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Adult Psychiatric Disorder and Childhood Experiences
The Validity of Retrospective Data

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Summary: In a sample of young mothers an association was found between a depressed mood and the recall of poor parental relationships during childhood. Women who had been depressed but had recovered by the time of questioning did not recall a poor relationship. A second retrospective measure of a childhood experience, based on more factual details, was unrelated to current mental state.

The belief that childhood experiences lay the foundation for adult psychiatric illness is a view fundamental to a number of theoretical schools in psychiatry. A great variety of types of upbringing and childhood experiences have been described as being of aetiological importance in the development of adult psychiatric disorders. To test these assertions is clearly difficult since in any investigation the researcher has usually to rely upon patients' and controls' retrospective accounts of early childhood experiences. These could well be distorted by any number of intervening variables. To minimise the possibilities of bias most workers in this field have tended to concentrate on obtaining retrospective accounts of factual happenings in childhood, such as early bereavement or loss rather than upon descriptions of early relationships between and with parents. The overall results of such studies are, however, conflicting and inconclusive (Ashcroft *et al*, 1973; Grad de Alarcon, 1976). No clear cut associations have been found, though the results of one important study suggest that even if there is no direct link, early loss of a mother might leave subjects more vulnerable to the effects of later stress, and hence to depression (Brown and Harris, 1978).

However others have tried to assess the quality of early family relationships. For example, Abraham and Whitlock (1969) using the Bene-Anthony Family Relations Test found depressed patients were more likely than controls to report poor relationships in their families of origin and it was neurotic patients who presented the worst reports. Raskin and his colleagues (1971) gave a questionnaire designed for children, *The Children's Report of Parental Behaviour Inventory* to groups of depressed and non-depressed adults and asked them to describe how they had perceived their parents during childhood. The adult samples produced dimensions of parental behaviour similar to those given by samples of children. Different scores on the dimensions were obtained from the depressed and non-depressed groups. On an acceptance-rejection factor the depressed adults described lower acceptance behaviour from their parents. They also described greater emotional deprivation during their adolescence. Jacobsen *et al* (1975) examined large samples of depressed patients and controls. There were no differences between the groups on conventional measures of childhood loss and they, too, looked for wider measures of emotional deprivation during childhood. Adult depression was strongly associated with reports of adverse parenting which included qualities such as rejection, shaming or over-protection.

A major objection to these studies is the possibility of systematic bias affecting information gathered retrospectively. In all psychiatric research it is necessary to be aware of the problems inherent in this strategy. Yarrow *et al* (1970) using data from a longitudinal study of child development were able to compare contemporaneous and retrospective accounts by parents. They showed how, over even a relatively short time span, parents tended at a later date to report earlier behaviour in a more favourable light. The researchers attempted to examine factors which might be particularly related to distortion. They had no measures of their subjects' mental state, but found that current family stress had no special effect. As to whether current mental state will necessarily affect recall in a selective way and cast doubt on the validity of the type of studies described above, there is surprisingly little evidence. Abraham and Whitlock (1969) in their study attempted to tackle this issue. On 38 of their depressed sample they repeated the Family Relations test after the depression had cleared. They give no details of how this sub-sample was selected nor of the actual results, but reported that there were no

changes in the test results with recovery. A problem with this technique is that when a formal test, examining issues unrelated to current state, is re-applied it may become very difficult for subjects to change their approach to the test on the second occasion. A better strategy would be to question for the first time and at a similar point in the life cycle, subjects who are clinically depressed, a group who have been depressed but are now recovered, and a group who never have been depressed. If the reported childhood experience was causally related to the adult disorder the association should be found in subjects with either current or previous depression. Such a procedure was possible during the course of a longitudinal study being conducted in the Family Research Unit of The London Hospital Medical College.

