Public Health Begins in the Family

By HALBERT L. DUNN, M.D., and MORT GILBERT

THE FAMILY, as the most important institution in society (*1*), is intensively studied by sociologists and anthropologists. It is seldom studied by public health agencies, and it is almost entirely outside the current framework of vital and health statistics.

Births, deaths, diseases, marriages, and divorces are generally reported as events occurring to individuals. Our routine statistics tell us next to nothing about the family setting or family situation of these individuals or about the role of the family in health and disease. Although information of this type is admittedly difficult and perhaps impossible to derive from routine records, it is quite feasible to collect routine data on the "universe" of American families. The factual background would provide a base for specialized sample studies.

In this paper we will suggest, on the basis of existing statistical mechanisms, some of the ways in which public health agencies might proceed to collect usable data on families as well as on individuals. This of course raises a larger question, which we will attempt to explore first: What does the family have to do with public health?

Dr. Dunn is chief of the National Office of Vital Statistics, Public Health Service, and Mr. Gilbert is publications officer. *Dr. Dunn presented a slightly longer version of their paper at the meeting of the Southern Branch of the American Public Health Association at Tulsa, Okla., April 4–6, 1956. Other reports on the family-centered approach to public health are presented on pp. 1011–1031.*

With some 40 million families in this country—the number depends on how family is defined—most of us have firsthand knowledge of only a few. Nearly everybody defines the family differently and holds strong, individual opinions on its character. High divorce rates, dispersion and mobility of families, changes in moral codes and in occupation patterns, and, until the 1940's, falling birth rates had convinced many that the family as an institution was crumbling. The consensus of modern studies is that the family is going through a profound transition but that it shows no signs of leaving the social scene.

Over the Past Century

To gain perspective on the structure and functions of today's family, it may be helpful to compare it with the American family of a century ago. Ignoring cultural variations and concentrating on the typical American family, we have surveyed the extensive literature of family sociology, starting with Ogburn's classic analysis, "The Family and Its Functions" (*2*), and including many of the more recent works. Although interpretations and emphases are controversial because nearly all aspects of the family need more intensive research, most students of the family appear to agree that the following changes and effects between 1850 and 1950 have been significant.

The family has shrunk in size.

Today's typical family has fewer children and is limited to two generations, parents and minor children. What sociologists call the "extended family"—several generations living near together and bound by close ties—has

given way to the "nuclear" family of parents and minor children, who live apart from other kin and keep in touch largely through Christmas cards and occasional visits. As children mature, they leave the parental home to form separate nuclear families of their own, in a continual fragmenting process.

Today's family is mobile.

In this moving van era, a high proportion of families pick up and move to a new community, away from former friends and relatives, to take advantage of new job opportunities.

Dependent aged parents are now less likely to be supported by their grown children.

Rejection or isolation of the aged, linked in part to the modern family structure and functions (*3*), has contributed to a major health problem. Many of the ills of the aged (for example, much of the so-called senile dementia) flow not only from organic aging but also from roles of social isolation dictated by family, cultural, and economic rejection (*4a*). From a public health viewpoint, it is important to investigate the ways in which the changing family, among other forces in the social environment, has affected the aged.

The production of most goods and services has passed from the home to the factory and to service industries.

In 1949 for the first time the number of wives employed outside the home exceeded the number of employed single women. Women in the home perform fewer economic functions: They no longer preserve great quantities of food, make the family's clothing, or cultivate large gardens (*5*). The typical family of a century ago was rural and a major productive unit. Wives were valued in proportion to their economic contribution, which in large part determined the family's status. Children were valued as producers. The change in the family as an economic team, today less frequently operating a farm or family business, is widely believed to be a contributing factor to its shrinkage in size and its relative instability. For the most part, only outside wage earners now make a direct contribution to the family's income although wives and children still may perform economic services at home.

The family's formal control over the decisions of its members is much less than in past years.

