

# *Butterworth Prize Essays 1955*

## **THE INFLUENCE OF HOME CONDITIONS DURING THE FIRST FIVE YEARS OF LIFE ON THE PHYSICAL AND MENTAL HEALTH OF CHILDREN**

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The influence of home conditions in the first five years of life on the mental and physical health of children has been the subject of much study and research during the past hundred years. Psychologists, paediatricians and others, have made notable contributions to our appreciation of the significance of the human relationship factor in the emotional development of the young child. At the same time, considerable attention has been focused on the material needs of the growing child and many new social agencies, both statutory and voluntary, have come into being to satisfy those needs. There is, therefore, an embarrassing variety of approaches available to anyone seeking to review this subject.

### **Method of Study**

For the purpose of this essay, I have set myself the task of reconsidering my own opinions, impressions and prejudices, which have been derived from my personal experience as a family doctor. In order to lend some objectivity to this study, I have made a detailed examination of the medical records of the children, under five years of age and registered in my practice, over the past year. The children concerned were all patients of my partner and myself, and attended one of the two surgeries of an urban group-practice. A condition of the survey was that they were all registered as patients throughout the calendar year from 1st May 1954 to 30th April 1955. Those children who left the practice for any reason at all during that year have been excluded, as have those who joined the practice during the year. The information has all been obtained from their medical records. While I have confined myself to their sickness record for the particular years of study, much of the background information, particularly with regard to social details, has been accumulated over a period of years. Of the 281 children under five years of age who satisfy the conditions mentioned above, only three lived in homes which I had not at some time visited to attend either these children, their siblings or their parents. There were five age groups, the first being children born between 1st May

1953 and 30th April 1954, the second group being born between May 1952 and April 1953, and, similarly, the other three groups consisted of children having a third, fourth or fifth birthday during the year under review.

At this point I must define some of the terms which are used throughout the essay. A *doctor/patient contact* is a consultation at the surgery or a home visit by the doctor. (This is the term commonly referred to as "item of service".) An *incident of illness* is a doctor/patient contact or series of contacts concerning which a single diagnosis has been made and recorded in the medical notes. Most of these incidents were diagnoses of organic disease, although in some cases the patient may have presented with an emotional upset or behaviour problem. Where this occurred it is the organic disorder which is recorded in the diagnosis column of the medical notes; e.g. a very disturbed boy attended the surgery with ringworm, and that incident in the medical notes has been labelled "ringworm", although, in fact, he is still attending the Child Guidance Clinic and his behaviour problem is of much more significance than his organic disorder. In a few cases, however, where the emotional upset or behaviour problem was severe, and where no organic disease was discovered, this incident was given the label "*emotional disorder*". Every illness in a child (or an adult) is accompanied to a greater or lesser degree by emotional upset; e.g. the well-known picture of the little girl who is brought up by her mother, who complains that she is excessively restless or naughty and examination reveals pyelitis. This incident would be labelled "pyelitis". Throughout this essay incidents of illness irrespective of their precise nature are used as an index of health or sickness. This method of recording organic disease to the near exclusion of emotional disorders, therefore, does not materially influence the central theme of my discussion.

The practice runs a weekly "well-baby" clinic for our own patients, who are free to attend it or the local authority child welfare clinic as they wish. These "well-baby" attendances have not been included in the doctor/patient contact rate.

The doctor/patient contact rate is the measure which I am going to use as an index of the reaction of the child to supposedly adverse circumstances in his home environment—whether it is a measurement of health or of ill health will become clearer as the thesis proceeds. The word Health is derived from an Anglo-Saxon word meaning "whole" and may be defined as "wholeness". The modern fashion is to describe health in positive terms; for example, Crew in *Modern Trends in Public Health* (1948) regards health as a state of harmony existing firstly in the body itself, and

secondly between the body and its total environment. While I am setting out to examine the incidence of disease and the record of the family doctor contact presented by this group of children, I do not wish to imply that health is merely the absence of disease. Since I have not at my disposal a precise method of recording positive health, I have used the only indices available to me, viz. the record of disease patterns as a means of studying the significance of certain measurable factors in the home circumstances of these young people.

