THE FAMILY

A FOCAL POINT IN HEALTH EDUCATION

Last April, the 16th Eastern States Health Education Conference at the New York Academy of Medicine dealt with the family as a "focal point in health education." But the main emphasis was on the family as a focal plane for health practice, as a basic ingredient of the social process. The program talks and lively discussions were sparked by questions and comments from the floor, as the audience discovered new resources and unsuspected peaks and valleys on what had been thought to be familiar terrain.

The full text of the papers offered is to be published by the academy, under editorship of Dr. Iago Galdston, secretary of the Committee on Medical Information. Dr. Galdston also is secretary to the conference committee, headed by Dr. Herbert B. Wilcox, chairman. He will welcome inquiries or suggestions with respect to this conference or future ones. The address is 2 East 103d Street, New York, N. Y.

Public Health Reports is publishing briefs intended to touch upon a few of the salient issues suggested by the speakers. This treatment necessarily omits essential background discussion and illuminating details. The charts which appear in this conference report were among those given the delegates in the statistical survey prepared by Edward A. Lew.

A paper by Dunn and Gilbert discussing the need for improving family statistics for public health applications precedes this section (pp. 1002–1010).

Evolution of the Character Of Family Life Education

PHR brief

In a book published in 1881, "Gems of Knowledge," Dr. Paul Barrington wrote that women have as much right as men to choose a life companion. This—and other statements in a similar vein—contrasted sharply with the Victorian view of women as chattel and the family as an institution for the pleasure and comfort of men. A new point of view was emerging—a point of view that recognized the need for study of the family and its members and the values of education for personal and familial living. What has happened since Dr. Barrington's day may be traced in the accompanying list of significant events.

In the beginning, organized interest was centered on some particular member of the family or some special aspect of family living: children, mothers, or sex, for example. No thought was given to the family as a whole. During the 1920's and most of the 1930's, the focus was on children and how they could be taught habits and how best to discipline them. Family relationships were reduced virtually to a set of rules.

The 1920's saw the beginning of courses in family living in colleges, but what gave generalized family life education one of its biggest boosts was the change in the concept of education itself. High school was recognized as the privilege of everyone and therefore a key place for education for marriage and family life.

Originally, family life courses in high schools concentrated on generalizations about the family, but the youngsters were not content with this. They wanted their questions answered, questions about sibling rivalry (though they wouldn't use those words), petting, or going steady. Thus, the discussion technique in family life courses evolved, and with it, the need for teachers trained in the subject.

Concurrently, parents, too, sought to find answers to family issues. General interest in the family court concept in the late 1930's showed that the legal profession was beginning to think

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Significant Events

1877. Family service agency established in Buffalo in recognition of the need for casework services for the whole family.

1888. Child Study Association of America founded in New York by a group of parents who wanted information on how to bring up their children; Association for Child Study and Parent Education organized in Chicago by a group specifically interested in child psychology.

1896. National Congress of Parents and Teachers founded for the study of the child at home and at school.

1911. Family Welfare Association of America organized to bring together persons and agencies engaged in family casework.

1914. Family court established in Hamilton County, Ohio; American Social Hygiene Association founded to promote "those conditions of living, environment and personal conduct which best protect the family as a social institution," with emphasis on suppression of prostitution and reduction of venereal diseases.

1918. Federal funds made available to the States for venereal disease control and education.

1922. Federal funds made available to the States for maternal and child health programs.

1925. Marriage preparation and family living courses introduced at the University of North Carolina.

1938. National Council on Family Relations organized to provide a meeting ground for all who share in helping the family solve its problems.

1951. American Social Hygiene Association began expanded programs in education for family life; projects aimed at teacher preparation for family life education courses started soon thereafter.

of the family as a unit. And about the same time, family welfare agencies, once absorbed in relieving cold, hunger, and the need for clothes and shelter, began to broaden their services.

Dogmatic Opinion to Objectivity

During the early days, each piece of educational literature contained a heavy dose of moralizing based on Victorian ideals. Shortly after the end of World War I came the fault-finding and finger-shaking approach which tended to favor the child-centered home and to find fault with the parents. Articles in slick-paper magazines carried such titles as "1, 2, 3 for Better Parenthood" or "Temper Tantrums? You're at Fault!"

In recent years, research has produced a greater degree of objectivity, and it has challenged many of the earlier assertions. For example:

1. Three studies refute the notion that fathers are of diminishing functional importance in the personality development of American children.
2. Three studies fail to support the idea that interfaith marriages are less likely to be happy than marriages of those of the same faith.
3. Conflicting findings in dozens of investigations challenge the idea that personality development is adversely affected if a child is an only child.

Another trend apparent in the family life education movement is that from personal or neighborhood concern to professional concern supported by charitable foundations and universities and to public concern backed by Federal, State, and local funds. Interest was first exhibited by groups of parents who wanted to learn how to rear their children. Early support for research came from foundations and was carried out at universities. Family life courses were first introduced in colleges.

Opportunities Unlimited

Health agencies have countless opportunities to participate in the movement for generalized family life education. Many aspects of the prevention and control of disease and the promotion of health can be approached effectively through the family framework. Nutrition, for example, is more than vitamins and proteins or calorie charts. It is the food customs of families that help give a larger purpose and meaning to mealtimes. Cancer is more than a question of early symptoms and the search for a cure. It is the adjustment of a family to a crisis, a test of its stability.

Changing Family Profile

PHR brief

The profile of the American family has changed markedly in the past 15 years.

More persons than ever before live in families. Americans are marrying earlier in life. The level of births continues to set new high records each year. And family size shows an upward trend.

Living in families are 94 percent of the population, with an average of 3⅓ persons per household.

The number of families has increased 28 percent, from 32,166,000 in 1940 to 41,202,000 in 1954, or almost one-fourth more rapidly than the total population (table 1).

Husband-wife families have accounted for almost the entire increase. The number of married couples in 1954 exceeded 37,300,000. And all but about 1.5 million had their own households, reflecting a considerable decrease in doubled-up families prevalent during the war years.

It is significant that married couples represent 7 out of every 8 families with their own households. Of the other than husband-wife families, approximately 3 out of 4 are headed by a woman, denoting mainly that there are many more widows than widowers and that many husbands are serving in the armed forces or are away from home for other reasons.

The marriage rate, which spurted to an all-

By Edward A. Lew, actuary and statistician of the Metropolitan Life Insurance Co.

Table 1. Family units in the United States, 1940 and 1954 [1]
(numbers in thousands)

Type of unit	Total	Own household	Type of family		
			Husband-wife	Other male head	Female head
	Units, 1940				
Families	32, 166	----------	26, 971	1, 579	3, 616
Primary	31, 491	31, 491	26, 571	1, 510	3, 410
Subfamily	2, 062	----------	1, 546	[2] 56	460
Secondary	675	----------	400	69	206
Unrelated individuals	9, 277	----------	----------	4, 800	4, 477
Primary	3, 458	3, 458	----------	1, 599	1, 859
Secondary	5, 819	----------	----------	[2] 3, 201	2, 618
All types	----------	34, 949	28, 517	----------	----------
	Units, 1954				
Families	41, 202	----------	36, 041	1, 336	3, 825
Primary	40, 961	40, 961	35, 875	1, 326	3, 760
Subfamily	2, 107	----------	1, 305	98	704
Secondary	241	----------	166	10	65
Unrelated individuals	9, 700	----------	----------	4, 075	5, 625
Primary	5, 932	5, 932	----------	1, 904	4, 028
Secondary	3, 768	----------	----------	2, 171	1, 597
All types	----------	46, 893	37, 346	----------	----------
	Individuals in units, 1954				
Families	147, 953	----------	[2] 131, 784	[2] 4, 125	[2] 12, 044
Primary	147, 248	147, 248	[3]	[3]	[3]
Subfamily	[2] 5, 920	----------	[3]	[3]	[3]
Secondary	705	----------	[3]	[3]	[3]
Unrelated individuals	9, 700	----------	----------	4, 075	5, 625
Primary	5, 932	5, 932	----------	1, 904	4, 028
Secondary	3, 768	----------	----------	2, 171	1, 597
All types	157, 653	153, 180	131, 784	8, 200	17, 669

[1] Excludes inmates of institutions; 1954 also excludes all but 822,000 members of the armed services.
[2] Estimated by the Statistical Bureau, Metropolitan Life Insurance Co.
[3] Not available.