The patriarchal figure, except in a few subcultures, has receded into myth; nowadays, grown children tend independently to choose careers, mates, and neighborhoods. Much of the family's former recreational, protective, and related functions have been transferred to community agencies, or they are purchased as services. Not all families and not all members of the family accept the changes equally or necessarily integrate them into their attitudes and emotions. Emotional conflict or deprivation often accompanies such a transformation, with implications for individual and public health.

The divorce rate, though down somewhat from its prewar peak, is relatively high as compared with levels of 1850 or 1900.

The future divorce rate will be affected by probable continuation of past changes in the family which have tended to weaken its stability (*6a*). Most of the evidence suggests that divorce is relatively more frequent in families with fewer children although we do not know to what extent children are a deterrent to divorce (*7*). (The past and present extent of desertions—the "poor man's divorce"—is unknown.) With the decline of the extended family and the anonymity of the urban family, particularly in a new community, there is less pressure by relatives and friends to keep the family together. The reduction of the family's economic functions diminishes the material dependence of the marriage partners on each other.

The Irreducible Functions

In view of the major changes and loss of functions, does the family still serve purposes of sufficient importance to assure its survival? The available data, fragmentary as they are, leave no doubt as to the affirmative answer. Marriage is more popular in the United States than ever: People now marry at a considerably younger age than, for example, in 1890; a much larger proportion of men and women are married today than two generations ago, and, though divorce rates are high, the remarriage rate is also high.

For the family to lose many of its traditional functions but still to become personally important to more people than ever before would

seem to present a paradox. Parsons and Bales (*8a*) in a recent study of family structure in the light of group interaction theory, resolve it this way:

"The family has become *a more specialized agency than before*, probably more specialized than it has been in any previously known society. This represents a decline of *certain* features which traditionally have been associated with families; but whether it represents a 'decline of the family' in a more general sense is another matter; we think not. . . . The family is not in any general sense less important, because the society is dependent *more* exclusively on it for the performance of *certain* of its vital functions."

These remaining vital functions include the rearing of children and the stabilization of the adult personality. Each is basic and irreducible, and in our culture it is difficult to imagine how they could be transferred to any other agency. Since the family is indispensable for bringing up the child and providing an emotional setting for most adult personalities, its optimum performance could avert many of the strains and maladjustments that now require pediatric, general medical, and psychiatric service.

The Rearing of Children

The newborn infant is without language, habits, customs, moral values, skills, or differentiated patterns of emotional expectation and response (*9, 10*). It is the family's function, particularly during infancy and the 6 early "golden years" of personality development, to transform the child into a social creature who is at home in the culture, and who carries and acts out the culture patterns without undue strain. The family has been variously called the cradle of the personality, the nursery of human nature, the porous buffer that lets the child meet experience as he can assimilate it, and that protects him from parts of the environment damaging to him if encountered too soon (*4b*).

It is in the family that the child acquires the basic patterns of living—everything from table manners to ethical values. He learns to look for certain types of emotional response from others, to strive for various types of approved experience, to avoid experience that brings him pain and disapproval. Interacting with his family, learning how to win acceptance and avoid rejection in this small world, he forms behavior patterns, attitudes, and even deep-seated emotional reactions that will profoundly affect his character and personality throughout life.

The family experience begins to provide the child with a usable set of responses, attitudes, and habits that will later enable him to function as an independent adult in society. Without this foundation, human behavior would be totally unpredictable, and even an uncomplicated social structure would be unworkable (*11a*). But the family, in its infinite variety, does more than this. No child-rearing family is society in miniature, but a unique group that is easy to differentiate from any other group.

Children in a family setting acquire not only the generalized patterns of the culture but also a unique interpretation of the parents' subculture. Although all children of the same generation in a society develop much the same kind of human nature, each child is somewhat different from the products of other families. Thus the role of the family is not only to nurture a new generation that fits into the society but also to provide the great variety of personalities that society needs (*8b*).

Infants and small children in order to thrive apparently need personal, adult response over and above the satisfaction of hunger and other physiological needs. The high death rate that prevailed in even the most sanitary foundling institutions and the host of studies demonstrating damage in institutionalized children are often cited as evidence of the child's need for personal attention (*12*). This is a principal reason that foundlings and young orphans are placed in foster families as quickly as possible: Even a poor family generally does better by the child than a scientific regimen without personal interest.