In this study, during 1975 all British-born primiparous women attending the ante-natal booking clinics serving a poor inner London borough were approached and screened for possible inclusion. The 534 women represented 97 per cent of all eligible women. One of the intentions of the study was to compare the early years of motherhood of a group of women who, at the time of booking, were married or cohabiting (80 per cent of total), with a group who were single and non-cohabiting. Using the code number of each screening interview and a table of random numbers, ten of these married women were selected each month to a total of 120 women, 15 of whom fell out of the study because of miscarriage or because they had left the borough before the seventh month of pregnancy. This left a random sample of 105 married women. It had been intended to compare them with all the single women but there turned out to be 105 of these, more than expected, and so 15, selected with random numbers, were excluded. However, nine were lost to the study before the seventh month, as before, and so the final sample of single women was 81.

We compared the married and single groups (e.g. Kruk and Wolkind, 1982), but as the project continued it seemed increasingly important to be able to report on a 'true' random sample irrespective of original marital status. Using random numbers, 26 of the single group were therefore selected and added to the 105 married group to give a sample of 131 women of whom, when booking 80 per cent had been married and 20 per cent, i.e. the proportions found in the original 534. The results presented here were obtained from this sample of 131.

Methods

Those selected for the study proper were seen again in late pregnancy and at 4, 14, 27 and 42 months after the birth of their child. Mothers were never seen consecutively and only rarely on more than one occasion by the same interviewer. Semi-structured interviews were used and all were tape-recorded. At each interview women were asked in detail about their experiences, their activities and their attitudes. Answers were rated according to pre-determined criteria and weekly interviewers' meetings were held to maintain consistency of coding. All questions used for analysis had at least 85 per cent inter-rater reliability.

Included in each interview was a standardized psychiatric examination, from the results of which a woman could be rated as having a psychiatric disorder or not. If any symptoms were elicited this section was discussed with the psychiatrist in the group. Women were then described as having no disorder, one with significant symptoms but no impairment of daily activities (a dubious disorder) or one with both symptoms and impairment (a definite disorder). For those with a dubious or definite disorder a clinical diagnosis was made. Examples of dubious and definite disorders have been published elsewhere (Wolkind and Zajicek, 1981).

Measures of childhood experience

Two attempts were made to obtain indications of the quality of the women's early lives. The first measure used was obtained during the *pregnancy interview*. The questioning was designed to elicit whether or not a woman had had a "disrupted" childhood and was focussed on a factual event. Each was asked whether before the age of 16 she had ever been separated from either or both of her parents. The interviewer ran through a list of possible reasons for a child or a parent leaving home. For each separation elicited, its duration, the reasons for it and the post-separation care, together with the child's age at the time, were established.

Significant separations were regarded as those that had lasted for one month or more before the age of 5 and 6 months or more for those above this age. For all who had had such a separation the reason for it and/or the care that followed were used to determine whether disruption had occurred. It was separations that were likely to have taken place in the context of continuing family difficulties that determined whether women were placed in the disrupted group. These included divorce or separation of parents, prolonged hospitalization of a parent and admission of the woman to local authority care or a special boarding school. Pilot work had shown that in a sample such as this loss of parent in childhood through death was followed by continuing difficulties and the small group of women with this experience were included in the disrupted group. Admission of the woman herself to hospital or separations such as those due to parents seeking

employment away from home were excluded. The justification for using this measure has been discussed elsewhere (Wolkind *et al*, 1977). It is relevant to mention, however, that it was not necessarily felt that the separation itself was of major importance, but rather that it was acting as an indicator of a childhood characterized by continuing dysharmonious family relationships or other difficulties.

The *second measure*, obtained 42 months postpartum, involved direct questioning of the women about the quality of the relationship between their parents. It was recognised that by its very nature this measure was likely to be distorted but it was nevertheless felt important to attempt to make an assessment of whether difficulties in early family life had existed for them apart from possible separation from parents. All subjects were asked how their parents had got on together when they were children. On the basis of the spontaneous response the reply was rated as:-

0 — Well, no difficulties.

1 — Dubious difficulties—any mention of problems not seen as a significant characteristic of the marriage, e.g. "Some rows, but I suppose most people have them"; "Up and down, they used to shout sometimes".

2 — Definite difficulties—any replies suggesting continuing problems, spontaneous mention of violence or a definite expression of concern or of unpleasant memories, e.g. "Not a good marriage, I used to lie in bed listening to their arguments"; "Dad used to drink, knocked Mum around a bit"; "They argued a lot, most of the time, in fact".