SOURCE: Bureau of the Census.
DEFINITIONS: *Family*—group of two or more persons related by blood, marriage, or adoption residing together. *Primary family*—embraces all the persons related to and including the head of the household. *Secondary family*—head of household is not related to the family sharing his dwelling, such as a group of roomers or resident employees. *Subfamily*—a married couple with or without children, or one parent with one or more children under 18 years, living in a household and related to, but not including, the head of the household or his wife.

time high of 16.2 per 1,000 population in 1946 upon demobilization, has since been declining. In 1955 the rate was 9.3 per 1,000. It is not expected that the number of marriages will vary greatly for several years to come. After the early 1960's, however, there should be a marked upsurge when the large number of babies born during the war and postwar years begin to reach marriageable age.

Early Marriages

The trend toward early marriage is equally marked for both men and women. In 1955 more than 14 percent of all girls at ages 14–19 had been married compared with only 10 percent in 1940. At ages 20–24 the corresponding proportions for women were 71 percent in 1955 and 53 percent in 1940 (table 2).

Slightly more than half of the men at ages

20–24 are now married, or have been, compared with only 28 percent in 1940. At ages 25–29, the proportion now is 72 percent compared with 64 percent in 1940.

The median age of men at first marriage is only about 23 and that of women barely 20.

A study recently made by the National Office of Vital Statistics of the Public Health Service points out that 1 in 3 couples marry on a "shoestring," with an income of less than $60 a week.

Currently, about 11,800,000 married women, 29 percent of the total, are in the labor force. While it has long been customary for young wives to work until the baby came, recently more and more of them are returning to the labor market as the children grow up. Thus, about a third of all wives at ages 35–54 now work outside the home; for the younger women the proportion is about one-fourth. The fact that 2 out of 3 married women live in urban areas enables them to take advantage of employment opportunities.

The Baby Boom

Even more remarkable than the recent increase in the married population has been the continuing boom in babies. Since the close of World War II, births have averaged 3,800,000 annually, with each of the past 5 years successively establishing new high records. Almost 4,100,000 babies were born in 1955, the equivalent of a rate of 24.9 per 1,000 population.

Accounting in part for the unprecedented number of babies born in recent years is an almost uninterrupted rise in fertility from its low level in the 1930's. In each of the postwar years, about 1 out of every 6 married women under age 45 bore a child, whereas in the mid-1930's the proportion was only 1 in 8.

The rate for first births began to climb immediately after 1933 and spurted sharply in 1941 and 1942. Demobilization brought an even greater jump in the birth rate of first babies in 1946 and 1947.

The upward trend in the birth rate of second and third babies since the beginning of World War II has raised such birth rates to considerably higher levels than those prevailing in the 1920's. Since about 1951 there has also been a definite rise in the birth rate of fourth and fifth children. This trend certainly presages a return to moderate-sized families, but it is not likely that families will become as large as those 50 years ago.

The high birth rates of the past decade are, of course, reflected in the proportion of families with dependent children, particularly among the younger married couples. A large proportion of families have a child within 5 years

Table 2. Percent ever married according to age, by sex, United States, 1890 to 1955

Age group, years	1890	1900	1910	1920	1930	1940	1950	1955
	Males							
14–19	0.4	0.9	1.0	1.8	1.5	1.5	2.9	2.9
20–24	19.1	22.1	24.5	29.0	28.8	27.8	41.0	51.2
25–29	53.9	54.0	57.0	60.3	63.1	64.0	76.2	71.9
30–34	73.3	72.2	73.7	75.7	78.7	79.3	86.8	85.1
35–44	84.5	82.9	83.1	83.7	85.6	86.0	90.4	91.1
45–54	90.7	89.6	88.7	87.8	88.5	88.9	91.5	91.5
	Females							
14–19	8.0	9.4	9.7	10.8	10.9	10.0	14.4	14.2
20–24	48.1	48.3	51.4	54.3	53.7	52.8	67.7	70.9
25–29	74.6	72.4	74.9	76.9	78.2	77.2	86.7	88.4
30–34	84.8	83.3	83.7	85.0	86.7	85.3	90.7	92.9
35–44	90.1	88.8	88.5	88.6	89.9	89.6	91.7	93.1
45–54	92.8	92.1	91.3	90.3	90.8	91.3	92.2	93.2

SOURCE: Bureau of the Census.

Table 3. Child dependents among married couples according to age of husband, United States, 1940, 1950, 1953

Age of husband (in years)	Percent with one or more own children under 18 years			Own children under 18 years per married couple with children	
	1940	1950	1953	1950	1953
14 and over	58. 1	54. 6	55. 7	2. 07	2. 15
14–24	49. 4	56. 1	61. 2	1. 41	1. 57
25–34	69. 2	76. 4	80. 0	1. 94	2. 13
35–44	76. 2	77. 5	79. 4	2. 40	2. 41
45–54	59. 3	49. 2	37. 6	2. 03	1. 98
55–64	34. 8	19. 5		1. 77	
65 and over	17. 1	5. 1	4. 6	1. 61	1. 70

SOURCE: Bureau of the Census.

of marriage. The average number of children per family has also increased appreciably where fathers are under 35 years of age (table 3).

Children under 18 years of age now number nearly 57 million, an increase of 15 million in the 11 years since the end of World War II. This increase has broken all previous records and is greater, in fact, than the gain in the preceding half century.

The total number of children is expected to continue to climb, and by 1965 it is estimated that there may be upward of 65 million children under 18 years in the United States. This would mean a somewhat larger average family than we have now.

Currently, close to 8 million children under 18, almost one-seventh of the total, live with only one parent or with neither, mainly because of family disruptions through death, divorce, or separation. Of these, almost three-fifths live with their mother, about one-tenth with their father, and the remainder under a variety of other arrangements, mainly other relatives.

The problem of orphanhood has been diminishing, but about 1 percent of the children under 5 years, 9 percent at ages 10–14, and 14 percent of those at ages 15–17 are orphaned.

Widowhood

Even though the number of widows in the population has been mounting rapidly, the proportion of women who are widows has been decreasing at every period of life. This is mainly the result of the decline in mortality.

Of the 7,600,000 widows, more than half are 65 years of age or older; two-fifths are in the age range 45–64, and less than one-tenth are under 45. Many of the widows in the younger age brackets have dependent children in their care (table 4).

Although widowhood has been increasingly

Births per 1,000 married women aged 15–44 years, by order of birth, United States, 1920–54.