**Age.** The children were almost evenly divided into five groups according to their dates of birth as follows:—

|            |                   |                |             |       |
|------------|-------------------|----------------|-------------|-------|
| Group I.   | Date of birth ... | 1/5/53—30/4/54 | 56 children | } 281 |
| Group II.  | „ „ „             | 1/5/52—30/4/53 | 59 „        |       |
| Group III. | „ „ „             | 1/5/51—30/4/52 | 60 „        |       |
| Group IV.  | „ „ „             | 1/5/50—30/4/51 | 49 „        |       |
| Group V.   | „ „ „             | 1/5/49—30/4/50 | 57 „        |       |

The sickness record of these groups was as follows:—

| <i>Age Groups</i> | <i>Doctor/patient contacts</i> | <i>Average doctor/patient contacts per patients at risk</i> | <i>Incidents of illness</i> | <i>Average number of incidents per patient at risk</i> |
|-------------------|--------------------------------|---|-----------------------------|--|
| I (56)            | 474                            | 8.4   | 202                         | 3.6  |
| II (59)           | 575                            | 9.7   | 239                         | 4.0  |
| III (60)          | 520                            | 8.7   | 204                         | 3.4  |
| IV (49)           | 364                            | 7.4   | 141                         | 2.8  |
| V (57)            | 279                            | 4.9   | 148                         | 2.5  |
| (281)             | 2212                           | 7.9   | 934                         | 3.3  |

The above tables shows a decline in the doctor/patient contact and in the incidents of illness with advancing age.

I was surprised to find that only 15 of the 281 children did not see the doctor in the year under review. In the practice as a whole 72% of all patients at risk saw the doctor during the year and averaged 4.8 contacts per patient. In this particular series 95% of the children at risk saw the doctor during the year and averaged 7.9 contacts per patient at risk. The average child had 3.3 “illnesses” during the year and each illness resulted in his seeing the doctor on a fraction over two occasions. Out of 934 incidents of illness, 18 were labelled “emotional disorders” as defined above. (No statistical help has been obtained for this study and the statistically naive method of calculating averages was used. Considering the nature of the essay I felt it would be unethical to consult a colleague.)

**Sex.** There were 142 boys and 139 girls. Their sickness record was as follows:—

| <i>Sex</i>       | <i>Average doctor/patient contacts per patient</i> | <i>Average number of incidents per patient</i> |
|------------------|--|--|
| Male (142) ...   | 9.1  | 3.3  |
| Female (139) ... | 6.5  | 3.3  |

From this table it will be seen that the average number of incidents was the same for each group but, when they were ill, the boys attended more often than did the girls. The incidents included emotional disorders in 13 girls and in 5 boys.

The doctor/patient contact and incident rates will be related now to certain measurable conditions in the children's home circumstances, namely:—

- Illegitimacy.
- Absence of one parent.
- Other persons in the home.
- Housing.
- Income.
- Certain defined conditions affecting the health and welfare of either parent.

### **Illegitimacy**

There were 15 illegitimate children and their sickness record was as follows:—

|                    | <i>Average doctor/patient contacts per patient</i> | <i>Average number of incidents per patient</i> |
|--------------------|--|--|
| Illegitimates (15) | 9.5  | 3.9  |
| Legitimates (266)  | 7.7  | 3.26   |

There was an increase in the average doctor/patient contact and illness rates of these illegitimate children, and this finding suggests that there are medical hazards of illegitimacy. This is, of course, common knowledge. There are higher still-birth, neo-natal and infant mortality rates in illegitimate children (Registrar-General's Annual Reports). In this series, only seven of the illegitimate children were first-born, the others being second-born (1), third-born (5), fourth-born (1), eighth-born (1). Some of these children, born of parous mothers, were living with their siblings in a family where the union was between a man and a woman who was not his wife. From my knowledge of them as their family doctor, I would assess several of them as providing a remarkably stable environment for their children. When, however, a woman tries to bring up her

child without male support she is usually at a social, economic and emotional disadvantage, and this may have an effect on the child. It seems appropriate, therefore, to consider the child who has a parent missing.

