Brit. J. Psychiat. (1967), 113, 753-759

The Late Effects of Loss of Parents in Childhood

By M. J. GAY and W. L. TONGE

The effect of loss of parents during childhood has been the subject of many studies. Although most reports agree that some emotional disturbance occurs in the child, it is not yet clear what are the late effects of such separations in adult psychiatric health and behaviour. Brown (1961) and Munro (1965) pointed out that childhood bereavement before the age of 15 is not a rare experience: both studies report an incidence of over 19 per cent. in non-psychiatric populations. While some studies (e.g. Brown, 1961) reported an increased frequency of bereavement in childhood in depressed patients, other studies (e.g. Hopkinson and Reed, 1966) failed to confirm this. Furthermore, as Ainsworth (1962) pointed out, the term "parental deprivation" requires careful definition. It can refer to insufficiency of parent-child interaction (which cannot be assumed to follow automatically in every separation, because of the presence of parent substitutes), to grief reactions which may be supposed to follow parental loss and predispose to depression (Bowlby, 1961) and to distortions of parent-child relationships. The psychological consequences of parental loss could be expected to differ according to the degree of pre-separation distortions of relationships.

The present study was designed to test the hypothesis that loss of parents in childhood would predispose to psychogenic rather than endogenous illnesses in later life, and therefore that a history of childhood parental loss would be found more frequently in patients suffering from neurotic and personality disorders rather than psychoses. A second hypothesis was concerned with the type of separation. Loss of a parent for some cause other than death (parental divorce, separation, hospitalization, etc.) or loss of both parents implies some degree of disorganization of the emotional environment of the child, and might be expected to have consequences different from that of simple loss of one parent through death.

The Investigation

The case material consisted of new consecutive referrals to the Sheffield University Department of Psychiatry. Our colleagues were requested to pay special attention to any history of parental deprivation in childhood. In fact there were very few cases in which essential data were omitted, and the necessary information was obtained at a later date from a visit by the Psychiatric Social Worker.

The subjects studied were divided into two groups, according to whether or not there was a history of separation from a parent for a period of at least six months before the age of 15. These two groups were then compared in respect of the following:

1. Diagnosis. Five main categories were used.
   (*a*) *Endogenous Depression* implied markedly endogenous features such as diurnal variation, loss of weight, self-reproach.
   (*b*) *Reactive Depression* covered the cases of non-psychotic depression of neurotic origin. Some psychogenic factors could be demonstrated in all the cases of reactive depression.
   (*c*) *Neurosis* included anxiety states, hysterical reactions obsessional disorder and compensation neuroses, without depressive features.
   (*d*) *Schizophrenia.* At least one of the primary symptoms of this illness was required for the diagnosis.
   (*e*) *Personality Disorder* included psychopathy, alcoholism, and drug addiction.

   The presence of obvious psychological factors judged to be important in the aetiology of the illness was also noted in inspection of the case histories.
2. Age at first psychiatric referral.

3. Suicidal behaviour. In fact this is confined to suicide attempts, as none of the patients committed suicide during the period of the investigation.

4. Occupational adjustment (men only). This was rated as stable when the subject had less than six months off work over the previous three years, and without unreasonable job changes. No attempt was made to distinguish between unemployment and sickness absence.

5. Marital adjustment. The age at first marriage was noted, and also the presence of conspicuous marital disharmony; this was defined as seeking advice specifically for the marriage from an out-patient clinic, the Marriage Guidance Council, a solicitor, etc.

Results

A total of 494 patients was studied, and of these 136 reported separation experiences before their fifteenth birthday: 73 had lost one parent through death, 30 had lost one parent for some other reason, and 33 had lost both parents. The remaining 358 patients, who had not been separated from their parents in childhood, formed the comparison group. These two groups did not differ in their mean age.

Table I
Diagnosis

	Subjects with parental loss	Comparison Group	Totals
Endogenous depression	10	49	59
Reactive depression	58	123	181
Neurosis	41	122	163
Schizophrenia	6	17	23
Personality disorder	14	24	38
Other diagnoses	7	23	30
Totals	136	358	494

In Table I, which gives the *diagnosis*, it can be seen that the frequency of parental loss is not the same in every diagnostic category. This is brought out more clearly in Table II, which shows an association between a history of parental loss and reactive depression.

Table II
Endogenous and Reactive Depression

	Endogenous	Reactive	Totals
Subjects with parental loss	10	58	68
Comparison group	49	123	172
Totals	59	181	240

$\chi^2 = 4 \cdot 688$; $P < 0 \cdot 05$, d.f.1.

This association between a history of parental loss and psychogenic illness is also demonstrated in Table III.