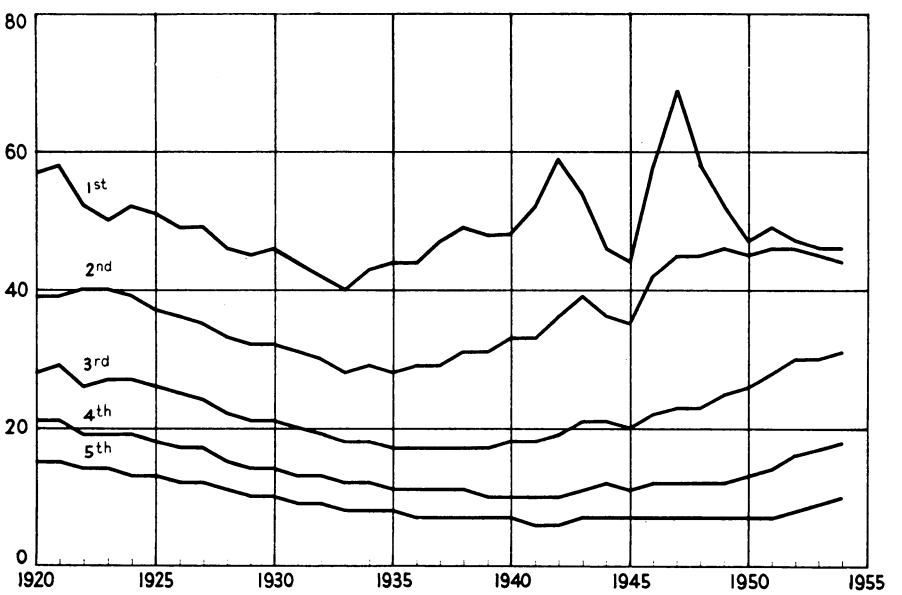

Table 4. Widows in the United States, 1930 and 1955

Age (in years)	1930 (4,734,374)		1955 (7,595,000)	
	Percent of all widows	Percent of all women	Percent of all widows	Percent of all women
14–44	18. 3	2. 9	7. 6	1. 6
45–54	18. 5	14. 0	13. 5	10. 8
55–64	23. 7	27. 8	24. 9	25. 6
65–74	23. 9	49. 0	30. 6	46. 5
75 and over	15. 6	73. 9	23. 4	70. 9

SOURCE: Bureau of the Census.

postponed to the older ages, it remains nevertheless an important social and economic problem. About 1 woman in every 2 who now becomes a widow before age 60 has 20 or more years of life ahead of her. Nine out of every ten widows live either in their own homes or with relatives. Of the remainder, about one-half live as lodgers or as resident employees; one-fourth live in hotels or similar places, and an equal number in homes for the aged or other institutions. Many widows past the prime of life are in the labor force.

Psychological Dynamics Of the Familial Organism

PHR brief

A new prototype of the American family is emerging from the steadily changing patterns of family organization.

There is the changed position of women in society, their new role in industry, their achievement of equal rights with men, their sexual awakening and emancipation. Also there is the removal of the working father from the home,

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the mother's expanded domination of home and children—the whole tradition of "momism." With all this has come an inevitable shift in the relations of men and women, and in child-rearing attitudes. The homestead has been stripped of the traditional functions of work, religious worship, schooling of the children, and care of the sick and aged.

The values of self-selection of mate, of compatibility in marital relationships, and of child-centered family life are accentuated. But the increased freedom, while promoting greater creativeness, also induces confusion and turmoil in family roles. What a man expects of a wife and what a wife expects of a husband has become complicated by a multiplicity of needs, many of which are contradictory in nature.

Unit of Diagnosis—the Family

Many persons and many families feel insecure, confused, and isolated in their community position. They perceive these rapidly changing social patterns as menacing and as a withdrawal of support. Young parents, separating themselves from the older generation but failing to find a substitute in the wider community, feel alone and adrift. They undergo personal torment in searching out an appropriate path. Their torment intensifies the strain in family relations and imposes an additional burden on the family's inner life. The family then tries to compensate to an exaggerated degree for the individual's lack of security in the wider community by providing a protective barricade against what often seems to be a cold, harsh outside world.

The experience of the modern family underscores the fact that accurate psychiatric evaluation and effective treatment of individual patients is simply not possible unless the disturbances of these individuals are defined in the context of their emotional position in their family. The family is the unit of growth and experience, and therefore the unit of health and illness. There must be a shift of interest from the individual as the unit of diagnosis and therapy to the family group as the unit of diagnosis, therapy, and prevention.

Clinically, the first person to seek psychiatric help may prove to be either the most or the least

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sick member of the family. In evaluating the primary patient, it is important to trace the lines of significant involvement with other family members and to judge the illness as a reflection of the level of the family's emotional functioning. It is important, too, to discern in the arena of family life where lies the most critical focus of conflict and anxiety, to determine whether the core of the disturbance rests in the illness of one member or in the conflict of a particular family pair. Or does the conflict pervade all family relationships? In this sense, the behavior of one member may be interpreted as a symptomatic reflection of the emotional distortion of the entire family.

Basic Principles of Diagnosis

A system of family diagnosis calls for the evaluation of the group patterns of the family, the personality dispositions of each member, and methods of correlating individual experience and group interaction. Three empirically documented principles are relevant toward evolving such a system.

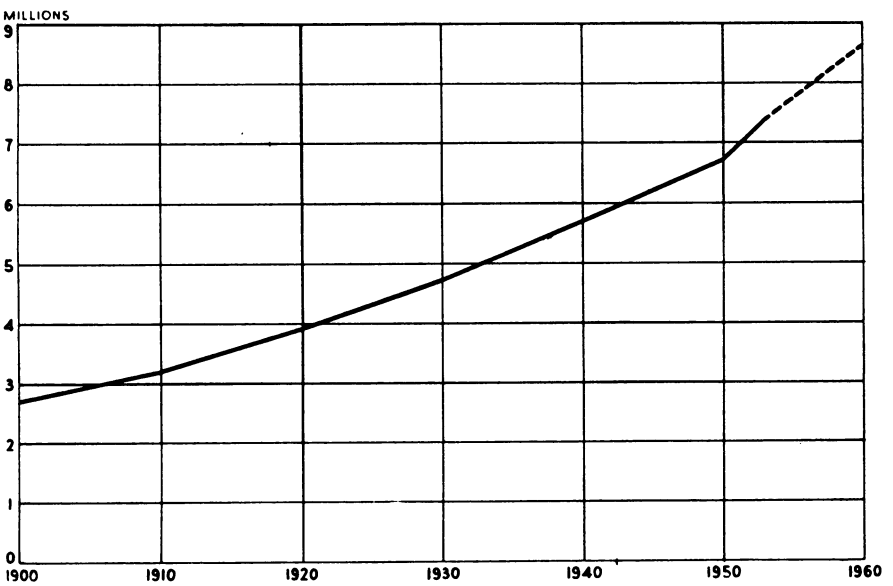
1. Abnormal behavior in adult persons is significantly rooted in the experience of childhood integration into a particular family, but continues to be molded by current family experience.

2. The diagnostic evaluation and therapy of emotional disturbance in a child, viewed as an individual apart from his family environment, is impossible. The proper unit for study and treatment is the child seen as part of the family, the family as part of the child.

3. Personality disorder and disturbances in social adaptation of adult persons may be better understood if examined not in isolation but as a dynamic changing pattern influenced continuously by the reciprocal effects of family interaction. Deviant behavior is thus seen not merely as a projection of fixed intrapersonality distortion but also as a functional expression of emotional interplay in significant personal relationships. The way in which the person perceives the image of others influences his image of self and vice versa. This two-way process continuously molds feeling, attitudes, and action.