### Absence of one parent

Twenty-one children had one parent missing permanently from the home. In 18 cases the father was missing and in the other three the mother was away from the home. In the cases where the mother was missing there was a mother-substitute present, e.g. the father's unmarried wife: one father-substitute was present in the group whose fathers were absent. The sickness record of these 21 children was as follows:—

|                            | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|----------------------------|--|--|
| One parent absent (21)     | 5.6  | 3.4  |
| Both parents present (260) | 8.0  | 3.3  |

This group contained the high number (for this study) of five emotional disorders for seventy-one incidents. The five children with these psychogenic illnesses were four girls and one boy. It seems possible, therefore, that the absence of the male parent has more effect on the female child than on the male. The effect of lack of maternal love is widely known. This has been emphasized by Bowlby in *Maternal Care and Mental Health* (1951). The father's role in the home is more complex. In the very early years, his influence operates perhaps mainly in so far as it affects the mother's well-being. Later, however, in the course of the normal emotional development of the pre-school child, the Oedipus complex introduces a new element. It was no surprise, therefore, to find that there was a preponderance of emotional disturbances among those children deprived of one parent.

Although they had virtually the same average number of illnesses as the whole series, the low doctor/patient contact rate is worthy of comment. One possible explanation is that these children are either brought to the doctor too late, or default treatment too early. A mother of six children, whose husband had drifted away from the home, has twice brought a child to me with a perforated ear drum and an otorrhoea which had persisted for several days before I was consulted. Another mother is always harassed and "never can find the time to come to the doctor". A low rate of doctor/patient contact is not necessarily an index of the severity of the illness.

After considering the missing parent, one might examine the situation where an extra person lives with a family.

### **Other persons in the family**

It is usual to think of the family unit as consisting of father, mother and the children. It may, however, consist of other persons if the family is regarded as all the people living behind the same front door. Thirty-four of the children had some blood relation as well as their siblings and parents in the family. Their sickness record was as follows:—

|                                       | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents of illness<br/>per patient</i> |
|---------------------------------------|--|---|
| Another relative in the family (34)   | 6.9  | 3.2   |
| No other relative in the family (247) | 8.0  | 3.3   |

The relative who probably has most contact with the family doctor in matters relating to the children's health is the grandmother. It is difficult to generalise about the significance of the grandmother in the family setting, for she can be guilty of unwarrantable interference in some cases or can be the most stable of all influences. A relative in the home may be of great help in relieving domestic tension and can contribute materially to the physical and emotional needs of the family. He or she can, of course, cause domestic tension. One mother of an enuretic child has this problem due to her husband's oath to his dying mother to look after his brother (already an adult). This mother found the lack of privacy in their two-roomed house unbearable and became very disturbed; this had an effect on the child.

While considering whether the effects of another relative in the home are beneficial or otherwise, we must note from the above table that the average contact per patient with the doctor was lower than for the series as a whole for relatively the same number of incidents. This might suggest that for the same number of illnesses the recovery required fewer contacts with the doctor.

Ten children had an unrelated person living in their home. These ten children had a sickness record as follows:—

|                                       | <i>Average doctor/patient<br/>contact per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|---------------------------------------|---|--|
| Unrelated person in the home (10)     | 5.1   | 1.3  |
| No unrelated person in the home (271) | 7.9   | 3.4  |

It will be seen that these children had a lower average doctor/patient contact rate and a lower number of incidents, and the explanation for this lies, I think, with other social circumstances. The unrelated persons in the homes were—domestic servants (4 children), mother's paramour (1 child), fathers' paramours (2 children), and lodgers (3 children). This shows that the group is loaded in respect of social status. The four children who had domestic servants in the house came from better houses with more room, gardens, a better economic state, etc.