But, as the psychologist John Dollard has remarked, "domestication" of the child "is without exception a process attended by conflict and strain" (*13*). Though the family is the best source of healthy, well-adjusted children, it is also the source of cases that crowd outpatient and child guidance clinics. This is not

the place to catalog child ailments that have their principal genesis in family maladjustments. A vast literature of psychopathology deals with the pathetic results of parental overprotection or rejection; of prolonged mother-child separation; of hostile, overpunishing, or hypercritical parents; of abnormal sibling rivalry; of homes with continuous tension and discord; and sometimes of homes broken by divorce, desertion, or death. Public health is interested in the family if for no other reason than to investigate the etiology and prevention of a wide range of childhood ills.

Though the American family today is most likely to be small and urban, the dominant ideal still clings to rural ways and large kinship. The American family concept has never adjusted to the facts of city life. Many people have not yet learned to live in the modern family, and this lag has contributed to family ill health. In the small, isolated family unit, every relationship is intensified and more continuous (*14*). A child slighted by his mother cannot seek or expect comfort from his aunt if the aunt lives in another city. Bossard makes this point (*15*):

"It is the consensus that many Americans suffer from a sense of insecurity, and there can be little doubt that this is in part a heritage of the immediate family form. The very size of the family unit is important to the child in this respect for the same reason that the size of the ledge from which we view the precipice below affects our sense of security. The American child who lives and matures in a father-mother-child family unit stands on a very narrow family platform, even if it is in no way imperiled. To this is added the constant danger for the child that the few persons he must rely on may falter or fail."

Despite vast clinical experience with psychosomatic illness, despite millions of hours devoted to the recall of childhood traumas, there still is no agreement on the role of childhood experience in the development of health or sickness in adults. Many cases of the so-called "maladaptive reactions" of adults—the chronic fatigue or neurasthenic syndromes, the organ neuroses such as peptic ulcer and colitis, the disabling hysterias, the anxiety disorders, and the other psychophysiological ills—have been traced (to the satisfaction of most psychiatrists and clinical psychologists) to inappropriate patterns learned too rigidly in childhood (*16–18*). Wartime evidence indicated that even the strong personality has a breaking point under sufficient traumatic stress; psychological disorder in adults does not necessarily stem from childhood maladjustment (*19*). Though the evidence is mixed, the family of childhood undoubtedly affects adaptations to stress in adult life. Whether we habitually react to stress or frustration by withdrawal, aggression, escape in fantasy or functional illness is often a reflection or continuation of fundamental patterns acquired in early life.

The Adult Personality

Emotional security in our culture is based mainly on assurances of affection and intimate companionship with other individuals. Human nature has a basic need for favorable emotional response from others (*11b*). No one outgrows it, and most suffer unhappiness and psychic, even physical, ills without it. This brings us to the other major function of the family: the stabilization of the adult personality.

The individual in an urbanized culture is often isolated and largely anonymous. He may be separated from kin and from most of his old, intimate friends. He makes new friends but in relatively formal relationships. Winch refers to the prevalent feeling of loneliness, to "the separation anxiety" that is apparently characteristic of today's society (*20*). For many individuals, the family has survived as the only remaining primary group, which Murphy defines as "the face-to-face world, the world of tenderness and immediacy, the world of security" (*4c*). Except for the family, our lives are now spent mostly in secondary groups—with associates on the job, in trade union or professional meetings, in fraternal or political organizations. We use these for many purposes, but they cannot meet our deep-seated need for love and emotional security. In this respect the family has become much more significant, and this is perhaps an important reason for its persistent strength.

Shurtleff has pointed to associations between marital status and mortality (*21, 22*). Taking

the 1949–51 death rates of married men as equal to the index 100, Shurtleff found that the age-adjusted rate for single men was 163. For widowers it was 185, and for divorced men 207—more than twice as high as for married men. For women, the comparable index figures were: married women, 100; single women, 124; widows, 155; and divorcees, 155.