Personality, born and bred in the social matrix of the family, and family and culture may be regarded as behavior systems existing at different levels of experience, each interdependent although interpenetrating parts of a whole which change and shift over time. Stability within the person and stability in the relations of persons and environment are mutually contingent, and the life and growth of the individual are inconceivable except within the group.

Number of widows in the United States, 1900–1953, and forecast for 1960.



The interrelations of individual behavior and family relationships need to be scrutinized in three dimensions: the group dynamics of the family; the dynamic processes of emotional integration of the individual into his family role; and the internal organization of individual personality and its historical development. The phenomena of family role constitute the bridge between the internal processes of personality and the group pattern of the family.

Purposes Served by Family

The family serves biological continuity by providing a socially supported group pattern for the sexual union of man and woman and a quality of parental partnership essential to the care of the young. The family is literally the cradle for the infant's tender mind as well as his body. Concretely the purposes served by the family are:

To provide food, shelter, and other material necessities which sustain life and protect it from external dangers; to form a matrix for the affectional bond of family relationships; to give opportunity to evolve a personal identity, tied to family identity, which supplies psychic integrity and strength for meeting new experiences; to set the pattern of sexual roles, preparing the way for sexual maturation and fulfillment; to establish social and ethical standards for social roles and acceptance of social responsibility; to cultivate learning and support individual creativity and initiative.

One important feature of family identity is its stability, its internal capacity for self-regulation and for restoration of a state of balance following an upset. There are at least two kinds of stability. One is characterized by resilience and capacity for accommodation to change and the other is marked by a rigidity toward change. In the meeting of new problems and crises, some families are weakened and others grow in solidity and emotional strength. Some families grow and learn from experience; others seem unable to do so because they are too inflexible and tend to disintegrate.

Families differ in their capacity to restore emotional balance. If this balance is not restored after disturbance, the inevitable consequence is a breakdown in emotional communication and empathy, increasing alienation in family ties, and confusion and impairment of family identity.

The interrelations of marital and parental identity and individual identity are delicately balanced. In a healthy family, out of the fusion comes a richer, stronger individual identity. The differentiation of the separate self is as important as is the basic family unity. The quality of difference in a family member need not be felt as a threat, any more than sex difference is a threat. Instead it should be welcomed as proof of the complementation of the self, the opportunity for new learning and greater fulfillment.

Mental health cannot be conceived in "all or none" terms. In emotional terms, people are neither wholly sick nor wholly well. Since mental health is largely a function of social processes, the more suitable test is the individual's integration into his group, rather than his personality structure defined in abstract terms. Surely mental health signifies the absence of mental illness, but it is much more than this. It implies confidence, courage in facing new experience, the capacity to grow, to learn, to live fully, to love and to share with others the adventure of life—in other words, a concern for the common good.

Family Health Maintenance

PHR brief

Social agencies have known for years that they must reach families before social and emotional disorders become fixed. The broken home, the vanished parent, the child in custody, all underline the fact that agency jobs are salvage jobs. Trends in medicine have coincided with trends in social welfare, and there has been a growing awareness of the interplay of social factors and

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disease. Molding the environment, health promotion, and prevention of social illness must be combined with treatment of all disease.

The organization of medical care for the family must consider its needs, modern knowledge of prevention and treatment in both the physical and the socioemotional fields, and the cost—the cost of organizing health service and the cost of not organizing it.

A research demonstration in health promotion and preventive medicine is being conducted at Montefiore Hospital under the joint auspices of the hospital, the Columbia University College of Physicians and Surgeons, the Community Service Society, and the Milbank Memorial Fund.

Selected at random from the Montefiore medical group of the Health Insurance Plan of Greater New York are 150 families and an equal number of matched controls. Advantages and disadvantages of participation in the study were discussed frankly with all participants because, while it was important to get as many families as possible to cooperate, it was equally important that these families continue participation to the end of the program. The controls responded to a long and time-consuming questionnaire in approximately the same proportions as the study families participated in the demonstration.

Evaluation

The information collected from the families is to be used as baseline data. From this information an evaluation schedule is filled out and a numerical score is given to each individual in 11 different areas. At the end of the 4-year study period, similar information schedules will be completed and evaluation forms will be filled in. From these, the study families can be compared with themselves and with each other as well as with the control families, who will have a final evaluation of the same order.

No equally comprehensive initial evaluation was made of the control families. However, they have filled in a Cornell medical index and supplied housing and nutritional schedules. We have physical examination reports in their HIP charts, also.

The Health Team

In the demonstration, the health team is composed of a physician, a public health nurse, and a social worker. Medical care, preventive medicine, health education, health promotion and guidance, and psychiatric advice and some psychiatric help are the elements of the team's functions.

Medical consultants aid in diagnosis and treatment through the matrix of medical group practice. A social scientist consultant offers specialized skills in diagnostic and treatment methods appropriate to social factors, social disability, and social disorganization. A psychiatrist, a psychologist, and a health educator also serve as consultants.

The decline in numbers of general practitioners and the increased medical knowledge, diagnostic and therapeutic equipment, and skill have necessitated a medical adviser who is closer and more accessible to the family than the specialist. Fortunately, a link between doctor and patient is already in existence. Public health nursing and medical social work arose in response to such a need. With changing attitudes of physicians and loss of rapport between doctor and patient, public health nurses and social workers have been developing in skill and numbers. In the demonstration, the new, important aspect of their roles is prevention—to reach into families before disaster strikes.

The public health nurse herself shares in many areas of the doctor's role that deal with preventive medicine in the areas of nutrition and health teaching. In the area of interpersonal relationships, the social worker has become the professional practitioner, helping patients to understand their problems, providing access to other agencies and sources of care, and "shoring up" the emotionally sick and the socially disabled.

The health team can act as the family's guide and adviser because it has information, authority, and the confidence of the patient. Internally, the team must operate with mutual confidence. The Montefiore team has no captain; decisions reached in conference are referred to the person with competence in a given area or to the person with whom the patient has the closest relationship.

Whether physical or emotional, preventive or therapeutic, individual conferences, group discussions, or consultations with parents about themselves or their children, action requires the resources of the entire team.

One important function of the health team is the service it can give in emotional upsets. However, a consulting psychiatrist orients and supervises the team members, inculcating psychiatric attitudes, information, and some techniques. He helps the team members to use the new skill to improve their own functioning and to add a new dimension of help to the patient.

The consulting psychiatrist does not actually perform services for patients. In weekly conferences with the team members he offers general information on psychodynamics, on patterns of behavior, and perhaps on a specific case or family. His social usefulness is enhanced many times by this means, and it may be that only through such organized service as a health team with a consultant psychiatrist will it be possible to bring the mental health approach into the medical care system.

Basic Hypotheses

Definitions of such terms as "health," "anxiety," "help," "guidance," and "support" were agreed upon early in the demonstration.

"Health" was defined as "harmonious functioning" in various facets of living. Emotional health is intimately tied to family relationships. Parents represent a profound influence in the health, or harmonious functioning, of the child and, consequently, of the adult since, as stated by Bowlby, "the form our family relationships take when we are grown up are, to a high degree, dependent on the form they took in our early years, and the very first relationship we make—that with our mothers—is the most important of all." The causes of failure in marriage often lie in family stress in the previous generation. Realization of this cyclical quality of emotional disturbance led us to concentrate health promotion efforts on providing parents with some knowledge and understanding of defects in their marital relationships, not to assess damages against them or their children.

In the early part of the study, more than half of the reports of doctors and social workers noted "anxiety" among family members. The term needs clarification. Anxiety as a response is useful and necessary, provided it is not more than the stimulus warrants. Our concern is with types of anxiety in which the response is disproportionate to the stimulus and interferes with an individual's effective functioning in all areas of living.