Table III
Aetiology of Illness

	Psychogenic	Others	Totals
Subjects with parental loss	119	17	136
Comparison group	272	86	358
Totals	391	103	494

$\chi^2 = 7 \cdot 947$; $P < 0 \cdot 01$, d.f.1.

The diagnostic categories of reactive depression, neurosis and personality disorder includes the majority of illnesses judged to be of psychogenic origin. Table IV shows the period of childhood at which parental loss occurred in patients with these diagnoses.

Table IV
Age at which Parental Loss Occurred in Patients with the Diagnosis of Reactive Depression, Neurosis and Personality Disorder

	0–4	5–14	Totals
Maternal loss	15	8	23
Paternal loss	19	43	62
Totals	34	51	85*

$\chi^2 = 8 \cdot 35$; $P < 0 \cdot 01$, d.f.1.
* Patients with loss of both parents were excluded.

There are also differences between these diagnostic categories in their history of parental loss. Reactive depression is associated especially with loss of a parent through death (Table V).

Loss of a parent of the same sex as the patient is associated with neurosis, while loss of the parent of the opposite sex is associated with reactive depression (Table VI).

https://doi.org/10.1192/bjp.113.500.753 Published online by Cambridge University Press

TABLE V
Diagnosis and Type of Separation

	Reactive Depression	Neurosis	Personality Disorder	Totals
Loss through death only ..	38	20	5	63
Other types of separation ..	20	21	9	50
Totals	58	41	14	113

$\chi^2 = 7 \cdot 197$; $P < 0 \cdot 05$, d.f.2.

TABLE VI
Diagnosis, Sex and Parent Lost

		Neurosis	Reactive Depression	Totals
Loss of father Loss of mother	Men .. Women ..	15 7 } −22	11 2 } −13	35
Loss of mother Loss of father	Men .. Women ..	5 7 } −12	7 22 } −29	41
Totals		34	42	76*

$\chi^2 = 8 \cdot 614$; $P < 0 \cdot 01$, d.f.1.
* Patients with loss of both parents are excluded.

2. *Age at first psychiatric referral* is given in Table VII.

On inspection, it would appear that both loss through causes other than death and loss of both parents are equally associated with earlier referral for psychiatric help.

TABLE VII
Age at First Psychiatric Referral

	0–44 yrs.	45+ yrs.	Totals
Loss of one parent through separation	25	5	30
Loss of both parents through separation	15	1	16
Loss of one parent through death	48	25	73
Loss of both parents through death	6	1	7
Loss of both parents through death and separation	10	0	10
Comparison Group	257	101	358
Totals	361	133	494

$\chi^2 = 11 \cdot 585$; $P < 0 \cdot 05$, d.f.5.

3. *Suicidal behaviour:* A history of parental loss is found more frequently in patients who have attempted suicide (Table VIII).

TABLE VIII
Suicide Attempts

	Suicide Attempts	None	Totals
Subjects with parental loss	42	94	136
Comparison group	69	289	358
Totals	111	383	494

$\chi^2 = 13 \cdot 97$; $P < 0 \cdot 001$, d.f.1.

Most of the suicide attempts occurred in patients with the diagnosis of reactive depression. It is therefore necessary to examine the history of parental loss in patients with a reactive depression according to whether or not they have attempted suicide (Table IX).

https://doi.org/10.1192/bjp.113.500.753 Published online by Cambridge University Press

TABLE IX

Parental Loss and Attempted Suicide in Patients with Reactive Depression

	Suicide Attempt		None		Totals	
Loss of mother only before 5 years	6		1		7	
Loss of mother only after 5 years	2		0			
Loss of father only before 5 years	7	20	5	15	35	
Loss of father only after 5 years	11		10		N.S. (d.f. 1)	
Loss of one parent only	26		16		42	
Double loss	8		8		16	N.S.
Loss of parent through death	24		14		38	
Loss of parent through separation	10		10		20	N.S.
Totals	34		24		58	

Although the figures are small, there is little difference between the depressed patients who attempted suicide and those that did not, except for an increased incidence of early maternal loss in those who attempted suicide. Loss of both parents and loss through separation seem to be less likely in patients who have made a suicide attempt, but none of these differences reach an acceptable level of statistical significance.

4. *Marital adjustment.* For women there was a clear association between parental loss in childhood and early marriage (Table X).

TABLE X

Age at First Marriage (women only)

	Less than 21	21+	Totals
Subjects with parental loss	30	27	57
Comparison group	46	104	150
Totals	76	131	207

$\chi^2 = 8 \cdot 773$; $P < 0 \cdot 01$, d.f. 1.