The figures themselves do not indicate whether marriage keeps people well or whether people who are well tend to marry and stay married. But various students of divorce, particularly the late sociologist Willard Waller, have likened the traumatic effects of separation to those of bereavement. They speak of the "terrific ego shock," the often "shattering" and "calamitous" effect of divorce on the personality, and point to the frequency of depression and occasionally suicide in the series of divorces that have been investigated (*6b*). Some recent studies suggest that the long-term personal disorganization that often followed divorce in the past is now on the decrease, perhaps because divorce has become socially more acceptable. But divorce, desertion, and bereavement are still major social forces with health aspects that deserve study and perhaps action programs.

The nature of marriage in our culture warrants study of its implications for public health. When the nuclear family is the only continuous intimate association, the partners expect more of each other in emotional response. This is one example of potential stress in an age of transition, characterized according to Kirkpatrick, "by confusion as to the family tradition." He continues: "Tangled ideologies produce family dramas for which the script and roles are not clearly defined. It is no wonder that family tragedies are enacted and that family members suffer confusion, anxiety, and unhappiness" (*23a*). Research studies of marital stress are inconclusive, but they indicate that a substantial proportion of husbands and wives are tense and unhappy in their marriage. Weiss and English, whose monumental survey of psychosomatic medicine includes a wide range of family-related illness, noted that "the advice to marry and have children has been a frequent prescription for certain ailments. But, paradoxical though it may seem, many illnesses arise from the marriage situation, and this fact has not been so clearly appreciated" (*24*).

In two recent population studies in New York City and a rural part of New York State, and in a study of routine admissions to the surgical service of Cincinnati General Hospital, about half of the people examined in each sample showed moderate to severe neurosis (*25*). Many outpatient clinics and private physicians report that from half to three-quarters of their patients have symptoms primarily nonorganic in origin or have organic pathology which is aggravated by emotional disorder (*26*, *27*).

These studies are cited not to suggest that any known proportion of this well of human misery originates in the family spring but rather to emphasize the need to explore the major human interrelationships that may bear on public health. One of these, though certainly not the only one, is the family situation. As Kirkpatrick says, "The family is the setting for the most intense emotional experiences which the individual has in the course of a lifetime. Birth, puberty, marriage, and death are family experiences. The family is the source of serene security, of anguished insecurity, of love and hate, of pride and shame, of ecstasy and anguish" (*23b*). It is small wonder that the family dramas and crises have a profound effect on the course of health and disease.

Illness and the Family Unit

Fifty years ago the family was the center of medical practice, as suggested in the old, revealing term, family practitioner. Before the era of specialization, the family doctor had a more intimate knowledge of all the family members, of their incomes and ambitions, of the subtle ways in which each reacted to the other. In treating each of his families, he could call on a store of firsthand social, economic, and cultural data, mostly unrecorded on the medical history, and apply this knowledge both to diagnosis and therapy. With the advance of medical science, the family doctor gave way to the specialist who rarely or never saw the patient in a family setting (*28*). Public health was devoted to preventing disease in the community at large, particularly through sanitary control of water, milk, and insects. In recent years, general

medical practice has recovered much of its former prestige, and public health has broadened its interest to include the chronic diseases and their long-term effects on individuals.

But, despite progress, the family often remains in a medical vacuum, largely outside the scope of private medicine and nearly neglected by public health. We say "nearly" because one public health practitioner, the public health nurse, has always focused her attention on the family unit. It has been obvious to her, as to the family caseworker in social service agencies, that health or illness or recovery occurs in a family context.

The public health nurse always has taken stock of the unique family situation, of the family's income and education. Her methods have been mostly rule of thumb, based on the impressionistic data of her own experience. Lack of reliable baseline data on the family as a unit in health and disease has not prevented her from doing an effective job, just as the lack of mortality and morbidity data did not prevent effective work by the physician and the health officer 50 years ago.