This concern for emotional disturbances is within the family setting, and it is within the family setting that maximum effort should be concentrated. However, stresses such as low income, prejudice and segregation, and national and international political tension must also be weighed and considered in evaluating help for the family.

The demonstration is concerned with giving "help, guidance, and support" in physical as well as in emotional stability and growth. Injections and vaccinations are given against contagious disease. The public health nurse attempts to provide the latest information on nutrition, particularly to pregnant women. Poor or inadequate housing is dealt with as constructively as possible.

Health Education

A variety of personal and group educational approaches are used in maintaining family health. These include conferences, literature, informal discussions, and group discussions. Family conferences, in which parents meet the whole health team, are valuable. After the initial study and evaluation of each family are completed, a schedule or plan for health supervision is discussed in conference between the family and the health team. The knowledge that this group of professional people is concerned and interested and is offering suggestions is very gratifying to the family.

Although attendance at group meetings was not large, the health team was gratified to be able to reach even a small proportion of the study families. Some of the reasons suggested for the small attendance are competing entertainment and the accessibility and perhaps repetitiousness of educational forums in schools, churches, and neighborhoods. Ease of access to individual conferences also may militate against attendance at group discussions.

The Physician And the Family

PHR brief

The character of the professional relationships of a physician both with the families of his patients and with his associates in health education and family care will be affected directly by the kind of education he receives in medical school. Recently developed teaching projects designed to advance the practice of health education in family living are evidence of a trend toward educating the physician to understand the health of the patient in relation to the family environment.

The origins and reasons for this movement are complex; their contributors, both individual and organizational, are many. In the past quarter of a century, the Association of American Medical Colleges particularly has emphasized the importance of appraisal of social and environmental factors in clinical teaching. The 5-day teaching institute held in 1952 by the Conference of Professors of Preventive Medicine and the Association of American Medical Colleges at Colorado Springs, Colo., gave considerable impetus to the further expansion of comprehensive medical care teaching demonstrations, with emphasis on home and ambulant care.

Of interest is the extent to which departments of preventive medicine have a responsible role in this form of extramural teaching, the appearance of psychiatry in a consultative teaching function on behalf of other departments, and new administrative arrangements and purposes in the relations of clinical departments for the demonstration of medical care. The Cornell comprehensive care and teaching program and Boston University's domiciliary medical care program are good examples of the latter.

By Duncan W. Clark, M.D., professor and chairman, department of environmental medicine and community health, College of Medicine, State University of New York, New York, N. Y.

The State University Project

As a learning device and as a form of service, the value of simultaneous appraisal of all members of a household has been demonstrated in the Family Health Study Program of the State University of New York College of Medicine at New York City. This family medical and social appraisal is the major project of a 1-month full-time clerkship in environmental medicine and community health carried on at the health department's Red Hook-Gowanus District Health Center in Brooklyn, N. Y. Each senior medical student is assigned a family chosen for the program by the health center's community nursing service and as much of the study as possible is conducted within the family home in a series of frequent visits.

Physicians, social workers, public health nurses, social scientists, and staff of community agencies serve as consultants to the student and evaluate his findings with him individually and in groups. The recommendations found most acceptable in the joint conferences are acted upon by the public health nurse in the further use of community agencies for continuing care.

The totality, size, and concentrated time span of the family studies of this program differ notably from what is usual in family medical practice where the physician's contact with a family is usually episodic and in response to a call for the care of the family member who is ill. In the State university study program all family members are equally the object of attention in the same time period. Some of the examinations performed go beyond those commonly made by a practicing physician; for example, after the student-family relationship has become stabilized, examination may be made of the home to discover hazards that might cause accidents.

The Student's Appraisal

In making his report, the student appraises each member of the family at three levels, according to the individual's personal health, the latter's role in and relations with other mem-

bers of the family, and his role in and relations with the community itself. The need of reducing the record to diagnostic and summary terms leads into the consideration of several general questions of instructional importance. One family's history illustrates two such questions: (*a*) the problem of selecting the initial steps and the frequently limited goals possible in aiding the restoration or promotion of family functioning and personal health and (*b*) the opportunity of examining the family for identification of diseases which have a familial risk.

The husband, an unskilled laborer, had been unemployed for a year. He had asthma and bronchitis, and official agencies were about to investigate the possibility that these conditions were sufficiently disabling to justify the transfer of financial support of the family from the category of home relief (for the fully employable) to that of aid to dependent children. He was found to be depressed, showed striking symptoms of self-devaluation, and his relations with his wife had deteriorated to the point of consideration of divorce.

Although the wife had not handled the family funds when the husband was the provider, she had since taken over the handling of public assistance funds. She seemed competent as a mother, but her ability as a wife was more open to question. Perhaps childhood illness and experiences, or the lack of much of a childhood—she had worked in a factory from age 8 to 18 years—may have qualified her ability to relate on a mature level.

A problem such as the unemployment of the head of the family offers a series of choices in the attempt at solution. Determined agency activity in finding the husband a job might restore his status again as the main provider and head of the household. Referral of the wife to a family agency for a fuller understanding of her situation and of her attitudes toward her husband and even of her version of his behavior might identify which adult member in the family is the better able to form a relationship. Or the husband might be referred to a psychiatrist for an examination to determine whether his behavior is evidence of a psychological disorder that may disqualify him for work or for certain kinds of work.

The nature of the training and experience of health personnel may be the main determinants of the choice of one of these directions toward more healthful functioning. The physician, the social worker, and the public health nurse each select a different approach to this family's problem. Further, there are times when vocational advice may require inquiry into the health status of family members and understanding of family relationships.

Family Disease and Familial Risk

In the care of an individual or family a doctor's concern must include attention to resistance and susceptibility to disease. Ideally, in a full appraisal and in anticipating susceptibility to disease, inquiry needs to be extended to all relatives, living and dead, to pregnancies unfulfilled, and even to the yet unborn. Such a case study approach will provide students and teachers with data for a discussion of existing knowledge, or lack of knowledge, of the mechanisms of disease as influenced by genetics and by environment.

As a teaching device we may conceive "family disease" as multiple cases of a disease among relatives or single cases of disorders known to carry a "familial risk" to children. In the family mentioned previously there were two likely instances of disorders associated with familial risk to children. The mother had dextrocardia and 1 of the 5 children had epilepsy. Two maternal aunts and the maternal grandmother had gallstones, but it is not known whether the mother had gallstones as well. She had eclampsia on one occasion and her mother had hypertension. Little of significance can usually be drawn from the history of more distant relatives. On the subject of disorders known to be common, there were nutritional deficiencies, and these were presumed to be due to the family's marginal economic circumstances.

The term "familial risk" denotes an empirical observation without the usual assumption of genetic etiology. Families share common environments as well as common genes, and families in consecutive generations show some tendency to remain within the same cultural, religious, and economic groups. In the family studied, two possible familial risks were present, epilepsy and dextrocardia. Because the

parents in this family were cousins, the question was pertinent whether children as yet unborn to this marriage might be heir to dextrocardia. However, since as many as five children had been born without this rare congenital defect there is little probability of a later child having the condition.

Attitudes Affecting Counseling

The possible role of personal and professional attitudes in counseling may be illustrated in a study of a family of four. The father had advanced pulmonary tuberculosis, one child had recently recovered from chorea, and the other child had had rheumatic fever for 2 years and had been in a special institution for this disease. The mother had gone to work 6 months earlier, at the time of her husband's hospitalization. There had been no untoward consequences to the children with the mother at work, but the question was raised speculatively in conference whether she should have made this decision.

