Families at risk / edited by Nicola Madge.

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Families At Risk

Edited by
Nicola Madge

in Deprivation and Disadvantage

SSRC
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Families At Risk

Some families have far more than their share of difficulties, and often their children suffer as a result. *Families At Risk* is about these people.

There are three main purposes of the book: to describe the lives of families who are less well off and less successful than households in general, to find out why the life chances of families are so different, and to develop some means of predicting those most likely to be in difficulty.

The first step is to look at the needs of children and the signs that these are not being met. Next follow eight chapters of empirical findings, drawn from the recent DHSS/SSRC programme of research into transmitted deprivation. One of the central questions examined by these is whether features of children's upbringing affect their functioning in later years and, in particular, their performance as parents. For instance, are there any adverse effects of growing up in multiple-problem households, 'in care', with single mothers, or in homes characterized by severe stress? Do women's attitudes to their children's health differ from those of their own mothers? With what consequences?

The final chapter draws together the results of these studies and tackles the problem of identifying families at risk.

A clear and authoritative work by experienced social scientists and practitioners, *Families At Risk* will be useful for those working professionally with disadvantaged families and for students, academics and administrators who wish to keep abreast of recent research and thinking.

Nicola Madge is a Research Fellow at the International Centre for Economics and Related Disciplines, London School of Economics. She is co-author of *Cycles of Disadvantage*, which reviews the literature at the beginning of the DHSS/SSRC research programme, and of *Despite the Welfare State*, the final report on it. She has also co-written *Ask the Children: experiences of physical disability in the school years*.

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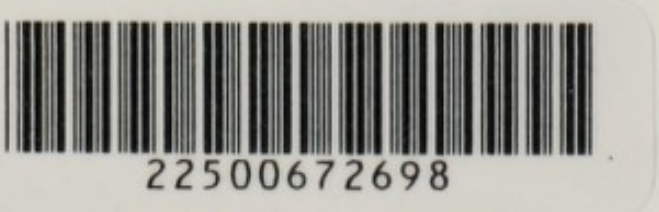

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Families At Risk

Studies in Deprivation and Disadvantage

Despite substantial economic advances and improved welfare services in Britain since the Second World War, there has been a conspicuous persistence of deprivation and maladjustment. In June 1972 Sir Keith Joseph, then Secretary of State for Social Services, drew attention to this. In particular it seemed to him that social problems tended to recur in successive generations of the same families – to form a 'cycle of deprivation'. Subsequently the Department of Health and Social Security, through the Social Science Research Council, made available a sum of money for a programme of research into the whole problem.

Academics and practitioners from a wide range of disciplines and professional backgrounds were invited to investigate many aspects of deprivation and the process of transmission. Their findings are now becoming available and many of the empirical studies, together with literature reviews and the final summary report on deprivation and social policy (entitled *Despite the Welfare State*) are being published in this series of *Studies in Deprivation and Disadvantage*.

Despite the Welfare State: A Report on the SSRC/DHSS Programme of Research into Transmitted Deprivation
Muriel Brown and Nicola Madge

1 Cycles of Disadvantage: A Review of Research
Michael Rutter and Nicola Madge

2 A Cycle of Deprivation? A Case Study of Four Families
Frank Coffield, Philip Robinson and Jacquie Sarsby

3 The Health of the Children: A Review of Research on the Place of Health in Cycles of Disadvantage
Mildred Blaxter

4 Disadvantage and Education
Jo Mortimore and Tessa Blackstone

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Alan Murie

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Edited by Nicola Madge

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So many people have helped both directly and indirectly in producing this book that it is not possible to mention all by name. However the central role played by members of the Joint Working Party on Transmitted Deprivation, in both supporting the various investigations and in encouraging this volume, should be noted. In particular I should like to acknowledge the advice and helpful comments made by Muriel Brown, Alan Clarke and Peter Collison, the three academic members of the Organising Group of the Joint Working Party.

Last, but not least, may I register appreciation of the tremendous help I have received, in turning a lot of pieces of paper into a book, from my secretary, Ruth Griffiths.

Nicola Madge

The Contributors

Mildred Blaxter, M.A., M.R.C. Sociologist, Institute of Medical Sociology, Aberdeen

Carole Bosanko, B.Sc., M.Psychol., Probationer Clinical Psychologist, Mersey Regional Health Authority

Frank Coffield, M.A., M.Ed., Professor of Education, University of Durham

Janet M. Empson, B.Sc., Ph.D., Lecturer in Psychology, Hull College of Higher Education

*__R.F. Garside__, B.Sc., Ph.D., F.B.Ps.S., Reader in Applied Psychology, Nuffield Psychology and Psychiatry Unit, Newcastle upon Tyne

S.R.M. Gatzanis, M.A., H.Dip.Ed., Research Associate, Nuffield Psychology and Psychiatry Unit, Newcastle upon Tyne

Philip Graham, F.R.C.P., F.R.C.Psych., Professor of Child Psychiatry, Institute of Child Health, London

Mavis Greathead, B.A., A.M.I.A., Part-time Social Worker, Scunthorpe Child Guidance Clinic

I. Kolvin, B.A., M.D., Dip.Psych., F.R.C.Psych., Professor of Child and Adolescent Psychiatry, Nuffield Psychology and Psychiatry Unit, Newcastle upon Tyne

Sue Kruk, B.A., Dip.Soc.Admin., Social Worker, Family Research Unit, The London Hospital Medical College

Christine Liddle, B.A., Dip.Soc.Admin., Dip.Soc.Wk.Studies., Research Worker, Department of Child and Adolescent Psychiatry, Institute of Psychiatry, London

J.E. Lunn, M.D., Ph.D., D.P.H., D.P.A., Senior Lecturer in Community Medicine, Department of Community Medicine, University of Sheffield

Alex. McGlaughlin, B.A., Ph.D., Lecturer in Psychology, Department of Social Administration, University of Hull

Susan McLaren, M.A., M.Sc., Senior Clinical Psychologist, Department of Child and Adolescent Psychiatry, Paisley, Renfrewshire

Nicola Madge, B.A., M.Sc., Ph.D., Research Fellow, International Centre for Economics and Related Disciplines, London School of Economics

* Deceased

F.J.W. Miller, M.B.B.S., M.D., F.R.C.P., D.C.H., Honorary Physician to the Children's Department, Royal Victoria Infirmary and University of Newcastle upon Tyne

Elizabeth Paterson, M.A., Ph.D., Research Fellow, Institute of Medical Sociology, Aberdeen

David Quinton, M.A., Lecturer, Department of Child and Adolescent Psychiatry, Institute of Psychiatry, London

Michael Rutter, M.D., F.R.C.P., F.R.C.Psych., Professor of Child Psychiatry, Department of Child and Adolescent Psychiatry, Institute of Psychiatry, London

Jim Stevenson, B.A., M.Sc., Lecturer in Development Psychology, University of Surrey

*__W.L. Tonge__, M.D., D.P.M., F.R.C.Psych., Consultant Psychiatrist and Honorary Clinical Lecturer in Psychiatry, Department of Psychiatry, University of Sheffield

Stephen Wolkind, M.D., F.R.C.Psych., Senior Lecturer in Child Psychiatry, Family Research Unit, The London Hospital Medical College

* Deceased

1 An Introduction to Families At Risk
Nicola Madge

This book tells the story of unhappy families, about parents who are badly off, burdened with problems, emotionally distraught, or lacking physical or moral support, and about their children whose welfare, well-being and development may suffer as a result. It is in part a sad tale as it relates how family misfortunes can be passed on from parents to their children and shows that troubles can be persistent and pervasive. But it does have some happy endings. Not all children from difficult backgrounds turn out to be scarred for life, and indeed some achieve considerable success.

There are three main purposes of this tale and these are to describe the lives of families who are less well-off and less successful than families in general; to find out why the life chances of families are so different; and to develop some means of predicting the families most likely to be in difficulty. The context is contemporary Britain and, in the main, the evidence used to examine these issues is drawn from research carried out for the DHSS/SSRC investigation into Transmitted Deprivation. This work was commissioned to test the 'cycle of deprivation' thesis, which suggests that personal and social problems tend to run in families and become concentrated within a small section of the community, and took shape in a range of studies that almost always focused on families where there was a good chance that both parents and their children would show some form of disadvantage.

Later chapters describe individual empirical studies carried out for this programme of research. Before introducing these in more detail, however, it is helpful to clarify two concepts encountered throughout this volume. First, what are 'families' today? And, second, what do we mean by the term 'at risk'?

What are 'familes'?

'Families', as referred to throughout this book, are children and their caretaker(s) – and by no means all conform to the popular image of youngsters and their two natural parents. As the Study Commission on the Family (1980) and others have noted, changes in social attitudes, followed by changes in the law, have resulted – even over the past decade or so – in earlier marriage, more marriage, more divorce and more remarriage, and an increasing number of children living in single-

parent families. At the same time greater longevity has meant that four-generation families are much more common. These trends have undoubtedly affected the shape of the family. Children are far more likely than in earlier times to have only one parent present for at least part of their upbringing (it has been estimated that probably one in eight children at any one time lives in a single-parent household) and to encounter step-parents and step-brothers and -sisters. In addition they will know more generations of the extended family.

The average size of families has also altered markedly. Better contraception and more freely available advice on family planning, together with different views on the ideal family size, have led to a recent and dramatic drop in the number of brothers and sisters a child can expect to have. This change, in conjunction with improved medical care and a decline in infant mortality rates, means that women now spend a far smaller proportion of their lives bearing children than they did in the past.

Families have changed socially as well as demographically. For instance, more and more women work if they can – whether this is to boost family income, or because they belong to a society in which family roles are evolving and in which families are becoming more symmetrical (Young and Willmott 1973), or because they are seeking self-fulfilment and status in their own right. One outcome of this change is that mothers in general have less time to spend at home carrying out household chores and joining in activities with their children. Many sons and daughters these days become used to a range of alternative caretakers and do not witness the maternal role as one of full-time housekeeper. At the same time it is interesting to note how rising unemployment in Britain is affecting the roles of some fathers in the opposite direction. Children of the unemployed may spend more time with their fathers than many other children, and they may not appreciate the traditional function of fathers as breadwinners. Over all there is much greater interchangeability of family roles than in the past, and this has important implications for the state of the family.

If our concern is with the immediate interests of children and their families, we must recognise and accept this changing shape of the family and seek ways of reducing difficulties and alleviating stress in the contexts in which such arise. In the longer term, social policies to encourage certain family types and discourage others might be desirable – but that is another matter. What is important in relation to families at risk is that social interventions are not narrowly based on a model of the family in which there is a mother, a father, and their children, and where the father goes out to work while the mother stays at home to wash the dishes and welcome the children home from

school. There may still be many families of this kind, but there are at the same time many – quite likely those most at risk – that have little in common with this stereotype.

The meaning of 'at risk'

Families manage to cope with responsibilities of parenthood to very varying degrees, and 'families at risk' as discussed in this volume are those *where it seems likely* that difficulties will arise. To say a family is at risk is not to say that it is necessarily in trouble, but rather to indicate, statistically, that there is a high probability of problems.

To be at risk, then, means to have an above-average chance of family difficulties. But what is meant by family difficulties and how do we recognise them? In general there are two main ways in which families in trouble can be detected. The first is when it is evident that parents are not able, for whatever reasons, to meet the needs of their children, and the second is if there are obvious signs of disturbance shown by the children themselves.

So, what are the needs of children which, if not met, mean that families are at risk? Although there is some debate about the details, it is generally agreed that all boys and girls have certain basic requirements if they are to have a healthy and happy upbringing. These are generally fulfilled within the context of the family, even if external influences help to determine whether or not they are fully satisfied. These needs have been widely described by writers over past generations – and indeed implicitly or more explicitly suggested in later chapters. Pringle (1974: 15), for instance, stated that 'Children's physical, emotional, social and intellectual needs must all be met if they are to enjoy life, develop their full potential and grow into participating, contributing adults'. Using Pringle's framework, a few brief examples of children's needs can be given.

To begin with physical needs, a first requirement is a decent standard of living relative to standards of the day. Many children are included among the quarter of the population in or on the margins of poverty (Layard *et al*. 1978) and most of these will have fewer material advantages than others of their age: Piachaud (1981) demonstrated that meeting even minimal needs for food, clothing and footwear, household provisions, heating and lighting, toys and presents, pocket money, expenses connected with schooling, entertainments and holidays, costs parents more than they would receive if on supplementary benefit. Children from poor families may have additional disadvantages. For instance a low family income is associated with an increased risk of underachievement at school (Mortimore and Blackstone 1982), reception into care (Holman 1980) and, if poverty leads to debt,

parents who separate (Adler and Wozniak 1981). Sometimes, too, material hardship may be shown in relatively poor housing: for instance 6 per cent of households lack the sole use of a bath or a shower, and 4 per cent are overcrowded in that they have fewer bedrooms than are officially recommended (OPCS 1980). Crowded and insanitary housing is not only unpleasant in itself, but it can affect health, sleep and school performance (Brown and Madge 1982)

Children also need physical care. Infants of all species require a period of protection and this is particularly extended in the case of humans. During the first year or so of life infants are almost totally dependent upon adults for most requirements, especially the crucial needs of food and warmth. And in later years needs are as great, even if rather different. As children become more mobile, for example, it becomes more necessary to keep them out of danger. The parenting role in this respect evolves as children grow up, and whereas at younger ages it often means making sure that harmful objects are kept out of the infant's reach, at later ages it has more to do with preventing children from playing in busy streets and other dangerous places.

The fulfilment of emotional needs is also crucial to a child's well-being and development. It remains undisputed that children need to form attachments during infancy if there are not to be severe emotional repercussions, and that they need to have a fairly stable caretaker on whom to depend during childhood. Generally natural parents provide this emotional support, although it may be given by foster or adoptive parents, by a member of staff in an institutional setting, or by someone else with whom an intimate and long-standing relationship is established. It is not necessary, despite Bowlby's (1951) claim, for infants to receive the almost undivided attention of their mothers, even during the first few years of life, and brief separations are not necessarily harmful (Rutter 1981). What is important, however, is that children feel emotionally secure and experience good relationships within the family. It is also crucial that when family separations do occur, infants are able to maintain contact with *some* familiar person.

Social needs are quite closely related to emotional needs. Children need opportunities to develop good relationships with their peers just as they need to be able to form attachments within the family. Moreover they have to know how to behave in the company of others and how to cope successfully in society. Many of the responsibilities for providing a suitable model and shaping children's behaviour appropriately fall to the parents. In very general terms, parents set an example in many spheres of daily living including, for example, how to cope with difficulties and how to perform certain skills, and they

provide models for a range of social roles from parenthood and marriage to breadwinner and citizen. More than this, the parental role involves conveying certain ideas to children, to help them form their own attitudes, and at the same time gradually meting out responsibility and encouraging youngsters to develop a sense of personal worth.

Fourthly, children have intellectual needs. At the most basic level they require enough, but not too much, stimulation to enable them to take note of their environment and to learn how it 'works'. They need to be exposed constantly to their native language and to be provided with opportunities – mainly in the early years through talking to other members of the family – to develop their own linguistic skills. Their range of experiences needs to be increased as they grow older and they should have suitable opportunities to check and expand their knowledge. When they go to school, children benefit if encouraged in their work by parents, and if their home life is organised to allow them to do homework without being disturbed. Finally, children's intellectual needs may be met only if there is access to stimulating educational experiences and if the means to pursue attainable academic goals are available.

Needless to say, it is more difficult to classify children's needs than it might seem from the preceding division into those that are predominantly physical, social, emotional or intellectual. For instance, children tend to respond best to intellectual stimulation if they are happy and well cared-for, just as they are more likely to be emotionally withdrawn if they have only few or poor-quality social contacts. In other words, children's needs are interrelated and youngsters function best if all these are simultaneously and adequately met.

It can be quite easy to identify families at risk if parents are evidently not able – even if this is for reasons beyond their control – to meet their children's needs. In other cases, however, it can be quite difficult. Partly this is because most family life takes place behind closed doors, and partly it is because the enormous variations in both good and less good parenting complicate accurate family assessments.

Fortunately there are other clues that are helpful in identifying families in trouble, and these are the characteristics and responses of children themselves. Physical development and health provide a first index of well-being. Although not infallible as a guide, markedly delayed milestones, a stature and/or weight much below the average for a given age, generally poor health or a high incidence of accidents and injuries, are all possible signs of physical neglect, poor living conditions, or inadequate care and supervision. Emotional problems, too, may occasionally result in poor physical health and development – the distraught child may refuse to eat and may be unable to sleep – but

more commonly they are reflected in behavioural disturbance. The first signs are likely to be disordered behaviour – including persistent nightmares, delinquency, temper tantrums and school phobias (Wolff 1981).

Behaviour is probably, over all, the best index of childhood emotional neglect. Nevertheless behavioural expressions cannot neatly be related to specific problems as not all children react to adversity in the same way. Some children, for example, respond to emotional unrest by acting-out ar d showing signs of aggression and rebelliousness, while others are more likely to become withdrawn, anxious and depressed. In general terms it is often said that the first group of children principally displays conduct disorders while the second group predominantly shows emotional disorders. For obvious reasons it is the former category of children that is most likely to come to notice quickly.

Behaviour like physical state is, however, no perfect guide to problems and even 'professionals' do not always concur on the significance of childhood behaviours: thus although teachers and parents may agree about the incidence of certain specific behaviours, such as lack of concentration and fighting, they are less likely to agree about the presence of 'sadness, withdrawal, solitariness, obsessionality, overactivity, disobedience and bullying' (Wolff 1981). Either different people see behaviour differently – or else behaviour really does differ according to context, as suggested by Mitchell and Shepherd (1966). Whichever is the case, such discrepancies do highlight how difficult it can be to recognise neglected children.

School progress, as reflected in high scholastic performance, leaving school with qualifications, and probably remaining at school beyond the first opportunity to leave, is currently valued highly in our society and tends to be associated with other forms of 'success', such as getting a 'good' job. Progress at school, in this sense, is another indicator of a child's well-being and adjustment. If pupils perform in line with their measured ability, they are unlikely to have many overwhelming problems of any kind. However children who underfunction markedly may well be under stress. For instance a child might do less well at school than expected if tired – either because of undernourishment or sleepless nights – or unhappy. Or performance might be hindered if there is no opportunity to do homework properly, either owing to noisy and overcrowded home conditions or because evenings and week-ends are taken up doing household tasks. Thirdly, progress could be affected by a lack of appropriate skills, possibly stemming from inadequate stimulation both at home and outside the family. And fourthly, lower attainment than expected might reflect poor

personal motivation and an absence of suitable parental models and encouragement.

Physical growth and well-being, behaviour and progress at school are the main areas in which family neglect is likely to be reflected. Nevertheless there are other things to take note of and these include a child's general appearance – including facial expression, activity level, dress and so on, participation in activities (which might be restricted by finances, parental decree or disinclination), friendship patterns, and, importantly, what that child might say. Care should be taken, however, in jumping to any immediate conclusions just because a child seems unhappy or unsettled. Children react very differently, and they are exposed to so many potential stresses and strains that it is not always possible to say quite what causes what. Moreover *all* children are disturbed at some time or another, and it is important to distinguish between transitory problems, which are after all fairly 'normal', and major underlying stresses and instances of neglect. The significance of signs of unusual behaviour should be judged principally by their intensity, the length of time they last, their rarity among children of a similar age, and the presence of suffering on the part of the child. Strong concern should be felt for children with particularly persistent problems, especially where there is some suggestion that difficulty in one context is leading to problems in others.

The rest of the book

In Chapters 2–9 the tale of unhappy families is taken up in greater detail as individual researchers describe findings from their own work on the Transmitted Deprivation programme. In Chapter 10 the conclusions from the different investigations are drawn together to assess the status of the 'cycle of deprivation' thesis and to develop a framework to help in identifying families at risk.

The description of families in difficulty begins in Chapter 2 with an ethnomethodological study of four families carried out by Frank Coffield, in conjunction with Philip Robinson and Jacquie Sarsby. Coffield begins by examining the plausibility of a dozen or so explanations of why similar problems might arise in both parent and child generations of certain families, including the possibility that factors outside the family are chiefly responsible. Nevertheless he notes how difficult it is to establish quite why some families have so many more problems than others, and concludes by describing the features that seem to be most important in characterising the families in his study.

In Chapter 3, W.L. Tonge, J.E. Lunn, M. Greathead, S. McLaren and C. Bosanko also describe the circumstances of markedly deprived families. These writers report on studies of 'problem families' in Shef-

field, and focus on the most recent investigation which followed up the parents and adult children in thirty-three problem and thirty-three comparison families originally studied by W.L. Tonge, D.S. James and Susan M. Hillam. In this follow-up, the main aim was to discover whether or not children from highly disorganised families were particularly likely to become the adult heads of a second generation of problem households – and, incidentally, to see whether problems in the older generation tended to be long term. Tonge *et al.* also consider some of the factors that might help to distinguish between adults who do and do not resemble their parents. Finally they draw some conclusions on the strength of the cycle of deprivation now and in the past.

This is followed by a chapter by Michael Rutter, David Quinton and Christine Liddle which again looks very directly at intergenerational patterns. The authors focus in the main on what might be termed parenting behaviour and examine both whether parents who cope less well than average seem to have had a particularly unfavourable upbringing, and whether those who were brought up under poor conditions appear to suffer as parents. To answer these questions, the early background of parents with children currently in care are examined as well as the current parenting behaviour of adults who grew up in care. The unusual technique of looking 'backwards' *and* looking 'forwards' is adopted by Rutter and colleagues to help to isolate the factors that are really crucial for successful parenthood.

A rather different methodological approach was adopted by Alex. McGlaughlin and Janet M. Empson who report on a study of mothers and their infants (Chapter 5). These authors examine whether family of origin heightens later family risk, and do this by comparing pairs of sisters and their infants. Sibling mothers, for example, are observed to see if they interact similarly with their infants during play, and to discover if their exposure to stress and their attitudes towards their children's development are comparable. Cousins are contrasted in the way they play with their mothers, in the way their mothers say they behave, and in their development by $2\frac{1}{2}$ years. This strategy enables McGlaughlin and Empson to draw conclusions on the transmission of deprivation within disadvantaged families as well as permitting them to examine various explanations as to why some children in some families appear more 'at risk' than others.

The emphasis is less directly on intergenerational continuities in the research reported by Sue Kruk and Stephen Wolkind in Chapter 6. Instead the concern is to find the most reliable way, as early as possible, of selecting families with children at risk. Accordingly Kruk and Wolkind begin by hypothesising which mothers would be most likely to have infants with behaviour problems and, on the basis of previous

research, predict that these would include unsupported mothers and their first babies. They proceed to compare the course of pregnancy, childbirth and early rearing as shown by such mothers and by a group of mothers married at the time of conception. Finally they examine other factors in a mother's history that may be more important than marital status in determining her ability to cope with motherhood.

All the chapters mentioned so far report on studies that focus from the outset on families likely to be in difficulty. By contrast, the following two chapters describe investigations based on normal population samples. In Chapter 7, I. Kolvin, F.J.W. Miller, R.F. Garside and S.R.M. Gatzanis present a preliminary report on the most recent follow-up of one thousand Newcastle families originally contacted in 1947. Study and analysis are not yet complete, but these authors at this stage describe the methodology of their study that aims to compare family generations longitudinally. They also present some early findings that described the persistence of problems over the life-cycle.

The second investigation to start from a general population group is described by J.E. Stevenson and P.J. Graham (Chapter 8). Data in this instance are derived from a longitudinal study which identified children showing difficult behaviour at age 3. Stevenson and Graham use this information to look at the role of child experience, child development and family-based disadvantage in the development of behaviour problems. Moreover they examine whether the influence of these different kinds of variable is similar within a representative group of 3-year-olds and within a sub-sample of children from relatively deprived home backgrounds.

The emphasis shifts again in Chapter 9 where the focus is on behaviour in relation to health. Mildred Blaxter and Elizabeth Paterson adopt an intergenerational perspective and look at grandmothers, mothers and children to see how far mothers and their adult daughters seem to share attitudes towards illness, disability and the use of services. In addition they consider whether maternal attitudes seem to affect the likelihood of avoidable poor health among children. Considerable weight is placed on the families' own accounts of their behaviour in examining these questions.

Finally, some attempt is made to assemble the findings reported in the foregoing chapters and to draw up some guidelines for predicting families most 'at risk'. The value of knowing about details of family of origin and early experiences – important in relation to the cycle of deprivation thesis – is considered, and the first five indices in an alphabet of family risk are outlined. It is never possible to predict families in difficulty with perfect accuracy – but this is no excuse for not trying.

References

Adler, M. and Wozniak, E. (1981), *Origins and consequences of default – an examination of the impact of diligence* (summary), Research report for the Scottish Law Commission, no. 5, Central Research Unit, Scottish Office.

Bowlby, J. (1951), *Maternal care and mental health*, Geneva: World Health Organization.

Brown, M. and Madge, N. (1982), *Despite the welfare state*, London: Heinemann Educational Books.

Holman, R. (1980), *Inequality in child care*, Poverty Pamphlet 26, London: Child Poverty Action Group.

Layard, R., Piachaud, D. and Stewart, M. (1978), *The causes of poverty*, Royal Commission on the Distribution of Income and Wealth, Background Paper no. 5, London: HMSO.

Mitchell, S. and Shepherd, M. (1966), 'A comparative study of children's behaviour at home and at school', *British Journal of Educational Psychology*, vol. 36, pp. 248–54.

Mortimore, J. and Blackstone, T. (1982), *Disadvantage and education*, London: Heinemann Educational Books.

OPCS (Office of Population Censuses and Surveys) (1980), *General household survey 1978*, London: HMSO.

Piachaud, D. (1981), *Children and poverty*, London: Child Poverty Action Group.

Pringle, M.K. (1974), *The needs of children*, London: Hutchinson.

Rutter, M. (1981), *Maternal deprivation reassessed*, 2nd edn, Harmondsworth: Penguin Books.

Study Commission on the Family (1980), *Happy families? A discussion paper on families in Britain*, London.

Wolff, S. (1981), *Children under stress*, 2nd edn, Harmondsworth: Penguin Books.

Young, M. and Willmott, P. (1973), *The symmetrical family: a study of work and leisure in the London region*, London: Routledge & Kegan Paul.

2 'Like Father, Like Son': The Family as a Potential Transmitter of Deprivation

Frank Coffield

The story is told of the social science researcher who was sent out into the field to interview young mothers as part of a study of family life. In the course of one interview he discovered that, although the woman had produced six children, she had not in fact been married. As tactfully as possible, he asked her why. 'Well', she replied, 'when I was young, my doctor told me I had a weak heart and warned me against it'.

There are problems in studying families, no matter which method is chosen. The approach we[1] adopted was participant observation, whereby we studied intensively over two years a small number of families in an industrial town in the Midlands. Ours was an inter-disciplinary study, combining the approaches of psychology, sociology and anthropology. We entered the social world of the families and acted as participant observers by joining family celebrations such as wedding anniversaries, birthday parties and christenings as well as the more run of the mill activities of family life. We also studied one family that was struggling out of a dense web of difficulties, many of them stemming from the mother's family of origin, to see if we could learn anything of the processes whereby certain people appear to break out of the so-called 'cycle of deprivation'. Apart from studying 'successful' as well as 'unsuccessful' families, we also aimed to produce detailed family biographies and genealogies, and to assess the quality of individuals' lives as revealed in their accounts of past and present problems.

Once the field-work was completed, I was invited a number of times to talk to young, administrative grade civil servants. This experience showed me that so-called 'multi-problem' families and civil servants had one thing, but only one thing, in common: neither group understood what is meant by long-term anthropological or ethnographic field-work. Both groups had only one image of social research – the statistical survey. This perception caused ethical problems with the families and intellectual rejection among the civil servants.

On other occasions when this work has been discussed, questioners have frequently asked how much trust can be placed in generalisations

based on only four families. Apart from saying that Oscar Lewis wrote two seminal texts on one family, the reply has been that in round numbers we came to know intimately over two years some sixty members of four families, and a further twenty close neighbours and friends. We also kept in touch with seven other families whom we used as invaluable points of comparison; such a method helped us to check continuously on the typicality of our four main families.

Generalisability is certainly important, but perhaps even more important is validity. Traditionally, ethnographers or anthropologists have stressed *natural context* as a key feature of their attempts to establish validity. I agree with Agar (1977) that the essence of participant observation is not the research setting, but the *type of relationship* that is established. In the words of Mead (1972: 152): 'Anthropological research does not have subjects. We work with informants in an atmosphere of trust and mutual respect.' If the word 'informants' were to be replaced by the word 'collaborators', her statement would be more acceptable.

Every research technique has its strengths and weaknesses and participant observation is no exception. If one, however, considers the amount of research that has been completed since the 1960s in the United States, in Britain and elsewhere under the general aegis of ethnography or participant observation, is it not about time we had some publicly acceptable criteria or some explicit techniques for arriving at particular underlying patterns? What are the generally recognised steps in thinking or in analysis that lead the ethnographer or participant observer from her empirical data to a particular set of critical factors? As Agar (1977) has also argued, how can a reader judge how hard the researcher has had to hammer his data to make them fit his emerging pattern or, worse still, the pattern he had to begin with? With participant observation more than with other methods, the reader's faith in the researcher becomes crucial because the reader is unlikely ever to be in a position to replicate the study. More recently, both Agar (1980) and Spradley (1980) have begun to make explicit the steps involved in reaching ethnographic conclusions – the selection of categories, the search for patterns or themes, and the constant testing of those themes by further observation. This does not, however, take us much further forward than Lofland's guide to analysing social settings which was published in 1971.

Possible mechanisms of transmission

We found that the task of suggesting possible mechanisms of transmission, which would go beyond the detailed description of family life by identifying specific causal links between one generation and an-

other, was the central intellectual challenge of the research project, and we set about that task in two ways. First, after we had been working with the families for over fifteen months, we examined the data that we had accumulated and categorised in the search for an underlying pattern or patterns. We spent considerable time trying to distil the critical elements of each of our families into a general model, but the conclusion was eventually reached that there was no single path to deprivation. Although, for example, three of the families had children in residential care and had other common features, we were still unable to encapsulate each of these factors into one system of explanation.

The second method we used to generate possible mechanisms was to scour both the relevant literature and our own minds. This approach appeared attractive at first but further exploration soon showed that the list of possible hypotheses was endless. For what it was worth, we began listing the major factors that anyone with an armchair and a knowledge of the area could have produced:

An hereditary explanation

The study of the Kallikak family (Goddard 1912) in the United States was seriously flawed and yet a crude version of it continued to exert influence on psychological texts and courses until the mid-1950s (Karier 1977). Kamin's (1974) more recent work, however polemically written, made clear the ugly political and eugenic aspects of much of the research completed by the pioneers of IQ testing such as Terman, Goddard, Burt and many others. Moreover, the whole IQ controversy (Block and Dworkin 1977) warned us about how much time, money and energy had been poured into attempts to estimate the influence of heredity with such very meagre returns. Eysenck's (1973: 203) comment on the topic is worth quoting here: 'heredity can produce *differences* between parents and children, as well as similarities' (emphasis as in original). In brief, while not wishing to discount the importance of genetics, our study was in no way capable of addressing itself to this question and so we turned to an examination of other factors.

Child-rearing practices

The problem here is that, despite many carefully controlled and painstaking studies of parents and children over many years, there is still no general agreement among psychologists about which child-rearing practices are responsible for particular adult personalities. This approach is historically associated with the ideas of Freud who was arguing in the 1920s that his concept of the 'superego' explained how

children internalised the norms of their parents, 'thereby providing for each generation a psychological means of transmitting culture' (Musto 1980: 122). More recent surveys of early social experience, by Clarke and Clarke (1976) for instance, have shown both that 'a child's future is far from wholly shaped in the "formative years" of early childhood' (p.24) and that 'longitudinal studies involving repeated measurements [of the same children] do not suggest the existence of *powerful* continuities' (p.21, emphasis as in original). Over the last thirty years developmental psychologists have been moving steadily away from models of explanation like Freud's which concentrated on single factors to models of multiple, indirect and interactive causation; indeed, they have begun to pay attention to quite different issues such as how children make fathers and mothers out of men and women (Rheingold 1969). In other words, socialisation is now seen by psychologists as a reciprocal relationship where the control exerted by the parent over the child is itself influenced by the control exerted by the child over the parent. More attention is now paid to the child's own temperamental characteristics which have been shown to differ markedly right from the time of birth and to be associated with the later development of emotional and behavioural disorders.

What is perhaps more to our purpose is Robins's (1972) careful review of longitudinal studies of behaviour disorders in children. She has shown that antisocial children, when adult, had 'more difficulties with the law, with their jobs, with their families, and with social relationships of all kinds than either neurotic or control children' (p.437). The review by Rutter and Madge (1976: 234) claimed that there was evidence 'that being reared in a home where there is gross family discord is conducive to the development of antisocial disorder', but that 'no direct evidence has been shown between this experience of child-rearing and later behaviour as a parent'.

The six children we studied in one family could certainly be described as being reared in a home marked by 'gross family discord'. Both parents claimed to have suffered disturbed childhoods, and the mother of the family had been 'the black sheep' in her family of origin. There was a long and continuing history of violence between husband and wife, the eldest girl had been found battered and bruised and taken into care where she was having a turbulent career, and a younger child had died at home. Despite considerable personal distress and suffering at home, the children were progressing well at school, performing well above average on formal reading tests, for example. Such a hopeful finding should help to counteract any brutal pessimism about the inevitable transmission of deprived status from parents to children. Some children escape from even the most damaging of backgrounds.

Imitation of role models

Another possible mechanism is that children imitate an admired role model in much the way that Bandura (1970) has suggested in a long series of articles and books. This process is likely to be more complex than the simple copying of specific actions, if early language acquisition is taken as an example of modelling. 'This work suggests', wrote Bruner (1971: 151), 'that modeling is not a simple form of transmission . . . the child is not so much copying specific language behaviour from observation-and-imitation, but rather is developing general rules about how to behave'.

Do not some children rebel against their parents' methods of upbringing or their values just as much as other children slavishly follow their example? Is it not possible to adopt any position between these two extremes by identifying with one parent more than with the other, for instance? (Lamb (1979) has demonstrated that the interactions of mothers and fathers with babies are qualitatively different.) Is it not also more likely that the influence of parental behaviour on children is indirect and subtle rather than direct and straightforward? Have we not all heard adults protest about their parents' child-rearing practices only to see them repeat the same practices with their own offspring? Are some discontinuities not to be explained by the fact that younger generations innovate and adapt their values to changing circumstances even in families like those of the Indian nobility which are typically depicted as despotic and tradition-bound (Rudolph and Rudolph 1980)?

There are, furthermore, other models outside the immediate family whom children may imitate and whom children may increasingly feel are more important in their lives than their own parents – their peer group (Salmon 1979) for example, or political movements like the National Front (Robins and Cohen 1978), or school teachers who, as Rutter *et al.* (1979) have argued, can provide either positive or negative models for their pupils to follow. In addition, young children have been observed learning the delinquent sub-culture by imitating the behaviour of boys slightly older than themselves (Patrick 1973; Parker 1974, etc.). The fact that the media and youth culture generally provide endless figures for young people to identify with has been neatly summarised by Wilson (1979: 37): 'The girl who initially wanted to be like mum may, on more mature reflection, decide that there would be a greater premium on combining the ability of Chris Evert, the allure of Mata Hari, the mind of Albert Einstein and the jewellery of Liberace.'

When we examined our families to estimate the significance of imitation of an admired role model, we had to conclude that the

families displayed as many discontinuities as continuities. Certainly, we documented in detail the efforts of a rather weakly son to imitate the mannerisms, language and attitudes of his very 'macho' father. He imitated his father even to the extent of sitting in a chair in the same manner. When his mother commented adversely on his misbehaviour by saying, in her standard phrase, 'He's just like his father', the boy immediately brightened and interrupted to say: 'Yes, I am, aren't I?' He repeatedly made attempts to adopt the required masculine image, practising the new behaviour before an audience. As Danziger (1971: 68) has pointed out, this childish imitation of adults is only one side of the coin, the other being 'the rehearsal of the new act to demonstrate the child's new competance. Without this second phase, imitation remains trivial and has no general or lasting effect on the child's behaviour'.

In the same family we recorded the progress of a daughter from her earliest court appearance to a Children's Home, and then to a secure Children's Home (an ex-approved school), and so appeared to be repeating the pattern of her father who went from detention centre to Borstal and then to prison during his adolescence. But could such a repetition not be explained as much by both father and daughter independently following a very common sequence of deteriorating behaviour by children 'in care'? Alternative hypotheses abound, and discontinuities were legion among our families.

Sex differences

Some Sheffield workers (Wright 1955; Parry *et al.* 1967; Wright and Lunn 1971) have produced the only comparative study in Great Britain of two generations of the same 120 families judged 'on very general lines by the health visitors to be problem families' in 1955. This work is reviewed and extended in another chapter of this book, and elsewhere (Coffield, Robinson and Sarsby 1981) the serious criticisms that can be made of the earlier reports have been detailed, but here the concentration will be on Wright and Lunn's most intriguing finding, namely that 'more of the married sons than married daughters are repeating the parental pattern in their own marriages' (1971:319). Wright and Lunn themselves produced three hypotheses to account for this finding:

(1) Daughters are able to break out of the 'cycle of deprivation' by marrying men who present fewer problems than either their fathers or their brothers.

(2) Boys may be more susceptible to the psychological and social stresses of being brought up in a problem family – certainly, Rutter's (1970) review of the evidence would lend some support to such a contention.

(3) The father who fails to be a competent breadwinner and an effective head of the family is likely to be a poor model for his sons who may become more adversely affected by his failures than by any incompetencies on the part of their mother.

It is, however, still possible that this sex difference may be in part the result of more boys than girls becoming involved in delinquency and of boys being more readily processed through the courts by the police. As more girls commit crimes, are convicted and suffer the social consequences of conviction, this gender difference may diminish.

Intimacy

Brown and Harris (1978: 278), in a major study of depression among women in a London borough, found that, when assessing the factors that made working-class women particularly vulnerable, 'if a woman does not have an intimate tie, someone she can trust and confide in, particularly a husband or boy-friend, she is much more likely to break down in the presence of a severe event or major difficulty'.

There was no such confiding relationship between the parents in the three families in our study who were still experiencing severe difficulties, whereas there was such a supportive bond between the couple whom we characterised as coming out of deprivation. Indeed, in one family we considered that one of the most critical factors was the mother's search for just such an intimate relationship (of a more nurturant than sexual kind, just as Brown and Harris suggest), for which she was prepared to sacrifice money, her reputation in the area, and even her child. When we first met her, she was a widow of 47 who wanted 'a nice man who won't mess me about', but who would devote time and attention to her. This was a central factor in understanding her relationships not only with men friends, but also with her son, her neighbours and relatives. She showed more interest in teenage clothes, in visits to under-20s discotheques, and in dyed hair and make-up than in feeding and caring for her 7-year-old son. As she was also willing to accept almost anyone whom she met at the pub, she affronted her neighbours, who counted on their fingers the number of men who crossed her threshold.

The marital relationship in the large family we studied was characterised by violence, emotional crises over debts, and depressions suffered by the mother. In the long-term unemployed family, the husband phlegmatically accepted the various associations with other men that his wife entered into. In marked contrast, the couple coming out of deprivation were very close, openly affectionate, and committed to one another and to their children. Despite some segregation of jobs at home and of entertainment, they still helped one another with the

children, both of them playing with them, disciplining them consistently, and going on holiday together as a family. In brief, the Brown and Harris hypothesis appeared to be supported not only by our four main families but also by their extended families and by the other families whom we used as points of comparison. Admittedly, ours was a small sample, but one of the strengths of such intensive field-work is that it has something to say about the quality and depth of relationships.

Relations with extended family and neighbours

In the family climbing steadily out of a morass of past problems we noted the support given by the husband's more settled relatives, mainly his parents and brothers and sisters-in-law. During the period of our field-work this family also moved steadily away from the deviant norms and mutual assistance current on their stigmatised housing estate to the more conventional norms and independence of their new neighbours on a quiet council estate. Correspondingly, we remarked on the social isolation of the families still in trouble. These families had become isolated from their relatives either because they had moved geographically in search for work, or because they had used up their store of goodwill by being a constant financial and emotional drain or a social embarrassment because of crime or irregular relationships. The effects of either close-knit or loose-knit social networks on norms, social control and mutual support have been emphasised by Bott (1957) and Mitchell (1969).

To give one example, the widow exchanged flats during our period of field-work partly because she complained of being isolated from neighbours. After a very short time in the new area she was relying very heavily on one female neighbour for a whole range of services (from using her cooking facilities to having her hair done). As with other relatives and friends, she soon pushed the neighbour to the limit, using her to confront her men friends with complaints that she herself did not have the courage to voice. She then turned on her neighbour, denied the earlier accusations, and called her a troublemaker who 'wants nothing but to cause upset among people'.

A 'filtering-out' strategy

In moments of extreme stress in our families we noted that even the very youngest children had learned a technique for coping with interfering or emotionally excited adults. When, to give an example from one family, the mother had already lost control over the older children and was shouting at the top of her voice and hitting out in all directions in a vain attempt to regain control, the toddlers in the family, instead of

adding to the total volume of noise (as was predicted), continued with their own activities as though nothing untoward was happening. Even when they were directly addressed at such moments, they pretended neither to hear nor to see: they literally filtered out the bawling adults as if they were not present. Although this allowed the children temporarily to preserve an outward appearance of calmness in the midst of much verbal and physical aggression, at other times both boys and girls exhibited signs of tension such as enuresis, emotional outbursts, sucking dummy teats at the age of 7, and psychosomatic illnesses. We also began to suspect that the children had transferred this 'filtering-out' strategy to their relationships with teachers at school and to any occasion when there was any conflict between adults and themselves. They had become skilled at withdrawing into their own world and ignoring the advice, admonitions and emotions that were being directed at them. If our field notes have picked up a common strategy employed by young children from stressful home backgrounds, it may mean that certain children arrive at school, having already learned to ignore adults who place demands upon them that they are not willing to meet. A similar process has been recorded by Willis (1977: 27) whose working-class lads restricted the demands made on them by teachers to an absolute minimum, while at the same time they exercised considerable personal freedom, 'moving about the school at their own will to a remarkable degree'.

