DEPRIVATION OF PARENTS DURING CHILDHOOD

ITS FREQUENCY IN SOME CONTEMPORARY YOUNG SERVICE MEN

BY

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The statistics presented below are offered not only because of differences which are apparent between the diagnostic groups but in the belief that they may serve as a background against which to assess the stress to be laid on a history of separation from a parent.

Bowlby (1951) reviewed the evidence pointing to the very frequent history of separation of the child from the parents in those with behaviour disorders. He regretted the paucity of controlled series in the case of psychiatric patients. An American study by Olman *et al.* (1952) would appear to meet this objection, though a comparable controlled series from this country does not seem to have been reported.

Among the statistics reported below, some relate to patients with a history of head injury. A number of workers have claimed that accident-prone persons tend to come from broken homes (e.g., Csillag and Hedri, 1949; Tillmann and Hobbs, 1949). Biesheuvel and White (1949) in a study of accidents among South African Air Force pilots recorded that "there was a highly significant difference between the accident and control groups in respect of the numbers of cases where the father had died."

Method

The statistics were collected from Royal Air Force personnel who attended for electroencephalographic examination. The medical officers by whom the patients were referred were wholly unaware of the inquiry and therefore it cannot be argued that they tended to send especially those with a history of deprivation. Only patients aged 18-29 were questioned. The questions were read out from a standard written form and the answers recorded in code and on punched cards. The standard form of questioning was rigidly adhered to in order that it might be possible to refute any complaints that improper questions had been asked. Though details of divorces and brutality were often volunteered, they were never asked for.

The questions were, "Are both your parents alive?" If the answer was in the negative the age of the patient at the time of the death was ascertained. "Can you remember, to the best of your ability, whether at any time during your youth or childhood you were separated from one or other of your parents for a period of about six months or longer, for any reason at all—for instance, your father in the Army, you evacuated, you or your parents in hospital, or any other reason whatever?" Where there was a history of separation, only the first episode of six months was recorded. Thus, multiple separations over the years, or continued separation, were arbitrarily classified under the age when the first separation occurred.

In most instances these questions were put, and the information was recorded, by the electrophysiological technicians of the department. They were carefully instructed in what to do, and were reliable and intelligent—four were university-educated, two were awaiting entrance to a university, and the other three were of comparable ability. Before the statistics were recorded the patient's diagnosis was noted

from the request form for an E.E.G. The diagnoses were arbitrarily grouped as E for epilepsy, P for psychiatric case, O for "other," HS for head injury (self-responsible), and H for head injury (not responsible).

It is important to note that the E group differs from those encountered in civilian hospitals. Nearly all had had only one or two fits, and the first of these had generally occurred in the Service. Chronic epileptics, whose families might have been disturbed thereby, were not encountered. A few neurotic patients who received the benefit of any doubt in the diagnosis of "black-outs" are probably included (which merely makes the observed differences from the P group more real).

The P group contained especially patients classifiable as of "inadequate personality," referred according to the varying tastes of their medical officers—especially if headaches, "dizzy spells," and aggressive behaviour were prominent.

The O cases were assorted neurological patients and cases of definite migraine, cardiovascular syncope, etc. It was expected that this group might contain a fair sprinkling of neurotics, and for this reason the hypothesis at the outset was that there would be a significant difference between the E and P groups and that the O group should be ignored.

The groups H and HS were made up of (a) those referred on account of head injury, and (b) those referred primarily for some other reason, but who, on routine pre-electroencephalography questioning, stated that within the previous two years they had had a head injury of sufficient severity to cause unconsciousness. The head injuries were also classified into groups—"driver," "passenger," "sport," and "other." These figures are not presented owing to the smallness of these groups. The decision on whether the individual was responsible or not for his injury was always made before the family history was taken; and while the P, E, or O diagnoses were occasionally altered on the basis of later information, the H or HS diagnoses were never altered. Emphasis was placed on severity in allotting responsibility, and, while passengers were mostly H cases, only two drivers were treated thus leniently.

Hypotheses at Outset

The initial hypotheses were: (1) that there would be an excess of cases of deprivation in the P group when compared with the E group; (2) that there would be an excess of cases of deprivation in the HS group when compared with the H group. As previously stated, the O group was to be ignored. The groups E and H were both expected to be normal control groups, and, as there are no cross-diagnoses between these two groups, they could be added if desired.

The distribution of the different varieties of deprivation in each diagnostic group is shown in the Table.

Frequency of Deprivation of Parents

Diagnostic Group:	P	E	O	HS	H
Total No. of cases in group	271	119	245	245	91
No history of deprivation	114	67	132	118	49
Deprivation of any kind at any age ..	157	52	113	127	42
" " " " ages 0-5 inclusive	87	32	61	68	23
Deprived by death or separation for 6 months from both parents at ages 0-5 inclusive	36	5	18	16	2
Mother dead	20	11	11	20	8
Age at mother's death, 0-5 years ..	7	3	6	10	3
" " " " 6-10	4	4	3	3	0
" " " " 11-15	3	4	0	2	2
" " " " 16-20	6	0	2	5	3
Separated for 6 months from mother ..	62	9	34	31	17
Age when separated, 0-5 years ..	33	4	18	12	8
" " " " 6-10	19	5	10	12	5
" " " " 11-15	10	0	6	7	4
Father dead	42	17	32	36	10
Age at father's death, 0-5 years ..	17	7	12	11	5
" " " " 6-10	6	2	4	6	0
" " " " 11-15	10	2	11	9	3
" " " " 16-20	9	6	5	10	2
Separated for 6 months from father ..	110	34	81	87	27
Age when separated, 0-5 years ..	63	21	41	50	16
" " " " 6-10	33	11	30	29	7
" " " " 11-15	14	2	10	8	4