The 16 medical students unanimously agreed that the mother should have gone to work. But medical students believe in hard work, and they have a strong pragmatic streak. After all, they seemed to say, the woman had been working for 6 months with no serious consequences to herself or her children.

The intended implication of the question was what response representatives of special fields might make to the question of the advisability of the mother's employment, according to their professional knowledge and orientation. The following responses might have been made.

A pediatrician might be primarily concerned with the fact that two young, recently convalescent children were unattended on their return from school.

A psychiatrist might feel that the wife's pursuit of work, while relieving anxiety in her, could have an emasculating effect on the husband and could pressure him to a premature return to work.

An anthropologist might say that it is traditional for Puerto Rican women to work hard and that the mother's employment was a decision acceptable to both sexes of this ethnic group.

An internist might feel that prevention of tuberculosis in the mother is the critical issue and that her undoubted recent exposure to the disease should weigh against her working, although his opinion might be based more on clinical prudence than on possession of the facts on the role of work.

Education for Parenthood

Modern education for parenthood centers around the family rather than the mother and her infant. Today's classes for families expecting another child now include not only the father but the children, offer shared learning for the greatest sharing experiences in life, seek to expand the boundaries of family feeling, and foster an environment conducive to psychic growth for parents and children.

Apparently, the enthusiastic response to our classes at the Maternity Center in New York City and in other large centers of population coincides with a widespread desire for help. Our classes consistently attract more applicants than there are chairs available. Sometimes, young couples apply even before a child is expected.

In part, we attribute the favorable response to the fact that young couples wish to be equal to parenthood. They feel a need to develop their inner resources. They wish to learn what changes to expect in their relationship to each other and in their pattern of living.

Few youthful parents know what they should about human reproduction. Although the majority in our classes have attended college, they have little real knowledge of how a baby is born. Confronted with the process of birth, they wish to understand rather than wonder. Those able to assimilate medical knowledge seek the help of experts. But rather than imprecise answers,

By Hazel Corbin, R.N., general director, Maternity Center Association, New York City.

they seek facts from which to make their own decisions. They are not willing to accept a passive role. This attitude is perhaps more crystallized in maternity care than in other medical services.

Only 25 years ago, emotional security was a concept limited to psychiatrists and other professional workers. The parents of today, conscious of their own personality disturbances, try to create a good emotional climate for their children. They are irrevocably committed to the momentous adventure of parenthood, and they are unsure of their ability to live it well. They need not only to learn the elements of bathing and diapering an infant. They need help also in understanding their own and the baby's behavior. They wish to avoid the mistakes they feel their parents made unwittingly.

Unlike their parents, who often felt they had to possess a house and car before they could afford babies, today's young people base their security on the family and its social value rather than on material things. Whatever adds social value to the family strengthens their sense of security. Since formal education is an important symbol of ego value in our culture, the undervalued role of parent gains in prestige when it is approached by the educational route.

Individual Goals and Aspirations

Education for parenthood should help the mature individual to derive the utmost satisfaction from the experience and to share that satisfaction with others in the family. It should help the personality to mature in proportion to the complex responsibilities of parenthood. For the unborn child, it should prepare a suitable home.

Education for parents should emphasize the primacy of the home since the disruption of family life is at the root of much unhappiness. It should encourage a broad conception of the family unit to provide the child with opportunities for effective relationships and for learning to live with others. It should provide learning of permanent value so that parents continue to build for happy, healthful living long after they have forgotton the details learned in classes for parenthood.

To be effective, health education must be acceptable to people. It is important therefore to help the individuals in the group work out their own methods of achieving what they desire. Although a core of pertinent information should be given, it is not desirable to insist on a particular pattern of performance or care. Effective education keeps in mind that individuals and groups are unique in goals, aspirations, and working methods.

By keeping the class small and having it meet over a fairly long period of time, it is possible to practice permissiveness, both in the teaching pattern and in the conduct of discussion. Young people are accustomed to frank talk, with each other and their friends. They are most receptive when the classroom discussion is at this level of freedom. As they become acquainted, the discussion grows in freedom. This spontaneous talk provides the teacher with the key to unexpressed and unformulated feelings.

Today's parents want to know about fertility and infertility, the uses and dangers of anesthesia and analgesia, the pros and cons of natural childbirth and rooming-in, and the psychophysical rationale of breast feeding. Many want movies of an actual birth.

A good educational program gives them the best available information on which to base their choices. The nature of the child, even before birth, is emphasized throughout so that parents are prepared to receive a baby as an individual personality and not merely as their creature, however loved, to be reared in the pattern of their personalities and wishes.

Often parents are far ahead of professional workers in their ideas of what they should learn. In controversial areas, it is wise to explain the difficulties that may prevent full realization of their desires so that they may adjust sensibly when their efforts fall short of complete success.

Whether they like it or not, for example, most women are obliged to have their babies in hospitals. Whether they like it or not, they are usually separated from their husbands during labor and from their babies after birth. If they make a choice between hospital and home based on realistic information, they are usually able to try sensibly to gain the advantages of both and to adjust without trauma if they don't.

Sharing of Attitudes

Naturally, all of the initiative does not rest with the class. A good discussion leader creates interest in what should be learned and brings about coincidence of teaching and learning goals. In an early session on intrauterine development, for example, we explain the baby's dependence on the mother and her food intake for the baby's body-building needs. Then parents are ready to receive the session on nutrition with real interest in the child's welfare as well as their own.

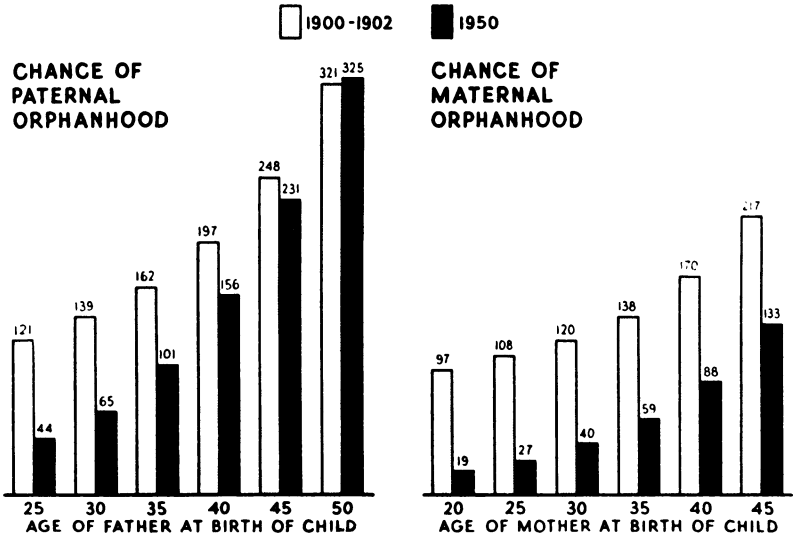
In teaching nutrition, we explain how different food elements serve the body. We do not say "eat this or that" but help each mother and father achieve good nutrition within the framework of familiar food habits and tastes.

Even though deliberate attempts at psychotherapy should be avoided, there can be no doubt that the airing of hopes and fears is beneficial. Throughout pregnancy, for example, there is a shift of interest back and forth between the child and self. Expectant parents often feel guilty and abnormal when their beginning parental attitudes give way to self-concern. They do not always realize that parental feeling is a developing and not a full-born thing. As they understand that a measure of emotional conflict is universal, they grow in self-confidence, and the motivation for learning is strengthened.