It was thought that some changes in perception could and would occur but that a reply coded as 2 (definite difficulties) would be reflecting a firmly held view of a poor parental relationship. For the purpose of this paper those women given this rating were compared with the rest of the women in the sample.

Results

Missing data

Of the 131 originally selected for the study 116 women were successfully interviewed during pregnancy. We have shown elsewhere how those not seen tended, on various measures from the screening interview, to have fewer problems than those seen (Wolkind and Zajicek, 1981). By 42 months after the birth seven women had been excluded from the study because of late miscarriage, death of the child, or, in one case, death of the woman. Of the remaining 124, 108 (87 per cent) were given the full interview at that time. The 16 not seen at that time similarly showed evidence of slightly lower rates of problems, 2 (13 per cent) coming from disrupted families of origin and 5 (31 per cent) having had an episode or psychiatric disorder (dubious or definite) at some time after the birth and before 42 months—as opposed to 32 per cent and 47 per cent respectively for those seen. Of the 108 women seen, seven were unable to answer the question on their parents' relationship; two women from disrupted families reported no memory of seeing their parents together; five women from intact families gave unclassificable answers of the "I'm not really sure" type. Five of these seven women had psychiatric disorders at 42 months.

Descriptions of childhood and current mental state

(a) *During pregnancy*

Of the 116 women seen during late pregnancy, 12 were rated as having dubious psychiatric disorder, i.e. one in which symptoms were present but there was no

TABLE I

Childhood experiences and mental states at two times

	A. Psychiatric state during pregnancy			
Answer	No disorder	Dubious disorder	Definite disorder	N
Disrupted family of origin: No	62	8	15	85
Disrupted family of origin: Yes	23	4	4	31
N	85	12	19	
	B. Psychiatric state 42 months after birth*			
Recall of parental relationship: No Problems	58	5	12	75
Recall of parental relationship: Problems	10	7	9	26
N	68	12	21	

*$\chi^2 = 14.22$, d. of f. = 2, $P < .001$

The criteria of childhood separation to qualify as disruption are described in the text.

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impairment of everyday functioning. Ninteen women (one in six) were rated as having definite disorders, i.e. symptoms and impairment of functioning. In Table IA the measure of childhood experience (a disrupted separation) obtained from the pregnancy interview is examined in relation to the women's mental state rated from that same interview. There is no association between the two measures.

(b) *At 42 month post-partum*

Of the 101 women seen 42 months after the birth of the child who were able to describe their parent's relationship, 12 had a dubious disorder, 21 a definite disorder. In almost all cases the clinical picture was one of depression with associated anxiety symptoms. This prevalence rate is not dis-similar to that found in other studies of working-class mothers of young children (e.g. Brown *et al*, 1975).

In Table IB women with disorder are far more likely than women with no disorder to report that their parents had problems in their relationship. As the rates of parental problems are similar in both the definite and dubious psychiatric groups they have been amalgamated in further analysis.

(c) *At intermediate times*

Of the 68 women with no disorder at 42 months post partum, 23 had, during at least one interview (i.e. at 4, 14 or 27 months), been rated as having had some disorder.

However, only one of these 23 recalled parental problems at 42 months, whereas 16 of the 33 with disorder at 42 months did so. The woman's disorder could have been noted from one to four interviews with her, but this made no difference to the parental problem score. In other words, whether she had a chronic or a short disorder made no difference to her recall, but recall at 42 months was dependent on being depressed then. It seems very likely therefore that a depressed mood was directly influencing the woman's recall of her childhood.

Discussion

We are not suggesting that childhood experiences are unrelated to adult psychiatric disorder, nor that it is not possible to obtain valid and reliable measures of the former. Detailed questions searching for examples of behaviour that could allow the interviewer rather than the subject to determine the final rating, as in the other of our measures would, in all probability, be much less open to distortion. What we *are* suggesting is that any measure whose rating depends solely on the direct response of the subject may give very misleading results. Any study using such measures should be treated with caution. In general it might be wise to recall the warning of Yarrow *et al* (1970) that in looking at past events "methodological interpretations may be more tenable than theoretical ones".

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