptoms date from their twenties or who have continued from childhood symptoms which have proved quite resistant to all forms of physical treatment, electric convulsive therapy and leucotomy. These, at times, show a very strong "hysterical" trait in the course of psychotherapy. The depressive episodes in these patients have such a regressive quality that they would almost justify the diagnosis of "recurrent regression". For this condition it seems that persistent psychotherapy, group therapy and attempts to introduce the patient into group activities are the treatment of choice, with periodical shelter in hospital for the acute episodes, rather than energetic physical treatment. Case No. 7 is an example of this condition, also Cases No. 8 and 9.

*Case No. 7*

*Diagnosis:* Recurrent regressive and depressive episodes.

A 37-year old single nurse seen following a suicidal attempt. She had made many previous attempts, always by taking barbiturates.

Since 1947 she had been periodically admitted to six different psychiatric clinics and mental hospitals. She had had E.C.T. and deep insulin with no change in her condition. Diagnosis had varied from depression with hysterical features and psycho-neurosis with psychopathic features to paranoid psychosis, according to her behaviour at the time and the mood of the psychiatrist of the moment.

In between these various hospital admissions she has been able to train as a nurse and function properly.

In June, 1957, at an out-patient department, she complained of migraine and was treated. She then developed depressive symptoms and was given a course of E.C.T. from August to 5 December. While she was receiving this twice a week she was working as a Sister in charge of a ward. She found it more and more difficult to concentrate and was in somewhat of a panic when she was admitted.

Her father was an Indian doctor who deserted his family when she was a child. Her mother committed suicide when she was an infant and she was brought up by foster parents of a different name to herself but she maintains that she never realized that she was not their child until she was 18. She rejected her foster parents as soon as she found out her true origin.

She tended to make quite intense friendships with women.

On examination she was somewhat sulky and depressed. Her memory was somewhat impaired. She complained of this "dreadful depression". She had considerable resentment against most of her previous treatment.

She was kept in bed and "babied" by the nurses. Barbiturates were cut down. She was given an opportunity to ventilate her very considerable resentment against doctors. She slowly recovered her interest in reading and in her work and, after a brief holiday with a friend, she was able to return to work.

Another episode occurred in August, 1958 for which she was sent to a mental hospital for a few weeks. She had another relapse in October, 1958 in which she was very depressed. She improved for a while but when she felt that a nurse had slighted her she discharged herself and then refused to go when another patient arrived for the bed. She was on the point of being sent to the Observation Ward when she decided to go home with a friend and is now employed again.

This woman does not really seem to be suffering from recurrent depression so much as recurrent regression. From time to time, when frustrated or irritated, this lady complains excessively to doctors that she is incapable of managing and develops a kind of crescendo of irritation and depression for which she has to be put to bed for a few weeks.

She has had E.C.T. but does not respond to it. She does however, respond to bed rest and "babying". It may be that her present reaction is a repetition of some of her infantile resentment and rejection.

The prognosis seems to be fairly good provided that she can be looked after when she regresses but, as she grows older, the environment becomes less tolerant of these recurrent regressions.

Two further cases may be quoted of depressive states developing in the first place in young women which have proved absolutely resistive to E.C.T. and even leucotomy.

*Case No. 8*

*Diagnosis:* Chronic depressive state, periodic regression, reactile to psychotherapy but not to E.C.T.

A 31-year-old nurse complaining of depression concerning which she has had many severe episodes since the age of 17.

She has had a good deal of treatment in various mental hospitals. She has had 100 E.C.T.s and a leucotomy.

The original episode at 17 seems to have been related to sex problems but also followed the suicide of one of her brothers who was in the army. Her father died when she was 28 but her mother is still alive. She has two surviving brothers.

The depression for which treatment was first obtained was at the age of 20 when she left her boy friend to go to a different district with her girl friend who, however, later got married. Extremely energetic treatment at various hospitals on and off for 10 years followed but failed to effect any radical improvement. She occasionally did domestic jobs. Her boy friend also received E.C.T.

She had been referred to the out-patients department so that monthly E.C.T. should be continued to maintain her. She was then given individual and group therapy; she is now improving and is hoping to obtain a nursing job again. An attempt was made to re-establish suitable contact with the original boy friend but after 10 years there seemed no future in this association. She has made improvement after about 2 years of group therapy—to which, however, she had not been able to make any vocal contribution.