But if the needed family data were available, the nurse and every other member of the health professions would learn to use the material, and come to rely on it as much as on our highly developed mortality data. None of us works in the dark by choice. Public health workers along with sociologists, demographers, family service workers, family counselors, child psychologists, psychiatric specialists, and business and market analysts would profit from real knowledge of the "universe" of American families: the norms and the ranges, the averages and the anomalies, and the interrelation of disease with varying families and family situations. Eventually public health, drawing on both the science of medicine and the methods of family casework, must develop an epidemiology of family disorders and diseases. Classical epidemiology knows how to deal with the spread of infectious disease in families, but for lack of technique and data it shies away from explaining why several members of a family develop the same gastrointestinal dysfunction or similar neurotic cardiac complaints. The wide spectrum of public health includes not only tuberculosis, poliomyelitis, and other infectious diseases that are routinely studied and attacked in the family context but also many noninfectious ailments such as obesity, alcoholism, asthma, and essential hypertension, all of which are influenced usually by the family situation.

Although many types of illness have little or no connection with the family situation, "illness is one form of family maladjustment" (*29a*). This observation was made by Henry B. Richardson, a doctor of internal medicine who collaborated with associates in psychiatry, public health nursing, and social service, in a pioneering study of the family as the unit of illness. After several years spent in establishing the direct connection of disease with specific family situations, Richardson wrote (*29b*):

"The individual is a part of the family, in illness as well as in health . . . The idea of disease as an entity which is limited to one person . . . fades into the background, and disease becomes an integral part of the continuous process of living. The family is the unit of illness, because it is the unit of living."

Sources of Family Data

How do we begin to build up the family data that public health officials can apply?

An immediate, basic task of public health agencies is to improve the reporting of information contained on marriage and divorce certificates. Marriage and divorce are major punctuation marks in family history, as are birth and death. All these events change the characteristics of the population and of the family units within the population. They interrelate with a variety of other material from the decennial census and the current population surveys of the Bureau of the Census and from the special surveys of Federal and State agencies. This material as a whole makes up the benchmark statistics that describe the American family as an institution and as a process. Consumers of marriage and divorce statistics want facts on the formation of new families, on their growth and composition, and on their dissolution. Marriage and divorce statistics are part of family statistics.

The collection of marriage and divorce statistics is a function of the public health agency in most States and in the Federal Government. Generally, it is among the less emphasized functions.

Although some health departments have worked vigorously to improve marriage and divorce reporting, the system on a nationwide basis is relatively primitive and compares unfavorably with that of most other countries of the western world.

No data at all are collected from a substantial number of registration areas in this country; marriage and divorce numbers and rates must therefore be estimated. One of the potential sources of error in these estimates is that in many areas marriage licenses are reported, but marriages are not; the proportion of unused licenses is a fluctuating variable. To take advantage of State differences in legal requirements for marriage and divorce, large numbers of people cross State lines; since reports do not distinguish between temporary and actual residence, the true marriage and divorce rates for any State's residents cannot be determined.

Because certificate information varies from State to State, national cross tabulations cover from 5 to 29 States, depending on the items included in the table. The number of States covered in tables of marriage and divorce characteristics varies not only from table to table but sometimes from year to year, making trend comparisons difficult and area comparisons all but impossible. This appraisal ignores the historical difficulties and the real progress that has been made (*30*, *31*), but discussion of these points is outside the scope of this paper.

In thinking of the potential use of marriage and divorce data as components of family statistics, we should not confine ourselves to the existing fragments, which obviously can have only limited application at present, but instead we should think of what kinds of data might be acquired and applied.

The National Office of Vital Statistics and the American Association of Registration Executives have submitted a proposal to the Association of State and Territorial Health Officers for the establishment of a marriage registration area to be followed by the establishment of a divorce and annulment registration area.

The reasonable criteria for the admission of States to the marriage registration area which were developed by the Public Health Conference on Records and Statistics (*32*) will permit the inclusion of about 26 States at the outset. The objective is the collection of a uniform body of data, consistent for all States in the initial area and eventually for the entire Nation, that will maximize the value of the statistics obtainable from items reported on marriage and divorce records.