Low IQ or low intelligence

There is a long and ignoble tradition in psychology, stretching as far back as Sir Francis Galton, which sought to establish a direct causal connection between hereditary mental deficiency and all forms of social evil including poverty. The wilder excesses of this tradition can be seen in the writings of Galton himself (1896, 1908, etc.), in the work of McDougall (1914, 1921, etc.) and in the reports of official committees like the Wood Committee (Wood Report 1929) of which Cyril Burt was a member. The link between low intelligence and 'problem families' was pursued in this country by Lidbetter (1933), Blacker (1937 and 1952), Savage (1946) and Sheridan (1956). Wootton (1959: 53), with characteristic clarity and bite, passed the following judgement on these studies: 'Unfortunately, all these early attempts to get at the facts of the "social problem group" are vitiated by an extremely crude, but at the same time highly pervasive fallacy – namely, failure to distinguish between personal inadequacy and simple economic misfortune'.

That the tradition is far from dead can be seen from Herrnstein's comment in 1973: 'as technology advances, the tendency to be unem-

ployed may run in the genes of a family about as certainly as bad teeth do now'. The idea that inherited intelligence might be responsible for society congealing into IQ castes was too much for Eysenck (1973: 202), who stressed the significance of regression towards the mean:

> Clearly, the genes are producing a tremendous shaking-up of any class system which might be set up on the basis of IQ-related abilities. If this process continues for a few generations, no predictions would be possible from the ancestors' I.Q. level to that of the newborn child . . . Consequently, heredity will break the 'cycle of deprivation', if not in one generation, then in two or three. The offspring of the 'lumpenproletariat' will not remain 'lumpenproletariat' for ever, and the offspring of the 'deprived' will not remain 'deprived' for ever.

More recently, Kamin (1981) has poured scorn on what he calls 'the myth of regression to the mean'.

Interestingly, the parents we studied seemed to have internalised a Galtonian rather than an Eysenckian view of the inheritance of intelligence. Even the brightest of them thought that they themselves were dull and, as a direct consequence, were convinced that their children would also be dull. Such a false and fatalistic view of the inheritance of intelligence led them to have very low expectations of themselves and their children; their position in the social hierarchy was not questioned by them nor thought to be questionable. According to them, their fate and their rewards were a simple reflection of their abilities; for neither they nor their children 'had the brains' to succeed. An outmoded and discredited theory may therefore be continuing to exert power long after it has been formally abandoned by psychologists.

The mother of one of our families had been labelled 'inadequate' by the social services department and was considered by them as borderline educationally subnormal, judgements that we came to question. We knew, for example, that she could both read and write, but no doubt she would have performed poorly on any formal tests of intelligence, literacy or numeracy. When she was injected against tetanus, she talked of 'a needle for titanic'. She gave us, however, ample evidence during field-work that she was by no means stupid, although perhaps educationally backward. To give but one example from many possible, she often rolled her eyes and appeared defeated and dejected, while recounting the latest misfortune to befall her. She did not look straight at us until our sympathies were engaged, and then she brought her tale to a tragic climax, fixed us suddenly with her eyes, and asked for a loan of a few pounds (which, incidentally, she always repaid promptly). This showed evidence of some social, not to say manipu-

lative, skills which she used successfully with us and with the social services department. She had a low IQ but was not unintelligent. There were more persuasive, alternative explanations (depression after the death of her husband, the search for a supportive and intimate relationship, learned helplessness, controlling others by manipulating them because there was little else in her life she could control) to account for what appeared on the surface to be rather dim-witted behaviour.

Psychiatric disorder

Rutter and Madge (1976) have comprehensively reviewed the evidence for intergenerational continuities among the many conditions that are covered by the very loose term 'psychiatric disorder'. Their main conclusion is worth quoting in full: 'With all conditions the likelihood is that troubles will not persist into the next generation of the same family. Nevertheless, considerable continuity is evident with respect to conduct disorders in childhood and personality disorders in adult life' (p.223).

The only psychiatric disorders among our sample were the serious depressions that affected the mother who had been recently widowed and the confusions and delusions that a long-term unemployed father related to us from time to time. He was, for example, obsessed about his health and told us strange, inconsistent stories of heart attacks, road accidents (when he was injected with a substance he called ZX), and industrial injuries. He even claimed to have died on two occasions and to have been resuscitated. This rich fantasy world and his professed dedication to work were his means of protecting himself from the harsh reality of being an incompetent adult without skills who had little contribution to make to a sophisticated, technological society. He and his twin brother were physically ill-equipped for unskilled manual labour, as our first description of them makes clear: 'They are in their early thirties, just over five foot in height, painfully thin, weighing probably seven to eight stones. One brother has very discoloured, rotten teeth, while his twin has not got any teeth at all. They are both unshaven, haggard and dressed in dirty old clothes; Peter's blue jeans are held together at the waist by a large pin'. Apart from this major example, psychiatric disorder was not a factor that played even a minor part in the lives of any of our other families and so we were unable to assess its importance in relation to intergenerational continuities.

Mechanisms outside the family

The dangers inherent in suggesting possible mechanisms were made clear to us by examples in the literature of apparent continuities

between parents and children which had on further investigation proved to have no connection at all with internal family dynamics. Three instances of spurious continuities particularly impressed us.

First, Liebow's (1967) study of adult Negro males in a blighted section of Washington's inner city during the early 1960s cautioned us against placing too much importance on children fashioning themselves in their parents' image:

> No doubt, each generation does provide role models for each succeeding one. Of much greater importance for the possibilities of change, however, is the fact that many similarities between the lower-class Negro father and son (or mother and daughter) do not result from 'cultural transmission'[2] but from the fact that the son goes out and independently experiences the same failures, in the same areas, and for much the same reasons as his father. (p.223)

The repetition of the economic slump of the 1930s in the late 1970s and early 1980s may be in certain cases a better explanation of poor work records by both father and son than the one favoured by Wright and Lunn (1971: 318):

> The man who, for one reason or another, has a weak drive towards employment finds difficulty in rising early in the morning to get to work and fails to do so frequently so that he has to take refuge behind a variety of ill-defined diseases which can be indefinitely prolonged since the symptoms are subjective.

Again, Wright and Lunn's research suggested that parental involvement with social agencies might lead to their children having a similar involvement. They were, however, unable to state unequivocally the reasons for such a continuity. Was it due to a family tradition of seeking help from certain agencies such as the NSPCC? Or to social inadequacy? Or to poor living conditions generally? Could the same mechanisms be at work here as Farrington, Gundry and West (1975) investigated in the 'familial transmission of criminality', where they showed that one of the important factors was selective prosecution by the police of boys from families where other members have a criminal record? Farrington *et al*. provided evidence for a connection between two generations, whereby the police pay more attention to – and are likely to be less lenient to – the children of parents whom they know to be criminals; so a link is forged between father and son, and no reference to internal family dynamics is needed to explain it. In much the same way social workers could become involved with the children of clients.

Thirdly, Hargreaves *et al.* (1975: 160) have drawn attention to a related process – 'the sibling phenomenon' – operating in schools, where certain pupils are 'pre-labelled' by teachers as potential deviants because their elder brothers or sisters had left behind them a reputation for causing trouble. Hargreaves's work was concerned primarily with showing how deviant pupils stand out from their contemporaries at an early point in their schooling, but Seaver (1973), studying elementary school children in Chicago, found evidence of pupils performing better if their older siblings had been bright, and worse if their older siblings had been dull. The expectations of teachers, based on their previous experience with pupils' older siblings, may therefore be creating greater similarities between members of the same family than exist naturally.

Listed above are the main familial and individual hypotheses that appeared to us at the start of our research to be capable of explaining intergenerational continuities. There was, however, a large number of socioeconomic factors not in the above list which we somehow had to keep in the forefront of our minds. To mention only the most salient: there were economic factors such as low pay, unemployment, redundancy, dismissal from work, and dirty or dangerous working conditions (Townsend 1974 and 1979); regional variations, 'difficult' housing estates (Wilson 1963; Baldwin and Bottoms 1976), and geographical concentrations of multiple deprivation in, for example, inner city areas (Holtermann 1975); increasing inequalities in wealth (Field 1974 and 1981), in health (Preston 1974), in education (Jencks *et al.* 1973; Halsey *et al.* 1980), and in housing (Rex and Moore 1969; Ineichen 1975); the discrimination and racial prejudice shown to ethnic minorities or other stigmatised social groups (Hill 1967); the generation or intensification of juvenile delinquency by schools (Power *et al.* 1967 and 1972; Reynolds 1976; Rutter *et al.* 1979) or by residential establishments (Cornish and Clarke 1975; Millham *et al.* 1978); debt and the interest rates charged by loan companies; major deficiencies or changes in social legislation, or in administrative procedures within the DHSS or other ministries at national and at local level; the stereotypes of officials and their effects on interactions with the poor; and, finally, broad social trends and wide societal changes, such as the greater availability of contraception and abortion with corresponding changes in family size, the steady growth in divorce and crime rates, the increasing numbers of old people, and the general rise in standards of living over generations.

Problems of interpretation

When we began to examine the fine detail of the lives of our families,

the first main conclusion we came to was the interconnection, not to say contamination, among all the main variables. No simple division into 'familial processes' on the one hand and 'socioeconomic processes' on the other made any sense of the data we had collected. How can one, for instance, dissociate the accidents, the illnesses and the violence at home from the overcrowding, the poor housing conditions and low pay? Distinctions between structural and individual factors more accurately reflect traditional academic divisions between sociology and psychology than real differences in the factors that impinged on the lives of the people we studied.

A father of one of our families, for example, who had been unemployed for a considerable period, had a pessimistic mental picture of the local job market. His view was quite at variance with our assessment of local industry as one where there was at the time steady employment in low-paid jobs. The man in question, who also suffered from a number of other delusions, had the personal impression that there was no point in applying for work because he was convinced that there was none available and so he was able to come to accept his long-term unemployment. No amount of factual information could shake his conviction which received continuous support from the media reporting on the *national* growth of unemployment. The argument would be similar with men who took a more accurate and realistic view of the labour market; for the general point is that part of the social structure that controls individual behaviour is to be found inside people's heads: there is no sharp dichotomy between socioeconomic and personality factors. The economic structure in any given area sets limits on the opportunities available in housing, education and employment and, within that particular set of opportunities, individuals differ in their ability to assess those opportunities appropriately and to cope with the demands of the housing, educational or job markets. The dynamic interaction between personality and socioeconomic factors is exemplified by behaviour that appears to outsiders as 'feckless' or 'irrational' but which may have structural origins.

Several other conclusions also seemed inescapable to us. To begin with, our case studies of a small number of families were likely to highlight familial and individual factors at the expense of structural and economic ones. Danziger (1971: 113) rightly drew our attention to the 'ironical fact that preoccupation with family influences appears to be most intense in societies where the importance of such influences is in sharp decline'.

Secondly, Valentine (1968) had argued strongly that disorganised, deprived or unconventional families may simply be adapting to

externally imposed conditions. In his own words: 'The distinctive patterns of social life at the lowest income levels are determined by structural conditions of the larger society beyond the control of low-income people, not by socialisation in primary groups committed to a separate cultural design' (p.129).

Furthermore, talk of 'causal chains' or 'the chain of cause and effect' created the wrong mental image, because it implied a simple, linear progression whereas our data constantly underlined complexity, interaction and contamination among variables. No single intervening factor was found (or is likely to be found) to be *the* transmitter of deprivation. The metaphors most commonly employed in this debate, whether those of 'the cycle of deprivation' or of 'causal chains', suggested inevitability, whereas in our research continuities between parents and children were, on the whole, weak and discontinuities were visible on all sides. Mechanisms to explain either outcome were best viewed as clusters of interconnecting and cumulative processes rather than as independent and single entities. We also concluded that if continuities were slight over two generations, they were even slighter over three; but, for obvious reasons in a project where field-work lasted only two years, we had little data on three generations of the same family *at the same point in the life-cycle*. It also became increasingly clear to us that explanations of how deprivations are transmitted from one generation to another could not be separated from explanations of how power and privilege are passed on. The mechanisms for the latter are likely to be very different and far less likely to be studied.

At the completion of field-work, we had amassed a wealth of detail on our families which we had categorised, assessed and discussed at weekly meetings as we went along. Inconsistencies and gaps in our knowledge were ironed out or filled in by returning to the families for help. Often, very straightforward solutions were offered by them for problems which had been given tortuous explanations by us. Our weekly meetings were often heated occasions and, with hindsight, one can see that, coming as we did from different disciplines, and using different concepts and vocabularies, we were arguing for different sets of variables. We saw the same families in the same settings and frequently at the same time, but our perceptions and our reports often varied. Considering that our field notes, for example, differed on occasions even about the length of time we had spent with a particular family, it should have been no surprise to us that there were disagreements about the weighting to be given to certain critical factors. Each member of the team was constantly challenged by the other two to provide evidence for cherished beliefs. Although it was our intention to abide by Nietzsche's dictum – 'It is a popular error to have the

courage of one's convictions: rather it is a matter of having the courage to attack one's convictions' – it was often easier psychologically to go on collecting more and more evidence to buttress a particular agreement that was held dear than to look for Popper's (1969) black swan, namely that one piece of evidence that would disprove a cherished generalisation. Indeed, when one colleague pointed out the black swan swimming under the very nose of another, it was often seen at first as off-white or grey – anything rather than black.

Findings

Using both the return to the families for further evidence and the cross-questioning of each other as the main checks on the validity and reliability of our findings, we finally faced the task of explaining why certain families, from all those in all social classes who lead complicated lives, come to the notice of the authorities and are labelled as public problems. In an attempt to answer this question, we pointed to four main features, which shall be discussed briefly:

(1) The families were overloaded with problems whose very complexity seemed to defeat them.
(2) They had no resources, either material, emotional or social.
(3) They had become stigmatised.
(4) Their family patterns of early marriage, large families and child-rearing seemed to militate against them.

The overlapping of problems

Our work increasingly became a comparison between the successful family whom we judged to be climbing out of deprivation and the other three families who were still in serious trouble and who had more than their fair share of problems which intertwined with one another. The latter were subjected to chronic stress by the very *number* of problems that they had to tackle simultaneously: the overcrowding, unemployment, low wages, poor nutrition, enuresis, depressions, and family violence that we observed were not discrete areas of deprivation, but interconnecting and cumulative forms of inequality. It was this interlocking network of inequalities, this web of deprivations, that was the families' greatest obstacle to coping in society. If they had had only one (or perhaps two) major disadvantages to cope with, they might have been able to overcome them, but we saw little prospect of these families tackling the dense mass of problems that surrounded them or of significantly improving their status.

Our case studies showed us how the more social and economic problems (low wages, shift-work, inadequate housing, poor employ-

ment prospects) were inextricably bound up with family relationships – between man and wife, between parent and child, between parent and step-child, between the children themselves, and between the nuclear family and the extended family. One cannot separate the divorces, suicides and ill health, the abortions, children in care, and accidents, the delinquencies, debts and family rows from the families' lack of money and lack of space, their low status and dirty jobs, their poor education and even poorer prospects, and their lack of power and control over their lives. Families from higher income groups experience many of the same or similar problems, although their genesis is likely to be different; but, because of their money and access to professional advice and services, they do not become public problems because they do not make demands on social agencies. Their problems may be just as serious, but they do not exercise the public conscience and no one talks of a cycle of deprivation in relation to *them*.

Our main conclusion, then, was that it was the dense network of overlapping psychological, social, medical and economic factors that overwhelmed the families and perpetuated their problems.

Lack of resources

Whether one examined their material, social or emotional resources, our three families had no margins left with which to play. One widowed mother, for example, had used up whatever fund of goodwill and friendship existed between her and either her family or her neighbours. She even destroyed some of the physical resources that had been given to her by social workers by throwing out the furniture when she wanted to move home or by giving her pension to her boyfriend to encourage him to stay with her. Similarly, the large family we studied used up with such speed the emotional resources of all who came into contact with them that they became a burden and a liability. When this family moved house, our field notes recorded that 'their furniture was rickety, old and dirty; the mattresses were soiled and smelled of urine; all their clothes were carried in a few plastic bags'. In times of high inflation, such families fell quickly into debt, began to impose on local shopkeepers and acquired reputations as bad risks. In sum, they lacked money, possessions worth selling or pawning in times of difficulty, and emotional support.

Their general lack of resources was particularly apparent in relation to employment, low wages and housing. The men we got to know were all part of the pool of unskilled labour, trading their physical strength and fitness for low wages. The women, housebound with young children at home, suffered from social isolation. The combined pressures of loneliness and the poor pay of their husbands drove them out to

part-time jobs. The many honest, hard-working men and women whom we met *earned* their poverty and could do little to improve their lot. We also studied families who through illness and lack of skills were wholly dependent on state benefits, the value of which was gradually being eroded by high rates of inflation. Even if jobs had been available, the wages would not have produced an income much above that which the families received from the state.

Those members of the extended family coming out of deprivation appeared to have made a conscious decision to limit their family to two children, and one couple had accumulated enough money for a deposit to buy their own house, but had been refused a mortgage. Another family had a history of severe overcrowding in the past in both rented and council houses; they moved to a much larger home during our period of field-work, but the patterns of violence begun in earlier days continued unabated. When one of our families moved from one council estate to another, their empty home was vandalised; we began to appreciate the problems of local housing managers who have to synchronise moves and allocate homes to families who have acquired the reputation for being 'dirty'.

Stigma

An emphasis on smells and dirt as the distinguishing mark of the 'problem family' has a long history: witness the classic description of the archetypal 'problem family' by Wofinden (1946: 128):

> Often it is a large family, some of the children being dull or feeble-minded. From their appearance they are strangers to soap and water, toothbrush and comb; the clothing is dirty and torn and the footgear absent or totally inadequate. Often they are verminous and have scabies and impetigo. Their nutrition is surprisingly average – doubtless due to extra-familial feeding in schools. The mother is frequently substandard mentally. The home, if indeed it can be described as such, has usually the most striking characteristics. Nauseating odours assail one's nostrils on entry, and the source is usually located in some urine-sodden, faecal stained mattress in an upstairs room. There are no floor coverings, no decorations on the walls except perhaps the scribblings of the children and bizarre patterns formed by absent plaster. Furniture is of the most primitive, cooking utensils absent, facilities for sleeping hopeless – iron bedsteads furnished with soiled mattresses and no coverings. Upstairs there is flock everywhere, which the mother assures me has come out of a mattress she had unpacked for cleansing. But the flock seems to stay there for weeks and the cleansed and repacked mattress never appears. The bathroom is obviously the least frequented room of the building. There are sometimes faecal accumulations on the floor upstairs, and tin baths containing several days accumulation of faeces and urine are not

unknown. The children, especially the older ones, often seem to be perfectly happy and contented, despite such a shocking environment. They will give a description of how a full sized midday meal has been cooked and eaten in the house on the day of the visit when the absence of cooking utensils gives the lie to their assertions. One can only conclude that such children have never known restful sleep, that the amount of housework done by the mother is negligible and that the general standard of hygiene is lower than that of the animal world.

The quotation has been given in full not only because it was used 'as a guide to field-workers in what to look for' (Blacker 1952: 15), but also because it encapsulates all the components of society's stereotype of the 'problem family'. Wofinden's physical and moral repulsion, and his melodramatic concentration of all social vices into one paragraph and into one family, obscure the very real differences *between* deprived families and the varying combinations of problems *within* one family at different points in the life-cycle.

Although we thought we had dismissed out of hand this crude vignette of the 'problem family', we ourselves in our early field-work did not remain unaffected by this tradition. Such is the power of the image of the 'problem family' conjured up by the literature that it coloured our earliest reports of visits to our families. Even being on our guard against the wilder components of the stereotype did not prevent us from exaggerating the 'squalor' of the homes we visited. Only the evidence collected on repeated visits enabled us to dispense with our preconceptions; such is the compelling force of the traditional picture.

The stereotyped image of the 'problem family' has had its effect on others also. We only had to use the term in our discussions with local officials for some, and especially those connected with education, to produce a rich stream of invective. One official, with thumb and forefinger extended to emphasise his point, described the 'nits the size of grasshoppers' which he had seen in the hair of 'problem family' children. The phrase could have been a captivating title for the book,[3] but caution finally prevailed. *Feckless, fecund and feculent* was another title that was discarded.

Yet to be called a 'dirty family' in the areas where we worked was no laughing matter. The term was used to single out deviant, unusual, or unpopular families. The phrase was hung round the necks of one of our families like an albatross, and it followed them from one district to another, isolating them from their neighbours. In our opinion, in matters of cleanliness and hygiene, there was little to choose between this family and some of the others we got to know well. When people in the area wanted to dissociate themselves from a particular family and

to insist that the family was lower down the social scale than themselves, then they described them as 'dirty'; the phrase was used not only to describe the physical state of a neighbour's home, it was also a term of moral disapproval and social rejection.

Specific family patterns

Some indication of the fragility of relationships can be gauged from the fact that we counted fifteen step-children and eighteen illegitimate children among the extended families of our four main contacts. Why were there so many unwanted pregnancies and early marriages? Why were children and marriages not seen as major events for which preparation and saving were necessary? The answer is not simple. For some girls an illegitimate baby seemed to be a means of escaping into adult independence from what appeared to them as intolerable stress at home; for others, deprived of affection, the arrival of a baby who would love *them* seemed to be the only means of achieving love. Scott, Field and Robertson (1981) have examined the many and varied explanations offered by teenage parents and the point is made that in certain areas and among particular cultural or religious groups there is a 'local script', whereby pregnant teenagers receive family and peer group support for behaviour that is not considered deviant. The pattern of teenage mothers conceiving illegitimate children was continued in one of our families by two out of three daughters which again shows how transmission is rarely a straightforward and inevitable process. As in all our work, it was not the fact of illegitimacy alone or of early marriage alone that plunged the families into difficulties: it was the interconnection of such factors with other problems which produced the dense web of deprivation in which our families became enmeshed. To illustrate, Ineichen (1975) found in his Bristol sample that it was pregnant teenage brides who were most likely to have married on a low income, without any further education, and in overcrowded conditions. The housing system then conspired to plunge them further into a 'vortex of disadvantage' by encouraging them to have more children in order to amass sufficient points to qualify for a council house of their own.

The large family we studied was also burdened by the fact that the birth interval between children was so short: in her second marriage the mother had had six children in eight years (and nine pregnancies and seven children in all). Because the father adopted a rigidly masculine role and retreated to the pub, in part to avoid the work and noise associated with so many children, the mother's task became Herculean: she longed for the days when school would take the toddlers off her hands. Harsh attitudes to contraception (it would

enable the mother to gallivant all over town), a cultural repugnance to breast-feeding (thought to prevent reconception), and a belief in the joys of a large family (untainted by monetary or wider social considerations) were all implicated in the problem. Such behaviour has also to be seen against the backcloth of secular trends in patterns of parenting, which have been well summarised by Rutter and Madge (1976: 226): 'the last few decades have seen marked shifts toward earlier marriage and earlier child-bearing, a higher proportion of illegitimate children [in all social groups], more frequent divorce and smaller families'.

The conclusions we drew about child-rearing practices had to be guarded and tentative, as the children we got to know well ranged in age from birth to 14, and because the families varied in many respects, such as size, composition, income, etc. Certain general points still seem to be worth making. Gender was imposed on babies from the day of their birth, with the father in one family collecting from a local shop the parcel of pink clothes for his new daughter and leaving behind the parcel of blue. The baby in each family was accorded much more licence and affection than the older children, but these were speedily transferred to the newest arrival. Love for children was described by most of our families in terms of buying them expensive presents at Christmas and birthdays, and little gifts of sweets and ice creams on a more daily basis. The lavish Christmas presents tended to be quickly discarded by the children.

In three out of four of our families, parental discipline was highly inconsistent and inefficient. The children did not know how to respond appropriately either because the reasons for their parents' rules were not explained to them so that they had little chance of learning, or because the rules changed so quickly and so often that they became confused. In addition, when they were disobedient or troublesome, we saw their parents threaten them, punish them physically, and also reward them with hugs, sweets, or by letting them do what they wanted – all within the space of a few minutes. One does not have to be a Skinnerian or a behaviourist to realise that such a contradictory pattern of reinforcement was likely to lead to both exasperation on the part of the parent because no technique appeared to work and to anxious confusion on the part of the children.

It is worth reflecting on one father's view that the aggressive tendencies that he inculcated in all his children were exactly what they needed if they were to survive in the streets and in the schools of the neighbourhood, in that 'jungle of might-is-right' which, according to the Newsons (1968: 133), awaits many working-class children outside their back door. There is a great deal of sense in his argument because life for his children was in many ways a fight for survival, in which

the values of co-operation were downgraded in favour of individual competition. Certainly, Wilson's argument (1974) that middle-class and child-centred methods of child-rearing are inappropriate in the milieu of poverty is applicable to this family. So it remains a possibility that the children's behaviour and the parents' child-rearing practices were in some senses very well adapted to their social situation. Wilson's (1980) more recent work, which emphasised the importance of parental supervision in determining whether children are at risk of becoming delinquent in high crime areas, was reflected in our work: the mother of the family coming out of deprivation exemplified her growing detachment from the mores of her neighbours by locking her children in the garden to seal them off from the contaminating influences of other children on the estate. In contrast, the parents in the other three families were very lax in allowing their children to wander where and when they pleased.

Conclusions

It is important not to end this chapter without stressing the many positive and appealing qualities that we found among the parents of our families and the remarkable resilience of the children. It was amazing that, in spite of everything that had happened and continued to happen to them, they were mostly so loving, so generous and so friendly. Our research would not have been possible but for their co-operation and on no occasion were we made to feel unwelcome in any of the homes we visited; we also noted the magnanimity of the large family which took, at short notice, two children into their already overcrowded, rented room. It was no wonder that they fell short of the even-tempered, well-organised ideal. The pressures on them were far greater than on those who have always lived in financial security and have stable affectionate homes. We noticed, however, a division between certain parents, who had a very positive desire to make a better life for their children than they had themselves experienced, and those who were not so concerned. It was a source of amazement and hope to us that the children from the large family, for all their trying home circumstances, were not only coping at school but were actually doing rather well: a triumph of the human spirit over adversity. Our observation is not so much original as part of a growing body of evidence (e.g. Clarke and Clarke 1976) that stresses the resilience of children in general, and of deprived children in particular.

It is also true that the families continued to surprise us and that two years of intensive field-work made us humble and guarded about drawing firm conclusions. Such surprises prevented us from thinking that we had ever reached 'the truth' about a particular family. The

most appropriate analogy for our approach was skinning an onion, where the outer layers corresponded to the earliest accounts from family members about 'superficial' matters such as biographical details. The inner layers were the accounts given to us at later stages when frequently major changes were made to even the most straightforward census data such as the number of children a mother had produced. As with an onion, no inner core of 'truth' emerged. This chapter, then, should be read as a provisional and tentative account, the inadequacies of which are all too well known to the author. In this regard, there may be a lesson to be learned from the hero of Heller's book *Good as gold* who becomes an adviser to the President of the United States and makes the startling suggestion that the President should say 'I don't know' in answer to extremely complex questions. The President eventually tries this ploy to which a reporter responds: 'Mr President, are you sure you don't know or are you merely guessing?' 'I'm absolutely sure I don't know', replies the President.

Notes

1 This chapter, although heavily based on the book *A cycle of deprivation? A case study of four families* by Frank Coffield, Philip Robinson and Jacquie Sarsby, 1981, is my own responsibility.
2 Liebow was here attacking the belief that lower-class Negro families have a distinctive sub-cultural pattern of behaviour (including serial monogamy, for example), which is passed on from generation to generation and which explains their failure.
3 Later entitled *A cycle of deprivation? A case study of four families*.

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References

Agar, M.H. (1977),'Ethnography in the streets and in the Joint', in Weppner, R.S. (ed), *Street ethnography*, Beverly Hills: Sage Publications.
Agar, M.H. (1980), *The professional stranger*, New York: Academic Press.
Baldwin, J. and Bottoms, A.E. (1976), *The urban criminal*, London: Tavistock.
Bandura, A. (1970), *Principles of behavior modification*, New York: Holt, Rinehart & Winston.
Blacker, C.P. (1937), *A social problem group?*, London: OUP.
Blacker, C.P. (ed) (1952), *Problem families: five inquiries*, London: Eugenics Society.
Block, N. and Dworkin, G. (1977), *The I.Q. controversy*, London: Quartet Books.
Bott, E. (1957), *Family and social network*, London: Tavistock.
Brown, G.W. and Harris, T. (1978), *Social origins of depression: a study of psychiatric disorder in women*, London: Tavistock.

Bruner, J.S. (1971), *The relevance of education*, London: George Allen & Unwin.
Clarke, A.D.B. and Clarke, A.M. (1976), *Early experience: myth and evidence*, London: Open Books.
Coffield, F., Robinson, P. and Sarsby, J. (1981), *A cycle of deprivation? A case study of four families*, London: Heinemann Educational Books.
Cornish, D.B. and Clarke, R.V.G. (1975), *Residential treatment and its effects on delinquency*, Home Office Research Study, no. 32, London: HMSO.
Danziger, K. (1971), *Socialization*, Harmondsworth: Penguin Books.
Eysenck, H.J. (1973), 'The triumph of the average', *New Society*, vol. 26, pp. 201–3.
Farrington, D.P., Gundry, G. and West, D.J. (1975), 'The familial transmission of criminality', *Medicine, Science, and Law*, vol. 15, pp. 177–86.
Field, F. (1974), *Unequal Britain*, London: Arrow Books.
Field, F. (1981), *Inequality in Britain*, London: Fontana.
Galton, F. (1869), *Hereditary genius*, London: Macmillan.
Galton, F. (1908), *Memories of my life*, London: Methuen.
Goddard, H.H. (1912), *The Kallikak family: a study in the heredity of feeble-mindedness*, New York: Macmillan.
Halsey, A.H., Heath, A.F. and Ridge, J.M. (1980), *Origins and destinations*, Oxford: Clarendon Press.
Hargreaves, H.D., Hestor, S.K. and Mellor, F.J. (1975) *Deviance in class-rooms*, London: Routledge & Kegan Paul.
Heller, J. (1979), *Good as gold*, New York: Simon & Schuster.
Herrnstein, R. (1973), *I.Q. in the meritocracy*, London: Allen Lane.
Hill, C.S. (1967), *How colour prejudiced is Britain?* St. Albans: Panther.
Holtermann, S. (1975), 'Areas of urban deprivation in Great Britain', *Social Trends*, no. 6, London: HMSO.
Ineichen, B. (1975), 'Teenage brides', *New Society*, vol. 33, pp. 302–3.
Jencks, C., Smith, M., Acland, M., Bane, M.J., Cohen, D., Gintis, H., Heyns, B. and Michelson, S. (1973), *Inequality: a reassessment of the effect of family and schooling in America*, London: Allen Lane.
Kamin, L.J. (1974), *The science and politics of I.Q.*, Potomac, Maryland: Lawrence Erlbaum.
Kamin, L.J. (1981), *Intelligence: the battle for the mind: Eysenck versus Kamin*, London: Pan.
Karier, C.J. (1977), 'Testing for order and control in the corporate liberal state', in Block, N. and Dworkin, G. (eds), *The I.Q. controversy*, London: Quartet Books.
Lamb. M.E. (1979), 'Social development in infancy: reflections on a theme', *Human Development*, vol. 22, pp. 68–72.
Lidbetter, E.J. (1933), *Heredity and the social problem group*, London: Edward Arnold.
Liebow, E. (1967), *Tally's corner*, London: Routledge & Kegan Paul.
Lofland, J. (1971), *Analyzing social settings*, Belmont, California: Wadsworth.
McDougall, W. (1914), 'Psychology in the service of eugenics', *The Eugenics Review*, vol. 5, pp. 295–308.

McDougall, W. (1921), *National welfare and national decay*, London: Methuen.

Mead, M. (1972), 'Research with human beings: a model derived from anthropological field practice', in Freund, P.A. (ed), *Experimentation with human subjects*, London: George Allen & Unwin.

Millham, S., Bullock, R. and Hosie, H. (1978), *Locking up children*, Westmead: Saxon House.

Mitchell, J.C. (ed) (1969), *Social networks in urban situations*, Manchester: Manchester University Press.

Musto, D.F. (1980), 'Continuity across generations: the Adams family myth', in Albin, M. (ed), *New directions in psychohistory*, Lexington: Lexington Books.

Newson, J. and Newson, E. (1968), *Four years old in an urban community*, London: George Allen & Unwin.

Parker, H.J. (1974), *View from the boys*, London: David & Charles.

Parry, W.H., Wright, C.H. and Lunn, J.E. (1967), 'Sheffield problem families – a follow-up survey', *The Medical Officer*, vol. 118, pp. 130–2.

Patrick, J. (1973), *A Glasgow gang observed*, London: Eyre Methuen.

Popper, K.R. (1969), *Conjectures and refutations*, 3rd edn., London: Routledge & Kegan Paul.

Power, M.J., Alderson, M.R., Phillipson, C.M., Shoenberg, E. and Morris, J.N. (1967), 'Delinquent schools?', *New Society*, vol. 10, pp. 542–3.

Power, M.J., Benn, R.T. and Morris, J.N. (1972), 'Neighbourhood, school and juveniles before the courts', *British Journal of Criminology*, vol. 12, pp. 111–32.

Preston, B. (1974), 'Statistics of inequality', *Sociological Review*, vol. 22, pp. 103–18.

Rex, J. and Moore, R. (1969), *Race, community and conflict*, London: OUP.

Reynolds, D. (1976), 'The delinquent school', in Hammersley, M. and Woods, P. (eds), *The process of schooling*, London: Routledge & Kegan Paul for the Open University.

Rheingold, H.L. (1969), 'The social and socializing infant', in Goslin, D.A. (ed), *Handbook of socialization theory and research*, Chicago: Rand McNally.

Robins, D. and Cohen, P. (1978), *Knuckle Sandwich*, Harmondsworth: Penguin Books.

Robins, L.N. (1972), 'Follow-up studies of behaviour disorders in children', in Quay, H.C. and Werry, J.S. (eds), *Psychopathological disorders of childhood*, New York and London: John Wiley.

Rudolph, S.H. and Rudolph, L.I. (1980), 'Authority and the transmission of values in the Rajput Joint Family', in Albin, M. (ed), *New directions in psychohistory*, Lexington : Lexington Books.

Rutter, M. (1970), 'Sex differences in children's responses to family stress', in Anthony, E.J. and Koupernik, C.M. (eds). *The child and his family*, London: John Wiley.

Rutter, M. and Madge, N. (1976), *Cycles of disadvantage*, London: Heinemann Educational Books.

Rutter, M., Maughan, B., Mortimore, P. and Ouston, J. (1979), *Fifteen thousand hours. Secondary schools and their effects on children*, London: Open Books.

Salmon, P. (1979), 'The role of the peer group', in Coleman, J.C. (ed), *The school years*, London: Methuen.

Savage, S.W. (1946), 'Intelligence and infant mortality in problem families', *British Medical Journal*, vol. i, pp. 86–8.

Scott, K.G., Field, T. and Robertson, E.G. (eds) (1981), *Teenage parents and their offspring*, New York: Grune & Stratton.

Seaver, W.B. (1973), 'Effects of naturally induced teacher expectancies', *Journal of Personality and Social Psychology*, vol. 28, pp. 333–42.

Sheridan, M.D. (1956), 'The intelligence of 100 neglectful mothers', *British Medical Journal*, vol. i, pp. 91–3.

Spradley, J.P. (1980), *Participant observation*, New York: Holt, Rinehart & Winston.

Townsend, P. (1974), 'The cycle of deprivation – the history of a confused thesis', *British Association of Social Workers' Conference*, University of Manchester, March.

Townsend, P. (1979), *Poverty in the United Kingdom*, Harmondsworth: Penguin Books.

Valentine, C.A. (1968), *Culture and poverty*, Chicago: University of Chicago Press.

Willis, P. (1977), *Learning to labour: how working class kids get working class jobs*, Westmead: Saxon House.

Wilson, C. (1979), 'The development of self', in Coleman, J.C. (ed), *The school years*, London: Methuen.

Wilson, H. (1974), 'Parenting in poverty', *British Journal of Social Work*, vol. 4, pp. 241–54.

Wilson, H. (1980), 'Parents can cut the crime rate', *New Society*, vol. 54, pp. 456–8.

Wilson, R. (1963), *Difficult housing estates*, London: Tavistock.

Wofinden, R.C. (1946), 'Problem families', *Eugenics Review*, vol. 38, pp. 127–32.

Wood Report (1929), *Report of the Mental Deficiency Committee*, London: HMSO.

Wootton, B. (1959), *Social science and social pathology*, London: George Allen & Unwin.

Wright, C. (1955), 'Problem families: a review and some observations', *The Medical Officer*, vol. 94, pp. 381–4.

Wright, C.H. and Lunn, J.E. (1971), 'Sheffield problem families. A follow-up study of their sons and daughters', *Community Medicine*, vol. 126, pp. 301–7.

3 Generations of 'Problem Families' in Sheffield

W.L. Tonge, J.E. Lunn, M. Greathead, S. McLaren and C. Bosanko*

Background

In Britain today there exists a small core of families who have far more than their fair share of social problems and who become involved with numerous social agencies. Whether or not these families are referred to as 'problem families', and whether their difficulties are thought to be the result of social conditions or personal problems, they have given rise to extensive concern. Their prolonged reliance on the services, a growing pessimism concerning the apparent intractability of their difficulties, and the feeling that their presence somehow contradicts the widespread and general improvement in living and social conditions, have largely been responsible for this interest. Furthermore, the fear of those such as Sir Keith Joseph (1972) that, by their very nature, such families might be repeating themselves generation after generation has done much to revive emotive consideration of their circumstances.

'Problem families' are by no means a new phenomenon, and they have been described by many researchers over the course of this century (e.g. Booth 1902–3; Wood Report 1929; Lidbetter 1933; Blacker 1952; Scott 1958; Wilson 1962; Philp 1963). Nevertheless they are not always an easily identifiable group, and in practice studies of which they are the focus tend to select samples from families in contact with multiple social agencies. This is probably the most viable approach but it does of course mean that identified families are disproportionately likely to be characterised by poverty, many children, chronic illness, slum housing, criminality, marital discord, child neglect and personality disorder.

In Sheffield, where considerable interest has been focused upon such families over the past thirty years or so, this has certainly been the research strategy normally adopted. Dr Catherine Wright was the first worker in this tradition, and she began by studying 120 families

* Deceased 1976.

registered by health visiting staff. She noted in her early paper (1955) that concern in the recent past had shifted from primary emphasis on the physical squalor, poverty, general fecklessness and child neglect in these families to the more far-reaching effects on children and adults of being brought up in a 'problem family', and her own findings supported this change of direction. Infant mortality, for instance, was much above average among her study families – 38 of the 562 children born died before they reached their first birthday – and the life chances of older children seemed little better. Of the 106 children aged over 15 years, 45 had by the time of her study already appeared in court at least once, and 39 were already married, only nine of such marriages being known to be satisfactory. Transmission of a problem family life-style seemed apparent.

Thirteen years later these same families were revisited to see how far their circumstances had changed. It emerged that 19 families had broken up and that employment – 45 per cent of the husbands were out of work, and the rest were mainly in unskilled jobs – and child care both presented serious problems (Parry *et al*. 1967). On the other hand there had been marked improvements in housing conditions and these, together with the fact that many children had grown up and left home, meant that household density was no longer a serious problem. The mean number of persons per house was 5.8, and overcrowding was rare compared to thirteen years previously when 34 per cent of families had been described as 'grossly overcrowded'. It appeared that most of the families had more or less settled down and presented a 'public face' with outward and material standards approaching normality.

Wright and Lunn (1971) carried out yet another follow-up of these families, reporting on the circumstances of the children who were 16 years of age or over at the end of 1967: altogether there were 835 known descendants of the original 116 families, and 577 of these were over 16 years old. Both the employment record and material possessions of these second-generation members were better than those of their parents. Improvements in employment, moreover, were marked. Some 76 per cent of the sons and 84 per cent of the daughters' husbands were working full time compared with only 45 per cent of the fathers; and in addition, 28 per cent of the married sons and 43 per cent of the daughters' husbands held skilled jobs relative to only one in six of the older generation. Other aspects, however, were less satisfactory. There was already a disproportionate dependence of social security benefits and the situation appeared to be worsening as the families increased in size. According to Wright and Lunn, it was certain that about 33 per cent of the married siblings were either problem

families or had started on a course of involvement with helping agencies that was unlikely to be reversed. A further 33 per cent gave the impression of functioning precariously in terms of marital harmony, work, living standards and income.

At about the same time, in 1968 and 1969, Tonge *et al.* (1975) embarked upon another study of problem families in Sheffield. In this investigation the aim was to evaluate the contribution of psychiatric illness and personality disorder to the characteristic social maladjustment, and to distinguish these effects from those of socioeconomic pressures. The thirty-three families, from two local authority housing estates, in contact with the largest number of social agencies were chosen to represent the problem group, and a further thirty-three families – matched for site of residence and age of the wife, but who did not have the same degree of agency contact – were selected for the comparison group.

Several interesting findings emerged from the study. First, the problem families had more children than the comparison families, and the wives of the problem group had a higher rate of miscarriages. Second, the prevalence of psychiatric problems and low measured intelligence was higher in both sexes of the problem families than in the comparison families. Third, gross marital disharmony was present in only three of the thirty-three comparison families but in nearly half of the problem group. Fourth, over two-thirds of the problem group appeared to be providing inadequate child care. Fifth, seven of the control group and nineteen of the problem group were in poverty, and many of the latter families were in debt; financial difficulties were significantly associated with abnormal personality traits in the wife.

Furthermore there appeared to be some support for the notion that problem families are 'friendless families'. Tonge *et al.* found that the problem group had fewer contacts with relatives and neighbours than comparison families and that they took little part in community activities. Both these aspects of social isolation appeared to be associated with child delinquency, marital discord, psychiatric treatment and criminal behaviour.

In conclusion Tonge and his co-workers decided that there was no evidence for a typology of problem families, although many displayed a common value system with the four characteristics of ignoring rules, discomforts and long-term consequences of actions, and distrusting education. Generally it seemed that the families represented a mosaic of maladjustment, with each piece of maladaptive behaviour related to a specific stress or handicap. All the same the extent of psychiatric pathology revealed in the problem families was not sufficient to account for all aspects of social maladjustment.