This patient was definitely diagnosed as suffering from recurrent endogenous depression. Nevertheless she was, even when badly depressed, socially reactile to psychotherapy and is an example of the type of case not helped by E.C.T. One of the more difficult aspects of this patient's present condition is the persistent sense of resentment against the medical profession for having, in her opinion, damaged her personality. A case history such as this suggests that for a certain type of depression, electricity, or even leucotomy, is no substitute for love.

Case No. 9 also illustrates this type of depression.

*Case No. 9*

*Diagnosis:* Chronic recurrent depression with many hysterical features.

This is a 35-year old widow complaining of depression and insomnia. She has had these symptoms for very many years.

Her mother died at her birth and she was cared for by her grandmother who died when the patient was 30. She had an unsettled and unhappy early life and no relationship with her father.

She was a W.A.A.F. during the war. Received a head injury while on duty. She complains of headache and dizziness but no organic lesion was found. Several attempts at suicide occurred and she became addicted to many pills, including thyroid, which enabled her to be treated in various hospitals for hyperthyroidism.

She married but the marriage was unsuccessful. the child died and later the husband also. The patient has attended numerous out-patient departments and been in many mental hospitals both in England and in America. She has had about 200 E.C.T.s and two leucotomies.

During the fortnight she spent in the Hampstead General Hospital after a suicidal attempt with barbiturates she proved to be a difficult patient in the ward but was able to return home. The question of her entering an Observation Ward was seriously considered.

She lives on her own in one room. Occasionally baby-sits for neighbours.

This patient from time to time regresses to an infantile state and seems to need considerable support at these times.

She is still reactile to an interview but tends to be very demanding.

There is no evidence that the E.C.T. and leucotomies have had any helpful effect.

All three of these cases, in fact, had a remarkable number of E.C.T.s, 60, 100 and about 200 respectively, and one has had one leucotomy and one has had two. It seems surprising that, in these cases, belief persisted in the efficacy of these treatments in spite of the obvious discouragement of the patients' failure to recover.

Electric convulsive therapy seems to be particularly effective in the depressive illnesses in older patients where the patient does not react to the therapeutic interview. This inability to react to the therapist as an indication for E.C.T. has been emphasized by Denis Hill (23). I would use the term "reactility" as preferable for this quality of ability to react to an interview rather than "reactivity", which can be confused with the old diagnosis of "reactive" depression, meaning depressions that are considered to be reactive to the present environment. "Reactility" to the therapist is, of course, a quality of the therapist as well as of the patient, and obviously different psychiatrists will have slightly different criteria for recommending E.C.T. The non-reactile depressive states are more common in the later half of life and include depressive states of psychotic intensity where there are delusions.

Suicidal attempts had occurred in 22 of the patients. Case No. 10 is an example where a particularly clear aggressive component against her husband was present. In some cases the infantile difficulties seem to have been so profound that the condition of the patient was one of a long-standing chronic character disorder.

*Case No. 10*

A married woman with one son aged 23.

A suicidal attempt was made for which she was admitted to Hampstead General Hospital. She took 29 grains of Soneryl but recovered fairly quickly with Megimide. A previous suicidal attempt had occurred at the age of 10 when she tried to jump out of a window but her father dragged her back. On this occasion she said she had been accused of doing something she had not done.

A second attempt occurred two years ago when she felt rejected by her husband.

Her father died four years ago. He was said to have been very strict but the patient was fond of him. Her mother is still alive and she has one brother aged 39, single, who lives with his mother. The father is said to have been disappointed with her as he wanted a boy. At the age of 5 she was sent away for 9 months to stay with an aunt while her brother was being born. She hated this and has been deeply resentful about it ever since. She was not told about her brother's birth until she returned home.

She did quite well at school and led a social life until her marriage at the age of 30. She has remained fond of her husband but he has tended to reject her from time to time. She had a miscarriage soon after marriage and again in 1941 and is now very fond of her 23-year-old son. She has been working in the Civil Service ever since 1941 and was driving ambulances during the war very competently. In July, 1958, she had a hysterectomy for menorrhagia because she had moods of severe depression for a few days before her periods. She thought that the hysterectomy would take away the depression. On account of the tension between her and her husband they ceased sex relations. Her husband developed a duodenal ulcer and then had an operation for this 3 years ago. Both had been jealous of one another. She was jealous of her husband's work and he was jealous of her friends as she was rather a social person.

On examination she was able to talk freely about her trouble and even smile. She said, "I wanted to die and was sorry for myself. It was silly to take so few." Of her husband she said, "I would like him to feel 'I drove her to it'."