This trend was associated with double loss and loss by separation (Table XI). In women there was no marked difference in the prevalence of conspicuous marital disharmony between the group who had suffered parental loss and the comparison group. However, in the subjects who had suffered parental loss, there was an association between marital disharmony and loss of both parents and loss of parents through separation (Table XII). There was no association between parental loss and marital disharmony in men.

TABLE XI

Age at First Marriage and Details of Parental Loss

	Less than 21	21+	Totals
Loss of parents through separation	13	7	20
Loss of parents through death only	17	20	37
Comparison group	46	104	150
Totals	76	131	207

$\chi^2 = 10 \cdot 577$; $P < 0 \cdot 01$, d.f. 2.

Loss of one parent	16	21	37
Loss of both parents	14	6	20
Comparison group	46	104	150
Totals	76	131	207

$\chi^2 = 12 \cdot 544$; $P < 0 \cdot 01$, d.f. 2.

5. *Occupational adjustment* was examined in male subjects only and showed an association between occupational maladjustment (long periods of unemployment and sickness absence) and loss of father through separation (Table XIII).

https://doi.org/10.1192/bjp.113.500.753 Published online by Cambridge University Press

TABLE XII
Conspicuous Marital Disharmony and Details of Parental Loss

	Conspicuous Marital Disharmony		
	Present	Absent	Totals
Loss of one parent	9	28	37
Loss of both parents	12	8	20
Totals	21	36	57
$\chi^2=7\cdot1$; $P<0\cdot01$, d.f.1.			
Loss of parents through death	9	28	37
Loss of parents through separation	12	8	20
Totals	21	36	57
$\chi^2=7\cdot1$; $P<0\cdot01$, d.f.1.			

TABLE XIII
Occupational Adjustment

	Poor	Stable	Totals
Loss of father through separation	14	10	24
All other subjects with parental loss	13	26	39
Comparison group	41	111	152
Totals	68	147	215
$\chi^2=9\cdot460$; $P>0\cdot01$, d.f.2.			

DISCUSSION

The results of this investigation in the main confirm and extend the observations of previous workers.

One finding which we wish to stress is the importance of treating separately the endogenous (psychotic) depressions from the reactive (neurotic) depressions. It seems likely that Brown's (1961) cases contained a higher proportion of the latter type of depression, having been collected from the out-patient department of a general hospital, and it is in this type of case that the most frequent histories of parental loss are to be found. On the other hand, Hopkinson and Reed were examining patients with well-marked features of endogenous depression admitted to a psychiatric unit similar to the one in which our investigation was made, and our results confirm that such patients do not have an excess of histories of parental loss.

At first sight, Munro's (1966) finding that severe depressions of endogenous type were associated with a previous history of parental loss may seem to be discrepant with the present results, but on reflection it seems likely that the endogenous depressions reported here do not correspond with Munro's group of severe endogenous depressions which are more likely to be admitted to a mental hospital than to the psychiatric unit of a teaching hospital where the present investigation was carried out.

The increased incidence of maternal loss in depressed patients who attempt suicide was pointed out by Walton (1958), and the trend in our figures tends to confirm this. However, we were not able to confirm Greer's (1966) observations of the increased frequency of loss of both parents in those who attempt suicide.

Some previous investigators have found difficulty in identifying the significant parent in histories of parental loss, and this may be partly explained by the unexpected finding in the present study of the association between neurosis without depression and loss of parent of the same sex as the patient, while patients with neurotic depression tend to have lost the parent of opposite sex to themselves. Another interesting difference between these two groups of patients was the increased frequency of parental death (as distinct from other forms of separation) in the histories of patients with reactive depressions. It is possible that the experience of childhood bereavement affects the quality of the mourning reaction, and predisposes to depression in the adult; but it is not clear why it should be especially concerned with loss of the parent of the opposite sex. In all patients with reactive illnesses, maternal loss appeared to be most frequent in the first five years of life, while paternal loss was more often noted in the second half of childhood. Munro (1966) has similar findings regarding paternal loss. This finding is not simple to interpret. It would seem reasonable to expect a higher figure of parental loss in the ten years of childhood 5–14 than in the first five years. The increased incidence of maternal loss in the early childhood of patients with reactive illnesses would therefore seem significant. In the present investigation there were only 18 patients suffering from endogenous illnesses and who had lost only one parent, and this is too small a number to allow a confident interpretation of these results.

It would seem reasonable to assume that

parental loss through break-up of marriage, hospitalization, etc., would be related to later marital adjustment. Pond, Ryle and Hamilton (1963) draw attention to the association between secure childhood (as recollected by their subjects) and marital happiness. Murdoch (1966) relates early marriage to being first born, but there was no preponderance of first-born women in the present group of subjects. For psychodynamic reasons it seems likely that insecure women will tend to marry early and probably unhappily; but why not men also?