The present study

The present study is a follow-up of the original families investigated by Tonge *et al.* (1975), and considers in the main their adult children. The primary aims are to re-examine the circumstances of the families earlier classified within the problem group, to study the problems currently shown by the second generation and to compare these with those shown by their parents, and to attempt to uncover factors that seemingly influence whether children fare better or worse than, or similarly to, their parents.

Following a pilot survey – based on the second generation of the pilot group used in the original Tongue *et al.* research – the main investigation began with visits to the original (first-generation) families to discover the addresses of their married children. Although some families were only too pleased to help, most of the tracing of the subjects was bedevilled by loose family ties, reluctance to involve children who had bettered themselves, the fact that some children had been removed into care and, in some cases, little regard for research or psychologists. The latter point was clearly and succinctly made by one respondent in reply to our letter of introduction who wrote: 'Enough is enough; no hard feelings I hope'.

The second-generation families were next contacted and visited. Information was collected via an interview schedule which included questions on fourteen main areas: family; medical history of children; the wife's view of the local school; housing; ownership of common durables; extended family composition; family interaction; neighbourhood interaction; work histories; contraception; earnings; expenditure and debt; attitude towards children; and impression of husbands and wives. Most of the more delicate information was gained through a process of 'social negotiation' in which the skills of the social worker were crucial and the memory of a tape recorder was invaluable.

Standardised test data on intelligence and personality were also collected. The Mill Hill Vocabulary Scale, Raven's Progressive Matrices, Cattell's Sixteen Personality Factors Test, the Personal Disturbance Scale and the Gibson Spiral Maze Test were employed for this purpose. In addition the DSSI, an inventory of delusions, symptoms and states of mental illness, was adopted to gain some indication of neurotic symptoms and states of anxiety and depression. All these measures were supplemented by clinical observations by the interviewers (a social worker and a psychologist).

Apart from the data collected during visits by the social worker and the psychologist, an attempt was made to investigate criminality via police records, and unemployment and sickness absence through the Department of Health and Social Security.

First generation families

As already mentioned, it was necessary to visit the original families studied in order to trace their grown-up children. Advantage was taken of the preliminary visits to make a brief assessment of the situation of these families in 1976 as compared with eight years previously. However, it first became necessary to eliminate four families from the analysis – two from the original problem group and two who had served as comparisons – as the earlier classification of these families seemed dubious. For example, in the course of the follow-up it became apparent that deep-seated problems existed in a family that had originally been classified as a comparison family. It was on the basis of the father's mental health, the mother's low intelligence, the poor child care techniques as well as marital disharmony, that it was decided that this family had more likely been a problem family from the start.

During the follow-up the families were assessed on husband's employment, housekeeping standards and the marriage. In all these areas the problem families continued to present a bleaker profile than did the comparison families. At this point in the investigation seven of the thirteen comparison men were employed, whereas only three out of twelve had jobs in the problem group. And, of those in work, men in the comparison group tended to be employed in a more skilled capacity. Poorer house care standards were also evident in the problem families, although the greater number of children present may have been partly responsible for this finding.

Furthermore, the marriage record was not good. In the problem group six out of sixteen marriages had broken up, and in three of these psychopathy or personality disorder had been noted in one or both partners during the original study. Such disorders were also present in seven of the ten intact marriages, and marital discord was suspected in four of these families and known in the other three. In the comparison group three out of the fifteen marriages had broken up, and personality disorders were present in two of the wives. There was also known marital disharmony in two of the remaining intact marriages within this group.

Generally marital break-ups resulted in a change in the over-all situation of the families. Following the six broken marriages in the problem group, it appeared that the situation had improved in three cases, that it remained unchanged in two, and that it was superficially improved in one, i.e. it had improved materially but not emotionally. In contrast the situation had deteriorated in two of the three broken comparison group marriages, but had remained stable in the third. It seemed that where families retained their problem status following the break up of their marriage, this was largely owing to factors such as

large families, financial difficulties, conflict with neighbours, and poor standards of hygiene, child care and home management.

When all factors were considered, a more general picture of the families' position emerged and this is illustrated by the changes observed among the first-generation families over the seven or eight years that elapsed between the two studies. Of the sixteen problem families, for instance, one had improved to the point of ranking as a comparison family and a further four had improved sufficiently to be reclassified as 'borderline' problem families. Eight were continuing as before and three by this later date were labelled as 'burnt-out' problem families as, despite still having deep-seated difficulties in the fields of child care, employment and contact with social agencies, they were much more secure materially. Among the comparison families, three out of fifteen had improved, eight remained unchanged, and four had become 'borderline' problems.

At this point it is important to note that definitions of continuing, burnt-out and borderline problem and comparison families are not identical to those used by Tonge *et al.* (1975) where contact with several social agencies was the criterion for problem family identification. Classification at the follow-up instead depends upon the presence or absence of various personal and social characteristics. Assessment is based on decisions on whether individual families had improved, not changed, or become worse since they were originally seen and these were made jointly by the doctors, psychologist and social worker in the research team.

Second-generation families

Married sons and daughters aged 21 and over, younger children, unmarried but with stable relationships, and some other grown-up sons and daughters, were all included within the second-generation group. Fifty-nine sons and daughters were studied: thirty-four of these were from the problem group and twenty-five were from the comparison group. The mean age of the problem group sons was 26 years of age and that of their wives 25.2 years: this compared with 24.9 and 23.8 years respectively for sons and their wives in the comparison group. Problem group daughters had an average age of 24.2 years, their husbands an average of 28.3 years, and the respective figures for comparison group daughters and their husbands were 24.1 and 25.5 years.

Of primary interest in considering the second generation is whether they showed similar, higher or lower levels of problems than their parents. Again a concept of social mobility was adopted to indicate the presence and direction of change and, as in comparisons of the par-

ental group at two points in time, consensual decisions on mobility were reached by the doctors, psychologist and social worker following observation of personal and social difficulties.

It emerged, on this basis, that there was some relationship between the social mobility of parents between 1968 and 1977 and the likelihood of change shown by their offspring. Thus the five first-generation problem families who had been upwardly mobile produced fifteen second-generation families showing improvement and only one remaining socially immobile, and the eight first-generation families whose conditions had remained static gave rise to ten second-generation families showing improvement and seven remaining socially immobile. The three first-generation families who became 'burnt-out' produced five second-generation families showing improvement and two second-generation families remaining socially immobile.

In the case of the comparison families, the social mobility of the second generation in relation to the first generation was more erratic. For instance, the four first-generation families who deteriorated between 1968 and 1977 produced seven second-generation families of whom three were socially mobile upwards, two unchanged and two mobile downwards, whereas the three first-generation families who improved over the same period produced five second-generation families of whom two were socially mobile upwards and three immobile. The eight first-generation families who did not show any social mobility between 1968 and 1977 produced seventeen second-generation families of whom twelve were socially mobile upwards and five immobile.

As has been reported in past studies, it was found that poor living conditions reflected the unsettled circumstances past and present of the families: almost half the problem group had unsatisfactory housekeeping standards and twenty-two families from this group, compared with eight from the comparison group, had houses rated as being in only satisfactory, or bad, structural condition. These factors, in turn, appeared to be linked to social mobility, in that standards were generally better among those showing upward mobility.

During the course of home visits, the social worker was able to observe whether or not households contained certain items of equipment and consumer durables. Both telephone rentals and car ownership were more common in the comparison than the problem group, and most common in families showing 'upward social mobility' irrespective of which group they belonged to. However, there was no clear difference between the comparison and the problem families in ownership of washing-machines and refrigerators.

Whereas general 'living' standards may reflect the problems of these families, there is no indication that they cause them. However, as

already shown, there is some evidence to support the concept of a 'cycle of transmitted deprivation' to the extent that the material disadvantage found in the first-generation problem group is more often shown by their sons and daughters than by the general population as a whole. Many of these disadvantage factors have been alleviated to a considerable extent by the growing over-all prosperity of Britain and by new social habits in relation to family and family size following easier contraception and abortion. Nevertheless, in a statistical sense, the concentration of 'disadvantage factors' is still quite recognisable in the households of the second-generation problem group.

Many surveys of problem families have shown that a high proportion of fathers work very irregularly or not at all. In this study, too, unemployment was concentrated in the problem group: six men from these families were unemployed as opposed to none from the comparison group. Moreover where they were employed, men from the former group generally held jobs of a less skilled nature than did their comparison group counterparts. Compared with the men, only a small proportion of the women were working full time. Out of twelve in the comparison group, four were working full time, three part time and five not at all, whereas two out of twelve problem group daughters had full-time jobs, three worked part time and ten were not employed.

Employment stability of both the men and women was also examined. The pattern that would emerge for the sons became fairly clear some time before the data were formally analysed, owing to the much greater difficulty in collecting information from the problem group. As might be expected, the comparison group, both males and females, tended to show greater employment stability. In the problem group seven of the sixteen sons had held over ten jobs since leaving school, whereas none in the comparison group had shown this amount of change.

In order to obtain objective evidence of gainful employment over two years (1973–5), the Social Security Central Records Office (with subjects' consent) supplied details of National Insurance credits awarded for unemployment and sickness. The fact that the problem group had been awarded more credits than the comparison group tallied with, and thus supported, the findings on employment.

Differences also emerged in relation to the income of sons who were working in 1977 and 1978. Whereas the mean weekly pay of the comparison group was £51, and the median figure £50, the mean income for the problem group was £60 with a median of £55. The disparity between the mean and the median in the problem group is partly accounted for by two subjects bringing in over £100 per week. If, however, figures were calculated to include those sons on social

security payments, the problem group would be bringing in markedly less money on average. It would seem that the relative poverty of the problem group is the result of the combined effects of long-continued absence from work and over-all lower earning capacity.

Crime has often been claimed to be unduly concentrated within problem families, and the present study supports such a claim. The over-all findings showed that offences were twice as common in the problem as in the comparison group, and over four times as common among males as among females in both groups. Offences against the person, public order offences and motoring offences were concentrated almost entirely among the men, but women accounted for 21 per cent of theft offences. Findings suggest that theft, offences against the person, and public order offences were predominantly committed by the problem group sons with an increase in offences after the age of 17 years. Analysis of these data was much curtailed by the need to preserve anonymity.

Criminal offences, as well as the persistence of poverty, have in the past been linked to mental health and personality characteristics. This study intended to investigate further these claims by considering relationships between personality factors and the mobility or improvement of the families. However, on examination of Cattell's primary personality traits, no significant difference was found between those families showing upward social mobility and those who were 'socially immobile' – all scores fell within the average range. It was only from the second order personality factor of anxiety that an association emerged, with the people who were rated as 'socially immobile' scoring as more anxious than those who had moved socially upwards. There was no real difference between hostility (Personality Deviance Scale) shown by the problem and comparison families, and this was also not linked to the mobility of the subjects. Furthermore the group mean scores for dominance, intrapunitiveness and extrapunitiveness all fell within the normal range. Depression, as measured by the Personal Disturbance Scale, was shown to affect a higher proportion of the problem group (twenty-six out of forty-seven) than the comparison group (ten out of twenty-six), but again this factor was not related to social mobility. So, in general, even though a few differences emerged between the problem and comparison groups, and between the different 'mobility' groups, these are too small to allow any statistically valid conclusion to be drawn.

Many earlier writers on problem families have suggested that inherited low levels of intelligence are largely responsible for the development of social problems. In this study the feasibility of this claim was investigated and three separate measures of the subjects'

intelligence taken. These comprised, first, the social worker's impression, which should be viewed with caution as the subjective nature of this investigation makes questionable the reliability of distinguishing between such narrow bands of ability and, second and third, standardised tests in the form of the Mill Hill Vocabulary and Raven's Progressive Matrices.

The RPM and MHV mean scores for the second-generation problem group were 92 and 90, respectively, compared with the comparable comparison group scores of 105 and 95.[1] It was apparent from both tests that the members of the problem group tended to be of lower intelligence than subjects in the comparison group – more were classified as 'dull' and fewer as 'bright' or 'average' – and this finding was confirmed by the impression of the social worker. Nevertheless, although low intelligence was evident in the problem group, it is suggested that poor intellectual skills are not a frequent cause of disability but, like unemployment, can be responsible for maintaining 'incapacitated' families.

As observers of social problem groups have frequently emphasised the stresses of large families, this study attempted to look at the additional economic, social and emotional burdens faced by families with many children. Examinations covered the three areas of (1) desired family size; (2) present family size in relation to contraceptive practice and desired family size; and (3) actual family size compared with parental (first-generation) family size, corrected for age and sex. The findings suggest that the problem group as a whole both desired a slightly larger family than the comparison group and, at the time of investigation, had actually conceived more children. Both groups appeared to be taking satisfactory contraceptive precautions and had consequently produced fewer children than their parents. This was particularly marked in the problem group where achieved family size was 1.8 children in comparison with a parental (first-generation) rate of 3.5. It is possible that these families might revise their estimates of desired family size, but on the whole the picture is reassuring in that few families looked likely to encumber themselves with a burden of children whom they would be unable to sustain both emotionally and financially.

In addition to family planning, parenthood involves child care. Differences were found between the two groups in the parents' attitudes towards their children, the problem group tending to be less consistent and more permissive. These contrasts were apparent virtually from the beginning of the study: when the social worker carried out her initial interview, it was noted that some families were highly organised and the children were in bed before the interview

began, whereas other families were less organised and the children appeared not to go to bed until late but instead grew progressively less controlled and more excitable. Subjective as these ratings are, they do support other reports of the withdrawal of protective care and the philosophy, as summed up by Spindley, that 'from now on he must grow up as best he can'. Although methods of child rearing have been shown not to have any direct influence on intergenerational transmission, it is likely that upbringing will contribute to the child's personality development and acquisition of social attitudes – and thus possibly have an indirect effect on later parenting behaviour.

So far the discussion has focused on a variety of personal and social circumstances characterising the study families. Nevertheless it should not be forgotten that the number of contacts a family has with certain social agencies provides a useful measure of the extent of their social failure and indeed, as will be remembered, was the criterion on which the first-generation families were selected for study. So how were second-generation families faring in this respect?

As expected, social mobility was related to agency contacts. The seven second-generation problem families who were socially immobile, relative to the standards of their parents, were also in touch with a variety of agencies. However, only four of the problem group families who showed upward social mobility had contacts. Furthermore, none of the comparison group, irrespective of their social mobility, were in touch with the social agencies.

The families: some illustrations

The foregoing discussion indicates that many of the offspring of an original group of problem families appeared to reproduce the troubles of their parents, although in all respects the second generation was better off than the first. Notably, the adult children from problem families had worse work and crime records than their counterparts from comparison families, particularly if they belonged to sons' families rather than daughters'.

Although the over-all findings suggest that 'disadvantage factors' are more prevalent among sons and daughters of problem than comparison families, there is no predictable way of determining who will develop into a problem family, or when, and it is evident that being brought up amidst difficulties can lead to a variety of outcomes. In some ways the issue resembles that of mortality data which allow predictions to be made of the proportion of people who will die by a particular age, or of the mean life expectancy of a person at a given age, but which can say nothing concerning *who* is going to die at a given age or *at what age* a given person is going to die. Such predictions at the best

of times are unreliable, even with good medical information. Nevertheless clinical descriptions can aid a general understanding of likely, or at least possible, outcomes.

In this way descriptions of some of the study families in a more clinical sense can serve to illustrate the different patterns of outcome found. For instance the PB² family illustrates how a relatively favourable second-generation outcome is possible despite very inauspicious beginnings. The first-generation parents had serious personality disorders from which stemmed sexual, marital and employment problems, poor standards of child care and criminality. Of their seven children, one was subnormal, on probation, enuretic and a drinker, and another was still of school age, but the other five had left the parental home and the problem family situation behind. They appeared to be prospering and were psychiatrically healthy despite a bad childhood that had included an episode of incest. The fact that they had broken free of the problem family situation did not mean that they had enjoyed a clear run. A pattern of early minor problems appeared to exist within the families, such as for Mr PB4S who estimated that by the time he was 21 he had had about thirty-five jobs, many of them unskilled. However, these appeared to be of little significance to the later improvement of the family which was evident in stable employment, marital concord, small families and house purchase. Indeed the outcome for the second generation was both surprising and gratifying. One could not have predicted such a favourable result for the offspring of two psychiatric parents, both with criminal histories involving offences against the person, and living a life-style of multiple contacts with social agencies.

By way of contrast, consider next the PD family where problems in the first generation were well repeated in the second. Mr PD was described in the case files as inflexible, rigid, forceful and lacking in intelligence. He dominated the family and discouraged independence, and by 1976 five of the six offspring had grown up and left. Although the consequent reduction in household size somewhat alleviated the situation, there were still problems in the form of unemployment, illness, and Mr PD's attitude to the family.

At the time of interview, the oldest son (PD1S) lived in a terraced pre-war council house with his wife, five children and a maternal aunt, and standards of hygiene were described as 'rather low'. This family was on the verge of statutory overcrowding. Mr PD1S had been unemployed for three years; in all he had had between twelve and fifteen jobs plus a period at the Industrial Rehabilitation Unit. Mrs PD1SW was working five evenings a week and regarded her husband's employment prospects as nil.

The family lived on supplementary benefit, children's allowances, small payments from the aunt and Mrs PD1SW's earnings, and there were several contacts with social agencies. Moreover there was a lot of tension within the marriage, and three separations had already taken place. This seemed like a well-developed problem family with little prospect for improvement in the future.

The eldest daughter, Mrs PF2D, presented a picture that was, if anything, worse than that shown by her parents. She had recently been divorced and was at the time of interview living in 'squalid' accommodation. There were three children, but only one was with her at the time of the visits. According to the interviewer's observations, he was warmly clad and friendly, but was backward in speech and sometimes very dirty. The eldest child was illegitimate and was presenting 'anti-social difficulties' that resulted in vandalism and being taken into care.

Mrs. PD2D was living on social security benefits, plus a little sporadic help from her current boyfriend. She was assessed as being of limited intelligence and in personality she seemed emotionally hostile and rather dependent. She was anxious and depressed, and acknowledged phobic symptoms. It was decided this was a problem family in which limited intelligence and an unsatisfactory marriage had encouraged repetition of problems shown in the parental generation.

The third daughter of Mr and Mrs PD is discussed later in the chapter so little about her will be mentioned here other than to say that her situation, which appeared irretrievable right up to the age of 24 years (she had a history of probation, an illegitimate baby and a disastrous marriage), was helped by her relationship with her second husband and by the adoption of his standards.

The next daughter, Mrs PD4D, had a rather complex background. She was an immature girl who had an apparently stable relationship with a more intelligent man seventeen years her senior whose first marriage had failed. They had been living together for a number of years and there were three children of the liaison. Although there was social mobility upwards, relative to the original PDs, there were still many difficulties in this second-generation family relating to child care, employment and minor criminality. For these reasons their future outcome was difficult to predict.

The last PD daughter, Miss PD5D, was 18 years old. She had one illegitimate child and showed poor standards of child care. Her accommodation situation was rather precarious: during the course of the investigation she moved from living with her sister to living with her unemployed boyfriend, and finally it was reported that she was living in lodgings elsewhere and that the boyfriend was 'in the hands of the police'.

Looking at the second-generation PDs as a whole, it appeared that there were three continuing problem families, one family where there was definite improvement but with unsatisfactory aspects, and one family who seemed to have broken clear after an apparently disastrous start. Continuity of problems across the generations was, therefore, fairly complete – although the escape of Mrs PD3D should not be forgotten.

These findings demonstrate that second-generation outcomes are never inevitable. This is further and well illustrated by the contrasting circumstances of two sisters brought up in the same problem family.

The first sister, aged 22, lived in an old terraced property with outside toilet, no bathroom and no running hot water. Hygiene was poor and a bucket, containing urine and faeces, was overflowing on the landing. The husband was unemployed, and evasive about alleged involvement with the police. There were three children, of whom the eldest was four years and possibly being mistreated. Another baby was on the way. At interview Miss PF1D was friendly and co-operative. Her intelligence was below average and she appeared emotionally labile and anxious.

The second sister, aged 28, lived in a well-kept and well-furnished maisonette on a council estate. The husband was employed as a buyer for a medical supplies firm on an annual salary of £3,500 (in 1975) paid monthly. There were two children and the husband had undergone a vasectomy because they considered their family to be complete.

There was no doubt that this family had moved socially upwards, and there was little contact with the parental home although Miss PF2D was still fond of her father. By contrast there were good links with the husband's family. At interview Miss PF2D was friendly and co-operative. She was of average intelligence and, regarding personality, she was rated as relaxed and outgoing with emotional strength and a sense of her own obligations.

All these case studies point to the fact that the experience of being brought up in a problem family can lead to a variety of outcomes.

Factors at work in the families

Although some offspring from 'problem families' develop quite normally, there is now considerable evidence to suggest that the likelihood of educational, psychiatric, occupational and family problems in the second generation is well above the national average. This study was not designed to be able to discover, conclusively, what the mechanisms are that lead to intergenerational continuities or discontinuities, but it has been able to derive some impressions as to what some of these might or might not be.

Nevertheless it is important to remember that problem families and their offspring are not a homogeneous group, and factors working in one family may be very different from those acting in another. Moreover factors will not necessarily be significant in isolation, and it may be patterns of combination that are critical. Finally, before examining five possible family mechanisms, it must be emphasised that discussion is restricted in the following section to issues on which there are pertinent data. Thus neither genetic factors, which are important in the development of intelligence, and seem to have some role in alcoholism, criminality and temperament, nor broader social factors, which doubtless also are of some significance, are mentioned. Their omission, however, is owing to data restrictions rather than because it is thought that they have no power of explanation in the aetiology of 'problem families'. It would seem very probable that both are involved.

Marital relations

It became clear from this study that often the first- and second-generation problem and comparison families who had improved over time, or families who had continued in the comparison group, not only showed considerable marital stability but also benefited from the presence of a steady and supportive partner. This point is well illustrated by the case of a problem group daughter who showed recovery from a bad start. The woman had an illegitimate child at age 18, was put on probation for some offence that was not specified, and then later cohabited with a married man which led to a disastrous marriage and four children. Finally she broke off the marriage, abandoned the children and ran away to another town. Here she settled down into steady employment, established a stable relationship with another man, and set up a comfortable home into which she gathered the children of her previous marriage. It was a remarkable transformation between the ages of 18 and 24 years which raises the question of just how late in life new standards can be taken up. It was, however, a pattern that had been described by Sheridan (1959) and in which the presence of a steady and affectionate partner appeared to have been of great importance.

Similar processes seemed to be going on in some of the intact first-generation families, from both problem and comparison groups, where marriages had improved between original study and follow-up dates. In these cases the families were becoming more stable owing to the father's increased interest in the family, his employment, and the children's growing independence and financial contribution to the home. In many ways the families had become more emotionally and

financially secure. One problem family who showed marked improvement over the years well illustrates these points. When seen in 1968, the wife had been under serious domestic pressure with ten children and inadequate financial and emotional support from her husband. By 1976 the family had been rehoused, both parents had jobs, and three of the children were also working. The husband was now contributing more to the family in terms of both time and money. The main factors responsible for the improvement were apparently the increased family support, the maturing attitudes of the second generation, and the fact that five wage packets were now coming into the house.

Just as marital stability, on the one hand, would appear to ease a family's difficulties, so, on the other, marital maladjustment seems often to be associated with the development of additional problems. Certainly poor marriages seemed to characterise both continuing second-generation problem families and families, problem and comparison, where standards had deteriorated. In general these families showed marital discord and in some cases displayed an inability to make permanent relationships. The case notes of a family classified as a continuing problem family, and with frequent social agency contacts, illustrate this point:

> The eldest of the PO family was Mrs PO1D aged 33 years and divorced. She had a very disturbed childhood going in and out of care. There was some doubt about her paternity and Mr PO never acknowledged her as his child. She started work as a nursing auxiliary and married at the age of 18 years. Her husband was 28 years old and they had a 'big white wedding'. By the time she was 21 they had three children but they were frequently separating because he was 'always off with young lassies' and she once found him in bed with her younger sister (PO2D) when she was only 15 years old. At the age of 22 years she deserted Mr PO1DH and the children and 'went on the streets'. The children went into care. In due course she claimed the eldest girl back and she was living with her at the time of the interview (aged 15 years). There was, also, a fifth child aged 5 years (father unknown) living with her at this time. A fourth child had been placed for adoption with the foster mother of the second child.
>
> After divorcing Mr PO1DH she married a coloured immigrant (Mr PO1DH2) and he was said to work while she was on the streets. They had a difficult relationship with many separations, reconciliations and violent episodes. She eventually divorced Mr PO1DH2 for cruelty and currently had a boyfriend with whom she was 'just friends'.

The lack of deterioration, or even improvement, of some first-generation families after marriage breakdown provides some additional evidence for this proposed mechanism. The findings suggest that a

change for the better, for all concerned, may follow the removal of the unreliable partner. This is exemplified by one family who continued as a comparison family after the marriage breakdown, but where there were signs of greater stability:

> Mr and Mrs CH were suffering from serious marital maladjustment when visited in 1969 but the reasons for the incompatibility were not discovered and the family, in other respects, appeared to be functioning well and was not in contact with social agencies. When visited in 1977 Mr CH had been out of the home for six years. Mrs CH was living on social security payments but the home was comfortable and clean and it was apparent that at least one of the sons (Mr CH3S aged 20 years) together with his wife was giving a lot of support. Mrs CH had been ill but was feeling much better and quite optimistic at the time of the visit. Referring to Mr CH she said 'I manage better without him'. Three of the family were still at home, Miss CH4D aged 16 who was attending a typing course and CH5S and CH6D aged 14 and 11 respectively, both at school and apparently no problem.
>
> This appeared to be simply a family in which the marriage had broken up but a stable home had continued.

Marital adjustment is important not only in relation to present state but also because of possible future consequences. A variety of studies have indicated that men whose parents were unhappily married are more likely themselves to show poor marital adjustment, and Tonge *et al.* (1975) showed that the parents of children with psychiatric disorders were more likely to show marital discord than parents with non-disturbed children.

One factor that would appear to counteract the effects of marital discord in families with difficulties is the change in society whereby divorce has become socially acceptable to many people, and consequently fairly common. Twenty or so years ago the unhappy marriages of poor families just struggled on with one child arriving per year for ten or twelve years. These unfortunate children were brought up in the midst of rows and marital stress. Such marriages now tend to break up early and the divorcees frequently find new, more compatible, partners and start afresh – often with success.

Family size

Many investigations of problem families have stressed the effect of family size and have, for example, indicated how individuals in the lowest social groups or with frequent unemployment tend to have greater than average numbers of children (Wright and Lunn 1971; Tonge *et al.* 1975). Secular trends, however, are important to take into

account and, as already pointed out, the second-generation families in this study were producing many fewer children than had their parents.

For this reason it cannot be suggested more than tentatively that family size may be among the significant influences upon a family's ability to cope. Certainly this study found, within the first generation, that large families seemed to have more than their share of problems, the number of children present being inversely related to social class, employment stability, good marital relations and better housing, and that second-generation problem families who followed in the footsteps of their parents generally had more children, a poorer work record and more marital tensions than those who had been upwardly mobile. Nevertheless, to put these observations in context, it must again be pointed out that although the adult children of the original problem families were much more likely than their counterparts from the comparison group to have a variety of difficulties, they tended to have produced only marginally more children. Moreover although the first- and second-generation families in many cases demonstrated comparable problems, their respective family sizes were very different.

All in all it would seem fair to conclude, on the one hand, that large families may reflect a certain disorganisation and that they may add to stresses and strains: in these ways family size can be related to problem family status. On the other hand, however, the evidence indicates that, in isolation from other factors, number of children is not a prime influence upon family circumstances.

Family contact

The majority of families in the study who showed social mobility upwards appeared to do so at the expense of family contact. Such rejection of family ties was generally accompanied by an adoption of the marriage partner's standards. One daughter who had moved socially upwards, and had little contact with the parental home, constructively criticised her parents when she stated 'there's no need to be dirty even if you cannot afford new furniture'. There were also a few families who remained in contact with their families but in so doing managed to keep an emotional distance and thus cope realistically with the situation. How much this reflects the intelligence of the subjects it is difficult to say, but it is obvious that this more mature attitude towards both past and present situation is crucial to the relatively problem-free existence of these families.

Having said this, it should be noted that there were also some families who were able to combine social and material improvement with continued and close family contact. This is not surprising as,

besides being seen as a burden, the extended family may be viewed in a more positive light. Limited family contact may in fact mean a lack of support for the problem family and an additional difficulty when the family is failing.

In conclusion, it would appear that a gap in the social network of families has a rather ambiguous function – in some instances it is beneficial, allowing second-generation families to get on with their own lives, but in others it is detrimental in that an important potential source of support is lost. Nevertheless in drawing comparisons between families it is unwise to make too strong assumptions about the family ties of those without serious problems.

Models

The family provides models of behaviour and many of the child's actions will be executed in ways similar to those of his parents (Rutter 1975). Parents also establish rules and attitudes by means of disciplinary techniques or the lack of them. It is evident that parents play a variety of roles in the development of their children. However, the family cannot be considered in isolation from society and its social forces. Children may be influenced by models of behaviour presented to them by social workers, policemen, other authority figures and the media.

If exactly the same problems of the first generation were evident in the second generation of the families studied, it could be proposed that these models of behaviour were responsible for the transmission of deprivation. In general much of the evidence supported the view that the various models did influence subjects, but at the same time indicated that the outcome could vary considerably. It could not be assumed that the children of a marriage would copy the pattern of their parents; indeed a number of second-generation families put a big effort into being different from their parents. Mr CB1S said that he learnt from his parents' mistakes and he did not wish to be like his father. He resented the size of the family in which he had been brought up and said 'it was like a conveyor belt – you wondered where they were coming from'. He had settled for a family of two and his wife was using an IUD while he considered having a vasectomy. Mr PS5S and his wife expressed similar views and were the fifth of twelve and ninth of ten children respectively.

It seemed that children were just as likely to scrutinise their parents and family home, and reject them if they proved unsatisfactory, as they were to copy them. Possibly this behaviour was generated by alternative models of life presented by the media, and in particular television and popular magazines. These forces should be emphasised, once

again, as powerful influences on children's minds while they are in the process of growing up and formulating their own patterns of life.

Sons' versus daughters' families

One possibly important finding to emerge from this study is that married sons' households were more likely than married daughters' households to show similar patterns of problems across the generations. In general the sons were more likely to be unemployed, and to show poorer employment stability, than the daughters' husbands. Although there was no difference between sons and daughters in terms of social mobility, daughters who were socially mobile upwards did tend to be owner-occupiers more frequently than their brothers. The sons also showed a greater degree of isolation, and difficulties with neighbours were more characteristic of sons' households than daughters'.

So far as crime was concerned, it was clear that far more offences (264) were concentrated in the sons' households than the daughters' (81). Unfortunately it is not possible from these data to say how far the total offences committed were attributable to a small number of persons with particularly bad police records.

These findings largely corroborate observations on the differences between the adult sons and daughters of problem families noted by Wright and Lunn (1971) in their earlier Sheffield study. Three possible interpretations were outlined by Rutter and Madge (1976) to account for such findings and these are reiterated below.

First, these authors reported that daughters may marry out of the problem family style of life. Certainly in this study the daughters tended to marry men who were apparently less criminal than their brothers: 23 known offences were recorded for the daughters' husbands compared with 255 for the sons, and whereas there was a reduction of offences after 17 years in the first group, offences increased after this age among the latter.

Secondly, it is possible that boys are more damaged than girls by being raised in a 'problem family' household. A variety of early studies (reviewed by Waller and Hill 1951) have indicated that men whose parents were unhappily married are more likely themselves to show poor marital adjustment. Rutter (1970) reviewed studies on sex differences in response to stress and found evidence that, in general, boys are more likely to suffer from psychosocial disturbance. However there are exceptions – poor institutional upbringing appears to affect girls more – and more work needs to be done on the different long-term consequences of stress for males and females.

Lastly, the father's personality could be more influential than

the mother's in determining 'problem family' status. Tonge *et al.* (1975) reported that paternal personality disorder appeared to be the most important determinant of family maladjustment. However this remains an open question, and no satisfactory data on the relative influence of men and women are available from the present study.

Conclusions

There can be little doubt that this study has shown, once again, that in statistical terms cycles of deprivation or disadvantage continue to exist. Characteristics commonly found in the first-generation families were frequently also concentrated among the second-generation families.

For all this it appears that the 'cycle of deprivation' is becoming less marked than in the past and the gloomy view induced by Dr Wright's data in 1971 no longer fully applies. At that time concern was felt about the proportion of second-generation families who were arising out of the original sample studied. In the absence of effective strategies for dealing with the transmission the need for a vigorous programme of contraception was stressed.

In fact it would appear that the 'cycle of deprivation' is already being curtailed, partly owing to the already mentioned greater acceptance by society of divorce, but partly because of the much smaller families that younger generations are now producing. Two main factors would seem responsible for this latter change. The first is that contraception has become easy, cheap and socially acceptable in the past few years, so that there is no longer any need for a couple to have more children than they can support in emotional and financial terms. And the second is the socialisation of income over the past few years, together with the widespread advertisement of 'high' living standards, which has produced a situation where people expect a fair proportion of the 'good things of life'. Consequently the newly acquired resources are spent on rent or mortgages, furnishing equipment, television, personal transport, food, drink, holidays and so on. With all these demands it is difficult to afford more than one or two children, particularly when these children themselves nowadays demand their own share of consumer goods. To put it bluntly, children have become far too expensive and demanding to rear in large numbers for people who wish to savour the other pleasures of life as advertised on the media.

On the basis of these observations one could expect the number of problem families to decrease in years to come, but there is no possibility of such families disappearing from the community. It is suggested that a continuing proportion of new problem families might well arise out of apparently stable and satisfactory homes. It is also suggested that this is a pattern which appears in other fields and at the

other end of the scale of human activities. After all, no one can predict from the population where genius in the arts or sciences or business will appear, and it does not persist in the second and third generations with any reliability. These people are exceptions and there are no rules for exceptions. It would seem that many of our problem families nowadays are exceptions and should be supported and treated as such. These families will be no easier to deal with than previously. Some of them will follow an old familiar pattern including chronic unemployment, squalid living conditions, police involvement, marital discord, poor child care, psychological disturbance, poor educational attainment and sometimes limited intelligence. Others will follow a slightly modified pattern related to the affluent Western style of living. It would appear that the most immediate and pressing problem of all local authorities will be the care of the established families so that their legacy may be minimised. Casework on, and monitoring of, these families will have to continue – however ineffective it may appear to be – in order to safeguard the future of the children. Although there are few guiding rules, policies of financial support, contraception, nursery care for the young children and housing are all important. Possibly even more crucial is the need for compassion and wisdom, as well as technical knowledge, on the part of the workers who are involved with these people.

Notes

1 Thus the second-generation problem group on average scored around the 25th percentile, while the comparison subjects' average was at about the 50th percentile, the mean for the whole population.

2 Codes for first-generation problem families and their offspring are prefixed by 'P', followed by another letter (different in each case) to distinguish between families. Second-generation members are represented by the family code followed, first, by a number indicating birth order and, second, a letter explaining family relationship, that is, S (son), D (daughter), SW (son's wife) or DH (daughter's husband).

References

Blacker, C.P. (ed) (1952), *Problem families: five inquiries*, London: Eugenics Society.

Booth, C. (1902–3), *Life and labour of the people in London 1891–1903*, 18 vols, London: Macmillan.

Joseph, K. (1972), 'The cycle of deprivation', speech at Conference of Pre-School Playgroups Association, 29 June.

Lidbetter, E.J. (1933), *Heredity and the social problem group*, London: Edward Arnold.

Parry, W.H., Wright, C.H. and Lunn, J.E. (1967), 'Sheffield problem families – a follow-up survey', *The Medical Officer*, vol. 118, pp. 130–2.

Philp, A.F. (1963), *Family failure: a study of 129 families with multiple problems*, London: Faber & Faber.

Rutter, M. (1970), 'Sex differences in children's responses to family stress', in Anthony, E.J. and Koupernik, C.M. (eds), *The child and his family*, London: John Wiley.

Rutter, M. (1975), *Helping troubled children*, Harmondsworth: Penguin Books.

Rutter, M. and Madge, N. (1976), *Cycles of disadvantage*, London: Heinemann Educational Books.

Scott, J.A. (1958), 'Problem families: a London survey', *Lancet*, vol. i, pp. 204–8.

Sheridan, M.D. (1959), 'Neglectful mothers', *Lancet*, vol. i, pp. 722–3.

Tonge, W.L., James, D.S. and Hillam, S.M. (1975), *Families without hope: a controlled study of 33 problem families*, British Journal of Psychiatry Publication no. 11.

Waller, W.W. and Hill, R. (1951), *The family: a dynamic interpretation*, New York: Dryden.

Wilson, H. (1962), *Delinquency and child neglect*, London: George Allen & Unwin.

Wood Report (1929), *Report of the Mental Deficiency Committee*, London: HMSO.

Wright, C.H. (1955), 'Problem families: a review and some observations', *The Medical Officer*, vol. 94, pp. 381–4.

Wright, C.H. and Lunn, J.E. (1971), 'Sheffield problem families, a follow-up study of their sons and daughters', *Community Medicine*, vol. 126, pp. 301–7, 315–21.

4 Parenting in Two Generations: Looking Backwards and Looking Forwards

Michael Rutter, David Quinton and Christine Liddle

Introduction

In Sir Keith Joseph's (1972) speech to the Pre-school Playgroups Association, in which he introduced his notion of a 'cycle of transmitted deprivation', there was an explicit focus on the need for a better 'preparation for parenthood'. He argued that . . . 'people who were themselves deprived in one or more ways in childhood become in turn the parents of another generation of deprived children'. The suggestion was that many psychosocial problems tended to persist from generation to generation and that the root cause of their transmission lay in some kind of failure in parenting. Questions need to be raised on the strength of these intergenerational continuities; also there are many reasons why it would be seriously misleading to view the mechanisms as mainly intra-familial in origin (Rutter and Madge 1976). Nevertheless, the idea that people's experiences in childhood might be linked with their later functioning as parents is not an altogether unreasonable one, even though the processes involved in such links may reflect extra-familial influences, or the structure of society, as well as the functioning of individual families. In this chapter, we consider some of the conceptual and methodological issues that apply to the investigation of possible associations between childhood experiences and parenting behaviour, and present some preliminary findings from our studies of parenting in two generations.

Issues in intergenerational continuities

The rather sparse findings from earlier studies of intergenerational continuities in parenting behaviour suggest that there are some continuities in parenting problems, but also that the strength of these links varies with the aspect of parenting under consideration, with discontinuities as striking as continuities in many aspects (Rutter and Madge 1976).

Obviously, further research was required simply to quantify inter-

generational continuities and discontinuities, and to specify how these applied to different features of parenting and to different types and degrees of parenting problems. Equally, however, there was a need to consider the possible mechanisms that might be involved. It was evident from the findings already available that this consideration raised a number of difficult questions of interpretation. First, it was necessary to ask what reason there was to suppose that the statistical associations reflected causal mechanisms; could adverse childhood experiences *cause* parenting deficits or abnormalities, that is, could the *experience* of poor parenting as a child cause a person to *become* a poor parent himself? Experimental studies of rhesus monkeys reared in isolation provide the most convincing evidence that experiences in early life may directly impair parenting (Rutter 1981). However, the early experiences comprised extremely gross distortions of upbringing of a type and severity rarely encountered in humans; it cannot be assumed that the results for infant monkeys necessarily apply to children; and it is known that there are important influences on parenting other than those that form part of childhood adversities (Rutter 1981). Accordingly, while certainly it is possible that harmful experiences in early life may interfere with the development of optimal parenting skills and capacities, other explanations of intergenerational continuities demand attention and consideration.

Secondly, it seems that intergenerational continuities may be strongest in the case of severe abnormalities in parenting (such as reflected in physical abuse) when they are associated with many other indications of psychosocial dysfunction. Thus, many abusing parents show abnormalities in social relationships other than those involved in parenting; many exhibit psychiatric disorder; and many are living in poor socioeconomic conditions (e.g. see Smith 1978). Accordingly, it is unclear whether early experiences have any effect on parenting that is independent of these other features. It could be that there is no direct effect on parenting as such; rather, childhood adversities may have their main impact on personality development (with parenting involved only in so far as personality disorders include problems in parenting), or alternatively it could be that childhood adversities are associated with a persistence of social disadvantage that may, in turn, impede good parenting (but again with no direct connection between childhood experiences and parenting that is separate from social disadvantage).

Thirdly, most of the data on intergenerational continuities in parenting behaviour look backwards rather than forwards. That is to say, it seems that many individuals now showing serious parenting problems had an abnormal pattern of upbringing. But, of course, that does not

mean that most children who experience deviant rearing will show problems in parenting when they grow up. If intergenerational discontinuities, as well as continuities, are to be investigated, both ends of the same stick must be grasped by combining retrospective and prospective research strategies with the same parenting variables.

Fourthly, if the processes involved are to be understood, it is as necessary to determine why some families do *not* exhibit continuities in parenting problems as it is to find out why others do. Of course, it is possible that discontinuities are to be explained in terms of a lack of, or at least a weaker exposure to, the adverse factors in society or in the family that predispose to intergenerational continuities in ineffective or maladaptive parenting. But, equally, it is possible that the discontinuities may be determined by the presence of compensating or mitigating factors of a *positive* kind, as well as by a 'lesser dose' of negative ones.

Fifthly, in this connection, it is important to recognise that intergenerational links necessarily involve at least two parents (with divorce and remarriage many children experience upbringing by three or four parents) and usually involve several children. For the most part, continuities across the generations have been considered in terms of the links between one parent and one child. But it is crucial to ask whether all children in the same family show the same course of development and adult outcome and, if not, why not. Similarly, it may well be that the effects of problems experienced by one parent are exacerbated or attenuated by the negative or positive qualities of the other parent.