Having reviewed the personnel making up the family, the house itself might now be considered.

### Housing

The waiting list for rehousing to a new council house in this area may be as long as six years, and half of the children (142) in this survey were found to be living in "sub-standard" housing thus:—

|   |             |
|---|-------------|
| Shared lavatory with one or more families and overcrowding ... .. | 33 children |
| Shared lavatory with one or more families, no overcrowding ... .. | 99 „        |
| Shared lavatory and water supply and overcrowding ... ..          | 4 „         |
| Statutory overcrowding only ... ..                                | 6 „         |

Their sickness record was:—

|                                   | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|-----------------------------------|--|--|
| In sub-standard housing (142)     | 9.0  | 3.8  |
| Not in sub-standard housing (139) | 6.7  | 2.8  |

As we might have expected, the children in sub-standard housing had a higher illness rate and a higher doctor contact.

I was interested to find, however, that the incidence of recorded emotional disorders in this group was no different from that of the series as a whole.

Overcrowding has been related to ill-health by many authorities, e.g. Spence, *et al.*, in *A thousand families in Newcastle-on-Tyne* (1955) found bronchitis and pneumonia related to overcrowding in the first year of life, as had the Board of Education survey with pre-school children (Newman, 1931). The Newcastle survey also found infantile accidents related to overcrowding. When seeking to contrast the sickness records of those, in my group, who were overcrowded, with those living in insanitary houses (i.e. sharing a lavatory and/or water supply), I would have expected those in

insanitary houses, without overcrowding, to have a lower sickness rate than those who had insanitary houses and, at the same time, were overcrowded. This was not the case in this series, and, indeed, those with both insanitary houses and overcrowding had the lower incidence both of illnesses and doctor/patient contacts. It may be, of course, where the overcrowding is by adults rather than by other children, the income of the family is higher. This again illustrates the multiplicity of factors even when one has singled out only one aspect of the home circumstances of these young children.

It was not, of course, a surprise to find that in the group with insanitary housing the incidence of dysentery and similar infections was high.

Continuing the theme of housing, it was noticed that forty children had gardens private to the family.

### **Gardens**

These 40 children had a sickness record as follows:—

|                  | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|------------------|--|--|
| Own gardens (40) | 4.5  | 2.7  |
| Others (241)     | 8.1  | 3.4  |

Children, who have their own garden, enjoy obvious opportunities for outdoor exercise, family recreation, and a lessened exposure to infection and street accidents. It is tempting to suggest the low incidence of contacts and illnesses in the above group could be thus explained. In reviewing the circumstances of the families concerned, however, it was obvious that this group was highly selected in respect of social and economic class. Many other factors were present which were of much more importance than the presence of a garden.

Two other aspects of housing were noted, namely, the state of cleanliness and the sleeping arrangements of the children in this survey.

### **Family Cleanliness**

The state of family cleanliness, both personal and in the home, was found to be poor in the case of twenty children. A condition of poor family cleanliness was "diagnosed" when I found constant dirtiness of the child's body, the bedding and living accommodation, the presence of vermin repeatedly found, and the presence of stale food and remains of meals lying around the house.

The record of these children was not dramatically different from that of the rest of the series. They had more illnesses, but saw the doctor less frequently thus:—



|                     | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|---------------------|--|--|
| Family unclean (20) | 7.7  | 3.5  |
| Others (261)        | 7.9  | 3.3  |

One of the dirtiest homes in this group is kept by a mentally defective mother. The children are happy, and have great affection for her, as she has for them. Others in the same group were definitely deprived children, but dirtiness, of itself, is not incompatible with well-being.

### **Sleeping Accommodation**

159 children slept in their own beds, cots or prams, while the other 122 shared a bed with other children or adults.