Discussion

No elaborate analysis of the figures is justified when the initial hypotheses are borne in mind. However, it may be noted that the first of these hypotheses is confirmed. If the P and E groups (there were no cross-diagnoses between these groups) are compared in respect of those with a history of deprivation of any kind and those without such a history, there is a significant difference between them ($\chi^2=6.7$, $P=0.01$). This difference could be interpreted as indicating that deprivation of parents increases liability to mental ill-health (though no figures for a probably more important history of unhappiness, brutality, etc., are available). Alternatively, it could be claimed that the mentally unstable tend to exaggerate a history of parental loss, or that they inherit their predisposition from parents whose own instability contributed to the breakdown of home life. Or, again, it is possible that the mentally healthy forget or gloss over parental deprivation. The difference between the two head injury groups is in the expected direction, but is small and not significant.

The effects of wartime evacuation of children, and war service by the father, on these statistics, which were collected during 1956 and 1957, are very obvious in the high incidence of separation from parents in the early age groups.

The Table shows also a high recorded incidence of death of fathers, and, to a less degree, mothers, for the age group 0-5 years. In this connexion it should be remembered that this group covers six years of life, unlike the other groups. Wartime casualties, particularly among the fathers, must also be considered. Even so, the incidence of maternal deaths in this period still seems high, and may be accounted for (a) because in the case of the P and HS groups such maternal loss does, in fact, cause behaviour disturbances, or (b) because of unreliability inherent in the nature of the inquiry. While it is reasonable to compare the different groups, the absolute figures may need to be treated with caution because of the rigid form of the questions asked. There was no mandate for questions about illegitimacy or adoption; and, indeed, to ask such questions of a patient referred for E.E.G. examination because he had crashed his aircraft and sustained a head injury might have led to justifiable complaints. Consequently the figures for the 0-5 age group, in particular, may be distorted owing to untrue or evasive answers.

Summary

The frequency of deprivation of parents during the childhood of a series of young Service men was investigated in relation to diagnosis. Significantly more of those who were psychiatric cases had a history of deprivation than cases referred on account of isolated epileptic attacks.

There was not a significant difference between a group of persons responsible for accidents and a control group.

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RESPIRATORY INADEQUACY AFTER THORACIC SURGERY IN TUBERCULOUS PATIENTS

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Respiratory function is always impaired to a greater or lesser degree after thoracic operations. The following factors, acting singly or in combination, are likely to reduce pulmonary ventilation: infection; paradoxical respiration, especially following thoracoplasty; lobar or lobular atelectasis; compression of the lung by air or fluid; pulmonary congestion or oedema; reduction of functioning lung tissue by disease or resection; wound pain, limiting chest expansion; and drugs, particularly analgesics and sedatives.

Most patients have a respiratory reserve sufficient to surmount these temporary difficulties, and measures such as physiotherapy, water-seal drainage, antibiotic therapy, and occasional bronchoscopy are usually adequate to prevent serious complications in the post-operative period. Many, however, whose respiratory reserve is grossly reduced by disease are now accepted for surgery. We have anaesthetized several with a pre-operative maximal voluntary ventilation (M.V.V.) of less than 30 litres a minute and in one it was as low as 17 l./min. Such patients require very careful pre-operative preparation, meticulous anaesthetic and surgical technique, and vigilant post-operative supervision.

Occasionally, despite careful post-operative management, the usual measures do not prevent the development of respiratory inadequacy, the features of which are due to hypoxia and carbon dioxide retention. When the main cause of respiratory insufficiency is atelectasis, ventilation may be sufficient to maintain the carbon dioxide tension of the blood within the normal range, but hypoxia may be severe as a result of impaired diffusion of oxygen and the shunting of blood through non-ventilated alveoli. When hypoventilation is due mainly to factors other than atelectasis, both hypoxia and carbon dioxide retention will be present. It must be noted, however, that the administration of oxygen to such patients will relieve the hypoxia and thereby remove the reflex respiratory drive from the chemoreceptors, thus aggravating the retention of carbon dioxide.

Method

When it was decided that respiratory inadequacy was present, a wide-bore cuffed tube was passed under direct vision laryngoscopy through the mouth into the trachea. If the patient was not already deeply unconscious, light general anaesthesia was induced to facilitate intubation. A period of hyperventilation through soda-lime followed, the patient's level of consciousness being assessed from time to time. A tracheostomy was made through the second and third tracheal rings in those patients who had considerable retention of secretions and who were likely to require a respirator for more than 24 hours. A shortened endotracheal tube fitted with a Magill T piece was inserted into the trachea, the cuff inflated, and connexion made to a mechanical respirator. Secretions were aspirated at frequent