Previous work (Hall and Tonge, 1963) has pointed out the association between poor occupational adjustment and paternal loss. The present investigation underlines the importance of separation rather than bereavement.

Certain types of parental loss appear to be related to psychiatric referral at an earlier age, but it seems probable that this is only a reflection of the larger number of patients in the comparison group with endogenous depression.

In summary, it may be said that while the overall frequency of a history of parental loss in childhood is probably not greater in a population of psychiatric patients than in any other, yet the frequency of parental loss is most marked in patients with psychogenic rather than with endogenous illnesses.

In the diagnostic categories of neurosis, reactive depression and personality disorder, maternal and paternal loss tend to occur at different stages in childhood; the sex of the parent lost (compared with the child) and type of loss appear to be important influences in predisposing either to neurotic and social maladjustment or to neurotic depressive reaction.

Summary

1. A history of parental loss in childhood was found more frequently in patients with psychogenic than endogenous illness.

2. Reactive depression was found to be associated with loss by death of the parent of opposite sex to the child, while other types of neurosis were found to be associated with loss of parent of the same sex as the child.

3. Marital disharmony in women was found to be associated with loss of both parents, and with loss through separation or divorce.

4. Occupational maladjustment in men was found to be associated with loss of the father through separation.

5. In the diagnostic categories of neurosis, reactive depression and personality disorder, loss of the mother was found more frequently in the first five years of life, while loss of the father was found more frequently in the years 5–14.

Appendix

Since this paper was completed, a recent issue of the *British Journal of Psychiatry* (October 1966) contains four further studies on this subject. Brown, and Brown and Epps stress the damaging train of events which follows childhood bereavement, and they cite evidence which associates this type of deprivation with delinquency and conduct disorders. This tends to support our own findings that loss of a parent due to family break-up tends to be associated with social maladjustment in occupation and marriage and with neurotic disorders in general. Dennehy (1966) deals with bereavement only in mental hospital patients, and while her investigations must be regarded as outstanding both in scope and in method her findings are not easily compared with our own. The depressive subjects whom she studied were probably more seriously disturbed than the patients in our own series, which may account for the fact that her findings do not agree with ours concerning the specific nature of the losses in depressed patients, in regard to the sex of the parent lost and the period of childhood in which it occurred.

Acknowledgments

We wish to thank Professor E. Stengel and Dr. C. P. Seager for making available to us the notes of patients under their care. We are grateful to all our colleagues for their helpful criticism, and to Professor J. Knowelden for advice on the design of this investigation. We are indebted to Miss Rosemary Evans for carrying out the home visits.

References

Ainsworth, M. D. (1962). *Deprivation of Maternal Care.* Public Health Papers, No. 14, W.H.O., Geneva.

Bowlby, J. (1961). "Childhood mourning and its implications for psychiatry." *Amer. J. Psychiat.*, **118**, 481.

Brown, F. (1961). "Depression and childhood bereavement." *J. ment. Sci.*, **107**, 754–777.

Greer, S. (1966). "Parental loss and attempted suicide: a further report." *Brit. J. Psychiat.*, **112**, 465.

Hall, P., and Tonge, W. L. (1963). "Long-standing continuous unemployment in male patients with psychiatric symptoms." *Brit. J. prev. and soc. med.*, **17**, 191–196.

Hopkinson, G., and Reed, G. F. (1966). "Bereavement in childhood and depressive psychosis." *Brit. J. Psychiat.*, **112**, 459.

Munro, A. (1965). "Childhood parent loss in a psychiatrically normal population." *Brit. J. prev. and soc. Med.*, **19**, 2, 69.

MUNRO, A. (1966). "Parental deprivation in depressive patients." *Brit. J. Psychiat.*, **112**, 443.

MURDOCH, P. H. J. (1966). "Birth order and age at marriage." *Brit. J. soc. clin. Psychol.*, **5**, 24.

POND, D. H., RYLE, A., and HAMILTON, M. (1963). "Marriage and neurosis in a working class population." *Brit. J. Psychiat.*, **109**, 592.

WALTON, H. J. (1958). "Suicidal behaviour in depressive illness." *J. ment. Sci.*, **104**, 884.

M. J. Gay, D.C.H., D.P.M., *Senior Registrar in Child Psychiatry, Royal Hospital for Sick Children, 3 Rillbank Terrace, Edinburgh*

W. L. Tonge, M.D., D.P.M., *Consultant Psychiatrist, United Sheffield Hospitals, Sheffield*

(*Received 26 July, 1966*)