The sickness pattern in both groups was identical and there was an equal number of emotional disorders for each group.

### **Income**

Poverty is generally accepted as having an adverse effect on the health and development of young children. I was particularly anxious to see, therefore, whether there was any relationship between the sickness record of these young children and their family incomes. Since I was unable to obtain accurate information of wages or other income for each family, I have confined myself to the examination of two small groups, one at each end of the socio-economic scale.

**Low Income.** To-day primary poverty should be unknown, and statutory social agencies such as the Ministry of Pensions and National Insurance and the National Assistance Board provide for a minimum subsistence.

Nineteen children lived in families who were subsisting on this minimum income for the year under review as follows:—

|                            |                   |          |     |     |            |
|----------------------------|-------------------|----------|-----|-----|------------|
| Widowed mother's Allowance | (M. of P. & N.I.) | ...      | ... | ... | 3 children |
| Sickness Allowance         | ...               | (do.)    | ... | ... | 1 child    |
| Unemployment benefit       | ...               | (do.)    | ... | ... | 8 children |
| Father Unemployable        | ...               | (N.A.B.) | ... | ... | 2 children |
| Unmarried mother           | ...               | (do.)    | ... | ... | 3 children |
| Father absconded           | ...               | (do.)    | ... | ... | 2 children |

Their sickness record was as follows:—

|                 | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|-----------------|--|--|
| Low Income (19) | 8.0  | 3.5  |
| Others (262)    | 7.9  | 3.3  |

While the differences were not dramatic, these children had more illness and a higher contact rate.

**High Income.** In contrast there were eight children, whose fathers belonged to the professions (five of them being children of doctors). Their sickness record was as follows:—

|                        | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|------------------------|--|--|
| Professional class (8) | 11.4   | 2.1  |
| Others (273)           | 7.8  | 3.3  |

While these children had decidedly fewer illnesses, they had a markedly higher doctor/patient contact rate (or more “items of service” per illness). Can this be an expression of their parents’ anxiety caused by their knowledge and daily contact with disease, or is it an expression of the anxiety of the family doctor, himself over-awed by the responsibility of looking after a colleague’s child. It may also be that those parents more readily use the family doctor as a medical adviser. They are quicker to realise his contribution in the field of preventive medicine and health promotion.

One brief comment concerning income. In attempting to evaluate the bearing which the economic circumstances of the family has on the health of the children it is probably just as important to know how the money is spent as to know the total family income. In many of these families, such a large proportion of the income may be earmarked, to meet excessive hire-purchase commitments, that the mother has to manoeuvre her budget within a narrow margin. A short illness or period of unemployment on the part of the wage-earner can quickly produce a major social crisis.

Let us now consider the personnel of the family more closely.

### **The Influence of the Mother**

Although the common pattern is for the father to be the breadwinner and the mother the housewife, the mothers of 48 of the children in this series went out to work, while 230 children’s mothers were fully employed in home duties. Thirty-one children had mothers employed part-time, and 17 had mothers employed full-time outside the home. Their sickness record was:—

|                                 | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|---------------------------------|--|--|
| Mothers’ home duties only (230) | 7.7  | 3.3  |
| Mothers employed (48)           | 8.1  | 3.4  |

Where the mother was employed, the children had more illness and a higher doctor/patient contact.

Five of the children had emotional disorders in the group where the mother went out to work. It is interesting to speculate on whether this high incidence of overt emotional disturbances was due to the reason for the mother going out to work, rather than to the mere fact that she was employed outside the home. There was some evidence to suggest that this might be so. In the case of six children, the father was absent from the home and the mother went out to work: in this group the incidence of emotional disorders was particularly high, thus:—

Mother working and father absent from the home—

6 children with 4 emotional disorders

Mother working and father present at home—

42 children with 1 emotional disorder

Mother home duties only and father present at home—

214 children with 11 emotional disorders

Mother home duties only and father absent from the home—

12 children with 2 emotional disorders.