No large-scale, continued evaluation of parents' classes has been made, though empirically it seems certain that the shared experience has psychotherapeutic value. Mothers comment on the supportive value of what they learned in class. They write of the pleased surprise and appreciation of their physicians at their performance during labor. Nurses report that women who have had prenatal preparation have an easier delivery and react better psychologically. Mothers and mothers-in-law remark on the emotional growth observed in their sons and daughters.

Education for childbearing does not pretend to eradicate neurotic attitudes or deep-rooted personality traits. It does seek to minimize or prevent new traumatic experiences, to help develop insights conducive to a favorable environment for the coming child, and to aid in the reconstruction of the family in a society that in many of its values and practices tends to rupture family bonds. Education for parenthood which is focused on the family and its individual and collective needs, and which fosters a secure, happy family setting, contributes to the welfare of society as well as of individual mothers, fathers, and children.

Chances in 1,000 that a newborn child will be orphaned before attaining age 18: mortality experience of white population, United States, 1900–1902 and 1950.



Culture and Health Practice

PHR brief

Health, once thought to be governed by the heavens, by implacable fates, or by simple principles of will or virtue, was late to be associated primarily with the elements of earth. And even the earthly view has been troubled by the complex interplay of man with environment and of the individual with society.

The concept that ills have a dominantly physical origin, based in microbes or toxins, was barely established before Claude Bernard, Walter B. Cannon, and Sigmund Freud demonstrated that man is a whole compound of related physical and psychological processes. Such men opened the door to the study of the role that human values, emotional attitudes, and habits play in health. Talcott Parsons searched for roots of psychological patterns and influences within human societies and their social processes. Kardiner spoke of social emotions patterned in social structure. Anthropologists investigated social patterns for clues to their origin.

A preoccupation with evolutionary theory in the 19th century favored the thought that men and their societies "progressed" biologically or culturally, with accompanying assumptions of superiority of advanced races or cultures over the "primitives." Assumptions of racial distinction were discredited by Boas, who linked mental processes firmly with culture and led to a searching analysis of cultural variations.

Since culture itself is a human agency or organization of instrumentalities for adjusting and adapting to nature, it bears upon the shaping of personality and health, both individual and public. Individual reactions are mediated by a whole system of values, attitudes, and behaviors, even with respect to heart disease, arteriosclerosis, or amebic invasion.

In 1940, Dr. Leona Baumgartner suggested that an understanding of the culture of a community would improve the effectiveness of health programs. There are many studies to illustrate how this principle applies in practice. But the culture is complex, requiring insights and knowledge from many contributing disciplines.

The concept of the family as a unit of practice was appraised in 1945 in a report by Dr. H. B. Richardson. Concerted skills of general practitioner, psychiatrist, and nursing and social work personnel were applied for a period of 2 years. It was concluded that the family concept led to better diagnosis and treatment, less pressure on existing clinical facilities, and relatively rapid progress toward sound medical action.

The concept of health and how to obtain it varies with the group, generation, and social class. One may start with existing health practices and behavior, note their function, and their integration into the culture. Such knowledge may become a component of epidemiology and administrative technique for the health officer.

By Marvin K. Opler, Ph.D., department of psychiatry, Cornell University Medical College, and Payne Whitney Psychiatric Clinic, New York Hospital.

An Approach to the Study Of Family Mental Health

PHR brief

In our clinical studies of patients suffering from neuroses and psychosomatic disorders, we have been impressed by the significance of periods of crisis which, in the early stages of an illness, seemed to have determined its direction. In other cases, a period of healthy emotional development appeared to change more or less abruptly to one of unhealthy development at the time of a crisis associated with an upheaval in the social milieu of the patient.

When Erich Lindemann and I joined forces at the Harvard School of Public Health in 1952,

By Gerald Caplan, M.D., D.P.M., associate professor of mental health, Harvard School of Public Health.

we began to develop a framework for communitywide preventive psychiatry based on such studies. Our plans aimed to extend mental health help to families at times of crisis by promoting collaboration between psychiatric workers and the caretaking agents of the community—clergymen, educators, nurses, physicians, and social workers.

Lindemann's investigations of the psychological reactions experienced by the survivors and close relatives of the victims of the Cocoanut Grove fire in Boston had convinced him that a mourning process is accompanied by characteristic emotional changes, that there is a well-defined psychological disturbance in direct reaction to a bereavement, and that an individual who does not succeed in handling the emotional problems involved will be likely to suffer from a consequent psychiatric illness. He also found that a physician, or better still, a clergyman could help a person successfully adapt to a bereavement situation and thus prevent the pathological sequelae of "unsuccessful grieving." His experiences in this venture led him to set up the Wellesley (Mass.) Human Relations Service, where community caretaking techniques are being developed to help individuals adapt in a mentally healthy way to a variety of hazardous life crises.

My findings from my studies in London and Jerusalem on the pathogenic effects of interruption or distortion of mother-child relationships in early childhood had aroused in me the hope that the introduction of mental health concepts into public health practice might improve the emotional environment of young children and lead to a communitywide reduction in the incidence of psychological disorder.

Such considerations have led us to a scientific study of certain common crises which we previously felt were the province of playrights and novelists.

Our Formulations

Our conceptual scheme constantly emphasizes the interplay between the individual and the significant persons in his social milieu.

When we say that someone is mentally healthy or unhealthy, we are rating the equilibrium of his functioning in relationship with others in his environment. We are rating his ability to initiate and maintain satisfying emotional relationships with others, to work productively and fulfill his inner resources, to perceive reality undistorted by fantasies, to adapt to his environment if adaptation is conducive to his welfare, and if it is not, to change his environment in a way that infringes minimally upon the rights of others.

The emotional equilibrium is kept stable by a complicated series of homeostatic mechanisms operating both within his personality and in the social system of his network of close interpersonal relationships. Changes in this equilibrium and in the person's state of mental health may occur during crisis periods.

The essence of a crisis is that a person cannot solve quickly a problem of basic importance by means of his normal range of commonly used problem-solving mechanisms but must employ novel patterns of solution.

Pregnancy, birth, death, and such important role transitions as starting school, a new job, or married life are examples of problems demanding novel solutions and involving the possibility of changes in the preexisting pattern of emotional equilibrium.

An alteration in relationships with those who satisfy emotional needs leads to frustration and eventual impairment of mental health.

In the disorganization precipitated by a crisis, old conflicts become symbolically linked with present problems. The pattern of their previous solution may influence the present adaptation.

A critical factor in determining adaptation to the changed situation is the support mobilized by the traditional helping practices of an individual's culture and by significant helping people in his environment. Help at this time produces long-lasting effects quite out of proportion to the effort expended.

The significant people in a person's environment whose behavior toward him is so important during a crisis are the members of his family, his close associates at work, leaders of the social and religious groups to which he belongs, and the caretaking agents of the community whose role is to help citizens in trouble.

Suggesting a number of avenues of explora-

tion, our formulations about large-scale preventive psychiatry should be tested by building up a body of knowledge concerning the range of adaptive and maladaptive problem-solving methods of individuals in regard to the more common crises, working out ways of integrating this knowledge within the professional framework of caretaking agents in the community, and developing an appropriate scheme for deploying the services of specialized psychiatric personnel in the most economical way to achieve community coverage.

Family Studies

To advance research on certain aspects of our program, we have established a mental health unit in a Boston health center and have built up a collaborative working relationship among psychiatric and public health personnel.

We chose the family unit for study so that we may understand how the family as a group augments or weakens the problem-solving capacities of its individual members.