Finally, there is the question of the extent to which the ill-effects of seriously adverse experiences in childhood are modifiable or reversible. In view of the consistency of the evidence on the matter (Rutter 1981), it is now widely accepted that a substantial degree of recovery in childhood is not only possible, but is quite common, if bad experiences are followed by good ones. On the other hand, there has been a tendency to assume that psychosocial functioning is unlikely to change greatly once adulthood is reached. As a consequence, most reports on intergenerational continuities in parenting behaviour are based on one-point-in-time assessments of parenting, with the implication that when problems are found they are likely to persist. However, the same animal studies that provided the most dramatic demonstrations of the serious distortions in parenting behaviour that can be caused by adverse experiences in early life, have also shown that later experiences of a positive kind can do something to ameliorate the damage inflicted by early social isolation (Novak and Harlow 1975; Novak 1979). Few data on humans are available but Sheridan's (1959)

early study of the rehabilitation of seriously neglectful mothers showed that many improved and came to cope satisfactorily; the best results were obtained with women who had a steady and affectionate husband, indicating the importance of adult relationships as well as child experiences. Similarly, it is apparent that some abusing parents not only cease injuring their children but come to function fairly adequately. We lack adequate knowledge on the extent and frequency of major improvements in parenting during adult life, and we lack information on the factors needed to bring about such beneficial change, but it is clear that it would be quite wrong to assume that behaviour and personality are 'fixed' once maturity is reached.

Concepts of parenting

In this discussion of possible links between childhood experiences and parenting behaviour, there has been the implicit assumption that we know how to categorise and quantify parenting skills and qualities, but it is necessary to ask whether we do have that knowledge. How should parenting be conceptualised; what are the crucial functions involved in child-rearing; what is meant by 'good' and 'bad' parenting; and how should such judgements be validated?

It is all too easy to be sceptical on this matter. 'Experts' have always been confident in asserting that they know what is best for children but they change their minds on the topic every decade or so (Harman and Brim 1980; Stendler 1950; Vincent 1951; Wolfe 1977; Wolfenstein 1955). However, there are many reasons for concluding that concepts of parenting are better developed than would appear from the child-care manuals. First, research findings have been very consistent in their demonstration of the parenting qualities that are maladaptive for the child. For example, it is well established that the family characteristics most strongly associated with delinquency are: parental criminality, ineffective supervision and discipline, family discord and disharmony, weak parent–child relationships, large family size, and psychosocial disadvantage (Rutter and Giller 1983). It is not that the empirical associations are in doubt; rather it is that there is uncertainty on the mechanisms that the associations represent.

Secondly, there is no difficulty in identifying the serious breakdowns in parenting as exemplified by physical abuse of the children, gross neglect, overt rejection or abandonment. Moreover, these breakdowns are not at all rare; on the contrary, they refer to distressingly frequent circumstances. For example, some 90,000 children *per year* are now admitted into the care of local authorities in Britain – to be placed in institutions or foster care for shorter or longer periods (see Rutter 1979); some 5,000 children each year experience non-

accidental injury, of whom 1,000 will be seriously injured and nearly 100 die (Court 1976); and altogether it has been estimated (Smith 1978) that at least 4 per cent of children are victims of some level of maltreatment by their parents. There is no doubt that in these cases there has been a serious failure in parenting, although opinions may differ on the extent to which this is a function of the personal qualities of the parents, as distinct from the adverse social circumstances in which they find themselves.

Thirdly, although there is some disagreement over the details, there is a reasonable consensus on the most important dimensions of parenting (e.g. see Harman and Brim 1980; Pringle 1974; Rutter 1975). To begin with there are 'skills' of various kinds – as reflected in sensitivity to children's cues and a responsiveness to the differing needs at different phases of development; in social problem solving and coping skills; in knowing how to play and talk with children; and in the use of disciplinary techniques that are effective in the triple sense of bringing about the desired child behaviour, of doing so in a way that results in harmony, and of increasing the child's self-control. Then, parenting must also be seen as one specific type of social relationship. It has its own particular qualities and characteristics but, still, it forms a part of a broader set of social qualities. The implication is both that the more enduring 'relationship' aspects of parent–child interaction must be assessed, and also that the quality and nature of the parents' relationships with each other and with friends, neighbours, and work-mates must be considered as well as those with their children.

Finally, parenting must be considered in terms of resources – as well as skills and social qualities. That is to say, there must be an *ecological* perspective that recognises that the family is a functional system, the operation of which will be altered by its internal composition and by external forces (Bronfenbrenner 1979). It makes no sense to view an individual's qualities as a parent as if they constituted an internal character trait. It is apparent, for example, that mother–child interaction tends to be changed if the father is present (Clarke-Stewart 1978); parenting is influenced by the parent's mental state (Weissman 1979); and cross-cultural data (Rohner 1975; Werner 1979) appear to suggest that socially isolated mothers, who carry the entire burden of child-rearing without the opportunity for shared responsibilities, are more likely to become rejecting of their children. Doubtless, too, parenting is likely to be influenced by the number of dependent children for whom the parent has responsibility. Thus, parenting resources must be considered in terms of such variables as the time available; the person's own emotional state; the presence of other life stresses and problems; the qualities of the spouse and the extent

to which child-rearing is shared; the existence of satisfactions and achievements apart from parenting (as in a job outside the home); the availability of adequate social supports; and housing conditions.

It follows, of course, that intergenerational continuities and discontinuities could reflect the persistence (or non-persistence) of these resources as well as the perpetuation of specific parenting qualities.

Research strategy and design

Choice of parenting index

It was with these considerations in mind that we planned our own study of the links between childhood experiences and parenting behaviour. The first decision to be taken concerned the index of parenting problems to be used. The principal criteria for the choice of index were: (1) it must reflect severe and persistent parenting difficulties; (2) such difficulties must be reasonably common in the general population; (3) they must be of a kind known substantially to increase the risk that the children develop disorders of psychosocial development; (4) it must be able to be employed on an epidemiological basis both to identify families currently experiencing parenting difficulties *and* to identify individuals who had experienced similar problems in their own rearing as children. The last criterion was necessary if we were to be able to combine retrospective and prospective research strategies using the same index.

The admission of a child into the care of the local authority because the parents were no longer able to cope with child-rearing constituted the most appropriate index that met all four criteria. Several studies have shown the very considerable difficulties in relationships and in child-rearing experienced by the parents of children admitted into care – even when the ostensible reason for admission is the mother's confinement or physical illness (Schaffer and Schaffer 1968; Wolkind and Rutter 1973); about 2 per cent of 7-year-old children in Britain have been in care for some period of their lives (Mapstone 1969); and follow-up studies have had the consistent finding of a marked increase in emotional and behavioural problems among the children taken into care (Lambert *et al.* 1977; Wolkind and Rutter 1973; Yule and Raynes 1972) with differences persisting into adulthood (Wolkind 1977). Social service records allow a rapid identification of all families living in a defined geographical area who have a child admitted into care, and an earlier study of children currently in care by King, Raynes, Tizard and Yule (King *et al.* 1971; Yule and Raynes 1972) provided a sample of adults who had the experience of institutional care when young.

Retrospective and prospective strategies

The combination of retrospective and prospective research strategies was essential in order to obtain an accurate picture of intergenerational links. In the retrospective approach, admission into care is treated as a *dependent* variable. That is to say, population-based-records are used to obtain a total sample of all families living in a particular area who have a child admitted into the care of the local authority during a defined period of time. The question asked, then, is how often the parenting problems shown by these *adults* were associated with their own experience of adverse parenting when they were children. To answer that question, of course, it is necessary to have a comparable group of parents living in the same geographical area whose children had *not* been taken into care. This retrospective design provides the best estimate of the extent to which parenting problems *now* represent a perpetuation of similar parenting problems in the previous generation of the same families, and of the extent to which they arise anew each generation. However, the design does not provide an answer to the complementary question on the likelihood that the *experience* of poor parenting in childhood will lead to parenting difficulties in the same individuals when adult.

That question requires a prospective approach in which admission into care is treated as an *independent* variable. That is to say, population-based records are used to obtain a sample of children currently receiving institutional care. A follow-up study into adult life is then required in order to determine the outcome in terms of parenting behaviour of the individuals who were taken into care when younger. Again, it is necessary to have a comparable group of individuals, not ever admitted into care, studied as children when living in the same area, and also followed to the same age in adult life. That design provides data on the extent to which the same adverse experiences in childhood lead to diverse outcomes and of the extent to which there is 'escape' from intergenerational cycles of parenting problems – in other words, how likely it is that someone suffering poor parenting themselves will nevertheless go on to provide good parenting for their own children.

Retrospective study

The 'in care' sample in the retrospective study consisted of a consecutive sample of forty-eight families with European-born parents who had children admitted to residential care by one inner London borough during a continuous eight-month period. In order to exclude cases in which admission occurred because of some short-term crisis, the series was confined to families for whom this was at least the second

time a child had been taken into care. Selection was further restricted to those with a child between the ages of 5 and 8 years living at home prior to admission, so that comparable assessments of parenting could be made. The comparison group consisted of forty-seven families with a child in the same age group living at home with its mother, but in which no child in the family had ever been taken into care by a local authority. This sample was drawn randomly from the age–sex registers of two group general practices in the same inner London borough (see Quinton and Rutter 1983a for details). It was possible to interview over 90 per cent of mothers in both samples.

Prospective study

The prospective study consisted of a follow-up into early adult life of 150 individuals who, in 1964, were in one or other of two Children's Homes run on group cottage lines. The children had been admitted to institutional care because their parents could not cope with child-rearing, rather than because of any type of disturbed behaviour shown by the children themselves. The regimes in the cottages were studied systematically by Tizard and his colleagues (King, Raynes and Tizard 1971) and the children's behaviour at school was assessed by means of a standardised questionnaire (the Rutter 'B' scale – Rutter 1967). Both sets of data were made available to us. As in the retrospective study, the sample was restricted to children identified as 'white' (on Tizard's original record sheets); and was defined in terms of those aged between 21 and 27 years on 1 January 1978. The women from both Children's Homes, but (because of limited resources) the men from only one, were studied. Of the ninety-four 'ex care' women, five had died by the time of the follow-up. Eighty-one of the eighty-nine women (91 per cent) still living were interviewed (including one in Germany and three in Australia).

The contrast group of 106, comprised a quasi-random[1] general population sample of individuals of the same age, never admitted into care, living with their families in the same general area in inner London, and whose behaviour at school was assessed at approximately the same age by means of the same questionnaire. The group was originally studied because it constituted the control group for a study of the children of parents with some form of psychiatric disorder (Rutter and Quinton 1981). The contrast sample was similarly followed to age 21 to 27 years using methods of assessment identical to those employed for the 'ex care' sample. Of the fifty-one female controls, forty-one (80 per cent) were interviewed, five could not be traced and five did not agree to be seen.

Methodology

In both studies data were collected by interviews with subjects and their spouses, lasting 2½–4 hours using a non-schedule standardised approach based on methods established in earlier investigations (Brown and Rutter 1966; Graham and Rutter 1968; Quinton *et al.* 1976; Rutter and Brown 1966). The interview covered the person's recall of childhood; their later family, peer and work experiences; and their current circumstances, functioning and adjustment. Parenting skills were assessed from detailed accounts of the parents' style of response in dealing with issues of control, peer relationships and distress. In addition, questions were asked on the amount and nature of parental involvement in play. Summary ratings included those on over-all style of parenting, effectiveness and consistency in control, parental sensitivity to the child's needs, and the amount of expressed warmth towards and criticism of the child.

The prospective design also included direct home observations of mothers with their 2–3½-year-old children (Dowdney *et al.* 1982; Mrazek *et al.* 1982) but these findings are not reported here.

Research findings: retrospective study

Parenting characteristics

A comparison of the current parenting characteristics of the two groups of mothers confirmed the excess of parenting problems in the 'in care' group, who were twice as likely as the comparison mothers to show difficulties. Thus, nearly half were low in expressed warmth to the child, nearly two-thirds appeared insensitive to the child's distress and a third did not play with their child. Five times as many 'in care' mothers (26 per cent versus 5 per cent) were ineffective in their discipline; twice as many used techniques that failed to resolve the parent–child conflict (that is, there was a lack of any indication of reconciliation or harmony at the end of the disciplinary episode). It was also evident that parenting difficulties of one kind or another were surprisingly common in the comparison sample, but that these were much more frequent in the 'in care' group in which only one in ten mothers lacked day-to-day parenting problems, as against 37 per cent in the comparison group (see Quinton and Rutter 1983a and b).

Current family circumstances

The family circumstances of the two samples were strikingly different with the 'in care' mothers markedly more likely to lack supportive relationships in the home or with their families. Less than half of the 'in care' mothers were in any type of stable cohabitation, compared with

90 per cent of the comparison group. Moreover, of the half living with a male partner, a third had a severely discordant relationship (as against 10 per cent of the comparison sample). Very few reported currently close relationships with their families and over a third had clearly strained relationships – in each case the contrast with the comparison group was marked. The majority of 'in care' mothers (71 per cent versus 15 per cent) wished they had someone to turn to for help on practical matters, but were less likely to have received help with their children.

The parenting burden of the 'in care' group was also greater in that three-fifths, compared with one-fifth, had at least four children. These circumstances had important implications for the children's parentage; in 93 per cent of the comparison families all the children had the same fathers whereas this was so for only 43 per cent of the 'in care' group. Furthermore, in one-third of the latter *with* two parents the mother's current cohabitee was not the father of any of the children.

Both groups were socially disadvantaged in a variety of ways compared with the population as a whole. Thus, for example, in two-fifths of the comparison families the father held a semi-skilled or unskilled job – a rate twice that in the general population. On the other hand, the 'in care' families were substantially *more* disadvantaged. Four-fifths were of semi-skilled/unskilled social class; nearly half were in manifestly unsatisfactory housing as shown by such features as a lack of basic amenities or the need for the children to share a bed (47 per cent versus 7 per cent); and a majority lacked at least one standard household possession (89 per cent versus 40 per cent) – for example, one half were without a washing-machine (54 per cent versus 19 per cent).

Characteristics of the parents

The mothers in the 'in care' group were very much more likely to have suffered some form of psychiatric disorder. Nearly half (44 per cent) had been in-patients in a psychiatric unit or mental hospital, in contrast with a mere 2 per cent in the comparison group; four-fifths, compared with less than a third, rated themselves as having emotional difficulties on the malaise inventory (Rutter, Tizard and Whitmore 1970) and about the same proportion (78 per cent versus 21 per cent) were assessed, on the basis of interview data, as having some kind of currently handicapping psychiatric problem. In most cases this took the form of a depressive disorder or anxiety state, but frequently this was associated with a personality disorder, as evidenced by a persistent pattern of maladaptive behaviour stemming from the teenage years or earlier.

The cohabitees of the 'in care' mothers were also generally more socially deviant than the fathers in the comparison group. Thus, over half had been put on probation or been in prison, compared with only 13 per cent in the general population groups; three times as many (44 per cent versus 15 per cent) showed a personality disorder; and twice as many (47 per cent versus 23 per cent) had a current psychiatric disorder.

These findings on the two groups demonstrate that parenting cannot sensibly be considered a unitary phenomenon or an attribute of individuals that exists independently of other circumstances. In the first place, there was only a moderate correlation between the several separate measures of parenting; thus whereas 89 per cent of the 'in care' mothers showed little warmth or had unreconciled disputes with their children, only 19 per cent had both problems concurrently. Secondly, a substantial monority of mothers in the comparison group had significant parenting difficulties although there was no question of their children going into care. Thirdly, the 'in care' sample was characterised as much by *other* types of family difficulties as by parenting problems *per se*. Indeed, their parenting problems seemed to be more a matter of general difficulties in interpersonal relationships than of specific faults or lacks in parenting techniques.

Parents' childhood and adolescent experiences

The mothers in both groups came from equally disadvantaged backgrounds, with about half having a father with a semi- or unskilled occupation and half having a sib group of four or more. Significantly more maternal grandfathers had psychiatric or drink problems or a criminal record. However, the greatest difference between childhoods of the two groups concerned seriously adverse family experiences. A quarter of the 'in care' mothers had been in care themselves as against 7 per cent of the comparison group; nearly half (45 per cent versus 14 per cent) had been exposed to severe discord between their parents, and more (50 per cent versus 14 per cent) had suffered from harsh discipline. Altogether three-fifths of the 'in care' mothers experienced two or more adversities of this kind, compared with one-fifth of the comparison sample.

These early adversities seemed to persist into adolescence: they were related to marked unhappiness at school and persistent truancy, which were more than twice as common in the 'in care' group (72 per cent versus 32 per cent), and to discordant relationships with parents which were four times as frequent. More than twice as many 'in care' mothers had left home by their nineteenth birthday (65 per cent versus 26 per cent), were already pregnant by this age (61 per cent versus 23

per cent), or left home because of intolerable circumstances. Three-quarters of the 'in care' mothers, compared with less than a fifth in the comparison group, began their first marriage or cohabitation for negative reasons and the majority (63 per cent versus 39 per cent) set up home with men from similarly adverse backgrounds and/or with current psychiatric problems or criminality.

Intergenerational continuities in parenting difficulties

It is not difficult to create a coherent story linking this unhappy chain of adversities and stressful experiences – with each problem creating an increased predisposition to the next. Indeed, it is scarcely surprising that with this background of deprivation, disadvantage, and discordant relationships that the women grew up to experience difficulties in parenting their own children. However, before accepting any kind of 'deviant personality development' explanation two features of the findings require both emphasis and explanation. First, although all manner of childhood adversities were more frequent in the 'in care' group, they were nevertheless surprisingly common in the comparison group. The question arises as to why these mothers did *not* show the same parenting difficulties. Was it just because they experienced less adversities over all, was it that some patterns of adversities were more damaging than others, or was it that the comparison group women experienced important protective factors? Secondly, it was striking that the 'in care' families were currently living in circumstances that socially and materially were markedly inferior to those of the comparison group. This observation raises the question of whether the childhood adversities were important, not because they predisposed to an impaired personality development but rather because they made it more likely that, as adults, the individuals would be living in seriously disadvantaged environments that interfered with successful parenting.

In discussing the role of current circumstances in perpetuating parenting problems it is first necessary to determine the over-all strength of intergenerational continuities to see whether current disadvantages exerted an *independent* effect.

Up to this point in the chapter we have considered intergenerational links in terms of one parent at a time. However, in assessing the over-all strength of continuities across the generations we need to take into account *both* parents simultaneously. In order to do this we have to restrict attention to the families in which we have information on care experiences, family discord and separations, poor parenting, and parental deviance on both the *current* parents – twenty-seven in the 'in care' group and thirty-nine in the comparison group. The cases with missing information mainly arose in the 'in care' sample. The

Table 4.1 Childhood adversities in mothers and fathers (retrospective study)

	'In care' group (N = 27) %	*Comparison group (N = 39)* %	*Residuals*
Neither parent	11	59	3.91
Mother only	33	15	−1.71
Father only	22	21	0.12
Both parents	33	5	−3.02

$\chi^2 = 19.18$; d.f. = 3; $p < 0.01$.

information available with respect to the seventeen families not included in the two parents analysis, on whom we lacked full data, showed that some disorders or childhood adversities were present in the mother and/or the first cohabitee in all the excluded cases (Quinton and Rutter 1983b). For this analysis family disorders/adversities were rated as present if there were at least two of the factors mentioned above.

The findings for the families with complete information are presented in Table 4.1. It is apparent that in a surprisingly high proportion (41 per cent) of families in the comparison group one or both parents had childhood experiences that reflected adversely on parenting in the previous generation. Evidently, people can experience quite marked difficulties in their own rearing and yet still have no problems of parenting so severe or widespread that any child needs to be received into care. The figures also show that one-third of the 'in care' families had *both* parents who experienced adversities in their own rearing as compared with only 5 per cent of the comparison group. The groups did not differ significantly when the adversities in the previous generation affected only the fathers. But most striking of all was the finding that in only 11 per cent of 'in care' families had neither parent suffered multiple problems in their own rearing. In terms of the familial antecedents of parenting breakdown, intergenerational continuity looking backwards was virtually complete. The three families in the 'no adversity' cell had, in fact, also experienced discordant family relationships in childhood but these fell short of the stringent criteria of multiple adversities used for this analysis (see Quinton and Rutter 1983b).

These data show that the question of the *independent* contribution of current circumstances to parenting breakdown is redundant. However, this does not mean that current circumstances are unimportant.

On the contrary they may be major links in the chain joining early adversities to parenting breakdown. This can be examined by fitting linear logistic models to early adversities as defined above, with housing problems and lack of marital support as intervening variables (see Fienberg 1977). Housing problems were rated as present if the family shared or lacked a bathroom, kitchen or toilet; or if a child shared a bed with sibs or a room with parents or if there were major structural problems that made part of the dwelling uninhabitable. Lack of marital support was rated if the mother was a single parent or if her spouse had current psychiatric, drink or criminal problems.

The results of this analysis are clear-cut (Table 4.2). The models fitting housing problems or lack of support only do not describe the data well, whereas the model fitting parenting breakdown (that is, group selection) provides an adequate explanation of the data on its own. The reduction in deviance when either 'housing only' or 'lack of support only' are fitted separately shows that early adversity was significantly associated with adverse current circumstances. However, even in combination, they provided a less satisfactory model than that provided by parenting breakdown. The implication is that current circumstances do not account for the link between early adversities and severe parenting problems later, but they do contribute to it.

The effects of housing problems and lack of support on current parenting rather than on breakdown can be illustrated with the data from the 'in care' sample using the same definitions for the variables as in the previous analysis. Only 15 per cent of these mothers were free from both adversities, but the occurrence of these two problems currently significantly increased the risk of current parenting difficulties

Table 4.2 Early adversity, housing problems, lack of support and parenting breakdown (retrospective study)

	Linear logistic analysis				
Model fitted	*Deviance*	*d.f.*	*Reduction in deviance*	*d.f.*	*Statistical significance*
Initial model constant	22.95	7			
Housing only	17.13	6	5.85	1	<0.025
Lack of support only	14.84	6	8.14	1	<0.01
Group selection	5.66	6	17.32	1	<0.001
Group + housing + lack of support	2.37	4	20.61	1	<0.001

($\chi^2 = 3.95$; d.f. $=1$; $p<0.05$). Housing problems occurred on their own in only 8 per cent of cases but where they did so there is a suggestion that they also increased the risk of parenting problems. This conclusion should be treated with caution, however, because of the significant association between early adversity and poor housing shown above. Finally, the most common adversities were those involving lack of marital support, but the overlap of those with housing disadvantage provides the largest single category. Since marital problems frequently occur in the absence of housing problems it seems unlikely that housing disadvantage carries the prime responsibility for current family difficulties, although they may contribute to parenting problems.

These analyses also illustrate the problems and limitations inherent in trying to disentangle causal chains from retrospective data in which the overlap between earlier and later adverse circumstances is so great. Accordingly, we need now to turn to the prospective study to consider these processes further.

Research findings: prospective study

Circumstances in childhood

The great majority of the 'ex care' sample in the prospective study had experienced prolonged periods of institutional care from an early age. According to the Children's Homes records, over a third had been admitted before the age of 2 years and over two-thirds before the age of 5. On their own accounts nearly 90 per cent spent at least four years in institutional care and over half remained there until age 16 years or later. On the other hand, many returned to their families for greater or lesser periods of time (over a third were with their families for at least one year between the ages of 5 and 11 years). Three-quarters of those who returned to their parents experienced persistent family discord. Thus, it may be seen that the 'ex care' group's experiences were a mixture of severe discord and disharmony with their own families and the more harmonious but less intense and less personal multiple care-taking of the institution.

King *et al.* (1971) have described the staff organisation and pattern of care provided in the two Children's Homes where the 'ex care' group spent their early years. Each Home contained about 350 children, the great majority of whom were of school age. The Homes were divided into living units, known as cottages, which held some fifteen to twenty children each under the care of a housemother together with her deputy and assistant. More than 80 per cent of the housemothers

had worked in the same unit for a year or more and some had been there more than five years; however, there was much more turnover among the junior staff, a majority of whom had been in the unit less than a year. A minority of the housemothers were married but there were no male junior staff in either Home. Although the facilities were felt by the staff to be less than adequate, all of the children had some private space in which to keep their possessions, and most cottages did not have an 'institutional' atmosphere. There was a good deal of individual contact between staff and children; the children received pocket money, most had the run of the cottage, and King *et al.* felt that: 'the cottages provided a system of care geared very closely to the individual needs of those for whom they existed' (p. 94). Overall, their measures showed that the two Children's Homes had a very high level of child-oriented practices – at least as compared with long-stay hospitals. Nevertheless, although they gave no quantitative data, their descriptions strongly suggest that most of the children who spent several years in the Homes are likely to have had a substantial turnover of houseparents – although this would not be so with all.

It was striking that most of the subjects' memories of their life in the institution were rather more negative than would be suggested by the King *et al.* report. Half said that their relationships with staff had been poor and only a minority reported developing any strong personal attachments to any of them. Nearly two-thirds had generally negative memories of their relationships with peers and sibs and only 6 per cent recalled *clearly* supportive relationships. Many of the interviews were characterised by rather undifferentiated descriptions of relationships in which neither adults nor other children were remembered as individuals. It was *not* that they experienced the regime as harsh, punitive or excessively restrictive (in that, most agreed with King *et al.*), but rather that their life lacked personal meaning or affection.

All studies of children in long-stay institutions have shown a high prevalence of emotional and behavioural problems (Pringle and Bossio 1960; Wolkind 1974). Our findings provided no exception to this picture. As judged by scores on the teacher questionnaire, twice as many of the 'ex care' boys as their controls (34 per cent versus 16 per cent) and six times as many of the girls (35 per cent versus 6 per cent) showed disturbed behaviour at school – both differences being statistically significant. This took the form of both emotional and conduct problems, but the latter were more common. The 'ex care' children also showed high rates of disturbance on questionnaires completed by houseparents (41 per cent of the boys and 26 per cent of the girls had deviant scores) but no comparison data were available for these. In all,

over half of both boys (56 per cent) and girls (53 per cent) in this group were rated as disturbed on one or both questionnaires.

Parenting outcome in adult life

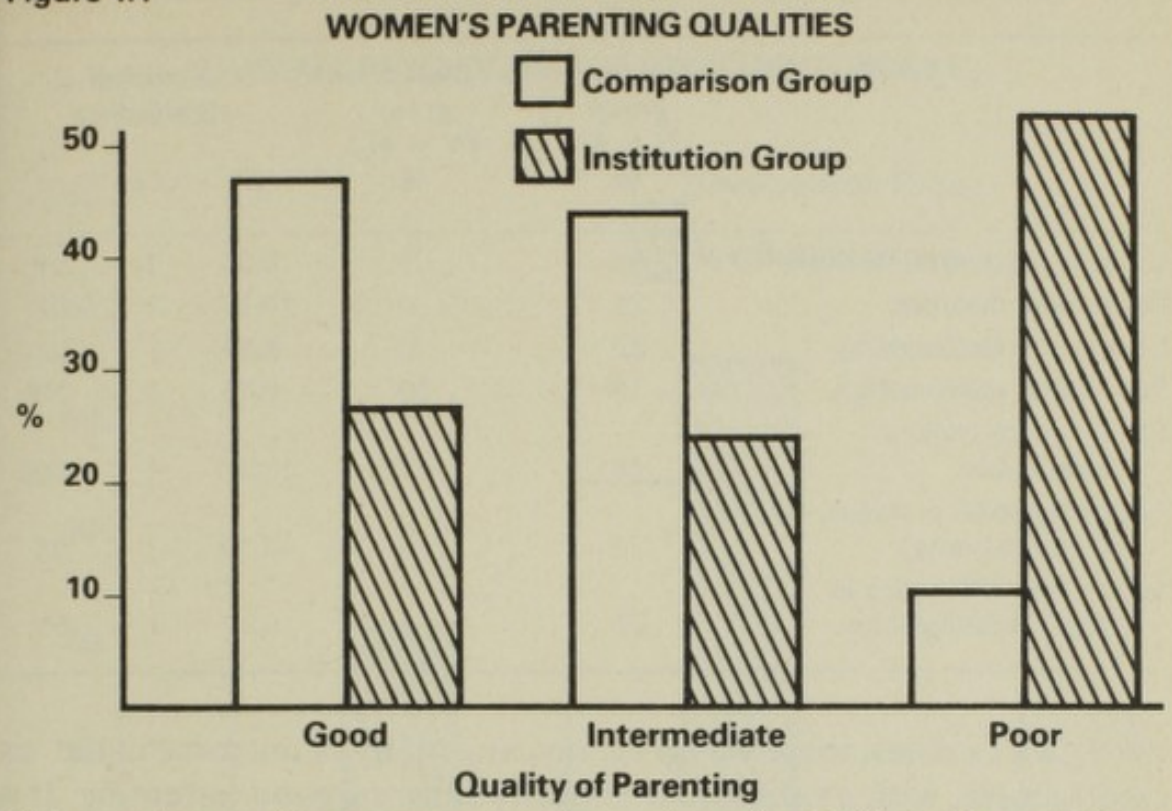
The outcome of the two groups of women may be considered first in terms of their parenting histories in which there were marked differences. Nearly twice as many of the women reared in an institution had become pregnant and given birth to a surviving child by the time of the follow-up interview; moreover, whereas none of the control group had become pregnant before their nineteenth birthday, two-fifths of the 'ex care' sample had. It is also apparent that the institution-reared women with children were less likely to be in a stable cohabiting relationship; only 61 per cent were living with the biological father of all the children compared with all those of the comparison group, and 22 per cent were without a current male partner compared with none of the comparison group. Serious failures in parenting were evident only in the institutional sample; nearly a fifth of the children had been taken into care for fostering or placement in a Children's Home and there had been one case of infanticide. Altogether, for one reason or another, 18 per cent of the 'ex care' mothers had children who were no longer being looked after by them, compared with none in the control group.

An over-all assessment of parenting for women with children aged 2 years or more was made by combining historical measures with our interview measures of current parental functioning. 'Poor' parenting was rated if any of the children had been taken from the mother because of parenting difficulties, or if there was a marked lack of warmth to the children (score of 0 to 2 on a 6-point scale) or low

Table 4.3 Pregnancy and parenting histories of women (prospective study)

	'Ex care' group (N = 81) %	*Comparison group (N = 42)* %	*Statistical significance* χ^2	*d.f.*	*p*
Ever pregnant	72	43	8.50	1	0.01
Pregnant by 19	42	5	16.75	1	0.001
Had surviving child	60	36	5.85	1	0.02
Of those with children	*(N = 49)*	*(N = 15)*			
Without male partner	22	0	Exact test p = 0.039		
Any children ever in care/fostered	18	0	Exact test p = 0.075		
Living with father of all children	61	100	6.52	1	0.02

Figure 4.1



Difference between the groups on overall parenting: $\chi^2 = 11.94$; 2 d.f.; $p<0.01$
Difference between the groups on current parenting: $\chi^2 = 8.29$; 2 d.f.; $p<0.02$

sensitivity to children's needs (score of 1 to 2 on a 5-point scale) *and* difficulties in at least two out of the three areas of disciplinary control (consistency, effectiveness and style). Conversely, 'good' parenting was rated if there had been no mother–child separations of four weeks or more, no past history of parenting failure, and no difficulties on any of the scales of current parenting. An intermediate rating meant no past history of parenting failure but some current problems or the converse.

Because so few of the comparison group had children aged 2 years or more, for this analysis the data for the comparison group are based on both the women in that group (thirteen cases) *and* the female spouses of the men (a further fifteen cases). The findings for the comparison women and the female spouses were generally similar.

Half the 'ex care' sample had a rating of poor parenting, compared with only about one in ten of the comparison group – a fourfold difference. To some extent the assessment of 'poor parenting' was dependent on historical data, but the difference between the groups remained even when the analysis was restricted to the interview ratings on current parenting (40 per cent versus 11 per cent).[2] On the other hand, nearly one-third (31 per cent) of the women reared in institutions showed good parenting. It is clear that in spite of the fact that *all* of them had experienced an institutional rearing for part of their childhoods, and that most had experienced rather poor parenting when with

Table 4.4 Psychosocial outcome of women (perspective study)

	'Ex care' group (N = 81) %	*Comparison group (N = 41)* %	*Statistical significance* χ^2	*d.f.*	*p*
Current psychiatric disorder	31	5	9.21	1	.01
Personality disorder	25	0	10.37	1	.01
Criminality (self-report)	22	0	8.59	1	.02
Poor social relationships	18	10	0.75	1	NS
One or more broken cohabitations	38	7	12.70	1	.001
Marked marital problems (of those cohabiting)	28	6	4.59	1	.05
Substantial difficulties in love/sex relationships	22	2	6.67	1	.01

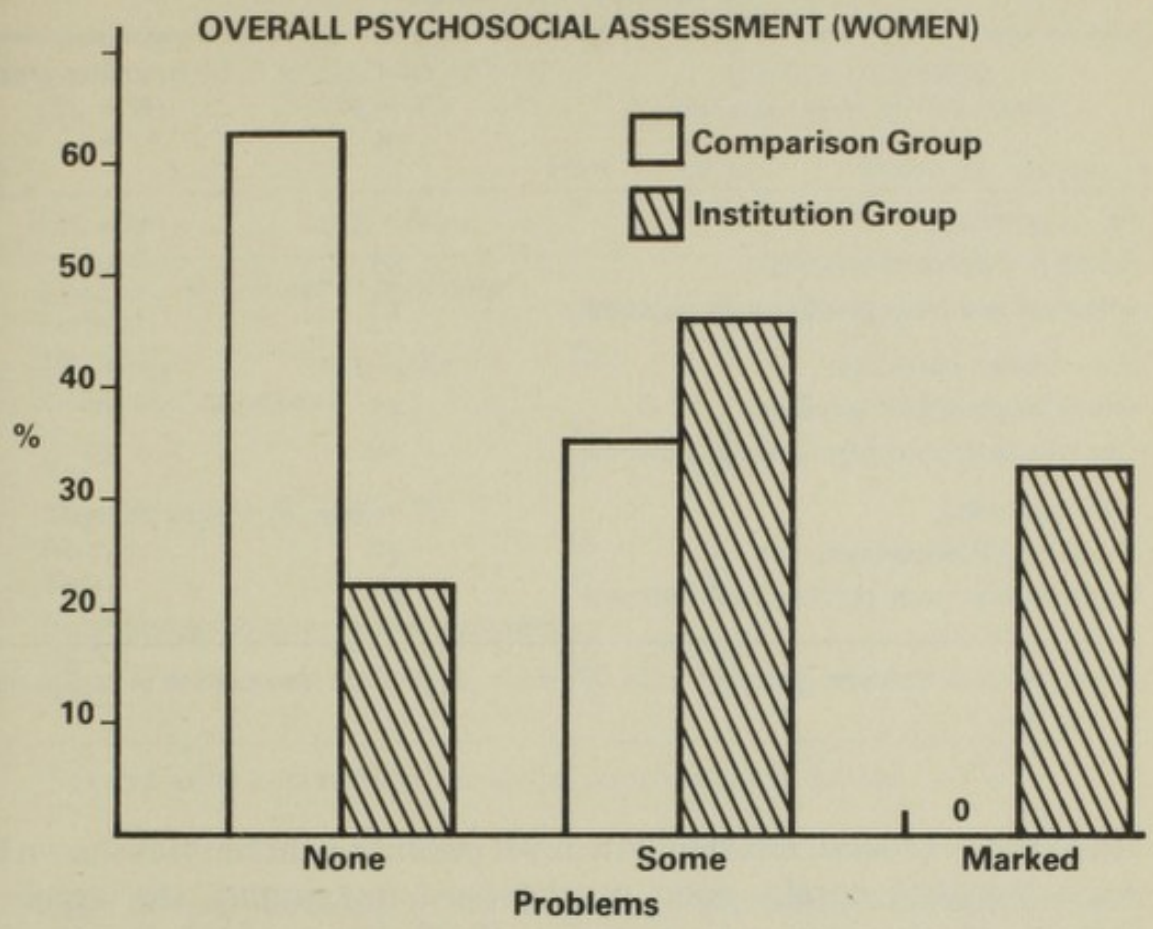
their own families, there was great heterogeneity of outcome in the 'ex care' sample, with a substantial minority showing *good* parenting. It is evident also that a surprisingly high proportion (just over half) of the comparison group mothers showed some problems in parenting, although far fewer showed severe difficulties.

Other aspects of psychosocial functioning

We may conclude from these findings that there is some continuity (as well as substantial discontinuity) in parenting across two generations. It is next necessary to consider whether these continuities apply to parenting *as such* or whether they reflect the intergenerational persistence of over-all psychosocial functioning (of which parenting was but a part), as they appeared to do in the retrospective study. Table 4.4. shows that the 'ex care' and comparison groups differed markedly in all aspects of psychosocial outcome. Many more of the former showed current psychiatric disorder, or had a criminal record, or had substantial difficulties in their sexual or love relationships. Over all, 25 per cent were rated as showing a personality disorder as evidenced by persisting handicaps in interpersonal relationships since their early teens or before (compared with none in the comparison group).

An over-all assessment of psychosocial outcome was obtained by combining these measures. A 'poor' outcome was rated if there was a personality disorder or severe and longstanding difficulties in sex/love relationships, or if there were definite current problems in *at least* three of six areas of marriage, broken cohabitation, social relationships, criminality, psychiatric disorder or living in hospital/hostel/or shel-

Figure 4.2



tered accommodation. A good outcome was rated if there were no problems on any of these measures. On these criteria, 32 per cent of the 'ex care' women but none of the controls had a poor outcome. Indeed, nearly two-thirds of the latter showed good functioning, a rating made for only a fifth of the institution-reared group.

Parenting and psychosocial outcome

The next issue is how far the parenting and psychosocial outcome measures overlap (see Table 4.5). Four main conclusions may be drawn. First, there was no association between the two measures in the comparison group. The implication is that parenting difficulties need not be a consequence of over-all psychosocial impairment. Secondly, the two measures overlapped to a very considerable extent in the 'ex care' group. As a consequence, there are very few 'ex care' women with poor parenting but a good psychosocial outcome on non-parenting measures (3/42), and scarcely any with good parenting but a poor psychosocial outcome (2/42). Thirdly, the main differences between the two groups applied to the proportions with both or neither set of difficulties. There is little evidence of parenting links across the two generations if parenting difficulties *occurring in isolation* are

Table 4.5 Association between current parenting and psychosocial adjustment (prospective study)

	'Ex care' group (N = 42) %	*Comparison group (N = 27)* %
Good parenting	*(N = 13)*	*(N = 12)*
Good psychosocial outcome	85	67
Intermediate/poor psychosocial outcome	15	33
Intermediate parenting	*(N = 11)*	*(N = 12)*
Good psychosocial outcome	45	67
Intermediate/poor psychosocial outcome	55	33
Poor parenting	*(N = 18)*	*(N = 3)*
Good psychosocial outcome	17	67
Intermediate/poor psychosocial outcome	83	33

Association in 'ex care' group $\chi^2 = 14.07$; d.f. = 2; $p<0.01$, association in comparison group NS.

considered. Indeed, intermediate level parenting difficulties shown by women with generally good psychosocial functioning are largely a feature of the comparison group (8/28 versus 5/42 in the 'ex care' group). That observation suggests the inference for the fourth conclusion – namely, that the explanation for isolated parenting difficulties of mild to moderate degree may well be different from that for severe and generalised psychosocial problems which include parenting difficulties as one of many areas of concern. These findings are consistent with those from the retrospective study where moderate levels of current handling problems unassociated with early adversities occurred in the comparison group.

Teenage difficulties and later parenting behaviour

Another aspect of the question of the extent to which parenting difficulties are just part of a broader spectrum of psychosocial problems concerns the role of emotional and behavioural difficulties during childhood and adolescence. As noted above, about half of the institution-reared women were already showing problems during the pre-adolescent and early teenage years. It is necessary to determine the extent to which these problems constituted precursors of later parenting difficulties. Table 4.6 shows that to an important extent they did. Of the women without any evidence of emotional/behavioural problems when young, 37 per cent showed poor parenting compared

Table 4.6 Girls' teenage behaviour and later parenting (prospective study: institution-reared group only)

	Quality of parenting (overall interview measure)				
	Poor %	*Good* %	*Statistical significance* χ^2	*d.f.**	*p*
Questionnaire ratings of behaviour					
Normal	37	42	8.39	2	0.02
Deviant	73	5			
Delinquent as juvenile					
No	50	28	4.71	2	NS
Yes	58	0			
Pregnant before 19 years					
No	35	25	3.71	2	NS
Yes	61	21			
Behavioural deviance and/or delinquency					
No	37	50	8.76	2	0.01
Yes	64	8			

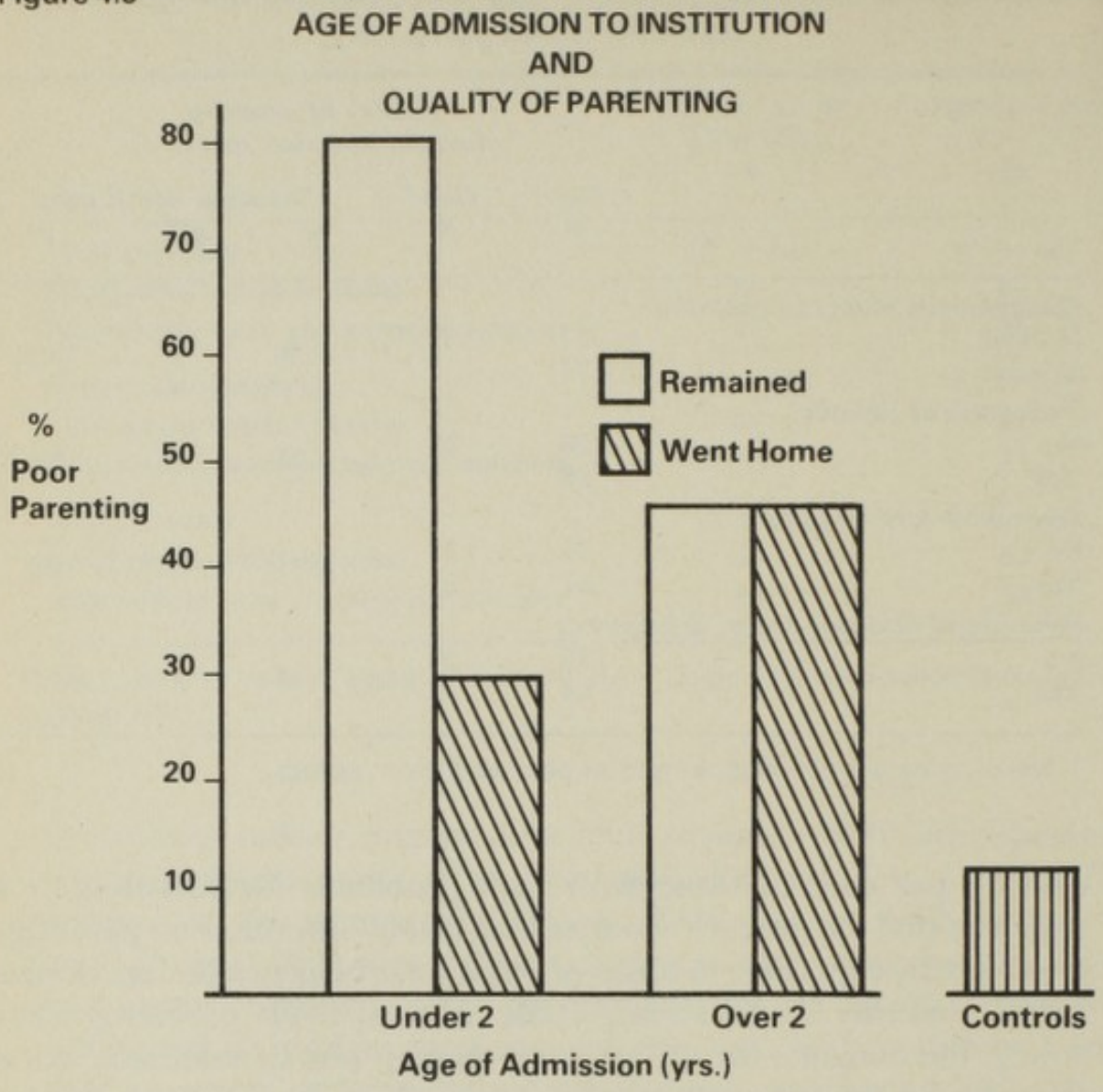
* Tested using intermediate, as well as poor and good, ratings.

with 64 per cent of those with such problems. Nevertheless, it is apparent that the 'ex care'–comparison group difference on parenting is not wholly explicable in terms of emotional/behavioural functioning before maturity. Even among those without overt problems when young, the outcome for the 'ex care' women was substantially worse than that for the comparison group (only 10 per cent of whom showed poor parenting).