A fairly good contact was made with her and her confidence obtained. Her husband was seen but he had as much resentment as his wife and was not very conciliatory. She had a few interviews in psychotherapy in which the main topics were her jealousy of her husband and her resentment at rejection and her faulty relationship with her mother.

On leaving hospital she attended group therapy for about 5 sessions and greatly improved. She found that she was able to help the other patients considerably and on moving to another neighbourhood she said she was going to take up some social work.

This suicidal attempt seems to have been an aggressive gesture on the part of this woman to a situation of rejection by her husband especially in her rather precarious state immediately after hysterectomy.

She seems to have been sensitized to rejection situations by the separation

of 9 months while her brother was being born. There was no actual bereavement in her childhood, but this separation and the resultant jealousy has remained a very dominant theme in her life. The aggression against the husband was fairly clear in this suicidal attempt.

Lack of knowledge of parents, even if they were not actually dead, seemed to be a factor in the following examples, Cases No. 11 and 12.

*Case No. 11*

A 35-year-old single woman complaining of depression and fear of insanity. "I feel so ill; I cry very easily; I am a failure all round, I cannot get down to anything."

The present depression has been coming on for 6 months and was related to the gradual termination of a relationship with another woman.

The patient was hard-working and conscientious in her work but had few friends.

Her mother and father were separated. She knew neither of them and had only once seen her mother 10 years previously in a mental hospital.

Her only brother, with whom she had been brought up, was killed in the war.

She had been brought up by her maternal grandmother abroad until the age of 16 and had never known much affection.

This patient was asked to attend for psychotherapy but wrote to say that she was helped by the discussion and proposed to deal with her problems by self-discipline and reasoning.

*Case No. 12*

An unmarried Irish tool fitter, aged 26.

He complains of lack of confidence and depression. He had been off work by himself in a bed-sitting room for 3 weeks before attending hospital.

Had been having a love affair with a girl who was willing to marry him but he was afraid of this relationship.

He never knew his own parents. He was in an institution for 3 years and from 3 to 19 years of age was boarded out with foster parents, at 19 he joined the R.A.F. and managed without illness for 5 years. Since leaving the R.A.F. there had been rather frequent changes of job. He has been unable to establish close relationship with any girl friend and his foster mother recently died.

He improved after a short period of hospital admission during which he showed some phase of irritability and depression. Since discharge he has returned to Ireland and there is a possibility of marriage.

Some patients who had not actually been bereaved in childhood had lost their families in concentration camps in Germany whilst the patients themselves had been able to escape. This particular situation is one which is liable to produce a rather rigid depression with guilt feelings at having been the only survivor. Case No. 13 is an example of this situation.

*Case No. 13*

A 50-year-old married woman who came to this country from Germany in 1939.

She complained of chronic depression with many bodily ailments, loss of interest, in a situation of being alone all day.

She is married but has no children. Her father, mother and nine siblings were all killed in concentration camps.

An attempt was made to maintain her by occupational therapy and socialization.

There were three cases in the present series of women who had had children adopted. Two of these women had not themselves been bereaved as children but one had.

*Case No. 14*

*Diagnosis:* Chronic depressive state. No childhood bereavement but converse situation due to separation between this parent and her child.

A 39-year-old widow complaining of depression, inability to settle down to anything. ("I must be made not to commit suicide.")

She has had many different jobs, cleaner, washing up in hotel, but off work for the last month and living on Public Assistance.

Her parents survived her childhood. Poor relationship with father, who is still alive and said to be alcoholic. Her mother died 7 years previously.

She married at the age of 22 but her husband was killed in the R.A.F. after 3 months.

Her condition seems to date from 6 years before her attendance when she had an illegitimate child. She went to work almost immediately after the birth and the child became ill. She had him adopted at the age of 1 year. She knows where he is and sometimes sees the child from a distance.

This patient was in a very chronically depressed state and was not really able to co-operate

very well with various efforts to rehabilitate her. She had twice been in rehabilitation centres without improvement.

The separation between mother and child here seemed to be an insoluble situation.

*Case No. 15*

*Diagnosis:* Depressive state in a situation of separation from her child.

A 29-year-old single woman, housekeeper, complaining of depression and difficulty in concentrating.

This condition mainly dates from about 1 year previously when she had an illegitimate child which shortly afterwards she fostered out. She has seen the child about 6 times since.