But if all this were achieved, the present certificates alone could provide only a fraction of the family data needed. Although the present certificate data are indispensable as a base, there is much more information to be acquired.

How do we go about exploring the potentials in family statistics? The question has special application to the organizations directly concerned with vital and health records and statistics: the statistics section of the American Public Health Association, the American Association of Registration Executives, and the Public Health Conference on Records and Statistics. The initiative should come from vital statistics and records people because they are in the best position to know the possibilities and the limitations of vital records as a source of family data.

Each of us concerned with records on individuals should search for additional items for cross tabulation that would enable us to connect individuals as family members and to connect marriages, births, deaths, and divorces of these individuals as related events occurring in families with particular characteristics.

To serve the statistical needs of public health, it is time we broadened our concepts to include statistics on the family as a unit as well as on the individual. None of us at this stage can be expected to come up with immediate, definitive answers on the specific content of vital certificates, on appropriate technical methods and mechanisms, on the total scope of benchmark family statistics, or on any particular office's proper share of the collection of these data. It will take considerable work and discussion within our organizations to formulate even the first actual steps, but here are some specific lines that seem to be worth exploring.

1. From a family-oriented viewpoint, what can be done to improve the systematic data collection from birth, death, marriage, and divorce records? In reexamining the standard record forms, especially in connection with future revisions, what statistical elements re-

lating the events to the family might be introduced as record items? Would it be valuable to know in what kinds of families deaths from various causes are occurring? Do we want information about successive deaths in families and the composition of the family remnants? What could be done to improve fertility data and child statistics in general through a family-centered approach to the birth certificate? In all of this, the vital statistics system would need the thinking and consultation of health program people at the planning stage.

2. What types of special studies and surveys should be undertaken to enlarge our statistical knowledge of the family in health and disease and to enrich the developing core of vital and health statistics relating to the family? In addition to cross-section studies of family-centered records, we should investigate the feasibility of cohort studies for followup of marriage records and follow-back from divorce records. Moreover, a variety of surveys undertaken for health purposes could be made more valuable if family aspects were considered at the planning stage and incorporated in the study plan. The vital records, perhaps with additional items agreed to by the selected area, might serve as anchor points for such studies.

An urgent research problem is to learn how best to classify families, to determine by limited, short-term studies the kinds of information most essential for characterizing families. Such studies would provide the basis for the collection of family-characterizing data on a larger or a national scale. Without this basic knowledge of the "universe" of American families, the usual study of disease behavior in a selected sample of families cannot be generalized to any known population since there is no way to tell what part of the population the sample represents.

3. In addition to the decennial census, which has always been a rich source of data to students of the family, the current population surveys of the Bureau of the Census are open to special questions on marriage, divorce, and the family structure. They have been used several times for this purpose in the recent past. Questions relating health to the family situation in selected samples could be answered quickly and economically by this means.

4. Hospital and clinic records not only should include questions on the family medical history, as many do at present, but the records for all members of the family might be more accessible as a unit. Exploration of the objectives and technical problems might well be undertaken jointly by vital statistics people and medical record librarians.

5. Similar potentials exist in public health nursing records, which routinely contain data on the family, and which for special study purposes might profitably be collated with birth, death, and marriage records.

From a public health standpoint, the family is not just a social unit, it is an epidemiological unit. Study of the family requires an interdisciplinary approach of classical epidemiology and the social sciences. The statistical technique, for want of a short and simple term, might be called "social biostatistics," to which family-oriented vital statistics would contribute a share of the basic data.

A final quotation from Richardson is appropriate (*29c*):

". . . we may now consider how to develop a science of the family. The language in which this science will be expressed will not have the precision of mathematical analysis, unless on a statistical basis. Much of the material, as in many of the natural sciences and in psychology, will remain on a descriptive level. Nevertheless we may hope to develop an understanding of the family unit, which will help us to predict the future course of events."

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