Institutional rearing from infancy

The childhood experiences of the 'ex care' women involved both overt discord (as evident at home before admission to the institution) and the more harmonious but discontinuous multiple caretaking of the institutional environment. In order to understand the possible mechanisms involved in the links between childhood experiences and parenting behaviour, we need to ask whether institution-rearing in the absence of overt discord constitutes a substantial risk factor. The possibility may be explored by focusing attention on the sub-group of institution-reared children who were admitted in infancy and who stayed there for the remainder of their childhood. It is likely that, for most of these children, their upbringing in a Children's Home meant multiple changing caretakers and a relative lack of strong emotional ties to those parent-figures who cared for them, but equally for most

Figure 4.3



the atmosphere was *not* one of open discord. Nevertheless, this sub-group (N=10) admitted before age 2 years and remaining until 16 years or later included the highest proportion of all (80 per cent) with poor parenting (although the sub-group differences fell short of statistical significance). The finding is particularly striking in that the great majority of those who returned to their families (or who were admitted after infancy) experienced very poor home conditions, with discord and disharmony as prominent features. Even with these small numbers we must conclude that both institution-rearing *and* rearing in an unhappy quarrelsome home predispose to poor parenting.

The same applies to the women's over-all social functioning at follow-up. Of the thirty-four women admitted to institutions before the age of 2 years, 74 per cent showed intermediate or poor social functioning compared with 51 per cent of those admitted after the age of 2 years. Furthermore, of the twenty-one women admitted in infancy who stayed in the institution for the whole of the rest of their child-

hoods (that is, until at least 16 years), 76 per cent had an intermediate or poor social functioning rating. As these figures are based on rather larger numbers, there can be some confidence in the observation that institution-rearing *as such* predisposes to a poor social outcome in early adult life.

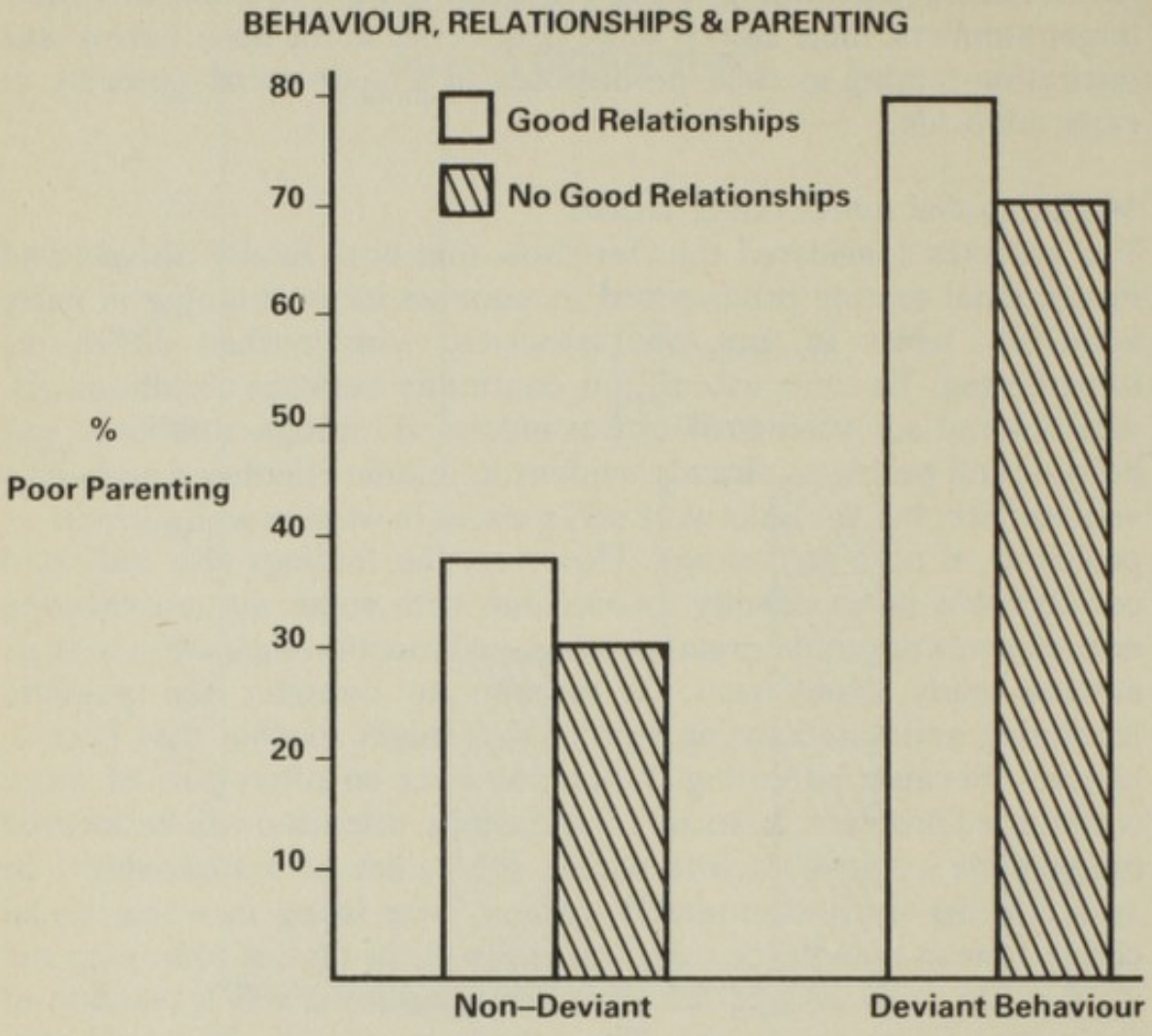
Mediating and ameliorating factors

The analyses considered thus far show that both family discord and institutional rearing predisposed to poor social functioning in early adult life, which in turn was associated with marked difficulties in parenting. To some extent, this continuity between childhood adversities and adult impairment was mediated through emotional and behavioural problems already evident in middle childhood and early adolescence; but the links were still present in women who showed no problems of note at that age. However, the findings also indicated considerable heterogeneity in outcome with some women showing normal parenting and normal psychosocial functioning in spite of their adverse early experiences. It remains to consider the possible mediating and ameliorating factors that might explain that heterogeneity. Because parenting difficulties were so often part of more widespread problems in social relationships, attention will be focused on possible positive factors within the realm of relationships. In addition, the institution-reared women were living in worse social circumstances than the comparison group at the time of follow-up and we need to consider whether their poor parenting was a function of their poor living conditions. The remainder of this chapter is concerned with these crucial issues.

Positive relationships during the teenage years

The first variable to consider concerns the girls' relationships with adults during adolescence. Relationships were rated as 'positive' if the subjects reported that, for a substantial portion of their teenage years, they maintained a stable relationship (or relationships) with an adult for whom they felt a definite attachment. The relationship need not necessarily be free of tensions or arguments but there had to be clear evidence of positive feelings and of a prolonged selective attachment to an adult – who might be a parent, foster-parent, house-parent or any other grown-up (peer relationships were excluded for this purpose). Because half the girls showed emotional/behavioural disturbance in childhood, and because this disturbance might influence (or be influenced by) the quality of relationships, it was necessary to include both variables in the analysis together. The findings (see Figure 4.4) show that both in those with and those without disturbed childhood

Figure 4.4



behaviour, the presence of positive relationships made no appreciable difference to the quality of parenting at the time of follow-up in the early to mid-20s.

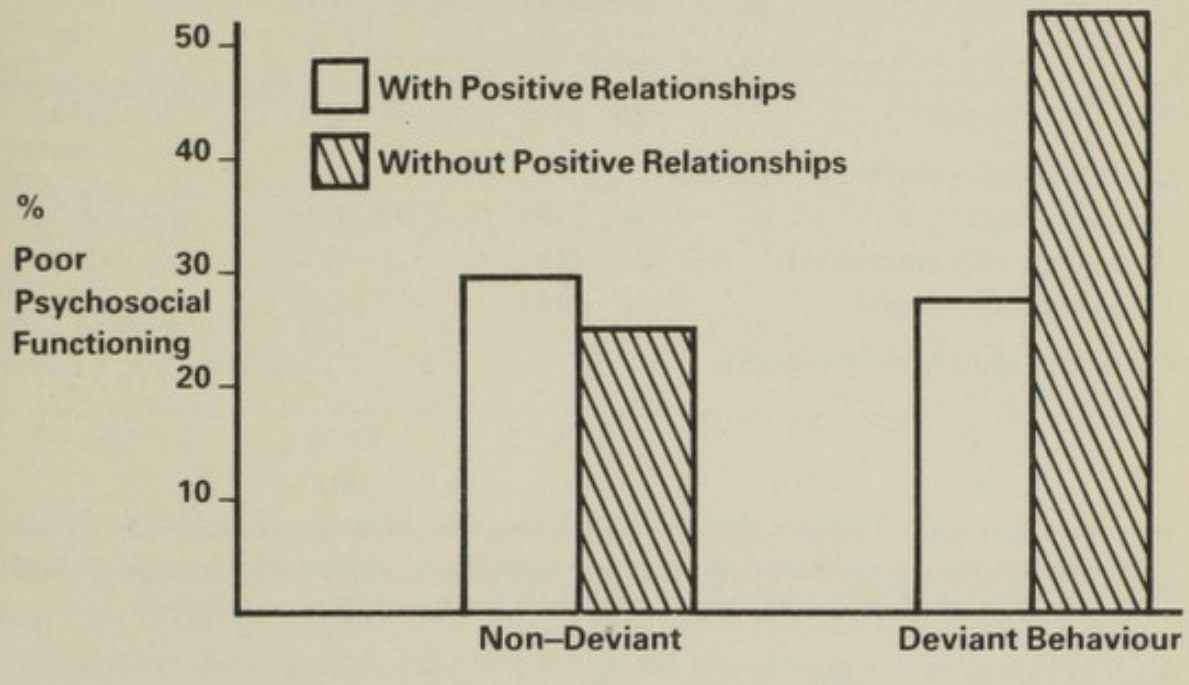
On the other hand, there was a suggestion that positive relationships might make more difference to the over-all social outcome (see Figure 4.5) – at least with respect to those who showed emotional/behavioural difficulties in childhood, where the difference fell only just short of statistical significance.

Family relationships on return home

The findings with respect to family experiences subsequent to discharge from residential care are summarised in Table 4.7. In most cases this involved a return to one or both biological parents but eight long-term fostering placements were also included. About half the girls returned to some kind of family environment, with the remainder staying in the institutions until they left to live independently. Although the numbers involved are quite small, a poor psychosocial

Figure 4.5

BEHAVIOURAL DEVIANCE IN CHILDHOOD, LATER POSITIVE RELATIONSHIPS AND PSYCHOSOCIAL OUTCOME



outcome seemed less likely if the girls returned to a harmonious family setting or one with no more than parent–adolescent disagreements. Of those going to a home with pervasive quarrelling and disharmony, half showed poor social functioning – a substantially worse outcome than that for those remaining in care. But, once again this did not apply to the quality of parenting. The outcome was much the same whether or not the girls returned to their families and there was no consistent association with the characteristics of the home to which they returned.

Pregnancy

The findings suggest that the mediating or ameliorating factors for parenting and for over-all psychosocial functioning may be somewhat different. However, one further point needs to be taken into account. As evident from Table 4.7, those who returned to a discordant family environment were much more likely to become parents than those who returned to a harmonious family or those who remained in the institution until they achieved independence. Altogether, 93 per cent of the discordant family sub-group gave birth to a child (often as a teenager) compared with 51 per cent of those remaining in the institution and 30 per cent of those going to harmonious families. These differences had implications for what happened subsequently. Thus, of the five cases of an overt breakdown in parenting, three came from the small sub-group of fourteen women who returned to generally discordant families;

Table 4.7 Circumstances on return home and parenting ('ex care' women in prospective study)

	Poor social functioning %	*Total No.*	*Live births* %	*Total No.*	*Poor parenting** %	*Total No.*
Remained 'in care'	26	(39)	51	(39)	55	(20)
Characteristics of home life on return						
Non-discordant	10	(10)	30	(10)	0	(3)
Arguments with parents only	33	(18)	72	(18)	54	(13)
General family discord	50	(14)	93	(14)	54	(13)
Statistical significance of home life trend (1 d.f.)						
χ^2	4.15		12.46		NS	
p	<.05		.001			

* Proportions based on those with children, but the 'poor parenting' rating includes those cases in which parenting broke down and the children were removed.

none came from those going to harmonious families and only one from those who remained in the institution. Also, the *timing* of the first pregnancy was associated with the quality of parenting as assessed at the time of follow-up. Nearly two-thirds (64 per cent) of the women who became pregnant by the age of 18 were rated as showing poor parenting compared with a third (32 per cent) of those who did not have their first baby until later.

Characteristics of the spouse and of the marital relationship

The next point to consider is whether the characteristics of the women's spouses and current marital situation at the time of follow-up were associated with the quality of parenting behaviour. Three aspects are summarised in Table 4.8. First, over half (56 per cent) of the small group (N = 9) without a spouse showed poor parenting. Secondly, parenting was significantly associated with the presence or absence of a supportive marital relationship (this was rated if there was a harmonious marriage, if a woman talked warmly about her spouse and/or if she said that she definitely confided in him). Thirdly, parenting was significantly associated with whether or not the spouse showed psychosocial problems (defined in terms of psychiatric disorder, criminality, a drink or drug problem, or long-standing difficulties in personal relationships). This last association is the more striking because the

Table 4.8 Spouse's characteristics and quality of mother's current parenting ('ex care' women in prospective study)

	Quality of parenting			*Statistical significance*		
	Good %	*Intermediate* %	*Poor* %	χ^2	*d.f.*	*p*
No spouse (N = 9)	22	22	56			
Spouse						
Non-supportive (N = 13)	0	38	62	10.07	2	0.01
Supportive (N = 21)	52	19	29			
Spouse						
With problems (N = 16)	6	19	75	14.53	2	0.001
Without problems (N = 17)	53	35	12			

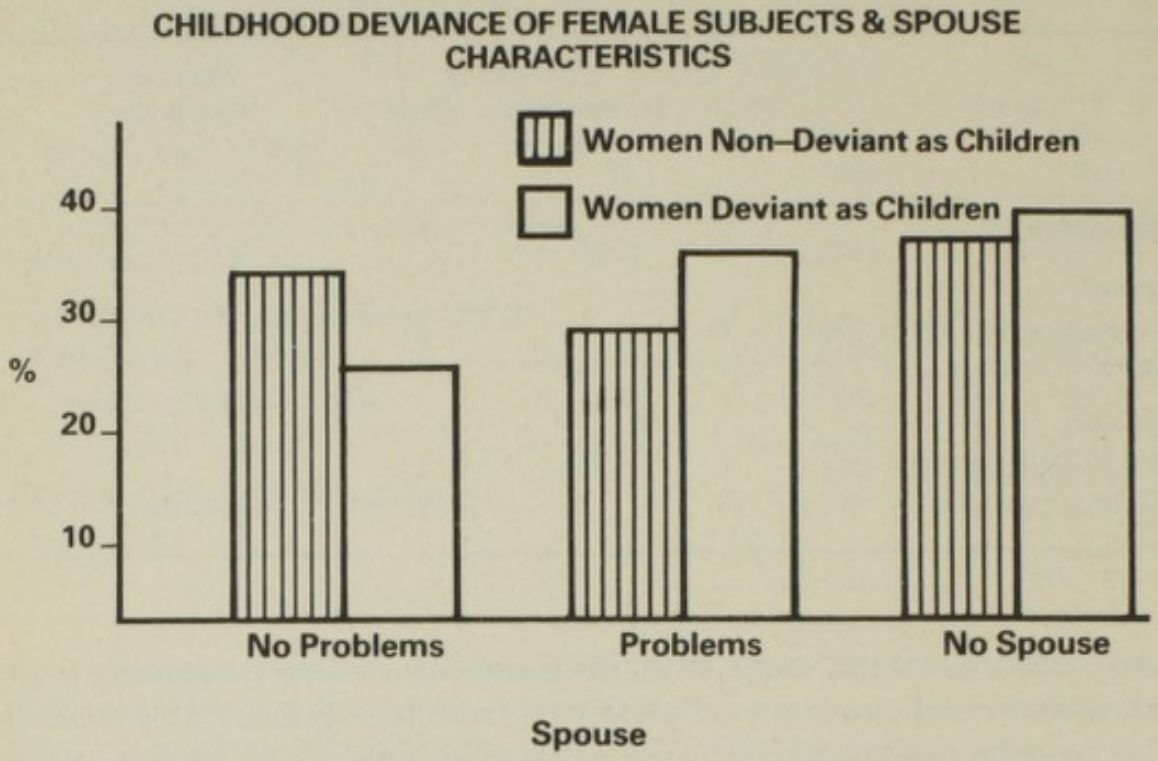
two measures largely came from different informants (parenting from the women and psychosocial problems from her spouse). It is striking that over half of the women with supportive spouses or spouses without psychosocial problems showed good parenting – a rate as high as that in the general population comparison group.

Choice of spouse

The findings suggest that the spouses' good qualities exerted a powerful ameliorating effect leading to good parenting. There was a substantial overlap between whether the spouse had problems and whether he provided a supportive relationship and, with the sample size available, it was not possible to determine which feature made the difference. However, the data suggested that both had an effect. But before concluding that the spouses' support constituted an ameliorating feature it is necessary to ask whether the statistical association merely reflected the women's own characteristics. Perhaps the girls who were non-deviant themselves during childhood and adolescence were the ones to choose better functioning supportive men to marry.

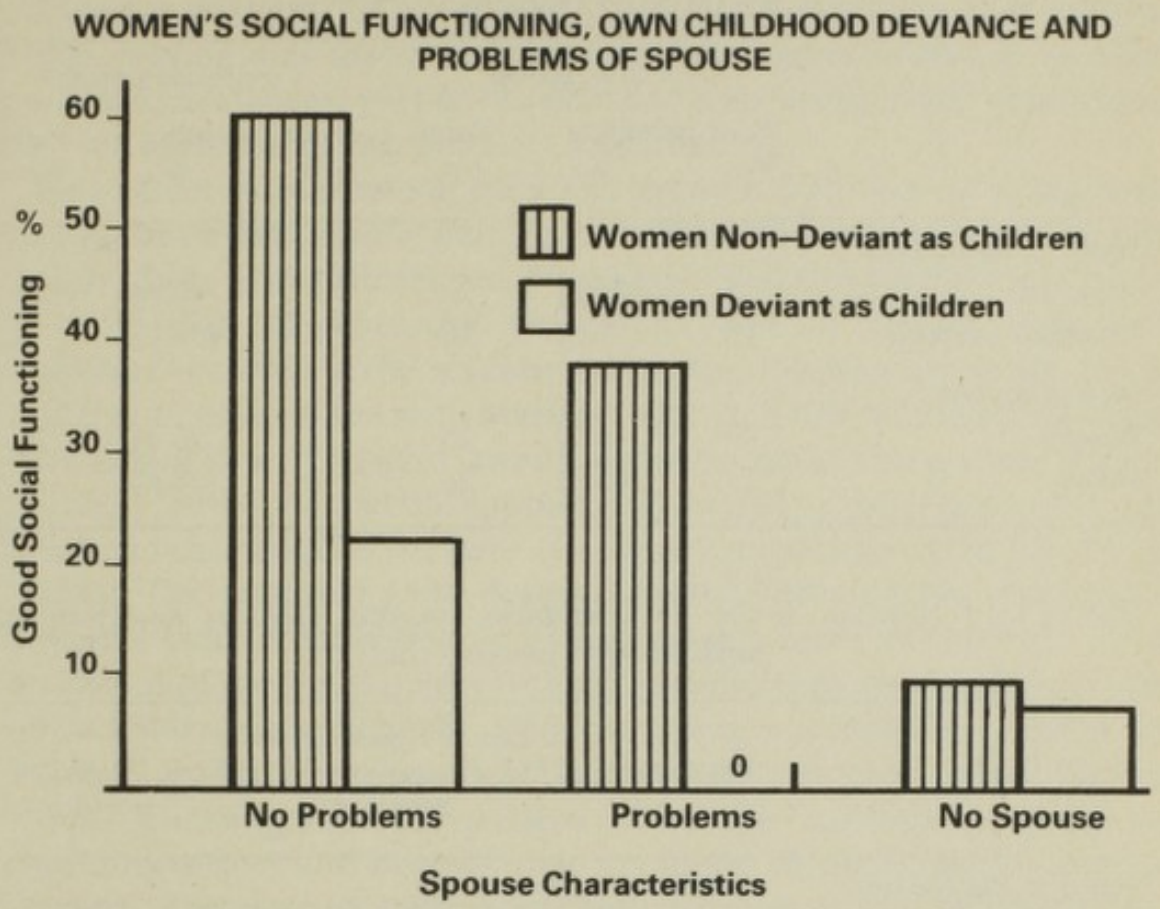
Figure 4.6 shows that this was not the case to any significant extent. The female subjects were subdivided into 'deviant' and 'non-deviant' groups according to their parent and teacher questionnaire scores in childhood. As shown already, those women deviant on one or other (or both) of these questionnaires had a substantially worse outcome. However, the presence of behavioural deviance did not predict the women's spouses' characteristics. Nearly two-fifths of both groups were without a cohabiting partner at the time of follow-up. About half the spouses of the remainder showed substantial personal problems of

Figure 4.6



one sort or another but there was only a very slight and statistically non-significant tendency for the deviant women to select men with problems as their spouses. The lack of assortative mating within the 'ex care' group may be a function of the fact that, on leaving the institution, the girls were scattered to a variety of settings different from those in which they had been reared – a circumstance that contrasts sharply with that of girls brought up in their own families and one likely to introduce a greater degree of randomness in the pool of men available. Whether or not this was the case, the findings indicate that it is most unlikely that the association between spouse characteristics and the women's parenting qualities was merely an artefact resulting from biases in the choice of marriage partner. Rather, it appears that the presence of a non-deviant supportive spouse exerted a protective effect making it more likely that women from a deprived background would be able to function effectively as parents. On the other hand, although there was no indication that the 'ex care' women's behaviour matched that of their male spouses, there was a marked tendency for the group of institution-reared women as a whole to be more likely than the comparison group to marry men with problems (51 per cent versus 13 per cent: $\chi^2 = 11.32$; d.f. $=1$; $p<0.001$). Moreover, as already noted (Table 4.3), the 'ex care' women with children were much more likely at follow-up to be without any kind of spouse (22 per cent versus 0 per cent). For both these

Figure 4.7



reasons, the 'ex care' women were much less likely to *experience* the protective effect of a supportive spouse (27 per cent versus 74 per cent).

The separate effects of a woman's own deviance and her spouse's characteristics in adult life are seen more easily with the measure of over-all social functioning at follow-up, as that is based on larger numbers. Figure 4.7 shows that the women who were non-deviant in childhood had better outcomes than those who were deviant; but also that the outcome was better for women who had spouses who were free of significant psychosocial problems. The women without a spouse included few with good social functioning.

Current social circumstances

Finally, we need to consider the women's housing and social circumstances. The 'ex care' women were living in worse social circumstances than the comparison group women at the time of follow-up (44 per cent versus 24 per cent living in intermediate/poor circumstances, operationally defined in terms of a score based on lack of facilities such as a washing-machine or telephone, the children having to share a bed or sleep in the parents' room, or overcrowding) and it is necessary to

Table 4.9 Current parenting, social circumstances and marital support (women in prospective study)

	'Ex care' group			Comparison group		
	Poor parenting		Total	Poor parenting		Total
	No.	%	*No.*	*No.*	%	*No.*
Social circumstances						
Adequate	5	(20.0)	25	2	(8.0)	25
Intermediate/poor	12	(75.0)	16	2	(50.0)	2
Marital support						
Present	0	(6.0)	15	1	(5.0)	20
Absent	17	(65.4)	26	2	(28.6)	7

Table 4.10 Group, social circumstances, marital support and parenting problem (prospective study)

		Linear logistic analysis			
Model fitted	*Deviance*	*d.f.*	*Reduction in deviance*	*d.f.*	*Statistical significance*
Initial model constant	41.36	7			
Group	33.45	6	7.91	1	<0.01
Group + social circumstances	18.70	5	14.79[a]	1	<0.001
Group + marital support	11.44	5	22.01[b]	1	<0.001
Group + support + circumstances	3.75	4	7.69[b]	1	<0.01

[a] from group model [b] from group + support model

determine the extent to which their poorer parenting was a consequence of their inadequate living conditions. Table 4.9 summarises the main findings with respect to both social circumstances and marital support and Table 4.10 gives the findings of the linear logistic analysis with the same set of variables. It is clear that poor parenting was substantially less likely to occur in adequate social circumstances in both the 'ex care' group (20 per cent versus 75 per cent) and the comparison group (8 per cent versus 50 per cent). However, also, poor parenting was more likely to occur in the 'ex care' women, irrespective of social circumstances. Thus, for those in adequate social circumstances the difference in poor parenting was between 20 and 8 per cent. The inference is that rearing patterns were associated

with parenting independently of social circumstances, but that social conditions exerted an additional effect. However, because institutional rearing was associated with an increased *likelihood* of poor social circumstances, part of the effect of poor living conditions was an *indirect* outcome of the pattern of upbringing.

The effect of marital support was greater than that of living conditions, but a comparable pattern of indirect links was evident. Nevertheless, there were differences. Three main features warrant attention. First, almost all instances (seventeen out of twenty) of poor parenting occurred in the 'ex care' group, but this was largely the result of the prior association with marital support. Thus, of the thirty-three instances of lack of support, twenty-six occurred in the 'ex care' group. Secondly, provided marital support *was* available, poor parenting was a rare occurrence (0–5 per cent of cases), irrespective of the pattern of rearing. The inference to be drawn is that childhood adversities had a powerful *indirect* influence on parenting as a result of their effect on the choice of spouse, but very little direct influence provided that there was marital support. Thirdly, poor parenting was more frequent in the 'ex care' group if support was lacking (65 per cent versus 29 per cent), indicating that the pattern of rearing exerted an effect on parenting above and beyond that mediated through lack of marital support. The over-all pattern of findings suggest that childhood adversities lead to poor parenting through two main mechanisms. The first concerns the process by which they set in motion a train of events that predispose the woman to the *experience* of poor social circumstances and lack of marital support. This arises through various happenings that limit opportunities – by virtue of teenage pregnancies, early marriage to someone from an equally disadvantaged background, lack of educational qualifications for occupational advancement and other features of a similar kind. The second mechanism concerns some type of increased vulnerability or decreased coping skills which make it more likely that the women will *succumb* when faced with poor social circumstances or lack of marital support. Only a minority of women with a stable harmonious pattern of upbringing exhibited poor parenting when subjected to chronic stress and disadvantage in adult life, but a *majority* of those who lacked good rearing in childhood did so. It seemed that the experience of childhood adversities had no *necessary* effect on parenting (as shown by the good parenting of the institutional women with supportive spouses) but it left the individuals less well prepared to deal with adult adversities.

The analyses summarised in Tables 4.9 and 4.10 used a definition of poor social circumstances rather broader than that employed in the retrospective study and Table 4.11 gives the linear logistic analysis

Table 4.11 Group, housing problems, lack of marital support and parenting problems (prospective study)

	Linear logistic analysis				
Model fitted	*Deviance*	*d.f.*	*Reduction in deviance*	*d.f.*	*Significance*
Initial model constant	27.64	6			
Group selection	18.21	5	9.43	1	<0.01
Group + housing	15.30	4	2.91	1	NS
Group + marital support	1.84	4	16.37	1	<0.001

with the variables defined in the same way as that in the first study, so that the comparison can be made with Table 4.2. The conclusions are similar to those from Tables 4.9 and 4.10 except that the effects of housing were reduced as a result of the rather small proportion of the sample in very poor housing.

Conclusions

Further work is required in order to disentangle fully the web of associations that the data represent. Moreover, the results apply to women only; it remains to be seen whether or not similar patterns apply to the men (see Quinton *et al.* 1983). Nevertheless, several important inferences can be derived from these preliminary analyses.

First, there can be no doubt that adverse experiences in childhood do indeed predispose to poor parenting in early adult life. Furthermore, this association is quite a strong one – poor parenting was five times as common in the institution-reared group as in the general population comparison group reared by their own families, and overt parenting breakdown was *confined* to the 'ex care' group. These findings support the data from the retrospective study and, taken together, suggest that women who suffer current parenting *breakdown* are almost entirely drawn from among those who had markedly adverse childhoods.

But, although strong, the association was far from inevitable. About a quarter of the institution sample showed good parenting in spite of all their adverse experiences in early life. This poses the important question of what it was that enabled these individuals to show such resilience.

The link between early experiences and parenting needs some qualification, as in most cases the poor parenting constituted part of a much broader pattern of poor psychosocial functioning. This was, again, true for both the retrospective and the prospective samples. Among the institutional children it was decidedly uncommon to find poor parent-

ing in the context of good psychosocial functioning. On the other hand, this pattern was rather more frequent in the comparison group. The observation suggests the possibility that the antecedents of 'pure' or 'isolated' parenting difficulties may be rather different from those of more complex parenting problems that form part of a generally maladaptive pattern of psychosocial functioning. Probably, adverse childhood experiences are more important in the genesis of the latter than the former. On the other hand, it would not be correct to regard poor parenting and poor psychosocial outcome as synonymous. The antecedents of the two differed in some respects.

Of course, there were similarities and these should be mentioned first. With both, the institution-reared group fared much worse and it seems apparent that adverse childhood experiences play an important predisposing role for poor parenting *and* poor psychosocial functioning more generally. With both, too, it is clear that emotional/behavioural disturbance during childhood and early adolescence plays an important mediating role. The outcome was substantially worse for the young people already showing difficulties at that stage. But, it was not simply a matter of disturbed children becoming disturbed adults. Among the institution-reared subjects without a crime record *and* without problems on either the parent or teacher questionnaire, over a third showed poor parenting in their 20s – a rate more than three times higher than the 10 per cent in the comparison group. Evidently an institutional rearing predisposed to poor parenting even in the minority of individuals who seemed to be free of notable psychosocial problems in childhood.

The two outcomes also showed a similar pattern in terms of the effects of current social circumstances – meaning both housing conditions and the marital relationship. Although childhood experiences had a more powerful effect on adult outcome, conditions in adult life also had a crucial impact. In part, this was because adversities in childhood predisposed to poor living conditions, along with other aspects of psychosocial outcome. But this was not the whole story; current circumstances in adult life seemed to make a significant contribution. It may be concluded that adult functioning is *not* 'set' by the end of childhood. Conditions in adult life may facilitate or impede adaptive psychosocial functioning.

Women's relationships with their spouses constituted a particularly important part of their current circumstances. Those enjoying a harmonious marital relationship with a non-deviant husband were much more likely to show good parenting. The findings indicate the importance of an ecological perspective – an individual's psychosocial functioning (including parenting) has to be seen in its social context.

Past experiences play a part in shaping personality development but, even in adult life, a person's behaviour is likely to be influenced to an important extent by situations and circumstances.

But, it would be misleading to regard this as an indication of developmental discontinuity, with outcomes largely the result of the vagaries of chance and of new circumstances in adult life that are independent of childhood experiences. Certainly the findings run counter to the view that early experiences permanently and irrevocably change personality development. Very few experiences have long-term effects that are independent of intervening circumstances (Rutter 1979 and 1981). On the other hand, the evidence suggests that there are continuities in development that stem from the opening up or closing down of further opportunities – a train of events in which there are lasting sequelae as a result of a cumulative chain of indirect effects. For example, the institution-reared girls who returned to discordant families were more likely to have babies early than those who remained in the institution or who returned to harmonious families; teenage pregnancy, in turn, was then associated with an increased risk of a poor social outcome. Similarly, the 'ex care' women were more likely than those in the comparison group to marry spouses with psychosocial problems; the presence of a deviant spouse then further predisposed to poor parenting. In this way, substantial intergenerational continuities arise. But, because the continuities depend on a multitude of links over time, each link being incomplete and subject to modification, there are many opportunities to break the chain. Such opportunities continue right into adult life – as shown by the powerful effect on parenting of the spouse's characteristics.

With respect to parenting two additional points need to be made. First, experiences of positive relationships with adults during the teenage years seemed to make very little difference – in spite of their beneficial impact on over-all psychosocial outcome. It would be wrong to interpret this as meaning that parenting functions were already predetermined by early adolescence. That they were not is shown by the ameliorating effects of a good marital relationship later. But, it does seem that it must be a particular kind of relationship or experience for there to be benefits in terms of parenting. Why should a marital relationship be helpful whereas other relationships are not? We can only speculate. It could be that the answer lies in terms of the person's receptivity being greater in early adult life than in adolescence. But, perhaps, the explanation is of a different kind. It may be that the difference does not lie in the relationship with the spouse as such, but rather in the quality of the spouse's own parenting. It is possible that the benefit lies in the modelling of good parenting

rather than in the marital relationship itself. The disentangling of these various possibilities, however, must await further analyses of the data.

The second point concerns the poor outcome for children admitted to a Children's Home in infancy and who remained there for the remainder of their upbringing. Perhaps surprisingly, this was the group with the worst parenting of all. The importance of this finding lies in both its practical and theoretical implications. It will be appreciated that the children had been admitted to the institution to protect them from the damage of remaining with their own parents in a discordant, disruptive and malfunctioning family. Accordingly, it is chastening to realise that this policy seems to have had such a devastatingly bad effect on the young people's functioning as parents. Of course, the numbers in this analysis were very small and replication is required before the finding can be accepted with any confidence. Nevertheless, it raises important questions for policy and practice. Also, there are theoretical implications. If rearing in a relatively harmonious group environment is worse than rearing in a discordant family environment, perhaps the main damage comes from what is *lacking* in the institution rather than from what is wrong in the child's own home. But, further data and larger numbers are required to examine this matter properly.

Notes

1 The sample departs from truly random only in so far as it was restricted to children in the same school classes as the children of mentally ill parents. The available data show that this introduced no relevant distortions or biases. (Further details on both samples are given in Quinton and Rutter 1982c.)

2 The finding from the interview data that poor parenting was significantly more frequent in the 'ex care' women than in the comparison group women was confirmed in the data deriving from direct observation of mother–child interaction in the families' own homes (see Quinton *et al.* 1983).

References

Bronfenbrenner, U. (1979), *The ecology of human development: experiments by nature and design*, Cambridge, Mass.: Harvard University Press.

Brown, G.W. and Rutter, M. (1966), 'The measurement of family activities and relationships: a methodological study', *Human Relations*, vol. 19, pp. 241–63.

Clarke-Stewart, K.A. (1978), 'And daddy makes three: the father's impact on mother and young child', *Child Development*, vol. 49, pp. 446–78.

Court, S.D.M. (1976), See Department of Health and Social Security.

Department of Health and Social Security (1976), *Fit for the future* (Report of the Committee on Child Health Services), Chairman: Professor S.D.M. Court, London: HMSO.

Dowdney, L., Mrazek, D.A., Quinton, D. and Rutter, M.(1973), 'Observation of parent–child interaction with two-to-three year olds', *Journal of Child Psychology and Psychiatry* (in press).

Fienberg, S.E. (1977), *The analysis of cross-classified categorical data*, Cambridge, Mass.: MIT Press.

Graham, P. and Rutter, M. (1968), 'The reliability and validity of the psychiatric assessment of the child: II. Interview with the parent', *British Journal of Psychiatry*, vol. 114, pp. 581–92.

Harman, D. and Brim, O.G. (1980), *Learning to be parents: principles, programs and methods*, London: Sage Publications.

Joseph, K. (1972), 'The cycle of deprivation', speech at Conference of Pre-School Playgroups Association, 29 June.

King, R.D., Raynes, N.V. and Tizard, J. (1971), *Patterns of residential care: sociological studies in institutions for handicapped children*, London: Routledge & Kegan Paul.

Lambert, L., Essen, J. and Head, J. (1977), 'Variations in behaviour ratings of children who have been in care', *Journal of Child Psychology and Psychiatry*, vol. 18, pp. 335–46.

Mapstone, E. (1969), 'Children in care', *Concern*, vol. 3, pp. 23–8.

Mrazek, D.A., Dowdney, L., Rutter, M. and Quinton, D. (1982), 'Mother and pre-school child interaction: a sequential approach', *Journal of the American Academy of Child Psychiatry*, vol. 21, pp. 453–64.

Novak, M.A. (1979), 'Social recovery of monkeys isolated for the first year of life: II. Long term assessment', *Developmental Psychology*, vol. 15, pp. 50–61.

Novak, M.A. and Harlow, H.F. (1975), 'Social recovery of monkeys isolated for the first year of life. I. Rehabilitation and therapy', *Developmental Psychology*, vol. 11, pp. 453–65.

Pringle, M.K. (1974), *The needs of children*, London: Hutchinson.

Pringle, M.K. and Bossio, V. (1960), 'Early prolonged separations and emotional adjustment', *Journal of Child Psychology and Psychiatry*, vol. 1, pp. 37–48.

Quinton, D. and Rutter, M. (1983a), 'Parents with children in care: I. Current circumstances and parenting skills', *Journal of Child Psychology and Psychiatry* (in press).

Quinton, D. and Rutter, M. (1983b), 'Parents with children in care: II. Intergenerational continuities', *Journal of Child Psychology and Psychiatry* (in press).

Quinton, D. and Rutter, M. (1983c), 'Family pathology and child disorder: a four year prospective study', in Nicol, A.R. (ed), *Practical lessons from longitudinal studies*, Chichester: John Wiley (in press).

Quinton, D., Rutter, M. and Liddle, C. (1983), 'Parenting behaviour of mothers raised "in care" ', in Nicol, A.R. (ed), *Practical lessons from longitudinal studies*, Chichester: John Wiley (in press).

Quinton, D., Rutter, M. and Rowlands, O. (1976), 'An evaluation of an interview assessment of marriage', *Psychological Medicine*, vol. 6, pp. 577–86.

Rohner, R.P. (1975), *They love me, they love me not: a worldwide study of the effects of parental acceptance and rejection*, New York: Human Relations Area Files, Inc.

Rutter, M. (1967), 'A children's behaviour questionnaire for completion by teachers: preliminary findings', *Journal of Child Psychology and Psychiatry*, vol. 8, pp. 1–11.

Rutter, M. (1975), *Helping troubled children*, Harmondsworth; Penguin Books.

Rutter, M. (1979), *Changing youth in a changing society: patterns of adolescent development and disorder*, London: Nuffield Provincial Hospitals Trust. (Cambridge, Mass.: Harvard University Press, 1980.)

Rutter, M. (1981), *Maternal deprivation reassessed, 2nd edn*, Harmondsworth: Penguin Books.

Rutter, M. and Brown, G.W. (1966), 'The reliability and validity of measures of family life and relationships in families containing a psychiatric patient', *Social Psychiatry*, vol. 1, pp. 38–53.

Rutter, M. and Giller, H. (1983), *Juvenile delinquency: trends and perspectives*, Harmondsworth: Penguin Books (in press).

Rutter, M. and Madge, N. (1976), *Cycles of disadvantage*, London: Heinemann Educational Books.

Rutter, M. and Quinton, D. (1981), 'Longitudinal studies of institutional children and children of mentally ill parents (United Kingdom)', in Mednick, S.A. and Baert, A.E. (eds), *Prospective longitudinal research: an empirical basis for the primary prevention of psychosocial disorders*, Oxford: OUP.

Rutter, M., Tizard, J. and Whitmore, K. (eds) (1970), *Education, health and behaviour*, London: Longman (reprinted, Krieger, Huntington, New York, 1981).

Schaffer, H.R. and Schaffer, E.B. (1968), *Child care and the family*, Occasional Papers on Social Administration no. 25, London: Bell.

Sheridan, M.D. (1959), 'Neglectful mothers', *Lancet*, vol. i, pp. 722–5.

Smith, S.M. (ed) (1978), *The maltreatment of children*, Lancaster, England: MTP Press.

Stendler, C. (1950), 'Sixty years of child training practices: revolution in the nursery', *Journal of Pediatrics*, vol. 36, pp. 122–34.

Vincent, C.E. (1951), 'Trends in infant care ideas', *Child Development*, vol. 22, pp. 199–209.

Weissman, M.M. (1979), 'Depressed parents and their children: implications for prevention', in Berlin, I.N. and Stone, L.A. (eds), *Basic handbook of child psychiatry: vol. 4, prevention and current issues*, New York: Basic Books.

Werner, E.E. (1979), *Cross-cultural child development: a view from the planet Earth*, Monterey, California: Brooks/Cole.

Wolfe, A. (1977), 'Parent education in popular literature', in *Seminar on the care of the child: final report*, Chicago: Department of Education, University of Chicago.