This stresses the importance of the absent father.

It might be appropriate now to consider the mental and physical health of the mother. On looking through the medical records of the mothers of the children in this survey, I found that in only six cases had there been specific diagnoses of mental ill health. Two mothers were gross mental defectives and four had required considerable supervision on account of emotional instability. Ten children of these mothers are included in this series and their sickness record was:—

|                                   | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|-----------------------------------|--|--|
| Mothers mentally handicapped (10) | 9.9  | 3.9  |
| Others (271)                      | 7.8  | 3.3  |

The high incidence of illness and of doctor/patient contact was not unexpected.

Three mothers, while remaining at home, were more or less confined to bed throughout the whole year of the survey because of organic disease (all three were cases of pulmonary tuberculosis; two refused hospital treatment and one had a slow and checkered convalescence after discharge from hospital). There were three children concerned and, although none suffered from tuberculosis, all these children had more illnesses and a higher rate of doctor/contact than the "average" child. In evaluating the significance of the increased doctor/patient contact one must bear in mind not

only the consequences of the mother's incapacity, but also the fact that the doctor is regularly visiting the home and is more accessible for consultation.

### **The Influence of the Father**

Similarly I consulted the medical records of the fathers of the children, and found that seventeen of them had fathers who were chronically unemployed or unemployable through temperament or illness for the duration of the year.

They had a high sickness record, namely:—

|                        | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|------------------------|--|--|
| Father unemployed (17) | 9.0  | 4  |
| Others (264)           | 7.8  | 3.2  |

This group also contained the proportionately high figure of three emotional disorders in seventeen children.

The father's mental background was examined as the mothers had been, and eight children were found to have fathers who had been mentally ill (one had a well-developed psychoneurosis; the remaining fathers had been diagnosed as having "psychopathic personalities"). Their sickness record was as follows:—

|                          | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|--------------------------|--|--|
| Fathers mentally ill (8) | 7.5  | 3.5  |
| Others (273)             | 7.9  | 3.3  |

These children had more than the average number of illnesses, but the doctor/patient contact was below the average.

To conclude the discussion of the individual's role in the family, it might be helpful to contrast the records of those young children, away from home for part of the day, with those who remain within the confines of the family.

### **Nursery attendance**

Twenty-nine children attended a day nursery or nursery school, and their sickness record was:—

|                             | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|-----------------------------|--|--|
| Attending nursery (29)      | 12.0   | 4.2  |
| Not attending nursery (252) | 7.5  | 3.2  |

A high average number of illnesses, and a particularly high doctor/patient contact was noted in the children who attended nurseries. Increased exposure to infection, the natural anxiety of the nursery staff to exclude any child with suspected infectious disease, the frequent medical inspection and supervision, and the conditions necessitating nursery care, would all contribute to this high sickness rate.

In each case, admission to a day nursery was recommended by the family doctor on medical or social grounds. Five of the twenty-nine children demonstrated major emotional disturbances during their stay in the nursery, but, from my knowledge of the family background, I am of the opinion that these were precipitated by, rather than caused by, admission to the nursery.

Finally, I would like to consider the child in his relationship to other children in the family.

### **Birth Rank**

The children were divided into six groups by birth rank. The sickness record of these groups is as follows:—

|                           | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|---------------------------|--|--|
| First-born (106)          | 7.9  | 3.5  |
| Second-born (73)          | 6.9  | 3.2  |
| Third-born (43)           | 8.4  | 3.3  |
| Fourth-born (34)          | 7.7  | 2.8  |
| Fifth-born (15)           | 9.2  | 3.1  |
| More than fifth born (10) | 9.6  | 4.3  |

There are many variables in considering the importance of birth rank in this series; for example, some of the families having children under five, which are included in this series, are almost certainly completed families with grown-up sons and daughters, who are now working, while others are very young families whose social and economic circumstances present a very different picture. Speaking from impressions, I would say that, on the whole, first-born children during the first year of life see the doctor more often than do their siblings in their turn. They tend to have more minor feeding disorders, and to receive more advice about weighing, immunisation, and general management. In the higher birth ranks, in so far as these imply larger families, the young children may see the doctor more frequently because of cross-infection, because he is more likely to be visiting the home to see some other member of the family, or because of other factors affecting large families (e.g. poverty, and over-crowding), which have a bearing on the health and well-being of the mother.