We chose as our main categories of hazardous circumstances three events in family life with which health workers deal routinely: prematurity, congenital abnormality, and tuberculosis. These categories have the advantage of being notifiable conditions and thus being easy to sample from health department lists.

Our study is still in the pilot stage. So far we have gained entry into 50 families and completed an intensive study of 15. Our families range from middle middle class to the lowest socioeconomic class.

In each case, the public health nurses and physicians continue their traditional services and also help us collect data. As early as possible after the impact of the crisis, they introduce our worker to the family. His first task is to enlist the cooperation of each member in the study and to obtain permission to visit them in their home once a week during the period of the crisis.

After the crisis is over, we carry out an indefinite followup of the study families at progressively longer intervals in order to assess the immediate and long-term results on their mental health.

We have discovered that the discussion of problems is welcome in middle-class families but is often viewed as dangerous by families of low status. Our general approach is to interfere as little as possible with the stressful situation and with the family's method of dealing with it, but after the crisis is over we take on a more therapeutic role in order to strengthen our relationship and obtain information about deeper aspects of the family interactions.

We have found that valid information about crisis reactions can be obtained only while the crisis is in progress. We postpone obtaining background information on the historical development of the family until the pressure of the crisis has passed.

In our studies we have found it profitable to refer to two patterns of family functioning which may be significantly related to eventual mental health changes. These are the "family life style," meaning the reasonably stable pattern of family organization which leads to a range of problem-solving possibilities from which the family, individually or collectively, may choose according to their perception of the demands of the situation, and the "intermediate problem-solving mechanisms," which introduce dynamic forms of adjustment to the crisis.

Although the life styles of certain families may be conducive to mental illness, in many others the life style affords greater or lesser opportunities for mental health. Whether mental illness or mental health develops will be determined by what choices are actually made during crisis periods. The current factors influencing the choices are therefore significant.

During the period when the new solutions are being worked out, certain patterns can be recognized in which the tension is reduced for the family as a group but at the emotional expense of one or more individual members. Emotional exploitation of a family member invests him with a role which infringes upon his needs. In such cases we have observed that the emotional problem was not being adequately dealt with by the group because of poor leadership, disorders of internal communication, or other organizational inefficiencies. Emotional exploitation of an individual reduced group tension by allowing abreaction of anxieties or ventilation of guilt in relation to an object acceptable to the family's value system.

We are beginning to tease out the factors which cause a family member to be singled out for exploitation in this manner as part of the family's response to a crisis, and which consequently endanger that person's future mental health by frustrating his basic emotional needs.

Social Work For the Family

PHR brief

Not many years ago public health workers, physicians, and social workers learned about the family empirically without adequate theoretical formulations on which to base their practice. Today, there is an ever-expanding body of validated theory regarding the family to be tested in application.

Social workers see the family as the cornerstone of society and, therefore, the focus of their attention.

The bulk of present-day social work seeks to sustain families by providing food, clothing, and shelter. Only if such support seeks to enable the individual and the family to contribute in some measure to society is it compatible with the objectives of social work. It is vital for social agencies to be philosophically oriented and practically endowed to provide help that is not on a pennypinching, rockbottom basis.

Professional Cooperation

Characteristically, the social worker operates where there are symptoms of family or social dysfunction. The social worker may know that a patient is well enough to go home and that the hospital needs the bed immediately, but may also know that the family is not in condition to receive the patient.

For example, a boy of 9, a victim of cerebral palsy, was admitted to an institution for handicapped children. Although he was living on an infantile level, he was found to have normal intelligence. During his 2 years at the institution, he learned to feed himself, to use the toilet, and to make his needs known verbally, although his speech improved but little.

The boy's discharge was recommended when it was apparent that he could be treated as an outpatient. However, his mother was not prepared for, in fact, refused to accept, the improvement in his condition. Consequently, the boy regressed at home and probably will require institutional care again.

Hospitals and social agencies must continue to work together in many ways to counteract situations in a family unit which may undo the work of the hospital and physician.

Group and Community Organization Methods

Social workers also use group work and community organization methods which strongly influence family health. The focus of such work is on larger social units, and provides recreational, creative, and citizenship outlets to promote the "pursuit of happiness."

Group interaction, peer relationships, and experience with authority and group leaders tend to produce changes in individual behavior which can be carried over from the immediate group, and the change is subsequently felt in family life.

I wish that public health workers had made more use of community organization skills during recent years in view of some of the roadblocks set up in segments of the community to the advances of medical knowledge. Their success in expediting therapy and release of tuberculosis patients, for example, had striking effects in the patients' families observed by social workers. There was an exacerbation of the anxieties and fears usually aroused by the return of a tuberculosis patient and an apparent prolongation of the period of readjustment.

The family accurately mirrors the community's stereotypes about the nature of contagion,

By Virginia Bellsmith, M.S., professor of social work, New York School of Social Work, Columbia University, New York City.

reinfection, and disability in tuberculosis. Much more than the dissemination of educational material has to be provided if discharged patients are to be accepted by the community. Community social planning is needed. Unless community resources are realigned and augmented, patients can be isolated and housebound.

The planned addition of social workers, with particular community organization skills, to the conventional health and welfare team might significantly alter community attitudes about tuberculosis and its victims and also modify community planning.

Similarly, the use of tranquilizers in mental illness and the mass application of poliomyelitis vaccines are other technological medical advances which require community cooperation for maximum acceptance.

Social Phenomenon

Although in the last 10 years, social workers have attempted to examine systematically concepts and formulations of social work, none of the completed studies have given attention to a phenomenon which social workers have noted in their records for many years, that some adults who make mature, healthy familial and social adjustments grew up in families characterized by gross pathology.

The fact that such growth occurs is variously ascribed to innate strengths in the individual, to hidden assets which counterbalanced deprivation and distortion in the family, or to the fact that we do not yet know enough about the relative significance of traumatizing familial experience in children at different stages of development.

More study of family processes would certainly add to our understanding of cause and effect in personality development. But an examination of the histories of such adults leads me to the belief that a systematic exploration of the importance of consistency and continuity of pattern in such families may provide new understanding about the basis on which healthy personalities and strong egos are built.

PHS Staff Announcements

Dr. Robert J. Anderson has been named chief of the Public Health Service's Communicable Disease Center, in Atlanta. He replaces Dr. Theodore J. Bauer, who has been appointed deputy chief of the Bureau of State Services in the Washington headquarters.

As assistant chief of the Division of Special Health Services in Washington for the past 2 years, Dr. Anderson has directed operational research in tuberculosis, chronic diseases, venereal disease, occupational health, and heart disease control activities.

Following his first service assignment in 1940 as health officer in Newton and Texas Counties, Mo., he entered tuberculosis control work and served in Philadelphia and San Antonio as tuberculosis control officer and later with the California State Health Department. He became chief of the Tuberculosis Control Division of the Service in Washington in 1948.

Dr. A. L. Chapman has been appointed chief of the Division of Special Health Services, replacing Dr. Seward E. Miller, who has been given leave of absence to accept a teaching and research position at the University of Michigan. Dr. Chapman has been medical director of the regional office of the Department of Health, Education, and Welfare in New York City.

Dr. Richard F. Boyd, now medical director in the San Francisco regional office, will move to New York City, replacing Dr. Chapman. Dr. Charles F. Blankenship, now medical director of the Kansas City regional office, will move to San Francisco, replacing Dr. Boyd.

Dr. Lewis H. Hoyle, formerly regional health services consultant at the Kansas City office, replaces Dr. Blankenship as medical director of the office.