Wolfenstein, M. (1955), 'Fun morality: an analysis of recent American child-training literature', in Mead, M. and Wolfenstein, M. (eds), *Childhood in contemporary cultures*, Chicago: University of Chicago Press.

Wolkind, S.N. (1974), 'The components of "affectionless psychopathy" in institutionalized children', *Journal of Child Psychology and Psychiatry*, vol. 15, pp. 215–20.

Wolkind, S.N. (1977), 'Women who have been "in care" – psychological and social status during pregnancy', *Journal of Child Psychology and Psychiatry*, vol. 18, pp. 179–82.

Wolkind, S.N. and Rutter, M. (1973), 'Children who have been in "care" – an epidemiological study', *Journal of Child Psychology and Psychiatry*, vol. 14, pp. 97–105.

Yule, W. and Raynes, N.V. (1972), 'Behavioural characteristics of children in residential care in relation to indices of separation', *Journal of Child Psychology and Psychiatry*, vol. 13, pp. 249–50.

5 Sisters and Their Children: Implications for a Cycle of Deprivation

Alex. McGlaughlin and Janet M. Empson

Tests of the hypothesis of generational transmission of deprivation usually involve either retrospective or prospective longitudinal study over a number of generations of the same families. Our alternative approach attempts a shorter-term answer. If the hypothesis is true, then we would argue that the tendency of some families to rear inadequate children, generation after generation, should also show itself in the child-rearing practices of different members of the same generation of such families. Put simply, if the argument holds that some mothers rear inadequate children who in their turn rear inadequate children, then two daughters of an inadequate mother should themselves demonstrate a markedly similar and inadequate pattern of child-rearing and raise similar and inadequate infants.

Our test of the hypothesis has therefore been to include in our sample only pairs of families. Each pair is chosen, first, because the family is deprived and in consequence the infants are disadvantaged, and second, because within each pair of families our target children are cousins and their mothers are siblings (sisters). To support the hypothesis, we should expect such pairs of mothers to prove similar in their attitudes to, or behaviour in, child-rearing, and their infants to demonstrate similar levels of development. Of course, the hypothesis is not necessarily disproved if this is not the case. But it is considerably weakened and would require substantial reformulation. For if sibling mothers are no more alike than unrelated mothers, the hypothesis of transmission through the family can only be sustained if it is modified to indicate transmission through some specified member or members of the family, but not others.

The evidence we shall present derives from more than one aspect of the lives of our sixty families. The thirty pairs of sibling mothers were judged for three sorts of similarity: behavioural similarity, when observed interacting with their children during play; similarity of circumstances, determined from various sources of stressful events; and similarity in the attitudes they expressed on their children's

development. The thirty pairs of infants (cousins) were also judged for three sorts of similarity: behavioural similarity, when observed interacting with their mothers during play; behavioural similarity, according to their mother's reports; and similarity in developmental status, based on our assessment at $2\frac{1}{2}$ years of age.

For the sample as a whole, the evidence for greater similarity between relatives as compared with non-relatives is not impressive. This is so for related mothers (sisters) and for related infants (cousins). However this general conclusion masks the fact that there is within the full sample a sub-group of families that demonstrate a very substantial level of similarity in behaviour *and* in circumstances *and* in the relative levels of language development of the children.

We shall begin this chapter with a consideration of our sampling criteria, methods and procedures. This is followed by the presentation of the evidence for similarities between sibling mothers, and then by the evidence for similarities between their infants (cousins). Next, we explore the relationships in this sample between stressful events, behavioural interaction and child development. Finally, we return to the issue of familial similarity from the perspective of a sub-sample of eighteen families.

The mothers and their children

Sixty families, each of which comprised at least a mother and one child under 1 year of age (our target child), participated in the study. Thirty of these families were selected as they had a child of the appropriate age, a sister who also had an infant of this age, and as they met our criteria of deprivation based on parents' education, income and father's social class. The remaining thirty families were the sisters of the first group of mothers, and their children.[1]

When the families of the original sample of mothers and their sisters were compared, a somewhat higher level of deprivation was found among the former group. In terms of education, for instance, neither parent in the first group had either been educated beyond the statutory minimum school-leaving age or had achieved any formal educational qualifications, whereas in the second group the mothers, although all had left school at the first available opportunity, had between them gained five passes in the Certificate of Secondary Education. Moreover some of the fathers in the second group had achieved relatively highly: one had attended night school, one had gained his Bosun's Ticket, one had a Higher National Certificate in Engineering, and five had completed apprenticeships. Regarding finances, all families in the first group were on low incomes and most were eligible for Family Income Supplement and/or supplementary benefit. The second group,

nevertheless, tended to be a little better off and, on average, these families had a weekly income that was about five pounds more than in the first group. Twenty families in the first group were in the Registrar General's Social Class V, and ten in Social Class IV (mainly fishermen, process workers or packers), whereas about half of the second group could be classified as Social Class III manual, a further three as Social Class III non-manual and only a comparatively small proportion as Social Classes IV and V.

Over all, however, most of the sixty families were in some respects deprived, and according to the Composite Index of Social Class (Osborn and Morris 1979), which takes into account class of father's occupation, education of both parents, type of accommodation, crowding, tenure, neighbourhood, amenities, car ownership and unemployment history, 65 per cent of the families fell within the estimated range for the bottom 15 per cent of the total population.

Interestingly, of the forty families for whom we were able to ascertain the social class of origin, there was a slight tendency for mothers to marry, or cohabit with, a man of lower social class than their own fathers: eighteen of these mothers had married into a lower social class, while eleven had married up and eleven had been socially immobile. In other words, many of our currently deprived families had been recruited into such circumstances from a more advantageous position in the previous generation.

No comparison or control groups were used in our study, nor do we believe that any were necessary. Indeed, more than a decade ago, Richards (1971) cogently argued the case against such comparative studies in favour of studies that examined differences within selected groups:

> A recurrent problem in cultural deprivation studies is the wide disparity in the two groups that are compared . . . Perhaps we could select our sample in a much more efficient way . . . we could look at differences within one relatively homogeneous population. In this way . . . we may more easily find those (differences) that really matter for development.

We have chosen our sample in just such a way. Fuller details of the sample characteristics are provided by McGlaughlin (1980).

Method and procedure

Four main types of information were collected during the study. First, data on attitudes to child-rearing were gained from interviews with the mothers, using an extensive structured schedule, when each child was 12, 18, 24 and 30 months of age.

Second, patterns of interaction between mothers and their children during play were observed and videotape-recorded in their homes for two periods of at least nine minutes at each of the four child ages. On the occasion when the child was aged 12 months the recorded sequences were of free play, but at the other three ages an appropriate box of toys was provided as a stimulus. The recorded sequences of interactions were divided into blocks of eighteen seconds' duration, and the first interaction occurring in each block was classified according to the initiator (mother or child), the responsivity of the other member of the dyad, the type of interaction (intellectual, social, caretaking or other), the provider of the subject of interaction (mother or child), the mother's technique during interaction (teaching, facilitating, directing, etc.) and the mother's use of talk and/or action during interaction. Full details of the operational definitions of these classes and their sub-classes, inter-observer reliability, behavioural stability across child ages and other methodological issues are presented by McGlaughlin (1980).

The third area on which information was sought was the level of stress imposed on each family by factors such as illness, unemployment, poverty and bad housing. Assessments were based on reports made during the interviews with the mothers, and were classified according to an adaptation of the Schedule of Recent Experience (after Holmes and Rahe 1967; Brown and Harris 1978).

Finally, we examined the developmental progress of the children at 30 months. A general assessment of development (after Gesell and Illingworth: see Illingworth 1970) and an assessment of language performance (Reynell 1969) were both made.

In the following discussion of our findings we refer, in the main, to the similarities and differences found between pairs of sisters and between pairs of cousins. (More general findings based on the study data can be found in McGlaughlin *et al.* 1980 and McGlaughlin *et al.* 1981.) In attempting to determine how similar related mothers or their infants were, we chose to examine pairs of scores at each of the four stages of measurement rather than to develop some composite index of attitudes and behaviour for the whole study period. Nevertheless it should be noted that we have measures of developmental status only at 30 months of age, and that measures of developmental status and competence at this age are likely to be predicted by earlier measures only if the behaviours selected for measurement are representative of the general and continuing relationship between a mother and her child.

Similarities between sibling mothers

Behaviour

In order to be able to compare the ways that sisters interacted with their infants, it was necessary to make some distinction between behaviours that primarily reflected the mother's contribution to the interaction and those that essentially reflected her child's. Although decisions of this kind are admittedly somewhat arbitrary, given the reciprocal nature of dyadic interaction, five characteristics of interactions were attributed mainly to mothers; these were: the volume of interactions; the mother's use of speech; whether or not there was a focus on intellectual activity; initiation of the interaction by the mother; and provision of the subject of interaction by the mother. Other variables, such as a focus on social activity, were excluded from this analysis because of the high variability between the two sets of scores obtained at each child age and because they failed to correlate with the dependent variables.

Scores for these five selected variables were available at all four child ages, thus providing twenty scores for each mother. Each score was rated as falling above or below the median for the sample on that variable, at that child age. The twenty scores of each mother were examined within each of the thirty sister pairs. If *both* mothers in any case gained scores either below or above the group median, they were classified as similar on that score. Over all, sisters were judged as being generally similar in their behaviour if they gained sixteen or more similar classifications (equivalent to a probability of less than 0.012 on a two-tailed sign test: Siegel 1956). Nine of our thirty pairs of sibling mothers were judged to be similar in behaviour on this criterion and three pairs were found to be notably dissimilar.

Further analysis considered the direction of similarity, that is, whether sisters resembled each other in that they were generally above or generally below the average in the extent to which they tried to stimulate their children. Of the nine similar pairs, three were found to be considerably more stimulating, and three considerably less stimulating, than the other mothers. The remaining three pairs were sometimes more and sometimes less stimulating, depending on which variable and which child age was examined.

Finally, every mother was accorded a weighted score of plus one for each raw score above the average and minus one for each score that was below the average. For all thirty pairs of families the correlation for these weighted scores was 0.24. For the nine pairs previously judged as similar the correlation was 0.92, while for the three pairs judged to be dissimilar it was −0.99.

We were led to conclude that *in general* there was little similarity in the way that the disadvantaged sibling mothers played with their young infants. Knowing that one member of a pair of sisters was generally more (or less) stimulating than most mothers provided few clues for predicting how her sister would interact with her own child (Yules Q = 0.14). However, *some* pairs of sisters (approximately one in three) were very alike in this way, and these cases were more numerous than those (one in ten) showing an equivalent level of dissimilarity.

Circumstances and stress

In considering the level of stress imposed upon a family, we have taken account of both structural and familial influences. Both these types of factor are likely to be important in contributing to the variation in development shown by the children in our sample.

Stressful experiences within the sample were considerable. Unemployment was approximately three times as prevalent as the national average, and many of the families had recently been uprooted, largely as a result of rehousing. Moreover a number of families had separated, divorced or lost a partner through death – in one case, murdered in a family feud. Many families, too, had suffered through ill health, hospitalisation and poverty. Nevertheless individual families showed enormous variations in these respects, and it was of interest to see if sisters showed any tendency to have stresses of these kinds in common.

We therefore gathered information on family, health, housing, work and money stress for each of our families at all four child ages. Family stress included such things as marital separation, discord and physical abuse, pregnancy, and prolonged separation of mother and child; health stress included severe illness or hospitalisation of the mother or her child, chronic illness, and frequent visits to the family doctor; and housing stress included quality of housing, loss of home or eviction, and changes of address. Loss or change of occupation or hours of work, and short or chronic unemployment, were taken to indicate work stress; and a loss of five pounds or more per week and chronic shortage of money, evidenced by qualification for Family Income Supplement or supplementary benefit, were regarded as implying money stress. Our procedure employed an adaptation of the Holmes and Rahe (1967) Schedule of Recent Experience and our analysis was influenced by the recent work of Brown and Harris (1978).

The raw scores for each of the five sources of stress, and at each of the four child ages, were processed in similar fashion to the behavioural data. Sisters were judged to be similar if fifteen or more of their twenty pairs of scores both indicated more or less stress than average (equivalent to a probability of 0.042 or less on a two-tailed sign test).

Five of our thirty pairs of sibling mothers were judged to be subject to similar levels of stress on this criterion, four of which appeared to be relatively free of stress and one of which seemed to be subject to high stress. None of the pairs of sisters were dissimilar to the same degree.

Finally, we calculated the correlation for stress between related families, using scores weighted in the same way as for the behavioural data. For all thirty pairs of families this correlation was 0.28, for the five pairs judged as similar it was 0.79, and for the remaining twenty-five pairs it was 0.13.

In the sample as a whole, rather fewer pairs of sisters seemed to be exposed to a similar level of stress than appeared to interact in a comparable manner with their infants. However, there was a greater uniformity in levels of stress, so that whereas three pairs were markedly dissimilar in their *behaviour*, no pair was as dissimilar for *stress*. Indeed, knowing whether one member of a pair of sisters is exposed to more or less stress than average was of considerable help in predicting the stress of the other member of that pair (Yules Q = +0.56). Thus, over all, evidence on stress leads us to conclude that disadvantaged families, related through maternal sibship, do show a substantial similarity in their circumstances.

Attitudes

The importance that a mother attached to providing her child with learning opportunities, talking to him/her and giving instruction, were gauged from her answers to fifteen questions asked at interview when her child was 30 months old. The quantity, quality and initiation of speech during daily exchanges between mother and child were assessed from answers given to three of these questions, and the mother's view of how her child learnt, and the relative importance she placed on her own influence and that of other people and experiences, were judged from the responses to a further seven. Finally, each mother's attitude to instructing her child was gauged from her replies to five questions dealing with providing explanations, teaching words and functions, and the child's apparent understanding during daily activities.

Seventeen of the thirty pairs of sibling mothers gained full-scale scores that fell on the same side of the median for the sample. In other words, just over half of all sets of sisters resembled each other in that both emphasised the importance of stimulating their child either more or less than most mothers in the group. The correlation between the thirty pairs of scores was 0.24, which suggested that the sibling mothers showed some similarity in the attitudes measured, although the association was rather weak (Yules Q = +0.26). Knowing the attitudes of

one member of a pair would not help greatly in guessing at those held by the other member of that pair.

The association between our measure of attitudes to child-rearing and the behaviour of mothers during interactions was also rather slight ($r = 0.34$), as was the association with an assessment of each child's language performance at 30 months of age ($r = 0.26$). But interestingly, of the nine pairs of mothers judged to be behaviourally similar, seven pairs were also expressing similar attitudes. Moreover, four of the five pairs judged as sharing similar levels of stress also expressed comparable attitudes.

Similarities between the children of sibling mothers (cousins)

Behaviour: as observed

We have already indicated our serious reservations in designating some aspects of dyadic interaction as primarily the contribution of one partner rather than the other. Reservations notwithstanding, we have chosen to adopt the same method as was used to examine similarities of behaviour between sibling mothers in seeking to evaluate similarities in behaviour between their infants.

Four variables were selected as being the most representative and stable measures of the child's contribution to mother–child interaction during play. These were: initiation of the interaction by the child; positive responses by the child to mother's attempts to initiate interaction; negative responses by the child to mother's attempts to initiate interaction; and provision of the subject of interaction by the child. Scores for these four selected variables were available at all four child ages, thus providing sixteen scores for each child. Each score was rated as falling above or below the median for the sample on that variable at that child age. The sixteen scores were then considered for each of the thirty pairs of related infants (cousins). If the scores of both members of the pair fell on the same side of the group median, they were classified as similar on that score. A judgement of general behavioural similarity between cousins was made if a pair achieved twelve or more similar classifications (equivalent to a probability of 0.08 or less on a two-tailed sign test).

Of the thirty pairs of cousins, only two pairs were judged similar on this criterion. This was far fewer than the nine pairs of related mothers judged to be behaviourally similar. It was also noted that both pairs of similar infants had mothers among the nine pairs judged as similar. Another two pairs of infants showed marked dissimilarity on the same criteria; their mothers, however, had been judged neither as similar nor as dissimilar.

Clearly, *substantial* behavioural similarity and dissimilarity among our cousins was rare. None the less, to complete the comparisons, all thirty pairs of infants' scores were reconsidered, taking account of their direction, that is, whether they were above or below the median. A weight of plus one was given to each score above the median and minus one to each score below. The possible range of scores thus became plus or minus 16. A rather high proportion of our infants achieved a weighted score of zero (fourteen of the sixty), with a further twenty-five achieving weighted scores within the range plus or minus four. Such strong clustering round the mean would support the view that infants tended to make both positive and negative contributions to interaction, and that these tended to cancel each other out where behaviour over all was examined.

A serious alternative interpretation of these findings, however, is that something was wrong with our procedure. In deciding whether to assign a positive or negative weight to any particular score we had to decide whether, for example, we considered highly co-operative behaviour positive or not. Our decisions were to weight high scores for co-operation, provision and initiation positively, but high scores for non-co-operation (negative response) negatively. If any of these decisions were 'wrong', it could have the effect noted, that is, a clustering of weighted scores around the mean. Examination of the scores suggested that our decisions were correct. It is possible, however, that other more significant aspects of the child's behaviour remain to be identified. Accepting the weighted scores, and ignoring any pair that includes a zero, left us with seventeen pairs, of which twelve pairs had similar scores (five positive and seven negative). The correlation of these twelve pairs of weighted scores was 0.67, whereas the correlation for the remaining eighteen pairs was -0.5.

In general, then, it would seem reasonable to conclude that cousins did not exhibit any marked level of behavioural similarity on the behaviours we chose to observe and examine. However, a substantial sub-group of cousins (40 per cent) who did exhibit some similarity could be identified within our sample, and these were particularly likely to be the children of mothers who had previously been identified as exhibiting considerable behavioural similarity. Indeed it emerged that seven of the nine sets of cousins born to 'similar' sisters were in the sub-group of infants considered behaviourally similar. It is tempting to discuss a possible cause and effect model of the behaviours of these mothers and their infants. But given the artificial nature of the distinction we made between behaviours that were to be considered primarily 'mother's' or 'child's', it is more parsimonious to assume that we were measuring the same phenomenon from different perspectives.

Behaviour: mother's report

During the structured interviews, at all four child ages, mothers were asked to assess their child's behaviour and development. These assessments by the mothers related to four main areas comprising difficulties experienced with the child, the child's level of dependence, his/her level of activity, and development in relation to conventional 'milestones'. This information was analysed using the same procedures as were used with the observational data. The analysis failed to reveal any notable similarities between the pairs of cousins.

Developmental status: home assessments

Two assessments of our sample children were made as each child reached 30 months of age. One was a General Developmental Assessment (after Gesell and Illingworth: see Illingworth 1970), which took account of measures of gross motor ability, manipulation, general understanding, speech and sphincter control. And the second was an assessment of both expressive language and verbal comprehension based on the Reynell Developmental Language Scale (Reynell 1969).

Of the thirty pairs of cousins, fifteen had scores on the full scale general assessment, and twenty on the Reynell, which both fell to the same side of the median for the sample. Cousins thus appeared to be just as likely to have similar as they were to have dissimilar general assessments of development (Yules Q = 0.0). However, they were twice as likely to have similar rather than dissimilar scores on the Reynell, and this relationship is robust (Yules Q = +0.6).[2] The correlation between the raw scores of the thirty pairs of cousins was 0.05 for general development and 0.44 for the Reynell.

Taken together, these results clearly do not suggest that cousins were similar in their general level of development. But they do offer some support for a similarity between cousins in their levels of language competence. It should not be surprising that cousins demonstrated such slight similarity in general development. After all, their mothers *in general* demonstrated little similarity in attitudes or behaviour.

Comment

The evidence presented so far does not support the hypothesis that in general sibling mothers were more alike than unrelated mothers. In only one in three cases were sisters similar in behaviour, and in only one in six pairs was there a noticeable similarity of circumstances. Sisters moreover had but a fifty:fifty chance of sharing the same attitudes. Clearly, far more sibling mothers did not than did behave in a similar fashion or live in similar circumstances. The case for similarity

between the offspring of sibling mothers is even weaker.

It is, none the less, revealing to examine the nature of similarities that did exist. The hypothesis of transmitted deprivation would lead us to expect similarity to be largely restricted to negative attributes in a sample of this sort. This was not the case. Those sibling mothers who were highly alike in their behaviour with their infants were just as likely to be engaging in behaviours that had positive indications for their child's development as they were to be failing to engage in such activities. The most notable feature of the whole sample was the very wide range of behaviours, attitudes, stresses and levels of development to be found, despite the uniform nature of families' over-all level of deprivation. The relationship between these variables is discussed in the next section.

Stress, behavioural interaction and child development

In order to examine the relationship between types of interaction, levels of stress and developmental status, each mother–child dyad was classified as either interactive or non-interactive, and as stressed or non-stressed. It was hypothesised that interactive non-stressed pairs would have developmentally superior infants while non-interactive stressed pairs would have developmentally inferior infants. No predictions were made concerning the development of infants from low stress and low interaction, or high stress and high interaction, pairs.

Of the sixty mother–child pairs, thirty-seven were either highly interactive and non-stressed or non-interactive and stressed, twenty-one pairs falling within the first sub-group and sixteen falling within the second. All thirty-seven of the infants from these families were classified as showing good, average or poor development according to scores on the Reynell, and their performance was related to membership of the two sub-groups. A strong and highly significant association was found ($\chi^2 = 15.22$; d.f. = 2; $p<0.001$; $r = 0.64$) which suggested that language development was enhanced among children who interacted highly with their mothers, and who came from unstressed home backgrounds, relative to their peers from less interactive and more stressed situations. And when the analysis was repeated, using a general development assessment instead of language scores, a strong and significant association was again found ($\chi^2 = 14.64$; d.f. = 2; $p<0.001$; $r = 0.63$). It seemed that on both assessments the strong relationships observed were owing to large differences in the numbers of infants found and expected showing the extremes of good and poor development.

The final step was to examine the matrices for any evidence of similarity between sibling mothers. In particular, the hypothesis of

transmitted deprivation would predict a greater than expected number of sibling pairs among the sub-groups demonstrating a low level of interaction, suffering high stress and having infants of poor developmental status. There were twelve *mother–child* pairs in this sub-group when developmental status was judged by performance on the Reynell, and ten *mother–child* pairs when scores on the general developmental assessment were used, and whereas the expected number of *sibling mothers* in each group was 1.1 and 0.76[3] respectively, the observed numbers were found by inspection to be 2 and 0. To complete the analysis, the converse hypothesis was also examined, that is, that family resemblance would be strongest among the least disadvantaged, albeit within an otherwise generally deprived sample, so that greater than expected numbers of sibling mothers would be found among the sub-group demonstrating a high level of interaction, suffering little stress and containing infants of good developmental status. In this latter case the group comprised twelve *mother–child* pairs when performance on the Reynell was examined, and eleven *mother–child* pairs when the general developmental assessment was used. Respectively, the expected numbers of *sibling mothers* in each group were 1.1 and 0.9, whereas the observed values were found by inspection to be 2 and 0.

Once again, the evidence does not support the view that in general sibling mothers were more alike than unrelated mothers. However there is a clear indication of a strong relationship, within the disadvantaged sample as a whole, between levels of interactive experience and stress and infant development. The chances that children would show poor progress were high where interaction was lacking and stress was marked; but prognosis was good where there was a lot of interaction and little stress. Thus for our sample we must note than an infant with a good prognosis was four times more likely to do well rather than badly. But with a bad prognosis he/she was twelve times as likely to do badly as to do well. Nevertheless these prognostic indicators may not have the same implications for a less deprived sample.

The sub-sample of similar sibling mothers

Finally, we decided to look more closely at the nine pairs of sibling mothers noted earlier to be markedly similar in their style and levels of interactive behaviour with their infants.

Our first question was: did their similarity lead to an equivalent level of developmental similarity between their infants? It transpired that this sub-set of cousins was highly similar in terms of their scores on the Reynell (intra-class correlation = 0.81, compared with 0.23 for the

remaining twenty-one pairs), but not at all similar on our measure of general development (intra-class correlation = −0.2 compared with +0.2 for the remaining twenty-one pairs). Next we asked how far the nine pairs of behaviourally similar mothers shared similar levels of stress, and found that they did to a considerable extent (the intra-class correlation for their stress scores was 0.77 compared with 0.02 for the remaining twenty-one pairs). Thus nine of our thirty pairs of sibling mothers were markedly similar behaviourally *and* in the degree of stress they suffered *and* in that they had infants with comparable language competence (but not over-all development).

Our last exploration was to examine the association between levels of stress, behavioural interactions and infants' language performance for this sub-sample. We found that stress levels were strongly and positively associated with levels of behavioural interaction ($r = 0.9$) and with infants' language performance ($r = 0.8$). Similarly, there was a strong relationship between level of behavioural interaction and language performance ($r = 0.8$). For the remaining forty-two families in the sample, the respective correlations were 0.15, 0.16 and 0.33, suggesting that these nine pairs of sibling mothers really did closely resemble each other. Unfortunately, there was not a large sub-group of sibling mothers exhibiting markedly different levels and types of interaction with which we could compare these 'similar' sisters. We could identify only three pairs who appeared to behave very differently during interaction, and this impression was confirmed by the intra-class correlation for the three pairs over our selected behavioural variables ($r = -0.99$). They also showed no similarity in levels of stress ($r = -0.07$) while their infants showed dissimilar levels of language performance ($r = -0.4$). These findings are based on only small numbers but they are in line with our expectations.

Conclusion

Approximately one in three of our pairs of related mothers proved to be remarkably similar in behaviour and stress levels, while their infants showed very similar performance on a language test (but not in general development). This sub-group accounted for most of the association between these variables when all sixty families were considered.

Indeed it might be argued that our sample of thirty related families comprised two distinct groups. The larger of these two groups showed very little evidence of anything more than slight similarity. The smaller group, however, demonstrated a high level of similarity in their attitudes, behaviour, circumstances and in the relative levels of development achieved by their children. These, of course, reflect the fact that similarities *and* differences between siblings are often

commented upon. For us, however, the remarkable point of our findings was the pervasive nature of similarities when these were found. While all of our sisters showed similarity to some degree on one or even a few characteristics, one-third demonstrated a remarkable degree of similarity across a large number of often very different variables.

It may be the case that these findings do not apply to other families, where there is little deprivation, or to those who may be considered even more grossly deprived than those in this sample. Concentrating on behavioural data also leaves open the question of similarities existing along other dimensions, for example personality or psychodynamic processes (cf. Cohler and Grunebaum 1981).

The transmitted deprivation thesis might predict the existence of a highly similar sub-group such as we have found. But it would also predict that siblings would all be similar on negative attributes (i.e. non-interactive, highly stressed, raising poorly-developed children). Our sample of siblings clearly does not support this argument, as among the nine highly similar pairs there were as many showing high levels of interaction, suffering little in the way of stress and raising very competent children, as there were contributing to the perpetuation of deprivation through the rearing of less well-developed infants. Indeed, we could identify only three pairs of families (one in ten) who conformed to the stereotype, despite the fact that the sample was selected because of its disadvantage.

We are not yet in a position to answer the question of why one-third of our sample exhibited marked similarity, nor why two-thirds did not. There were some indications of greater similarity in personal characteristics among the similar mothers, for example in attitudes, levels of anxiety (malaise scores) and in levels of contact with members of their families and each other. But it could simply be that their similarity of contemporary life experiences (measured through our stress score) led directly to behavioural similarities and consequently to similarities in their infants. For the moment this remains speculative.

We wish to conclude not with speculation, however, but with hard facts. Rutter and Madge (1976; 304) state that 'at least half of the children born into a disadvantaged home do not repeat the pattern of disadvantage in the next generation'. Our evidence supports this view, in so far as at least half of our children, judged on assessments at 30 months of age, were developing well and had a good prognosis for the future. But within the sample we could identify a sub-group, none of whom were developing well and for which the future looked decidedly gloomy. This group of twelve children all came from families subject to high levels of stress *and* within which low levels of interaction occurred

between mother and child. Conversely, in the sample families in which there was both a high level of interaction and an absence of stress, most of the infants were developing well. It was the *combination* of these structural and familial influences that was so strongly predictive of the developmental status of our infants. Both of these types of influence have an effect, but in combination that effect is devastating. To emphasise the point: *not one* of our children enjoying high levels of interaction and little stress was developing poorly; and *not one* of our children suffering high levels of stress and having little in the way of interactive experience was developing well.

To promote the development of all our sample children, therefore, it would not be enough to concentrate on interactive experience *or* stress from the environment: both need to be changed. Coffield, Robinson and Sarsby (1981) have drawn attention to the fact that concentrating on aspects of parental care alone means ignoring the effects of problems of persistent unemployment, low income and bad housing. The evidence from our sample provides considerable support for the importance of *both* these kinds of influence. But there is also some counter-evidence. Despite high levels of environmental stress, including inadequate housing and unemployment, a few of the children in such families *were* developing well (five out of twenty-three). Similarly, despite low levels of interactive experiences with their mothers, a few of the children in such families *were* developing well (two out of nineteen). Although it was clearly very much the exception rather than the rule, some of our sample children developed well in spite of adverse structural influences and others did well in spite of adverse familial influences. But not one of our children did well in the presence of both types of adversity.

Finally, the significance of high levels of stress in the daily lives of many families should be re-emphasised. Indeed the majority of those in our sample who might be judged as incompetent – whether we judged competence in terms of providing plenty of interactive experiences for children, or in terms of each child's level of development – had much to cope with owing to difficulties involving housing, health, work, family and money. For a few of our families, provision was available to alleviate some of these sources of stress, but they were either unaware of where to seek help, or had not sought such help or had been unsuccessful in their attempts. For other families, the available provision was simply inadequate. Better housing and opportunities for work just may not exist; health problems may be exacerbated by long delays in being offered treatment; and the levels of supplementary income relief may be too low. Of course, assistance with these problems will not of itself guarantee successful child-

rearing. Relief from such burdens will only allow the expression of adequate child-rearing practices in those families where such abilities have been suppressed: families in which the performance side of competence has been smothered. In some cases the skills of child-rearing may also need to be acquired. But simply to teach such skills in the continuing presence of the stressful events we have mentioned would appear to be a futile task.

Illustrative case histories

To give a little further insight into the lives of some of our families, a brief pen-portrait of three pairs of families is provided below. Each pair consists of sibling mothers. The first pair, Mrs Adams and Mrs Baker, were both highly interactive, suffered few stresses and had infants who were developing well, although one rather better than the other. The second pair, Mrs Lacy and Ms Moss, were average for the sample in terms of levels of interaction and stress, and neither of their children was in the top or bottom quartile of the sample for developmental status. Finally, the third pair, Mrs Wilson and Ms Young, both interacted little, suffered high levels of stress and had children who were developing poorly.

Mrs Adams and Mrs Baker

Mrs Adams was a well organised, highly devoted mother with two daughters, the younger of whom was our target child. There was a five-year age gap between the two children, so that when the older one was at school her mother had plenty of time for the younger one.

The family were living in a new, immaculately kept council house since they had moved from a poor-quality maisonette on the same estate. Mrs Adams's biggest difficulty was having to look after the children alone for long periods when her husband was away at sea. But when he was at home she considered him to be helpful and highly participative with the children. Both parents tended to dote on the target child. Mrs Adams considered her to be very bright and expected her to do well at school. However she did not believe that what she did with her child was in any way relevant to how she would get on in school later.

Mrs Adams's sister, Mrs Baker, also ran a highly organised, clean and tidy home. Her only child was born while she and her husband lived with the maternal grandparents. They now owned their present small, terraced house, in a decaying area of the city, and were saving towards an eventual move, once they could afford a mortgage. Both parents were devoted to their daughter, providing much in the way of clothes, toys and companionship. Mr Baker had become very involved

in looking after his daughter during a number of periods of unemployment. More usually, he was employed as a joiner. Mrs Baker foresaw a rosy future for her daughter, believing that she would do well at school and that her own involvement with her was important for that later success.

Mrs Lacy and Ms Moss

Mrs Lacy and Ms Moss lived opposite each other in dilapidated, owner-occupied, terraced housing, in a city area scheduled for demolition. Despite the very poor amenities, both expressed satisfaction with their housing. The house in which Ms Moss lived was owned and occupied by her mother and divided physically between them.

Mrs Lacy's target child was the last born of her three children. The two elder children were both at school and their mother spent most of her spare time in the company of nearby relatives. Such occasions were mostly adult centred, with relatively little attention paid to the target child. Mr Lacy was in regular employment as a lorry driver, but earned very poor wages. Mrs Lacy considered him to be fairly participative with the children. She was unsure as to how her daughter might do at school, but considered a good education to be crucial, and thought also that what she did with her daughter during the pre-school years would be important for her later school performance.

Ms Moss cohabited with the father of her two children, the younger of whom was the target child. Their shared house was invariably full with their relatives and Ms Moss's mother's foster children. During the early months of our involvement the cohabitee left to work in London for a while but, as a result of an industrial accident, he later returned home unable to work, and supported the family on social security payments. His participation with his children was considered to be minimal. Ms Moss spent a lot of her time playing with her young daughter and viewed this as important for her later achievements at school. But she did not consider school performance to be important for later adult life.

Mrs Wilson and Ms Young

Mrs Wilson worked hard in the house to care for her husband and four children, the second born being our target child. They lived in a modern corporation house, having previously lived with the maternal grandmother until shortly after the birth of their second child. The home was always clean, tidy and well organised, but there was a chronic shortage of money owing to Mr Wilson's long-term unemployment. A degree of marital discord centred on Mr Wilson's unwillingness to do things with the children. Mrs Wilson expressed concern over

the apparent slowness of her son (our target child). She wanted a decent education and career for him, and believed in the importance for later school success of teaching children during the early years. The main cause of the child's slowness appeared to be the fact that he was the second born of four children and his mother was thus unable to spend much time with him – a situation compounded by her attempts to solve more general difficulties.

Ms Young was an unmarried mother of two children. Her son was the younger and our target child. Her daughter suffered from obesity and behaviour problems, including bedwetting at the age of 10, and was due to go to a school for maladjusted girls. Her son was vicious towards other children, and relatives suspected his mother of beating both children. The family lived with the maternal grandparents, in damp and overcrowded conditions, in a two-bedroomed, prewar, terraced house with outside toilet and no hot water. The home was disorganised, dirty and poorly furnished. Ms Young was not satisfied with these conditions but had so far had no contact with the housing department.

Ms Young paid very little attention to her child during our visits, speaking to him rarely and playing with him even less often. There was no evidence that the grandparents paid any greater attention to the child. This mother's expressed view was that children learnt from each other. She considered teaching by adults to be unimportant and did not know what she wished for her child's future.

Notes

1 Initially, thirty-seven pairs of sisters had been recruited to the study but seven pairs had been lost: five pairs refused to co-operate from the outset and two pairs decided not to continue beyond the first interview.

2 Of course similarity as it is being defined here does encompass somewhat disparate raw scores. The median score on the Reynell was 64.5, with the highest 97 and the lowest 32. Thus one 'similar' but low scoring pair had scores of 32 and 60. However, these are the extreme instances of widely differing scores which both fell to one side of the median.

3 Given that the cases have been drawn from a known population of sixty cases comprised of thirty pairs, the expected values are $\frac{12 \times 11}{2} \times \frac{1}{59}$ and $\frac{10 \times 9}{2} \times \frac{1}{59}$

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References

Brown, G.W. and Harris, T. (1978), *Social origins of depression: a study of psychiatric disorder in women*, London: Tavistock.

Coffield, F., Robinson, P. and Sarsby, J. (1981), *A cycle of deprivation? A case study of four families*, London: Heinemann Educational Books.

Cohler, B.J. and Grunebaum, H.U. (1981), *Mothers, grandmothers and daughters: personality and child care in three-generation families*, New York: John Wiley.

Holmes, T.H. and Rahe, R.H. (1967), 'The social readjustment rating scale', *Journal of Psychosomatic Research*, vol. 11, pp. 213–18.

Illingworth, R.S. (1970), *The development of the infant and young child: normal and abnormal*, 4th edn, Edinburgh: Livingstone.

McGlaughlin, A. (1980), 'Early child development and the home environment', Final Report to the SSRC on Grant HR5017/1, 13/4/77 to 12/6/80.

McGlaughlin, A., Empson, J., Morrissey, M. and Sever, J. (1980), 'Early child development and the home environment: consistencies at and between four pre-school stages', *International Journal of Behavioural Development*, vol. 3, pp. 299–309.

McGlaughlin, A., Morrissey, M., Empson, J. and Sever, J. (1981), 'Language performance of disadvantaged children at 30 months: interpersonal and other environmental influences', in Robinson, W.P. (ed), *Communication in development*, London: Academic Press.

Osborn, A.F. and Morris, A.C. (1979), 'The rationale for a composite index of social class and its evaluation', *British Journal of Sociology*, vol. 30, pp. 39–60.

Reynell, J. (1969), *Reynell developmental language scales*, Slough: NFER.

Richards, M.P.M. (1971), 'A comment on the social context of mother–infant interaction', in Schaffer, H.R. (ed), *The origins of human social relations*, London: Academic Press.

Rutter, M. and Madge, N. (1976), *Cycles of disadvantage*, London: Heinemann Educational Books.

Siegel, S. (1956), *Nonparametric statistics for the behavioural sciences*, New York, Toronto and London: McGraw-Hill.

6 A Longitudinal Study of Single Mothers and Their Children

Sue Kruk and Stephen Wolkind

Over the last fifteen years epidemiological studies have demonstrated that behavioural problems in childhood are very common, particularly among children living in an inner-city area (Rutter 1976). It has also become increasingly clear that these disorders should not be regarded as transient difficulties, but that in many cases the affected children will remain handicapped by emotional and behavioural problems for a considerable proportion of their childhood (Graham and Rutter 1973; Wolkind and Renton 1979) and even adult life (Robins 1966). Scarce child psychiatric and other resources mean that help can be offered to only a very small proportion of this total, and even then not with clear confidence that existing approaches and techniques will necessarily markedly reduce conduct or antisocial disorders. One response to this somewhat depressing state of affairs has been for increased consideration to be given to setting up programmes of preventive work. It is at present uncertain how such programmes could best be organised or what would be their chances of success. If, however, they are to be attempted a first step must be to determine the most efficient criteria for selecting families whose children are thought to be at risk. For really early intervention the ideal would be to find criteria that could be used to select families or mothers even before the birth of their child or children. Preventive work could then start from the very beginning!

This has been one of the goals of a longitudinal study of child development being carried out in the Family Research Unit of the London Hospital Medical College. Various maternal characteristics were used to select groups of mothers-to-be whose, as yet unborn, children were expected to have a greater than average chance of developing behavioural problems. One of these groups consisted of unsupported women, who were neither married nor cohabiting, at the beginning of their first pregnancy. They were selected as at risk of producing children with difficulties on the basis of findings from previous work.

Some early psychoanalytically oriented studies of single mothers have emphasised both the high level of broken homes and/or disturbed relationships within the woman's family of origin, and inner conflicts, as causes of an unplanned pregnancy (Young 1945). Other writers,

such as Binder, have stressed the high level of overt psychiatric disturbance among unmarried mothers (Wimperis 1960). More recent work, however, suggests that though young single expectant mothers tend to come from families marked by social and economic disadvantage, there is no reliable evidence that they suffer from a high level of psychological disturbance (Shaffer *et al.* 1978).

The National Child Development Study, which has followed a cohort of British babies born in 1958, showed that children who had been born illegitimate were, by the age of 7, significantly more likely than legitimate children to be maladjusted according to the Bristol Social Adjustment Guide and to exhibit 'syndromes' of 'hostility to adults', 'hostility to children', 'unconcern for adult approval' and 'inconsequential behaviour' (Crellin *et al.* 1971). They were also more likely to be described as below average on six measures of ability and attainment.

A large proportion of pre-marital pregnancies occur among teenage girls and have done so at least since the 1960s (Illsley and Gill 1968). The children of young teenage mothers have been described as more outgoing, dependent and distractable, to have infantile behaviour problems, acting out difficulties, poor reading ability, and low IQ (Oppel and Royston 1971). Illsley (1967) found that the IQ of the child (as measured by the Moray House picture test) was significantly related to mother's age at delivery, with younger mothers producing children with the lower IQs.

Furstenberg (1976), however, found that although pre-school children of young teenage mothers, who had not planned their pregnancy, displayed cognitive disadvantage in the pre-school years, evidence as to their poorer *social* adjustment (as measured by the child's ability to defer gratification, and his/her sense of trust and self-esteem) was far from conclusive.

Retrospective data, on the other hand, have often shown that single status and/or maternal youth is common among those demonstrating extremes of disturbed parenting, such as neglect or abuse (Helfer and Kempe 1968), which common sense would suggest might lead to difficulties for the child. However, it is unlikely that this would apply to more than a small proportion of single and teenage mothers.

These various studies, despite their differing orientations, suggest that the women in our sample who were single at conception might well constitute a group particularly vulnerable to child-rearing difficulties on account of their lack of marital support, their youth and possible immaturity, and the inadequacies of their inner-city environment.

The selection of samples and Structure of the study

During a one-year period in 1974–5, all British-born women attending the antenatal booking clinics serving the inner London Borough of Tower Hamlets, and expecting their first baby, were approached by a research worker. There were 534 women in this group, of which 29 per cent were single when contacted, and approximately 95 per cent agreed to a preliminary interview. On a variety of indices, Tower Hamlets can be regarded as a deprived area. There are extreme social problems with very high rates of crime, delinquency and illegitimacy. A higher proportion of children are in care than in any other part of the country.

Initially it had been planned to select groups of women who had and had not been married or cohabiting at the time of first attendance at the booking clinic. However as the study progressed it became clear that family composition often changes during pregnancy and the early years of motherhood, and that assessing marital status at this point was an arbitrary decision. Consequently it was decided instead to distinguish between mothers who conceived before and after getting married or establishing a cohabitation and, although not precisely accurate, these women are referred to as 'single' and 'married' throughout this chapter. These samples comprised ninety and eighty-three women respectively who, together with a third group of women in two-parent families who reported particularly high levels of various psychosocial difficulties, and who are referred to at later points in this chapter, constitute the main subjects of this study.

All women selected for the main part of the study were seen in late pregnancy and at 4, 14, 27 and 42 months after the birth of the child. Completed interviews were obtained on between 85 per cent and 92 per cent of the women at each stage. Interviewers were rotated and no woman was seen consecutively, and only rarely on more than one occasion, by the same interviewer. Attitude questions were used only if there was at least 85 per cent agreement on ratings between interviewers, and regular weekly meetings were held to maintain constancy of criteria for coding.