## Marital Problems

The father, mother and child have been considered separately in respect of their roles within the family. I would now like to refer briefly to a group of twenty-four children, who illustrate the importance which marital relationships have on the health and welfare of young children. There is hardly a day passes in which I am not consulted about some aspect of personal relationships between husband and wife, and over the years there must be many mothers in this practice who have discussed such matters with me at some time, probably in the course of routine consultations. But during the year of this survey, there were eighteen mothers who consulted me specifically about some difficulty they had in marital adjustment. These varied in character from simple human relationship problems to separation, divorce and the dissolution of the marriage. The twenty-four children, under five, of these mothers had a record as follows:—

|                               | <i>Average doctor/patient<br/>contacts per patient</i> | <i>Average number of<br/>incidents per patient</i> |
|-------------------------------|--|--|
| Overt marital disharmony (24) | 10.0   | 4.4  |
| Others (257)                  | 7.7  | 3.2  |

A high contact and incident rate was found. There were again a great number of associated and inter-related factors, which have already been mentioned, for example, several children had a chronically unemployed father, a parent absent from the home, or were attending the nursery.

## Illustrative Cases

Before summing up, I would like to give four short case summaries, to illustrate some of the major points, and to indicate the background against which the family doctor can collect material for the study of the factors influencing the growth and development of young people.

**Case 1.** Catherine is the second child of a family of two children. She was born in summer 1951, the year in which her father died. Her mother is now aged 36 and is employed as a clerkess in a store. They live in two rooms with outdoor shared sanitation, and only cold running water in the house. The income comes from the mother's earnings, her industrial pension and the family allowance.

Catherine attends a day nursery while her older sister is at school. Her medical history during the year under review is as follows:—

May—Measles—admitted to hospital for “social reasons.”

June—Knock-knees.

November—Behaviour disorder (the nursery staff complained that Catherine spent nearly the whole day masturbating and would no longer play with the other children).

December—Injury to finger.

January—Coryza.

Points that must be noted are: the father is dead; the mother had to work to keep up what she regarded as the right standard of living. All the family were well-dressed and were not at all physically neglected. Her mother worked all day and did housework all evening: the family had no evening playtime as recreation following their separate "occupations" during the day. They had an annual holiday together with her paternal grandparents. When Catherine developed measles she had to be "put into" hospital so that her mother could continue working. The behaviour disorder started when the matron at the nursery changed. Catherine was being emotionally starved at home because of the tense atmosphere of work and maternal fatigue, and she had been very attached to the previous matron. The combination of these two things was the precipitating cause of her emotional upset.

**Case 2.** Ann was also born in 1951 but is an only child. Her father, aged 34, is a salesman and her mother, aged 30, is a clerkess. Ann attends a day nursery. They live in three rooms in a house which they are buying through a building society. It has indoor sanitation. The income comes from the combined earnings. Ann's medical history for the year was as follows:—

May—Papular urticaria.

July—Head injury (mild).

This history is interesting when compared with the previous one. Ann's mother also works and Ann is also in a day nursery. In contra-distinction to the previous one, this is a conscious choice and is part of a family plan. Ann's mother is working to help to pay off the loan on the house more quickly and the decision to admit Ann to the nursery as an only child needing company preceded the mother's decision to go out to work. The child-bearing is "planned" as more children are wanted later when they have more security. It is a healthy family.