Her parents are alive but she has a poor relationship with them, especially with her mother.

She was treated in the out-patients department with psychotherapy and was helped to handle the social problem.

*Case No. 16*

*Diagnosis:* Severe depression, marital discord. Adopted orphan.

A 36-year-old married woman, complaining of depression, suicidal thoughts, weeping spells following rows.

Immediate situation seemed to be reactive to an extremely unhappy marriage. There had been a few not very serious suicidal attempts during recent years.

She had had an illegitimate child and had had it adopted. She herself was illegitimate and had not known her mother or father at all. Was adopted. Her adoptive mother died when she was 13 and her adoptive father re-married. Patient did not get on well with new wife.

She was reasonably intelligent and managed clerical and telephonist's work satisfactorily. She attended out-patients department a few times.

Left her husband and broke down completely and went into a mental hospital. Had E.C.T. subsequently. Later took job and is managing fairly well on her own.

## Actual Suicides

Actual suicides occurred in 3 patients in this series in spite of considerable efforts to remedy the situation. There were 2 women aged 25 and 51 and one man aged 57. The male patient had had to retire early owing to the liquidation of the firm to which he had devoted his life as an accountant. He was single but had had a long-standing inconclusive liaison which he had finally decided to give up. He had no close friends or hobbies. He had persistent guilt feelings that he had not cared adequately for his parents who had died 10 years previously. This patient refused in-patient treatment and E.C.T. He was not certifiable. He was persuaded to attend for occupational therapy and an attempt was made to support him in the out-patients department. However, he missed an appointment, having the good manners to send a letter of explanation, and several days later was found drowned in the Thames.

Both of the female patients had been bereaved between the ages of 10 and 14. Case No. 17 shows an apparently mild but fatal depression in a woman of rather psychopathic personality and most unstable early background.

*Case No. 17*

A 25-year-old married woman separated from her husband.

She had worked as a gardener, a mother's help, secretary, smuggler, etc. She complained of depression and suicidal urges. Her mother died when she was 10 of gas poisoning. This had occurred after a quarrel between her parents. Her father was accused of murder but the episode was considered to have been an accident.

Her father committed suicide a month later. This patient was then sent to a boarding school and went to various aunts for holidays. She did very well at school being highly intelligent but did not get on very well with the other girls.

She worked successfully as a mother's help to a psychiatrist for 6 months. She left this employment and went away with a married man by whom she had a baby girl. He left her when the baby was 10 months old. The man was jealous of the child, although fond of it, and she had the girl adopted when it was one year old. She said she wanted to get rid of the baby in order to get back her lover.

She subsequently married a homosexual and worked for a while as a professional smuggler and was sent to prison for a short time.

She had been making suicidal attempts by taking pills from the age of 16 onwards. She first decided to commit suicide when she was 12.

She had intensive treatment in rehabilitation centres without any real improvement. It was felt that some relationship was able to be made with her and she was maintained in the out-patients department for 5 years during which she worked as a clerk in market research.

In the course of psychotherapy this patient was very clear about her antagonism to her mother, especially after the birth of her sister when this patient was 3.

She seems to have been conscious of fairly persistent death wishes before her mother actually died.

This patient committed suicide by taking barbiturates in 1959. The pattern of this unfortunate woman's life seems to have been persistent rejection of anyone she loved since the death of her parents. For her there seemed to be only one way out.

The other patient, Case No. 18, had also been bereaved in childhood but had managed fairly well until she encountered a situation in a love affair which resulted in the suicide of her lover's wife necessitating an almost retributory suicide on the part of this patient.

*Case No. 18*

A 51-year-old married secretary, no children, complaining of depression, insomnia, agitation, inability to concentrate, "My brain is going to snap—I am afraid I will have to commit suicide."

A highly competent, intelligent secretary, she had been having an affair with her boss for some years. His wife found out and committed suicide. Following this the patient developed the thought that she must herself commit suicide. Her father died when she was 10 and she was very strictly brought up by her mother and stepfather.

She had been married for 20 years but had no children.

This patient had been incapacitated for 3 weeks before she was first seen in out-patients department. Her admission was arranged and she had E.C.T. with temporary improvement.

Her dilemma was that she had not wanted to give up her job and could not adjust to another one but yet was unable, emotionally, to tolerate this job in the presence of her boss with whom she had had an affair.

She was admitted 4 times to mental hospitals in the course of 3 years and received E.C.T. and largactil but improvement was only temporary and she committed suicide.

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