Incorporated within the larger study was an observational investigation conducted on a sub-sample of the women. Data from this will not be presented here but further details of the methods and some results can be found elsewhere (Wolkind *et al.* 1978; Pawlby and Hall 1979; Hall and Pawlby 1981). At the time of writing the study is still in progress and the mothers are being interviewed for the final time now that their children are nearly 7 years old and have settled in school.

The objectives of the study, part of which is described in this chapter, were as follows:

(1) To describe the home background and family of origin of single women having their first baby and compare them with those of the married women.
(2) To describe and compare the experiences of pregnancy of women who were single and those who were married.
(3) To describe and compare the experiences of labour of the single and married women and the condition of their children at birth.
(4) To compare the physical and emotional care given to, and the environment provided for, the children at various stages through infancy and early childhood.
(5) And finally, to compare the social and emotional development of the children born to mothers in the single group, with the children of married women, as measured by the rate of behaviour problems at age 42 months.

In fulfilling these objectives we hope to be able to show whether there is in fact evidence that single women constitute a group at risk of rearing children with emotional difficulties and whether there is any evidence suggesting intergenerational transmission of maladjustment.

Family background

The first task was to describe and compare the backgrounds of the married and single women during their first pregnancy. Table 6.1 shows that the majority of both groups had been born and brought up in the community in which they still lived. The marital status groups differed considerably, however, in their ages, in that 60 per cent of the single women were still teenagers when they conceived, as opposed to only 14 per cent of the married women. The single group also included more women whose families of origin, as measured by their father's occupation, were of lower social class.

The single women, as shown in Table 6.2, appeared to have come from more disadvantaged families. Fewer of them had had an unbroken family life, in that almost half the single women, compared with only a quarter of married women, had experienced some form of separation from one or both parents before the age of 16 which involved potentially disturbing circumstances, such as divorce, homelessness, or chronic illness and death. Of these, a small minority (14 per cent) of single women had experienced a home life disrupted enough to culminate in institutional or local authority care, as had an even smaller proportion (5 per cent) of the married group. This difference between the groups is statistically significant ($\chi^2 = 4.51$; d.f. = 1; $p<.05$).

Twice as many single as married women came from large families

Table 6.1 Marital status and residence, age and social class

Residence maternal age and social class	*GROUP 1 — Married women (post-marital conception) (N = 83)* No.	%	*GROUP 2 — Single women (pre-marital conception) (N = 90)* No.	%	χ^2 (d.f. = 1)
Born in Tower Hamlets	49/83	59	48/83	58	NS
Brought up in Tower Hamlets	57/83	69	64/84	76	NS
Mothers aged 16–19 at conception	12/83	14	54/90	60	37.95***
Parents Registrar General Social Class IV and V	11/68	16	30/73	41	10.6 **

** p <.01; *** p <.001.

and had five or more siblings. Perhaps not surprisingly, more of the single women had received help from social and welfare workers in the past. More, too, reported problems in relationships with their parents in the years before pregnancy.

We concluded that the two groups of women came from backgrounds that differed considerably in both family structure and the quality of family life. It seemed that the single women were far more likely to have been brought up in large working-class households in which there was early disruption and considerable family disharmony.

Table 6.2 Marital status and early home background

Early background	*GROUP 1 — Married women (post-marital conception) (N = 83)* No.	%	*GROUP 2 — Single women (pre-marital conception) (N = 90)* No.	%	χ^2 (d.f. = 1)
Disrupted childhood	20/83	24	43/90	48	10.46**
Five or more siblings	18/81	22	35/84	47	7.15**
Ever received help from social/welfare worker	8/82	10	33/90	37	17.11***
Problems in earlier relationships with parents	12/77	16	27/76	36	9.01**

** p <.01; *** p <.001.

Table 6.3 Marital status and health and attitudes in pregnancy

Health and attitudes in pregnancy	*GROUP 1 — Married women (post-marital conception) (N = 83)* No. %	*GROUP 2 — Single women (pre-marital conception) (N = 90)* No. %	χ^2 (d.f. = 1)
Non-hypertensive physical problems	16/82 20	36/86 42	9.81**
Pregnancy not welcomed	23/83 28	60/83 72	25.95***
Not positive about pregnancy at seven months gestation	25/83 30	35/84 42	2.42 NS
Smoking during pregnancy	22/83 27	44/84 52	11.69***
Wanting named sex baby	31/83 37	48/82 59	7.42**

** $p < .01$; *** $p < .001$.

The pregnancy of the single woman and the birth of the child

Any concern felt about the background of the women in the single group and its possible effects upon their, as yet, unborn children was heightened by an examination of data collected during pregnancy. Data on a number of measures are shown in Table 6.3.

Excluding hypertension, which was widespread (and usually fairly mild) among both groups, physical disorders were more common among the single women. Members of this group were, moreover, far more likely to smoke during pregnancy, despite the active campaigning against smoking that was taking place in the hospital at the time of the study. Not surprisingly, far fewer of the single women initially welcomed the onset of pregnancy; however a considerably smaller number remained negative by the time the interviews were conducted at seven months. The single women were more likely than those married to have a firm idea of which sex baby they wanted.

An analysis of the extensive data collected from the medical records on the birth of the children showed few differences. If anything, the married women were more likely to have delivery complications. However lower birth-weight was apparent among the babies born to single mothers. The mean weight of the babies of married women was 3332.8 grams whereas for the babies of single mothers it was 3093.9 grams ($s = 467.8$ grams; $t = 3.29$; $p < .01$). Eleven (13 per cent) of the single women had babies weighing under 2500 grams, compared with one (1 per cent) of the married women.

During the early post-partum period, we sent the health visitors of the borough a short questionnaire to fill in after their first visit to the

new baby asking about their impression of the home situation. These workers felt that the majority of all women (76 per cent of married and 80 per cent of single mothers) were free from depression, that 74 per cent of married and 73 per cent of single mothers were confident in handling their baby, and that 96 per cent of married and 87 per cent of single mothers were coping adequately. They reported, however, that 84 per cent of married women, but only 61 per cent of single women, had good home facilities. Of these the women who were still single at the birth were in worst conditions, only 53 per cent having good facilities. Over all, the health visitors, on their first visit, felt some level of concern for 18 per cent of married women and 39 per cent of single women.

To summarise, the single women were more likely to have come from a lower social class family, and one that was marked by a variety of difficulties. In particular, the high rate of separations from parents experienced by these women during their own childhood caused us some concern. The work of Frommer and O'Shea (1973a and b) suggests that such separations might be associated both with later maternal depression and difficulties in child-rearing. The large group of possibly immature teenagers within the single sample seemed particularly vulnerable and confirmed our belief that the early years of childhood would cause difficulties for them and their children. Finally, the single woman's experience of pregnancy and labour, marked as it was by a high rate of smoking and reported physical problems, and resulting in lower birth-weight babies, corroborated this view.

The outcome for the child up to 42 months after the birth

In contrast to our somewhat gloomy predictions, most of the children of the single mothers appeared to be progressing well at 4, 14, 27 and 42 months. At each of these ages interviews were carried out and data collected on the physical health of the children as measured by the number of visits to a general practitioner, out-patient and in-patient hospital visits, the number of treated accidents and the mother's perception of her child's health. Interview data on cognitive development were limited, as our primary interest was in behavioural difficulties. Nevertheless, an amended version of the Vineland Social Maturity Scale was used at 14, 27 and 42 months to monitor general development, and details were obtained on the child's speech. Over the whole period of the study, rates of problems were sometimes slightly higher for single mothers, but differences never reached statistical significance. Throughout the early years of childhood, it was the similarity of the children born to the two groups of women – married and single – that became strikingly apparent from the interview data.[1]

The emotional development of the children was examined at all four interviews by questions about various behaviour problems and difficulties. At 4 months, for example, we inquired about sleeping, feeding and bathing problems; at 14 months we asked about a wider range of behaviour and the mother's perception of such as problematic; and at 27 and 42 months we used the Behaviour Screening Questionnaire (BSQ) of Richman and Graham (1971) (amended at 27 months), designed to identify problem behaviour in the pre-school child.

At all four interviews there was virtually no difference between groups in the reported presence and frequency of most individual items of problem behaviour. A score above 10 on the BSQ suggests a possibility of emotional disturbance in the child and, as shown in Table 6.4, there is even at 42 months only a small difference in the proportion of children from each group with such a score. Moreover, a *similar* proportion – over half – of the children from both groups have low scores (6 or under) on the BSQ.

Table 6.4 The outcome for the child at 42 months post-partum, as measured by the Behaviour Screening Questionnaire

Score on BSQ at 42 months	*GROUP 1 — Married women (post-marital conception) (N = 74)* No.	%	*GROUP 2 — Single women (pre-marital conception) (N = 76)* No.	%
0–4	29	39	19	25
5–6	14	19	21	28
7–9	21	28	20	26
10–15	10	13	16	21
Mean score	5.98		6.5	

Table 6.5 Interviewer's subjective rating of the home situation at 42 months

Home situation at 42 months	*GROUP 1 — Married women (post-marital conception) (N = 71)* No.	%	*GROUP 2 — Single women (pre-marital conception) (N = 73)* No.	%
No worries	43	61	33	45
Some misgivings	20	28	28	38
Real concern	8	11	12	16

The evidence suggests, therefore, that marital status at conception does *not* predict women most likely to have children who will develop behaviour problems. Nor does it seem that women who conceive out of marriage constitute a group in which disadvantages experienced are transmitted to their children, at least in terms of disturbances in behaviour.

This conclusion is supported by one other set of data. Interviewers often spent between two and three hours administering the interview and, at the same time, observing the family life about them. On the basis of this experience they made a subjective rating of 'prognosis' for the child in which they expressed their 'common sense' feelings about the home situation and the child's possible future adjustment. As can be seen from Table 6.5, they showed some uneasiness about the situation of 39 per cent of the married women and 55 per cent of the children of single women. They felt very real concern, however, for only a small and similar minority of both groups, that is, 11 per cent of the children of married women and 16 per cent of the children of single women.

The most important conclusion to be drawn from these findings is not that some children of single mothers were exhibiting difficult behaviour or that family situations caused us definite anxiety, but that the majority of women and children in the single sample had avoided such extremes despite the inauspicious background and the circumstances of the conception.

Evaluation of risk

Were we mistaken, then, in describing our group of single women as vulnerable? For purely practical purposes, marital or cohabiting status at conception would indeed seem to be of little use in identifying women who would have children with behaviour problems. Nor did it seem that single women, as defined here, automatically constituted a group at risk of transmitting deprivation – according to measures used.

Having found this predominantly negative answer to our main question, it seemed useful to go on and examine a number of related issues.

(1) Were the originally single mothers at risk of any other form of disadvantage?
(2) Was it possible that within the single group a significant sub-group of women could be detected who were, in contrast to the rest, at risk?
(3) Was it in practice possible, within the framework of our study, to detect women at risk – or is the degree of change during the early years of family life so great that no prediction is possible?

In attempting to answer these questions, reference will be made to the findings from the Family Research Unit's study as a whole. Some of these findings depend upon analyses of the married 'risk group' mentioned earlier as well as those of the random samples.

Marital status and other forms of disadvantage

Are mothers who are single when they conceive likely to be more disadvantaged than their married counterparts? As a partial answer to this question we consider differences within the sample in economic circumstances, the quality of marriage, and the development of psychiatric disorder.

The economic circumstances of single women

The only striking difference between married and single women in our study was in their economic circumstances. Although there was generally little difference between groups in the number of women working after the baby was born, the majority of married women had their husband's income for support, whereas the single women depended upon social security benefits. It was not surprising, therefore, that at all four post-partum interviews the majority of married women had access to modern conveniences, such as car and telephone, while the single women did not (e.g. at 42 months 67 per cent of the married women had access to a car and 76 per cent to a telephone as opposed to 32 per cent and 24 per cent of those in the single group). This could have been expected from our other data, which showed the relative disadvantage of the home background of the single women, and from the health visitors' observations. The poor circumstances of single mothers have also been well documented (Finer Report 1974; Crellin *et al*. 1971).

Although not our main area of interest, this *continuity* of relative poverty made the lack of significant differences between groups on our more psychological data all the more notable. We do remain concerned, however, by the possible long-term effects of this financial disadvantage as well as by possible present and past effects which we did not or could not measure. Ferri (1976), for instance, has shown differences in economic position account for much of the variance in school performance between children from one- and two-parent families.

The single mother, change in marital status and the quality of later marriage

Although our group of single women all conceived outside of an established two-parent relationship, 14 per cent had already married

or started to cohabit by the time they attended the antenatal booking clinic. By late pregnancy, at the seven-month interview, this proportion had risen to 41 per cent, and by four months post-partum 55 per cent of the single women were in two-parent families.

This changing of marital status was to continue throughout the study. We therefore asked, first, whether there was any difference between those women who set up a two-parent family during pregnancy, and those who were still single at the birth. We found that the group who remained single *at birth* were more likely to come from homes characterised by low social class, to have had more contact with social welfare agencies, and to have had disrupted backgrounds involving childhood separation from parents. The women who remained single were more likely than those who followed conception by marriage to report past problems in their relationships with their parents, and to indicate that their parents were not positive about their expected grandchild. They were more likely, however, to see their parents every day, probably because most were still living with them.

It seemed, however, that marital status *per se* was not particularly helpful in identifying women likely to have later child-rearing problems. The mothers who remained single at birth were more likely to share a bed with the baby, and they were more likely not to hold their baby while feeding, but on all measures of attitudes towards their babies, and in the behaviour shown by their children at 14, 27 and 42 months, they were extremely similar to the women married either before or just after conception. Moreover there were no differences in these respects at 42 months between the women who were still single at that time and those who had married after the birth. Perhaps we should not have been surprised at this finding as there is strong evidence that it is the *quality* of a relationship that will most influence the child's development (Rutter 1972).

Because a poor marital relationship is associated with behaviour disturbance in children (Rutter 1971), it was thought important to assess the quality of the marriage at the three later interviews. This was attempted based on a method described by Quinton *et al*. (1976), but unfortunately on many occasions the presence of the husband or other family members and friends made it difficult or inappropriate to administer this part of the interview. Because data were thus collected on only small numbers, any conclusions drawn must be very tentative.

Quality of marriage was rated on a five-point scale – two categories of 'good' marriage, which were characterised by mutual concern, tolerance and communication, one category of 'moderate' marriage, in which there was less expressed concern, or some irritability, and a category of 'poor' marriage, marked by dislike and avoidance or by

Table 6.6 Marital status at conception and the later quality of marriage

Quality of marriage	*GROUP 1 — Married women (post-marital conception) (N = 83)* No.	%	*GROUP 2 — Single women (pre-marital conception) (N = 90)* No.	%
14 months post-partum				
Good	48	75	18	51
Moderate	13	20	9	26
Poor	1	2	5	14
Broken	2	3	3	9
Total	64		35	
27 months post-partum				
Good	34	68	15	45
Moderate	9	18	7	21
Poor	6	12	4	12
Broken	1	2	7	21
Total	50		33	
42 months post-partum				
Good	32	58	24	51
Moderate	16	29	12	26
Poor	6	11	5	11
Broken	1	2	6	13
Total	55		47	

quarrels and irritation. The final rating was reserved for marriages in which separation and/or divorce had taken place. The results are shown in Table 6.6. As there are many missing data, no statistical tests have been applied to this information.

It is generally recognised that marriages precipitated by pregnancy, or contracted by teenagers, have a higher chance of later breakdown. It seemed that our findings for a relatively small sample confirmed this tendency. We could also conclude that more of the single women had children who were exposed to a less than optimal parental relationship. Equally important, however, it seemed that approximately half the children of single mothers appeared to be in the care of parents living harmoniously together and that by 42 months after the birth this rate was identical to that of the original married group. Of particular interest in this context is the work of Ryder (1973) who has described

the natural history of marriage as deteriorating after the birth of children, when there is less shared interest and mutual support, but improving again as the children grow up.

The psychiatric health of the single mother

The psychiatric well-being of the mothers, and the consequent emotional environment provided for children, have been of major interest throughout the course of the study. During the original screening interview we asked women whether they had ever had any trouble with their 'nerves', and noted whether as a result they had had GP, out-patient or in-patient treatment. We also asked them to fill in a 'malaise' inventory about their health before pregnancy. From these two measures we were able to identify women we considered had had some form of psychiatric problem prior to the pregnancy.

Using a standardised psychiatric instrument (Rutter 1976) at the pre-natal interview and at all four of the post-natal interviews, we assessed whether the mothers were suffering from a psychiatric disorder serious enough to impair their everyday functioning. When psychiatric disorders were present, they usually took the form of depression with associated anxiety. These data were collected as previous studies had shown an association between maternal depression and child behaviour problems (Weissman and Paykel 1974; Richman 1976; Wolff and Acton 1968).

However, in this area, too, findings are negative. As can be seen from Table 6.7, the single women varied very little from the married women at any time during the course of the study, and only at 42 months was the rate of psychiatric problems marginally higher among the single women.

Table 6.7 Marital status and psychiatric problems

Definite psychiatric problems	*GROUP 1 — Married women (post-marital conception) (N = 83)* No.	%	*GROUP 2 — Single women (pre-marital conception) (N = 90)* No.	%	χ^2 *(d.f. = 1)*
Pre-pregnancy	7/80	9	9/89	10	NS
Pregnancy	11/83	13	18/84	21	NS
4 months post-partum	7/80	9	13/75	17	NS
14 months post-partum	11/72	15	11/70	16	NS
27 months post-partum	8/67	12	11/68	16	NS
42 months post-partum	15/71	21	23/71	32	NS

In the study as a whole, analysis has shown that a high proportion of women who had psychiatric problems prior to pregnancy continued to have them post-partum. By the time the children were 27 months old an association was found between maternal depression and child behaviours such as eating problems, fears and difficulties in attaining bladder control (Zajicek and De Salis 1979). Child problems at 27 and 42 months were related in an interactive way with present and past depression in the mothers (Ghodsian *et al.* 1981). Clearly these associations are in no way mediated through any difficulties that might be associated with marital status.

Is there a significant 'at risk' group within the single sample?

We noted that 60 per cent of the single mothers had conceived when they were still in their teens, as compared with only 14 per cent of the married group. As half of these single teenagers were only 16 or 17 years old, as adolescence is a stage of life marked by transition and change, involving biological, intellectual, emotional and social maturation (Wolkind and Coleman 1976), and as earlier work has found effects of teenage mothers on children's behaviour (Oppel and Royston 1971), we thought these mothers might be particularly likely to transmit deprivation to their children. This concern had been intensified by an analysis of our pregnancy data, where it became clear that teenagers, irrespective of marital status, were more likely to have had family problems and to have particular attitudes towards, and expectations of, the baby that suggested a less than optimal preparation for motherhood.

A detailed analysis of the interview data after birth has, however, shown no difference in the final outcome for the mother and child according to age at conception. As far as the single group were concerned, there were no detectable differences in the rate of psychiatric disorder, poor marriages, children's behaviour problems or concern for the future expressed by interviewers between women who were teenagers when they conceived and those who were older.

Interestingly, a recent study (Burd 1980) of thirty mothers chosen randomly from a general practitioner's patient list, who had conceived as teenagers and whose children were now aged 9 to 13, presents similar findings. Most of these women were still in intact marriages, of which only one in ten was described as problematic. The children born to mothers aged 16 to 17 at conception were no different from those aged 18 to 19, as measured by the Rutter 'A' Child Behaviour Score and the Holborn Reading Scale.

Is it in practice possible to detect women 'at risk'?

Most of the findings presented to date could suggest that the original intention of selecting women at risk of producing children with problems was not possible. It may be that change is so great in the early years of family life that little, if any, *continuity* of difficulty would be found. A second possibility is that the measures we had been using were insufficiently sensitive to detect the types of difficulties in which we were interested. To examine this second suggestion we will briefly present some findings on the two main variables used to select women for our married risk group.

Women with previous psychiatric problems

The very simple measure of pre-pregnancy psychiatric disorder employed in this study was described earlier. We examined whether women who reported problems would have children with high rates of difficulties. As shown in Table 6.7, there were seven women showing possible psychiatric disturbance in the randomly chosen married group, and nine in the single group. One child had died and we had data on only fourteen of the fifteen remaining women at 42 months.

It was found that seven of these fourteen children had very high scores of 10 or more (suggesting a behavioural problem) on the BSQ, a further two had high scores of 9, and two had high scores of 8. Only three children had relatively low scores of 5. Our interviewers' rating of the 'prognosis' suggested that thirteen out of fourteen caused some concern, four of these cases causing serious concern.

Our data showed that all but two of these fifteen women (whose children nevertheless had scores of over 10 on the BSQ) showed definite psychiatric impairment after the birth of their child. This was invariably on more than one occasion. Only two women out of the nine for whom we had full ratings had 'good' marriages.

We concluded that psychiatric disorder before pregnancy, irrespective of marital status, was a risk factor for the transmission of difficulties from mother to child, but that this risk was confined to a small minority of women.

Women who have experienced childhood separation

As was discussed earlier, one of the reasons for our concern for the single women was the high rate of childhood separation they reported as such experiences in other populations have been associated with child-rearing difficulties. Nevertheless, in the over-all study there appeared to be no differences between women who had experienced separation and those who came from intact homes. It was only when the women who had experienced separation were subdivided into

those who had received institutional care (which we regarded as an indication of a childhood marked by *extreme* disruption) and those who had remained within their family of origin, that a significant finding was obtained. The latter group had rates of difficulties similar to, and only slightly higher than, women from intact homes, whereas the former showed very high rates of problems in a number of areas.

Although more single than married women had been in care (14 per cent versus 5 per cent), they were still a small minority. Of the seventeen women in the random groups who had received institutional care, thirteen had been single and unsupported at the time of conception, two single but cohabiting, and two married. By 42 months postpartum, at least twelve of these had at some time formed a two-parent family.

By the time the children of these mothers were 42 months, one was dead (our four-month data, shortly before, revealed unstable social circumstances and a grossly inappropriate diet); two others were in the care of their grandmothers, under the supervision of social services departments: one of the natural mothers had lost contact completely with her son, the other formed a new unstable family well known to social workers. We lost contact with three other children.

Of the remaining eleven, three had scores of 10 or over on the BSQ, one of whom had been referred for psychiatric help. Three others had high scores of 7–9. The interviewers felt some concern about the child's future progress in ten of the eleven home situations. Eight mothers had received a rating of definite psychiatric disorder at some stage during our study. Of the nine who married, five had marriages rated as poor or broken, and only two as good, at some stage during the study. All eleven had at some time had at least one of these difficulties. It seemed reasonable, therefore, that we should regard this minority of women, again irrespective of marital status, as vulnerable and their children as at risk of emotional difficulties, even if definite problems had not become evident by 42 months.

Protection and support

In an earlier section of this chapter we showed that ten of the children of the seventy-four married women and sixteen of the seventy-six who were single appeared to have developed a behavioural problem by 42 months (Table 6.4). We have also demonstrated that we were able during pregnancy, using simple criteria, to detect the two sub-groups of women who were more likely than most to have children who would develop these difficulties. In terms of *predicting* behaviour disturbance in childhood we have to note, however, that only a minority of children with high scores on the questionnaire – three of the ten in the married

and six of the sixteen in the single sample – were born to mothers in these risk groups.

Not only were the majority of mothers whose children were at risk missed, but also other mothers were predicted to show, but apparently did not develop, problems. Ghodsian *et al.* (1981) have reported on the associations and possible mechanisms found to lead to problems among the children of women apparently not at risk, and it seems that *current* difficulties such as psychiatric disorder or family stress are highly implicated. But what of mothers who, contrary to expectation, do not seem to transmit deprivation? Is there any evidence of 'protective' factors at work, ones that help produce the better than expected outcome for our single sample? We will not examine the general issue of protective factors here; this would include discussion of a wide range of topics including items such as the child's temperament and sex. Instead we will direct our attention to one area that seems particularly relevant to the single woman: the role in her life of her extended family.

We are fortunate in that the area in which our study took place has been well studied and documented. For instance a generation ago the extended 'matriarchal' families of Bethnal Green were vividly described by Young and Willmott (1957). The mother was the chief figure who provided advice, encouragement and physical help for her adult daughter during the years of child-rearing. Throughout our own study, in Tower Hamlets, we were aware, despite the vast geographical changes wrought by the rebuilding of the East End, that family life was still of extreme importance. As Table 6.1 showed, the single and the married women were likely to have been reared in the same community. During pregnancy, moreover, most single women (84 per cent) were still living with their parents. In addition 64 per cent of the single and 62 per cent of the married women regarded their mothers as future sources of help. This pattern continued after the birth, and the majority of both single and married mothers were in frequent contact with their own mothers throughout the early years of their children's lives. At 4 months post-partum, for example, 71 per cent of married women, and 81 per cent of single women, saw their mothers at least once a week. Of these, however, far more of the single women (61 per cent) than of the married women (26 per cent) saw their mothers more than three times per week. By 42 months post-partum 61 per cent of married women and 75 per cent of single women were still seeing their mothers at least once a week, and 10 and 26 per cent respectively were seeing them every day.

The idea that a woman's mothering capacity is formed by her own childhood experience is central to a number of theories of personality

development which lay particular stress on the importance of her relationship with her own mother (Deutsch 1945). This gained some support from our own study, as subjects clearly indicated the importance of their families of origin. At the interview during pregnancy, 45 per cent of the single women said that they intended to bring up their child for the most part as they themselves had been brought up, and 65 per cent of the married women said the same. At the 42-month interview we again asked about maternal influence on the women's own mothering. Virtually the same percentage of single (33 per cent) and married (38 per cent) women saw themselves as similar to their own mothers, slightly fewer single mothers (20 per cent) than married mothers (33 per cent) said they had brought up their child in the same way as they themselves had been, and slightly less, 30 per cent compared with 49 per cent of married women, saw their own mothers as a good example or model on which to base their own actions.

On such figures we can suggest only tentatively that the child's maternal grandmother plays an important role by continuing to support her daughter throughout the early years of child-rearing. The *absence* of such continuing support as measured by the same variables was noticeable, however, in the group of women who had been in care and whose difficulties continued throughout the early years. It is interesting that Furstenberg (1976) points to 'collaborative child care' between mother and grandmother as a possible reason why the majority of children of teenage mothers in his study showed better social development than might have been expected. It may well be that support from their mothers gives these young women the 'breathing space' that will allow them the time to develop to full adulthood and cope with the responsibilities of child-rearing.

Conclusions

This study of women single at the time of conception has shown that, compared with married women from the same community, they came from more disadvantaged backgrounds and, during pregnancy, were more likely to report circumstances that appeared to give cause for concern. They have been shown, as a group, to be significantly more likely to continue through the early years of child-rearing in relative economic hardship.

All the same, we have been unable to show that the single women automatically constitute a group at risk of rearing children to whom they transmit *emotional* problems. Certain factors, such as maternal age and marital status, have been found to be of little value in predicting later difficulties. When a broader sample of women was studied, other variables such as a woman's previous psychiatric history or

her experiences of a severely disrupted childhood appeared useful in identifying some women whose children will later be exposed to potentially disturbing circumstances and who will be at particular risk of later behaviour difficulties. It is possible to regard these families' situation as one of a general accumulation of interrelated problems from which it is difficult to escape. In such families the concept of transmitted deprivation seems particularly appropriate. It must be stressed, however, that even in a deprived area only a small minority of women fall into such a category. The majority of mothers in our sample, single or married, escaped such extreme problems despite living in a markedly deprived area. Most single women did *not* have a disturbed child or a psychiatric disorder, did *not* establish a bad marriage, and did *not* originate from homes characterised by extreme and longstanding interpersonal difficulties. The majority had effective support systems that may well have acted as a 'protective' factor and alleviated any stresses inherent in single status or immaturity.

We make these conclusions with some caution, first because of the economic situation of the mothers, as already described, and secondly because we were emphasising extremes of difficulty, rather than non-optimal child development, and also confining ourselves to emotional rather than cognitive functioning in the child.

As far as the more practical aim of identifying, antenatally, women who are 'at risk' of child-rearing difficulties is concerned, we have shown that taking a short social history is extremely useful in detecting a minority of women likely to have later problems of various types. It seems unlikely, however, that other obvious characteristics such as marital status or age, which can worry observers, would be useful in predicting the majority of those with later problems.

One could also speculate that an expected child is a family event, and the reactions of the father and the wider family are probably of as much importance either directly or indirectly to the final outcome for the child as are the characteristics of the mother herself. It therefore becomes debatable whether the best way of providing preventive care to families is necessarily to select mothers thought to be in most need and then concentrate scarce resources on this minority. It might be better to reorganise antenatal care for *all* women so that, within the context of a more personal service, the social circumstances and emotional strengths and needs of the individual mother *and* her family could be recognised, and help offered when and where appropriate.

Note

1 For economy of space many of the variables that failed to discriminate between the single and married groups are not presented here. Tables of data are available from the authors.

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References

Burd, M. (1980), 'Teenage mothers: ten years on', unpublished M.Sc. thesis, North East London Polytechnic.

Crellin, E., Pringle, M.K. and West, P. (1971), *Born illegitimate: social and educational implications*, Slough: NFER.

Deutsch, H. (1945), *The psychology of women, vol. 2, Motherhood*, New York: Grune and Stratton.

Ferri, E. (1976), *Growing up in a one-parent family* (A National Children's Bureau report), Slough: NFER.

Finer Report (1974), *Report on the committee on one parent families*, London: HMSO.

Frommer, E. and O'Shea, G. (1973a), 'Antenatal identification of women liable to have problems in managing their infants', *British Journal of Psychiatry*, vol. 123, pp. 149–56.

Frommer, E. and O'Shea, G. (1973b), 'The importance of childhood experience in relation to problems of marriage and family building', *British Journal of Psychiatry*, vol. 123, pp. 157–60.

Furstenberg, F.F. (1976), *Unplanned parenthood*, New York: Free Press.

Ghodsian, M., Zajicek Coleman, E. and Wolkind, S.N. (1981), 'A longitudinal study of maternal depression and child behaviour problems' (submitted for publication).

Graham, P. and Rutter, M.L. (1973), 'Psychiatric disorders in the young adolescent: a follow-up study', *Proceedings of the Royal Society of Medicine*, vol. 66, pp. 1226–9.

Hall, F. and Pawlby, S.J. (1981), 'Continuity and discontinuity in the behaviour of British working class mothers and their first-born children', *International Journal of Behavioural Development*, vol. 4, pp. 13–36.

Helfer, R.E. and Kempe, C.H. (1968), *The battered child*, Chicago: University of Chicago Press.

Illsley, R. (1967), 'Family growth and its effects on the relationship between obstetric factors and child functioning', in Robert, P. and Parkes, A.S. (eds), *Social and genetic influences on life and death*, London: Oliver & Boyd.

Illsley, R. and Gill, D.G. (1968), 'Changing trends in illegitimacy', *Social Science and Medicine*, vol. 2, pp. 415–33.

Oppel, W. and Royston, A. (1971), 'Teenage births: some social, psychological and physical sequelae', *American Journal of Public Health*, vol. 61, pp. 751–6.

Pawlby, S.J. and Hall, F. (1979), 'Evidence from an observational study of transmitted deprivation among women from broken homes', *Child Abuse and Neglect*, vol. 3, pp. 844–50.

Quinton, D., Rutter, M. and Rowlands, O. (1976), 'An evaluation of an interview assessment of marriage', *Psychological Medicine*, vol. 6, pp. 577–86.

Richman, N. (1976), 'Depression in mothers of pre-school children', *Journal of Child Psychology and Psychiatry*, vol. 17, pp. 75–8.

Richman, N. and Graham, P. (1971), 'A behavioural screening questionnaire for use with 3-year-old children: preliminary findings', *Journal of Child Psychology and Psychiatry*, vol. 12, pp. 5–33.

Robins, L.N. (1966), *Deviant children grown up*, Baltimore: Williams & Wilkins.

Rutter, M.L. (1971), 'Parent–child separation: psychological effects on the children', *Journal of Child Psychology and Psychiatry*, vol. 12, pp. 233–60.

Rutter, M.L. (1972), *Maternal deprivation re-assessed*, Harmondsworth: Penguin Books.

Rutter, M.L. (1976), 'Research report. Isle of Wight studies, 1964–74', *Psychological Medicine*, vol. 6, pp. 313–32.

Ryder, R.G. (1973), 'Longitudinal data relating marriage satisfaction and having a child', *Journal of Marriage and the Family*, vol. 35, pp. 604–6.

Shaffer, D., Pettigrew, A., Wolkind, S. and Zajicek, E. (1978), 'Psychiatric aspects of pregnancy in school girls', *Psychological Medicine*, vol. 8, pp. 119–30.

Weissman, M. and Paykel, E. (1974), *The depressed woman: a study of social relationships*, Chicago: University of Chicago Press.

Wimperis, V. (1960), *The unmarried mother and her child*, London: George Allen & Unwin.

Wolff, S. and Acton, W.P. (1968), 'Characteristics of parents of disturbed children', *British Journal of Psychiatry*, vol. 114, pp. 593–602.

Wolkind, S. and Coleman, J.C. (1976), 'The psychiatry of adolescence', *Hospital Medicine*, vol. 15, 575–82.

Wolkind, S.N., Hall, F. and Pawlby, S.J. (1978), 'Individual differences in mothering behaviour: a combined epidemiological and observational approach', in Graham, P.J. (ed), *Epidemiological approaches in child psychiatry*, London: Academic Press.

Wolkind, S.N. and Renton, G. (1979), 'Psychiatric disorders in children in long term residential care: a follow-up study', *British Journal of Psychiatry*, vol. 135, pp. 129–35.

Young, L.R. (1945), 'Personality patterns in unmarried mothers', *The Family*, vol. 26, no. 8.

Young, M. and Willmott, P. (1957), *Family and kinship in East London*, London: Routledge & Kegan Paul.

Zajicek, E. and De Salis, W. (1979), 'Depression in mothers of young children', *Journal of Child Abuse and Neglect*, vol. 3, pp. 833–5.

7 One Thousand Families over Three Generations: Method and Some Preliminary Findings

I. Kolvin, F.J.W. Miller, R.F. Garside and S.R.M. Gatzanis*

A unique opportunity to study deprivation across three generations arose from the possibility of following up the thousand Newcastle families originally contacted in 1947. Good records have been kept on these families, and advantage was taken of these to examine, longitudinally, whether children who had grown up in deprived families were more at risk, for their own and for their children's functioning, in adulthood.

The follow-up investigation is not yet complete, and we cannot yet report on intergenerational patterns of deprivation. Nevertheless we can indicate some of the methodological issues that have arisen, and decisions we have had to take, so far. We can also present some preliminary data on deprivation over the life-cycle which begin to suggest that problems at one age increase the risk of problems in later years.

The thousand family survey

A series of local studies in Newcastle upon Tyne in the 1930s (Spence 1931; Charles 1934; Brewis *et al.* 1940; Spence and Miller 1941) demonstrated that health in children was related to conditions of family life and pointed to the need for a study of acute infections in infancy. Such a study was undertaken, after the Second World War, of all infants born in the city between 1 May and 30 June 1947. As each baby was born, parents were asked if members of the research team could visit their home and observe the progress of their infant. In all, 1,142 babies were included in the study, and only seven families withdrew their co-operation in the first year. Although planned originally for one year only, the study continued until the children entered school and then until they were aged 15. A detailed description of the planning and organisation of the investigation over this period is

* Deceased.

presented by Spence *et al.* (1954), Miller *et al.* (1960), and Miller *et al.* (1974).

By the end of the first five years a close relationship had developed between the families of the Red Spot babies[1], 847 of whom remained in the study, and the survey team decided to continue until the children were 15 years old. Thus by 1962 continuous records of some 760 children and their families over fifteen years had been collected. Throughout the school years the Thousand Family survey team sought and received increasing help from the Education Committee and school teachers, a series of studies of special groups of children was conducted, housing was surveyed, records of growth were collected and school achievement was documented.

After 1962 no further work was done apart from gathering information on schooling and employment – and following up some 500 families in 1969 to study growth between the ages of 15 and 22 years – until in 1975 it was suggested that the families might be recontacted to see whether the original subjects, as adults, were the parents of children showing similar social handicaps. In other words, were children in families with problems likely to become the parents of children with problems? As the data on the Thousand Families had, over the years, been carefully and systematically catalogued, it became feasible to examine this question, and a follow-up investigation was mounted.

The method of the recent follow-up

Tracing the families

The initial task of the recent follow-up of the Newcastle Thousand Families was to trace a sample of the 847 Red Spot children who were 5 years old in 1952. The tracing exercise took place from 1979 to 1981 when the average age of these subjects was 33. A high rate of success was achieved: we were able to trace 96 per cent of the members of the original sample, and interview and assess 92 per cent of the members of this group. The search was made easier by the very static nature of the population in the north-east of England: only one in five of our Red Spots were found to be living outside this region, and less than 3 per cent were known to have emigrated.

We started our search with an appeal on local radio and in newspapers, and about 30 per cent of families contacted us as a result. The next step in the search was through the offices of the Registrar General from which we obtained the names of the current general practitioners of our sample. We then wrote to these GPs to ask for permission to contact the families, and in this way we were able to trace a further 37 per cent of the Red Spots. Families not found through these sources

were usually found via local housing agencies or through direct home searches.

Criteria of deprivation

Areas of family deprivation relating to the Red Spots' first five years of life were described and collected (Miller *et al.* 1960). In the current follow-up these were reorganised in a way that allowed us to identify the main areas of deprivation and to study overlap between them. Six main areas of family deprivation were accordingly identified for the Red Spots at 5 years of age, and these were:

(A) *Family/marital disruption*
  (i) Divorce/separation
  (ii) Marital instability
(B) *Parental illness*
  Parent incapacitated by illness
(C) *Defective care*
  (i) Personal cleanliness
  (ii) Domestic cleanliness
  (iii) Poor clothing
(D) *Social dependence*
  (i) Debt
  (ii) Unemployment
  (iii) National Assistance
(E) *Housing* (overcrowding)
(F) *Poor maternal capacity* (coping)

All families were given a score of zero or one on each of the above six criteria and their scores were added to give a total deprivation rating.

Selecting the four groups for study

The next step was to identify all the children with evidence of 'deprivation' in any of these six areas at 5 years of age. From the records it was found that of the 847 families, 482 (57 per cent) were not deprived in any respect, 365 (43 per cent) were deprived on at least one criterion, and 116 (14 per cent) were deprived on at least three criteria. The degree of overlap between pairs of criteria is shown in Table 7.1.

We had three main aims in selecting sub-samples for special study. The first was that, to avoid focusing only on mild rather than significant deprivation, a multiply deprived group should be identified. Second, we wanted to be able to compare a deprived group not only with a control sample representative of families living in the city but also with a comparison group in which there was no evidence of deprivation.

Table 7.1 Percentage overlap between pairs of criteria

			(A)	(B)	(C)	(D)	(E)
Family/marital disruption	—	(A)	—				
Parental illness	—	(B)	16.5	—			
Defective care	—	(C)	17.4	18.6	—		
Social dependence	—	(D)	22.6	37.9	25.6	—	
Housing (overcrowding)	—	(E)	14.7	15.0	27.4	25.4	—
Poor maternal capacity (coping)	—	(F)	22.4	18.4	50.3	25.3	26.4

And third, we wished to examine each of the types of deprivation separately and hence in a reasonably pure form.

To satisfy these criteria we selected four samples of families as follows:

(a) *Supercontrols:* a random sample of families in which there was no evidence of deprivation (N = 63; 7.4 per cent of total sample of 847).
(b) *Random controls:* a randomly selected group representative of the 847 families in Newcastle in 1952 (N = 67; 7.9 per cent of total sample of 847).
(c) *Deprived group:* a 50 per cent random sample of families deprived in at least one respect (N = 185; 21.8 per cent of total sample of 847).
(d) *Multiply deprived group:* a random sample of families deprived in at least three respects (N = 78; 9.2 per cent of total sample of 847).

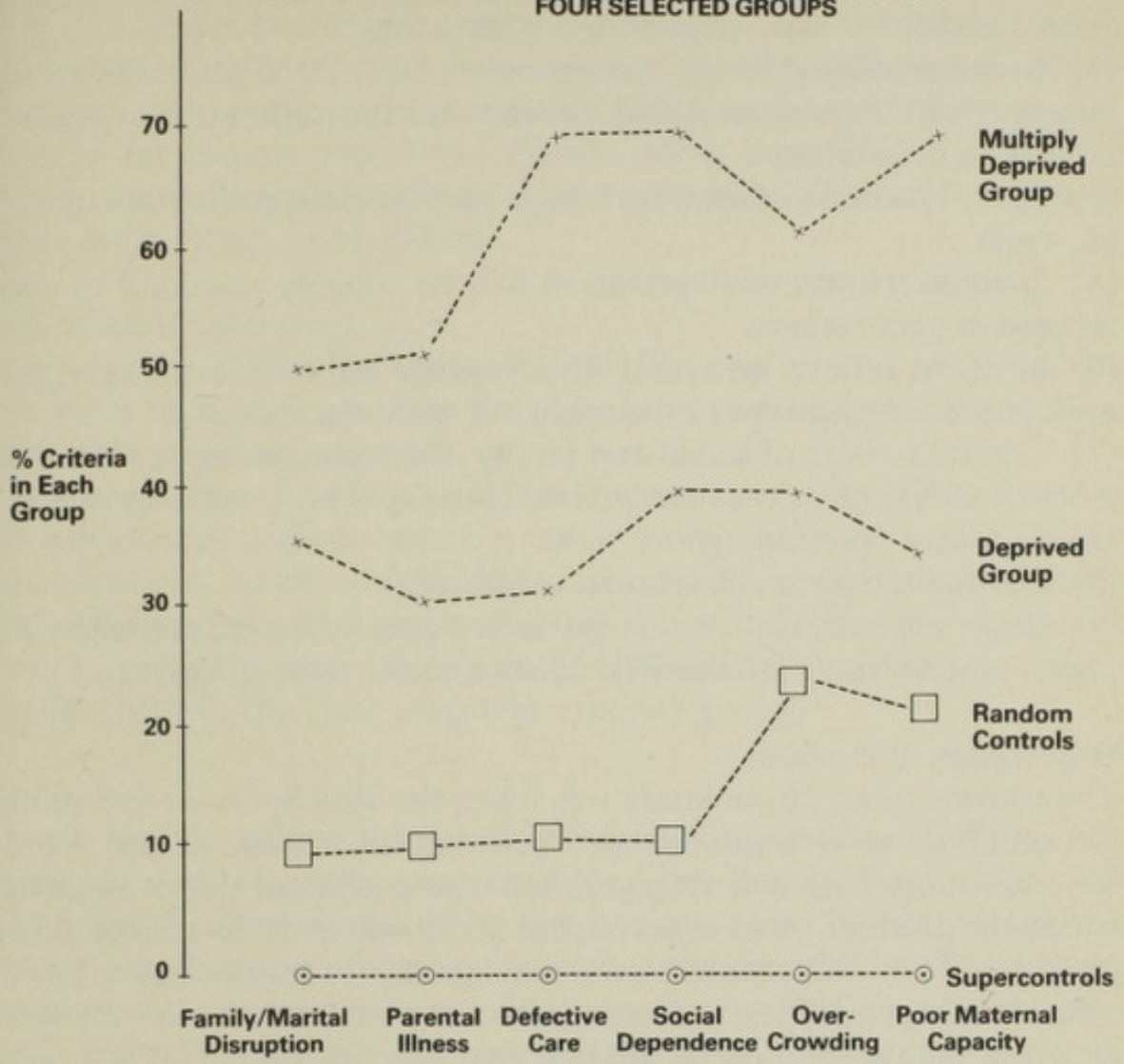
These groups of families were selected so that there was no overlap of the control and the deprived groups, and the profile of deprivation in these four groups is shown in Figure 7.1. In addition we isolated six groups of families representing each type of deprivation under study. These showed evidence of: Family/marital disruption (70 families); parental illness (63 families); defective care (66 families); social dependence (89 families); overcrowding (92 families); and poor maternal capacity (81 families). As these groups were not mutually exclusive, they can be compared only with the supercontrols.