**Case 3.** June, Irene and Donald are the three children of an unhealthy family. Their dates of birth are August, 1950, October, 1951, and February, 1954. Their father is a dispatch clerk aged 30, and their mother is aged 27. She is emotionally unstable. They own their own house which has indoor sanitation and cold running water. It is full of expensive toys. The income is about £8 a week plus family allowances. June and Irene attend nursery school.

Their medical history is as follows :

|          | June                                | Irene                           | Donald                        |
|----------|-------------------------------------|---------------------------------|-------------------------------|
| May      | "Sore neck."                        | Behaviour disorder (screaming). |                               |
| June     |                                     |                                 | Tonsillitis and otitis media. |
| August   |                                     |                                 | Tonsillitis.                  |
| October  | Wax in ears.                        | Coryza.                         | Anorexia (no cause found).    |
| November | Behaviour disorder (sleepwalking).  |                                 |                               |
| December | Cervical adenitis.                  |                                 |                               |
| January  |                                     |                                 | Bronchitis.                   |
| February | Tonsillitis and eustachian catarrh. | Otitis media.                   |                               |
| March    | Tonsillectomy.                      | Catarrh.                        |                               |
| April    |                                     |                                 | Otitis media.                 |

Much of this family's illness is due to the mother's temperament. The two older children were told repeatedly by the mother that she had to "put them into the nursery" because "she hadn't time for them now there was a new baby": this probably contributed to their behaviour disorders. The high incidence of upper respiratory infections may have

been partly due to contact with other children in the nursery, although this was not noticed in the last two case histories. The family leisure time may have been more to blame. The mother seems to spend her time "trailing" round the streets window-shopping, or gossiping with her sisters or friends. When mother and father went out together a neighbour who was known to have pulmonary tuberculosis, was employed as a baby-sitter—fortunately with no bad results. There are "frequent" matrimonial quarrels, and discipline is inconsistent and harsh.

**Case 4.** Nancy, Andrew and Charles are the three children of another family; they were born in 1950, 1951 and 1953. Their father, a motor mechanic/driver, is aged 42, and their mother is aged 41. Like the last family, they own their house, but in this case they also have two lodgers in the family. The house is newer, contains a bathroom with hot water, and there is a garden. The income is £10 plus family allowances and payments from the lodgers. The medical history is as follows:—

|   | <b>Nancy</b><br>( <i>A spastic and an idiot</i> ) | <b>Andrew</b> | <b>Charles</b> |
|---|---|---------------|----------------|
| February  | Otitis media                                      | —             | Tonsillitis    |
| (Plus monthly visits by the doctor for supervision and observation) |   |               |                |

The first difference between this family and the last is in the personality of the mother. Both mothers have average intelligence, but Nancy's mother is emotionally stable. She has "coped" with an idiot child well, while also bringing up two younger children. The children accept Andrew, the second-born, as their leader, and Nancy, the first-born, as the baby. She is uneducable, but has made a little progress due to the family's patient care. There is a state of harmony and health in this family (in spite of the gross disability of one child).

### Conclusions

In this essay, I have reviewed my impressions of the influence of the home circumstances in the first five years of life on the mental and physical health of children, in the light of the sickness record in my practice over the past year. Although this review was not a statistical survey, some calculable evidence was obtained confirming the impressionistic relationship of illness to illegitimacy, the absence of a parent, poor housing, low income, occupation, the physical and mental ill-health of parents, nursery care, and parental marital problems. A great many variables were involved, and these interacted to make many of the findings difficult to interpret, illustrating the difficulties of research, especially in single-handed investigations of this kind. From my knowledge of these families, I consider that the factor which had the greatest influence on the health of those children was the degree of mutual adjustment which their parents had achieved in their own personal relationships. Where the adjustment was poor, the children were rarely healthy. The state of health in a child may be considered almost synonymous with happiness, and I think this state has been portrayed by Wordsworth, as follows:—

" . . . Delight and liberty, the simple creed  
of childhood, whether busy or at rest,  
with new-fledged hope still fluttering in his breast."