Hypotheses

The main aim in following up the Red Spots was to establish whether or not there were continuities of deprivation within their families and over a generation.

In the strict sense, continuity can be defined as occurring when circumstances of deprivation appear to repeat themselves in successive generations at an equivalent point in the life-cycle. Alternatively, continuity can indicate the presence of certain criteria of deprivation at

Figure 7.1 PROFILE OF DEPRIVATION CRITERIA IN THE FOUR SELECTED GROUPS



different points of the life-cycle in the *same* generation. A wider concept still of continuity is that it occurs when underprivileged *family* environments give rise to underfunctioning children showing poorer than average physical development and poorer social, behavioural and educational functioning in the school years. Further, such underfunctioning in childhood may subsequently reveal itself, when the children become adults, in poorer emotional, social and economic functioning, and also in a relatively poor ability to provide adequate care for their own children. These children may, in turn, show poor development, and so on. The concept of continuity is used in all these senses in the current study which examines deprivation both within and across generations.

The main hypotheses under investigation are that:

(1) Underprivileged family environments are associated with poorer social, behavioural and educational functioning during the school years.

(2) Underprivileged family environments are associated with poorer

emotional, social and economic functioning in adult life, and hence poorer ability to care adequately for children.
(3) Underprivileged family environments lead to the transmission of poorer social, behavioural and educational functioning from generation 1 to generation 3.
(4) Specific criteria of underprivilege (deprivation) persist across the life-cycle.
(5) Specific criteria of deprivation will be roughly repeated in two successive generations.
(6) Multiple criteria of social disadvantage have an even stronger association with all types of subsequent underfunctioning.
(7) Certain indices of social and family disadvantage appear to have more harmful influences than others. These may be specific for certain types of later functioning.
(8) Certain factors have protective effects.
(9) Experiences of deprivation in the first generation are predictive of poor outcome both for the Red Spots and for their offspring.

Deprivation at 5 years

The starting point of our study was when the Red Spots were 5 years old, and it is useful to provide an account of the families at that point. Some of these data will simply reflect the criteria of deprivation by which the families were selected, but some will provide a more fine-grain picture of differences between the groups in terms of family and social factors, and illness. In some instances we report on relevant data covering the whole span of the first five years of life.

Family size and position in the family

Our data confirm that deprived children tend to come from larger families. Thus, at 5 years, the mean family size was 2.2 (with a standard deviation of 1.1) for the supercontrols and 3.1 (s.d. = 1.8) for the random controls, but 3.4 (s.d. = 2.0) for the deprived group and 4.3 (s.d. = 2.2) for the multiply deprived. Furthermore, the Red Spot was the third or subsequent child in only 14 per cent of the families of the supercontrols, but in 58 per cent of the multiply deprived families. Most of the groups showing particular types of disadvantage had a mean family size comparable to that of the deprived group. Only within the family/marital disruption group was the mean family size less than for the other deprived groups and similar to that of the random controls.

Parental loss

Just over one in fifteen of the Red Spots either entered a family in

which there was no father or permanently lost their fathers before the age of 5, and our data indicate that absence of a father was significantly associated with the degree of deprivation. Loss of father was, as might be expected, particularly common in the family/marital disruption group, but uncommon in the overcrowding group. Loss of mother showed a similar pattern of associations, although it was comparatively rare for mothers to be absent.

Maternal employment

During their infants' first five years of life, just over a quarter of the mothers of Red Spots were employed for various periods in either full-time or part-time work.

The work pattern of the groups is not easy to explain. Mothers in less disadvantaged circumstances seemed more likely to have full-time employment, whereas those from more disadvantaged circumstances tended to hold part-time posts. The rate of full-time and part-time working was extremely high in the family/marital disruption group and rather high in the poor maternal capacity group.

Housing

Considerable information on housing was collected in 1949. At this point four in ten of the control families, but only half this proportion of multiply deprived families, lived in adequate housing – that is, in detached or semi-detached houses, bungalows, council or terrace houses, but not in prefabricated houses, flats in houses, sublet rooms, etc. The substandard housing was, in the main, old properties without the basic requirements of hot water, bath or indoor sanitation (Miller *et al.* 1960). In addition, degree of deprivation was clearly associated with inadequate toilet and bathing facilities in 1948. Such amenities were especially lacking in the defective care and the overcrowding groups. Shared toilets were particularly common among the defective care group.

About 85 per cent of the families over all were living in rented accommodation, and information on rent paid was available in most cases. It was found that about four in ten families among the super-controls and the random controls paid rents in the upper third of the range, but that the same applied to only two in ten of the deprived families and one in eight of the multiply deprived. In other words, there was a clear association between the degree of deprivation and the proportion of families paying lower rents. Low rents were particularly prevalent within the overcrowding and the defective care groups.

Miller *et al.* (1960) report that a lack of sleep or poor sleeping arrangements were noted in 8.5 per cent of families when the Red

Spots were 5 years old. The risk of these circumstances rose sharply with increased deprivation and they affected 44 per cent of multiply deprived families. They were, surprisingly, not particularly frequent in the overcrowding group, but they were prominent in the defective care group and also fairly common in the poor maternal capacity group.

Health of the children

Between the ages of 1 and 5 years the Red Spots showed a high rate of severe respiratory infection, the risk of which was significantly related to degree of deprivation.

Use of health services over this period was also related to family deprivation. On the one hand the multiply deprived were half as likely as the supercontrols to attend child welfare centres six or more times, but on the other hand hospital out-patient and in-patient attendances progressively increased as the degree of deprivation became more severe (69 per cent of the children from multiply deprived families had had hospital out-patient consultations and 27 per cent had had hospital in-patient admissions, whereas the respective proportions of the supercontrol children were 49 and 11 per cent).

Speech disorders

It was demonstrated by Miller *et al.* (1960) that about one in five of the children had disorders of speech at some stage during their first five years in that they 'were slow in developing language, had defective articulation or stammered'. From our reanalysis it is evident that the incidence of speech disorders in the deprived groups was more than double that in the control groups. It also emerged that speech defects were relatively common in the defective care group (over half the children were affected) but comparatively rare in the family/marital disruption group (one in five children were affected).

Deprivation in the first year of life

There is much empirical and theoretical evidence to suggest that a child's pre-school years are crucially important for physical, cognitive and personality development, as well as for behaviour adjustment (Pringle 1974; Clarke and Clarke 1976). In the light of such evidence, we consider it important to sketch a picture of the children's life experiences before the fifth year, which is our baseline. The first year data we have available cover social factors, family factors, marital factors and health/illness.

Social factors

The four deprived and control groups differed significantly in social class assessed according to the Registrar General's occupational classificatory system. Thus greater deprivation meant a lesser likelihood of belonging to the upper and middle occupational strata and a greater probability of coming from the lower occupational strata. An examination of the groups classified by type of deprivation revealed a similar pattern. Although the lower social strata were significantly represented in all six groups, they were especially common within the social dependence, defective care, poor maternal capacity and, notably, overcrowding groups.

As at 5 years, the housing conditions of children at 1 year were more likely to be substandard, lacking in amenities and overcrowded, within the most severely deprived families. In addition these families were less likely than others to have a cot for the infant to sleep in. Overcrowding and lack of cots were associated with all types of deprivation, but most strongly with defective care, poor maternal capacity and, unsurprisingly, overcrowding.

Family factors

A number of family characteristics were found to relate to degree of deprivation. For instance, the greater the deprivation, the more likely were mothers to have been married by the age of 19 years and to have shown a high parity. As mothers in the deprived groups not only married younger, but also had larger families, more tended to have children at younger as well as older ages than the mothers in the control groups. Among families with different types of deprivation, it was those showing defective care and overcrowding who were most likely to have four or more children by the first year of the Red Spot's life.

It is relevant to mention at this stage that no cases of illegitimacy were recorded for the supercontrol and random control groups, whereas 10 per cent of the deprived group and 17 per cent of the multiply deprived group had illegitimate children. Illegitimacy, moreover, was most prevalent in the family/marital disruption group (occurring in 17 per cent of families) but lowest in the overcrowding group (only 6 per cent of families were affected). In addition, the more severe the degree of deprivation, the less mothers seemed able to cope during the first year of life: just over a quarter of mothers in the multiply deprived group, as compared with all those in the supercontrols, appeared competent in this sense. Inability to cope was especially common in the poor maternal capacity and the defective care groups.

Marital factors

The risk of marital instability was heightened in deprived families. Thus a high proportion of the children from the deprived groups was exposed to and experienced distressing marital, and consequently family pressures during the highly formative first year of life. It is interesting to note that in almost six in ten cases of family/marital disruption identified during the fifth year of the Red Spot's life, the condition had already been present by the first year. Marital instability proved widespread in that it was significantly more prevalent within each of the groups identified by type of deprivation than among the supercontrols.

Illness

Mothers in the deprived groups experienced more ill health during the first year of their children's lives than their more advantaged counterparts. A similar pattern was found for each of the groups showing a specific *type* of deprivation, and in all cases rates of ill health were almost treble the rate found among the supercontrols. However, as expected, maternal ill health was particularly common in the group identified on the basis of poor maternal capacity when the children were 5 years of age.

Children's health was also related to deprivation, and there was a greater degree of serious respiratory illness during the first year in the deprived groups than in the control groups. This difference was maintained across all groups representing a specific type of deprivation.

Deprivation beyond 5 years of age

From information on deprivation at 5 and at 10 years, we were able to examine life-cycle changes occurring over a period of five years. We found that, in general, the deprivation suffered by the families diminished considerably during this time.

The reduction in deprivation over the five years in question applied both within the sample of 847 families as a whole, and within the selected sub-groups of families. When we examined the life-cycle patterns of deprivation shown by these families we found that:

(1) Of those scoring zero at year 5, 10 per cent scored more at year 10.
(2) Of those scoring one at year 5, 67 per cent scored less and 7 per cent scored more at year 10.
(3) Of those scoring two at year 5, 75 per cent scored less and 12.7 per cent scored more at year 10.
(4) Of those scoring three at year 5, 83 per cent scored less and 8 per cent scored more at year 10.

(5) Of those scoring four at year 5, 75 per cent scored less and 10 per cent scored more at year 10.
(6) Of those scoring five at year 5, 86 per cent scored less at year 10.

In other words, the reduction in deprivation was considerable in all groups apart from the group initially showing no problems. The Red Spots, by the age of 10, were living under far better conditions than at 5 years. Moreover, as a reduction in deprivation was most marked in those originally most deprived, and as some of the initially non-deprived later showed some signs of deprivation, fewer differences between deprived and control groups were found at 10 years than had been evident at 5 years.

In order to ascertain whether deprivation continued in the same families within groups, we examined correlations between deprivation at 5 and 10 years. We found that while all the correlations were positive and significant, only those for family/marital disruption and defective care showed a moderately high association at the two dates, suggesting that family/marital disruption and defective care were among the most stable aspects of deprivation in the lives of children between 5 and 10 years. Global deprivation, too, seemed fairly stable, and further analysis suggested that this was particularly owing to its association with defective care and social dependence.

The data reported so far do not indicate the proportion of families showing particular *types* of deprivation when the Red Spots were 5 and 10 years. These percentages are provided in Table 7.2 and indicate that there was an over-all reduction in deprivation over the intervening period, with the greatest reduction occurring in overcrowding and the least in family/marital disruption and social dependence.

This evidence suggests that a number of families 'deprived' when their children were aged 5 were no longer so to the same degree by the tenth year. We decided that families showed improvement if:

(1) They fell within the deprived group at 5 years, but their deprivation score was zero by the tenth year.
(2) They fell within the multiply deprived group at 5 years, but their deprivation score was zero or one by the tenth year.
(3) They fell within one of the six groups classified by *type* of deprivation at 5 years, but they no longer did so by the tenth year.

On this basis, analysis of all the 812 families still in touch with the research team when the Red Spots were 10 years old indicated that about half of both the deprived and the multiply deprived groups improved by the tenth year (see Table 7.3). Nevertheless improvement was not even across the different types of deprivation: most

Table 7.2 Prevalence of deprivation at fifth and tenth years

	Groups				
	Family/marital disruption	*Parental illness*	*Defective care*	*Social dependence*	*Overcrowding*
% of families in groups at fifth year (N = 847)	14.5	12.2	12.6	17.5	18.7
% of families in groups at tenth year (N = 812)	10.7	6.2	6.7	12.7	6.6

Table 7.3 'Improvement' between the fifth and tenth years

	Groups						
	Deprived	*Multiply deprived*	*Family/marital disruption*	*Parental illness*	*Defective care*	*Social dependence*	*Overcrowding*
Total no. of families in groups at fifth year	331	103	112	88	98	130	147
No. of families 'improved' by tenth year	167	51	51	72	53	68	113
% of families 'improved' by tenth year	50.5	49.5	45.5	81.8	54.1	52.3	76.8

improvement was shown in parental illness and overcrowding, and the least improvement was evidenced for family/marital disruption.

The analysis of data on events beyond the tenth year will become available in subsequent reports. Among other findings, this will include evidence that at almost every age between 3 and 15 years, children from supercontrol families were significantly taller and heavier than those from the multiply deprived group. It has also been clearly shown that the likelihood of behaviour disturbance at 10 years, cognitive ability shown in the 11-plus examination, and delinquency, relatively poor school attendance and a lack of attempted examinations at 15 years, were strongly related to the degree of family deprivation.

Conclusions

Perhaps the most important finding at this stage of the study is the clear reduction in deprivation in absolute terms in the years 1952–7 when the children were aged 5 to 10 years. Nevertheless there is evidence of transmission to the next generation, particularly when deprivation is severe, indicating that early adverse environmental influences take their toll, in the short term, in physical, behavioural and cognitive fields. In the longer term we intend to study the effects of deprivation, defined in a broad sense, both within and across generations, and we look forward with interest to the results of the analysis of the data relating to the Red Spot children as adults and parents.

The design of this study should be noted. The prospective long-term study, although ideal in theory, presents many practical difficulties of organisation and expense. In particular there are problems in assessing change that stem from the relative coarseness of the original measures compared with those that would have been used in a study adopting a more modern and sophisticated methodological approach.

We used the 'catch up' prospective design (Robins 1980) and obtained our material from existing records of the Thousand Family survey collected thirty years previously. The families enrolled in the original study in 1947 were representative of all families in the city of Newcastle to whom a child was born in that year. Thus we were able to start our work immediately and at the same time obtain an unbiased sample of families at risk. Further, we were in a rather unique position in that one collaborator in this study was a member of the original team from 1946 until the publication of the third volume of the Thousand Family study in 1974. Hence, we are strategically poised to complete the research within the active lifetime of a single researcher.

Such a 'catch up' study is, however, possible only if two conditions can be satisfied. First, that the families and members of the samples can

be traced and are willing to co-operate, and, second, that the original records are of a quality sufficient for use. The first condition was clearly met as 96 per cent of the families in the samples were traced inside or outside the United Kingdom and as more than 90 per cent co-operated in a detailed interview. The second condition was also met in that the records were of satisfactory quality. Information had been collected systematically so that the data contained in the records reflected the situation of families with young children in the City of Newcastle in the immediate postwar years. This enabled the isolation of a stratified sample and the delineation of six areas of deprivation that were conceptually and statistically valid.

Note

1 From the beginning of the study, all documents and correspondence were marked with a red stick-on legal seal – so that the infants soon became known as the Red Spots. Each child later received a birthday card each year designed to include the appropriate number of Red Spots.

References

Brewis, E.G., Davison, G. and Miller, F.J.W. (1940), *Investigations into health and nutrition of certain of the children of Newcastle upon Tyne between the ages of one and five years* (1938–9), City and County of Newcastle upon Tyne.

Charles, J.A. (1934), *A study of the diets of 69 working-class families in Newcastle upon Tyne*, City Health Department, Newcastle upon Tyne.

Clarke, A.M. and Clarke, A.D.B. (1976), *Early experience: myth and evidence*, London: Open Books.

Miller, F.J.W., Court, S.D.M., Walton, W.S. and Knox, E.G. (1960), *Growing up in Newcastle upon Tyne*, London: Oxford University Press.

Miller, F.J.W., Court, S.D.M., Knox, E.G. and Brandon, S. (1974), *The school years in Newcastle upon Tyne 1955–62*, London: Oxford University Press.

Pringle, M.K. (1974), *The needs of children*, London: Hutchinson.

Robins, L.N. (1980), 'Longitudinal methods in the study of normal and pathological development', in Earls, F. (ed), *Studies of children*, New York: Prodist.

Spence, J.C. (1931), *Investigation into the health and nutrition of certain of the children of Newcastle upon Tyne between the ages of one and five years*, City and County of Newcastle upon Tyne.

Spence, J.C. and Miller, F.J.W. (1941), *Investigations into the causes of infant deaths 1939*, City and County of Newcastle upon Tyne.

Spence, J.C., Walton, W.S., Miller, F.J.W. and Court, S.D.M. (1954), *A thousand families in Newcastle upon Tyne*, London: Oxford University Press.

8 The Effects of Family Deprivation on Pre-School Children

J.E. Stevenson and P.J. Graham

Introduction

Our approach to the study of the transmission of deprivation has been to examine the influences acting upon the cognitive development and behaviour of pre-school children. It has been suggested that the first five years of life are of crucial significance to later outcome in terms of intelligence (Bloom 1964). Psychoanalytic and other theories of child development also put considerable emphasis on this period of early childhood as of special significance in personality development and the risk of developing later psychiatric disorder. It therefore seems possible that intensive study of the specific effects of deprivation in this phase of life could be fruitful.

At the time that research interest in the cycle of deprivation reflected in the work reported in this volume was roused, we had just conducted, in collaboration with Dr Naomi Richman, a cross-sectional study of behaviour problems and cognitive development in a total population of 3-year-old children. We had examined in more detail than had previously been the case the prevalence of psychological problems in this age group and the background factors related to their presence. We had a great deal of information on the material and social circumstances in which the families were living, the physical and mental health of the parents, and the quality of family relationships. Our main interest in analysing the data had been to consider the factors relating to the presence of behaviour disturbance in our sample (Richman *et al.* 1975; Richman 1977). Our initial analyses did not particularly focus on material or social deprivation as background factors, but we did examine the relevance of some related variables, for example housing circumstances. In the light of interest expressed, however, we asked ourselves whether we could possibly illuminate the processes underlying the transmission of deprivation by reanalysing the data we had obtained.

Our first concern was to consider the concept of deprivation. It immediately seemed likely that it would be more profitable to focus on the family as the unit to be examined in terms of deprivation, rather than the very young child. However the notion of a family as possessing a deprived status does not have a very clear conceptual basis. Rutter

and Madge (1976) suggest four possible ways of classifying families as deprived, just with regard to the presence of poverty. Families could be regarded as deprived if their income fell in the bottom 5 or 10 per cent for the total population. Income is, however, inconsistently related to need which will vary greatly according, for example, to the number of children in the household. Secondly, an administrative definition, such as the receipt of a particular income supplement, involves the application of a set of financial criteria. Even in pure economic terms this may be misleading, for some families below the administrative line may not apply, and others, above it, may be living under great financial constraint. A third definition would involve the self-perception of the family as deprived (Runciman 1972). Such an attitudinal measure might be reliably applied, but its consistency over time would certainly be in doubt, as would the possibility of applying such a criterion to compare groups of people living in different social circumstances. Finally, a notion of 'impairment' can be introduced. This could be related to the inability of the family to achieve certain agreed standards across a range of goods or skills which a consensus of the population might agree to be the right of every member to possess or achieve. Further, although there may be families in which life circumstances such as finance, housing, and stability of level of occupation are consistently disadvantageous, it is by no means certain that, if one investigated a group of families drawn from the general population, it would be possible to identify a homogeneous group warranting the application of the label of deprivation.

In the event, we decided to tackle the problem empirically, to see if we could identify a group of deprived children within the total population we had studied by examining the worst off 10 per cent on the whole range of background variables on which we had information. Assuming that it *is* possible to identify a group of children living in families with deprived status, the next question that arises is whether, in the development of cognitive deficits and emotional and behaviour problems, the same processes are at work as in non-deprived children. In so far as this matter has been investigated previously it has been considered in relation to children living in so-called 'problem families'. Families with multiple problems have been defined in a variety of ways. Most investigators have used either an administrative definition – for example referral to a particular social agency for child neglect, or referral to a particular number of agencies – or they have used a criterion of multiple handicap. Wedge and Prosser (1973), using a definition of this latter type, found that 6 per cent of children suffered significant multiple social disadvantage.

It has generally been assumed that children forming part of problem

families who show signs of disturbance or learning difficulties are manifesting these problems for the same reason as children living in non-deprived families. Thus Rutter and Madge (1976: 255) conclude that problem families 'do not constitute a group that is qualitatively different from families in the general population' and support this conclusion with a mass of evidence. In particular they cite the work of Tonge *et al.* (1975) who showed that disturbed children living in an administratively defined group of problem families differed from those who were undisturbed in that they were more likely to be living in disharmonious families and to have parents who themselves showed personality disorders or other types of mental dysfunction. Even if the same factors operate in producing psychological deficits in deprived children as in the non-deprived, the mechanisms or processes concerned may be different. Thus Rutter (1977) has suggested in another context that when numerous disadvantages are present in the background of the same child, they may interact in a number of different ways. There may merely be an additive effect; there may be an interaction between the background factors; or, finally, there may be a transactional mechanism in which the outcome studied may actually influence the background variable (e.g. a mother with a severely disturbed child may limit her family size to a greater degree than she otherwise would). In the light of these considerations we decided to use our data to develop a new statistical model to examine the effects of disadvantages present in the family on the child's behavioural and intellectual development. We have derived this model from data obtained on a random sample of the total population we studied. Subsequently we have applied it in order to compare the group of deprived children within the total population to see whether particular disadvantages are of greater or lesser importance in the two groups.

The approach to transmission that this entails involves the assumption that factors affect children in a continuous manner across the whole range of their manifestation. The effect of a particular disadvantage on a child is assumed to be the negative end of a continuum of influence, with, for example, good housing having good effects and bad housing bad effects. The transmission of deprivation is seen as one end of a continuum of transmission of life chances. However, in fact, the influence of particular factors in families with accumulated disadvantages may be different from that in the remainder. Families may be viewed as providing influences on children's development, and these can be described as transmitting life chances, but in families with many disadvantages there may be particular parts of this transmission process that distinguish them from other families. Further, the effects of certain types of deprivation might be revealed to be different from

those of other types. It is, for example, generally assumed that cognitive deficits in childhood are more likely to be produced by genetic factors and lack of appropriate environmental stimulation. Many studies (e.g. Douglas 1964; Davie *et al.* 1972) have demonstrated that poor material circumstances are associated with low intelligence and educational retardation, while other investigators (e.g. Hess and Shipman 1967) have shown how the quality of parental stimulation affects a child's performance. By contrast, emotional and behaviour disorders are thought to be more related to disharmonious family functioning and to have little association with social class as assessed by parental occupation (Rutter *et al.* 1970). Is this the case to the same degree, and are the same processes operating, in deprived as in non-deprived families?

The identification of such differential significance could provide a basis for guiding social policy action. Given the administrative difficulties of applying social policies based on individual identification of families in need, and the invidious consequences of 'means testing' and 'labelling', a universal policy has distinct advantages. However the problem with an unselective approach is that whatever action is taken, such as the improvement of housing in an area or the implementation of positive discrimination in the allocation of school resources, the non-deprived always seem to benefit more from action than do the deprived. By identifying differential weightings of the effects of family disadvantage for deprived children and the normal population, it was hoped that areas for social policy action could be identified that would particularly benefit children within deprived families.

Method

The study design

The findings to be presented are a reanalysis of data collected as part of an epidemiological study of behaviour and emotional problems during the pre-school years. The design of the study as a whole has been longitudinal, and by following a group of children identified as presenting difficulties at three years, together with a matched control group, it has been possible to investigate factors associated with the persistence of problems and those related to the development of problems at a later age. In this context, however, attention is restricted to the circumstances of children at 3 years, and the focus is particularly upon the transmission of deprivation. Other findings that derive from the data collected at age 3 years have already been published (Richman *et al.* 1975; Richman 1977; Stevenson and Richman 1976; Stevenson and Richman 1978) and the results of a 5-year follow-up study are now available (Richman *et al.* 1982).

One major methodological difficulty in epidemiological studies of pre-school children is the identification of the population in question. This problem was overcome in the present study as a sampling frame was provided by a register of pre-school children developed and maintained by the MRC Unit directed by Dr James Douglas. This register, whose operation has been described elsewhere (Richman and Tupling 1974), is based on the birth records of all children born in a London borough during a certain period, kept up to date by health visitors in terms of moves in and out of the area. It has been estimated that the register identified accurately approximately 90 to 95 per cent of the pre-school children in the borough while it was in operation.

For the purposes of this study, the register was used to select a random sample of one in four of all the children living in the borough whose third birthday fell in one of twelve monthly intervals over a sixteen-month period. The names of 1,060 children were initially obtained in this way, although later losses occurred: 76 children were found to have addresses outside the borough; a further 29 were excluded because of an incorrect date of birth, because they were stillborn, or owing to information error; 90 children had moved from the address given and we were unable to trace them; 15 had parents whom we could never contact; 5 had lived in homes where no English was spoken; and 17 had parents who explicitly refused to co-operate with the study.

When the study began, 828 children remained in the random sample. These were visited at home and individually tested using standardised developmental assessments. General level of development was measured by the Vineland Social Maturity Scale (Doll 1947), emotional or behavioural problems were detected by the Behaviour Screening Questionnaire (Richman and Graham 1971), and language development was rated according to responses to items from the English Picture Vocabulary Test (Brimer and Dunn 1962) and the Reynell Developmental Language Scales (Reynell 1969).

The mothers of these children were given a screening interview by one of a number of special trained interviewers. During these interviews, information was collected on aspects of family background such as family income, family size, parental occupation and education, housing conditions and recent personal and material stresses. Data were also obtained on the child's health, birth history, subsequent health service contact, separations from one or both parents, and recent social contacts with neighbours, relatives and friends.

From the data obtained in the screening interview, 123 children from immigrant backgrounds were identified. These children were born to a mother who was either herself born outside the United

Kingdom or who had not lived in the United Kingdom for more than twenty-five years. Although the screening information was obtained on these 123 immigrant children, they did not take part in the rest of the main study. However a separate study of this group was made, and this is reported by Earls and Richman (1980a and b).

This exclusion left 705 non-immigrant children, and of these 101 with behaviour problems identified by the Behaviour Screening Questionnaire, and a further 101 who did not show behaviour problems but who were matched for sex, social class and age with the behaviour problem group, were selected for further study. This number was augmented to 210 by the addition of a further eight children showing language delay according to the language screening procedure.[1]

These 210 children were the subjects of the second stage of our investigation although, for various reasons, full information was collected at age 3 on only 205 of them. At this stage there was a second interview with the mother, concentrating on relationships between family members, the marriage, the mental and physical health of the parents, and the child's development and behaviour (Richman 1977). In addition the children were individually assessed, in their own homes, on a battery of developmental tests.

Analysis of the data

Altogether 256 separate items of information (variables) about the child's development and family background were obtained from the screening interviews. Visual inspection of these data suggested that there were eight general areas of potential family disadvantage and five areas in which the child might possibly suffer. Based on clinical judgement and the available literature, indices of disadvantage and development were derived for these thirteen areas from a sub-set of forty-seven of the original pieces of information. In each case weights were assigned to individual values of the variables and these weighted scores were summed to form the indices. Cases were allocated the modal value for variables where there were missing data.

There were five aspects of the child's experience and development for which indices were constructed. These were health, behaviour, language, development and social contacts.

Information from thirteen variables was incorporated into the health index. Data were accordingly assembled on the use of health facilities during the previous year – including general practitioner visits, hospital out-patient appointments and accidents requiring medical attention; on use of drugs, for example, antibiotics over the same period for general medical purposes, for sleep problems, for

sedation and for problems with appetite; and on the presence of certain conditions, that is, asthma, eczema, epilepsy, difficulties with vision or hearing, and other chronic physical or mental handicaps. Although it was recognised that some of these variables, such as the child's use of health facilities, might chiefly reflect parental anxiety about the child's health, it was nevertheless thought that a weighted score across the thirteen variables would provide a reasonably accurate picture of the child's health over the previous year.

The child's score on the Behaviour Screening Questionnaire, designed to identify children with behaviour problems at the age of 3, was also taken as his/her score on the behaviour index. Ratings were based on the mother's report, on a three-point scale, of problems in twelve areas of the child's behaviour, for example temper tantrums, sleep, management, eating, worries, activity, etc. The maximum score a child could gain was 24, and it has previously been demonstrated that pre-school children attending psychiatric services are likely to achieve scores of ten or more.

The language index was based on four variables. These were a measure of comprehension (more specifically passive vocabulary) based on the English Picture Vocabulary Test (Brimer and Dunn 1962), expressive language vocabulary, also based on the EPVT, the syntactic complexity of the child's spontaneous utterances, based on the Reynell Developmental Language Scales (Reynell 1969), and the intelligibility of the child's speech rated on a four-point scale.

Information from mothers on developmental status was the basis of scores on the development index. The majority of items taken into account were derived from the Vineland Social Maturity Scale, although these were supplemented by additional items, such as fine motor co-ordination.

The final child-based measure of disadvantage was the contacts index, and this reflected social isolation experienced by the child. Contacts with neighbours, relatives and friends in the preceding week were taken into account, as was the number of different people such contacts had involved.

Of the eight family-based indices of disadvantage, an amenities index was based on the quality of housing in which the families lived. Aspects taken into account were the floor above the ground in which, if they were flat-dwellers, accommodation was situated; overcrowding as measured by persons per room; and access (full, shared or none) to a bath, kitchen, indoor W.C., electricity supply, running hot water and a garden.

Also a stress index was calculated on the number of social stresses the family had been under for the previous year. These stresses were

life events – such as economic problems, contacts with the police, deaths in the family, moving house, etc. – that had previously been shown to be related to psychiatric disturbance (Brown *et al.* 1973).

Furthermore, family income was measured by the mother's report of her own and her husband's take-home earnings, family size was assessed as the number of children under 16 years living at home, and father's occupation was classified according to the Registrar General's (1970) codings (unemployed fathers and single mothers were rated separately).

The separation index was based on seven items of information. These each referred to the child's experience of separations from parents, and included in-patient stays in hospital, care by persons other than parents at various stages in the child's life, and the longest separations experienced from the mother only, the father only, and both mother and father. Both frequency and length of separations were taken into account.

Conditions at birth, too, were recorded and this index was based on the mother's age at the birth and the child's birth-weight. Finally, the parents' education index was determined by the age at which both mother and father completed full-time education.

Findings

The distribution of disadvantage

Before attempting to identify the most deprived within our sample, we examined the distribution of scores shown by subjects on both child-based and family-based indices of disadvantage.[2] A variety of patterns was found. Of the child-based indices, three – the behaviour index, the language index and the development index – showed a more or less normally distributed set of scores; one, the health index, was markedly skewed, that is, most children were healthy and only a few showed multiple evidence of ill health; and another, the contact index, showed a more clumped distribution with a strongly bi-modal appearance, that is, some children had quite a number of social contacts while others had very few.

The indices of family disadvantage also showed skewed distributions and – with the exception of the education index – the tails of these distributions were extended towards the adverse end.[3] In other words there were few families that were particularly disadvantaged according to the criteria we examined.

Identifying the most deprived

A main intention of the present study was to identify a sub-sample of

children whose families showed a cluster of disadvantages. As there was no means of judging the equivalence of adversity on the various indices described above, it was arbitrarily decided to look at the most disadvantaged 10 per cent of families on each index. A count was then made of the number of indices on which each child and family fell within the worst-off 10 per cent, separate note being made for child-based and family-based indices.

The findings are presented in Tables 8.1 and 8.2. It can be seen that on neither type of index were there many children consistently disadvantaged across a large number of measures. It is notable that only 6.6 per cent of families were in the worst 10 per cent on three or more of the eight measures of family disadvantage.

The final designation of the deprived sample was that it should comprise children whose families were in the worst 10 per cent on four family measures of disadvantage: parents' education, father's occupation, parental income and amenities. These four were chosen,

Table 8.1 The frequency with which children appeared in the most adverse 10 per cent on the five child indices

Number of child indices on which the child was in the worst 10%	*Number*	%
0	452	64.1
1	178	25.2
2	46	6.5
3	23	3.3
4	6	0.9
	705	

Table 8.2 The frequency with which children were in families in the most adverse 10 per cent on the eight indices of disadvantage

Number of family indices of disadvantage on which the family was in the worst 10%	*Number*	%
0	342	48.5
1	212	30.1
2	105	14.9
3	35	5.0
4	9	1.3
5	2	0.3
	705	

from the eight possible measures, as those most commonly associated with the notion of social disadvantage and deprivation. They were also the aspects of disadvantage that were most extrinsic to the family situation – family size, birth conditions, separations and stress were thought to be more intrinsic to the family set-up and to reflect characteristics of family functioning.

On this criterion, a deprived sub-sample of thirty-five children and their families was identified. This procedure enabled us to pick out the majority of the multiply deprived on any combination of three or more of the eight measures of family disadvantage, that is, thirty-five of the forty-six whose scores fell in the bottom 10 per cent on three or more indices.

Finally the mean scores on the indices gained by the deprived sub-sample and the remainder of the total sample were compared. By definition these groups were significantly different from one another on parents' income, father's occupation, parents' education and amenities. However in addition they were significantly different in their mean scores on birth conditions and stress, and in both cases it was the deprived sample that showed greater disadvantage. Nevertheless on only one of the child-based indices was there a contrast between the groups: only on language development were members of the deprived groups worse off than the rest of the sample.[4]

The path analysis

The next stage in our analysis was to attempt to produce a model depicting the way in which family background variables might influence child development and behaviour. First we apply this model to the total sample under study, and then we compare these patterns with those that emerge when the technique is applied to the deprived sub-group only.

A 'path analysis' technique was used which meant that the first task was to order the variables to be examined logically in an historical sequence. Decisions such as that parents normally finish their secondary education before they produce their first child, that a child must be born and have a birth-weight before it can be separated from its parents, and so on, therefore have to be made. On this type of reasoning we applied the following causal sequence to our family background data: parents' education, father's occupation, parents' income, family size, household amenities, birth conditions, separations and stress. The assumption is that any variable can influence any other variable later in the causal sequence, but can only be influenced by those prior to it in the sequence. The path analysis itself cannot elucidate the direction of a causal sequence and it therefore has to be assumed *a priori* that the

causal sequence proposed is correct.

Family size is the most difficult of the variables used in this model to place unequivocally within the causal sequence. We have, for example, assumed that parents' income will influence the number of children they have rather than the other way round. Similarly, family size is assumed to influence amenities rather than amenities influencing family size. Both of these assumptions can be debated.

The ordering of the last three variables in the causal sequence was determined solely by historical priority: birth conditions must precede parent–child separations, and whereas separations were measured over the first three years of the child's life, stress within the family referred to life events over only the previous year.

The next step in the path analysis was to calculate the strength of association between the variables, and in this study this was done using standardised partial correlation coefficients.

In summary, we found no relationships greater than would be expected by chance at the 5 per cent level, and therefore none would conventionally be regarded as statistically significant. Nevertheless it did appear that father's occupation and family size were the two variables with the largest direct effect on language development in the total sample of 705 children. The over-all development of the child was not significantly affected by the measures of family disadvantage we employed, and the largest direct influence on children's behaviour appeared to be stress within the family. It emerged also that scores on each different child-based index were most strongly related to a different background variable, although family size was quite strongly associated with a number of sets of ratings on the children. Over all, however, it must be concluded from the path analysis on the total sample that only very few of the differences found between children can be explained by the various background factors examined, and that patterns identified are not in any way consistent.

The next question was whether the factors associated with child status in the total sample were the same as those effective within the deprived sub-sample. To make this comparison it was necessary to re-estimate path coefficients as the deprived children had been identified using some of the variables used in the full path model. For this reduced group of children a smaller model, with a reduced number of variables, thus had to be set up, and this consisted of the following variables in the following causal sequence: family size, birth conditions, separations and stress.

This small model was estimated for the total sample and for the deprived sub-sample, and the outcomes in relation to each of the child-based indices were compared. It emerged that a marked charac-

teristic of the deprived, relative to the total, group was the large effect of family size on language and development. Also notable was that birth conditions and separations were much more strongly associated with language development in the deprived than in the total group. Birth conditions and stress factors in the environment, too, were much more closely linked to the development of behaviour problems among the deprived children.

Effects of family relationships

Detailed information on family relationships was gathered on only the 101 children with behaviour problems and their 101 matched controls. From these 202 children a group of 98 was randomly selected, hereafter referred to as the representative sample, to examine the links between the quality of family relationships and parental mental health, and the various background variables already discussed.

During a two-hour interview with mothers of the children in the representative group, questions were asked about mother's mental state, father's mental state, mother's criticism of the child, father's criticism of the child, mother's warmth towards the child and father's warmth towards the child. On the basis of the mother's report, the interviewer rated each of these areas on four- or five-point scales.

These aspects of relationships within the family were examined with interest as it was thought they might account for variance in the children's status that had been unexplained by the measures of disadvantage reported so far. However the percentage of the variance in family relationships and parental mental health accounted for by the disadvantage indices was generally low (with the possible exception of father's mental state where 13 per cent of the variance was explained) and it seemed that these aspects of family life were explained to only a minor extent by the presence of family disadvantage as measured by features such as family size, parental income, etc.

Finally we looked to see how far outcomes for the children could be predicted if *both* family disadvantage and family relationships were taken into account. The results are presented in Table 8.3 and show that although prediction was never good, it was considerably better when effects of family relationships were included than when they were not. On two of the child indices – language and behaviour – the addition of the relationship measures substantially increased the percentage of the variance explained. Although the child's language development was better predicted by family disadvantage alone than by any single aspect of family relationships, these latter variables raised the amount of variance explained from 20 per cent to about 30 or 36 per cent. By contrast family relationships were more closely

Table 8.3 Predicting child indices from family indices of disadvantage alone, and then with additional family relationship measures

	Dependent child indices									
	Language		*Contacts*		*Development*		*Health*		*Behaviour*	
Independent variables	*B*	R^2	*B*	R^2	*B*	R^2	*B*	R^2	*B*	R^2
Family indices of disadvantage alone	—	.20	—	.09	—	.06	—	.07	—	.08
Family indices of disadvantage plus:										
Mother's mental state	.001	.30	−.062	.10	−.041	.08	.170*	.10	.286*	.20
Father's mental state	.278*	.36	.113	.11	.021	.08	.045	.08	.137*	.14
Mother's criticism of child	.072	.30	−.032	.10	.157*	.10	.053	.08	.409*	.28
Father's criticism of child	.079	.30	−.040	.10	.076	.08	−.003	.07	.225*	.17
Mother's warmth to child	.113*	.31	−.032	.10	.140*	.10	.069	.08	.215*	.17
Father's warmth to child	.041	.30	.086	.11	.201*	.12	−.052	.08	.185*	.16

* $p < .20$
B: standardized partial regression coefficient
R^2: proportion of variance explained

related to child behaviour than was family disadvantage, and the addition of the relationship data at least doubled the percentage of the variance explained.

The remaining three child indices were relatively unaffected by the addition of the family relationship measures. In each case only two or three further percentage points were thereby explained.

Discussion

Size of the deprived group

We found that 6.6 per cent of children in our sample were multiply disadvantaged in the sense that they were in the worst 10 per cent on three or more of the eight indices of family disadvantage. This rate fell to 5 per cent (or thirty-five children) when the deprived were instead defined as those in the worst 10 per cent on three out of four of the family indices of parents' education, father's occupation, parental income and household amenities.

Although the figure of 6.6 per cent multiply disadvantaged or deprived children was higher than would be expected by chance, it was somewhat lower than we had anticipated. Previous work, especially that of Wedge and Prosser (1973), had suggested that about this rate of multiple disadvantage would be found in the general population, so that, as our sample was drawn from an urban area, we expected to find a rather higher prevalence.

Nevertheless our study location was an outer London borough, and not an inner-city area. And although the housing stock in quite large areas of the borough concerned was old, and many of the new housing developments were held by reputation and local officials to be areas where problem families were concentrated, perhaps our findings underline that even within urban areas there are marked differences in the patterns of disadvantage found in inner-city locations and just on the periphery of the inner ring.

Also contrary to our expectations, we found that problems in this particular geographical area were rather evenly spread across families with young children. This was shown by the findings that 45 per cent of the total sample were in the bottom 10 per cent on one or two of the indices of family disadvantage and that only 48.5 per cent of the sample were not in the bottom 10 per cent of any of the indices examined.

Characteristics of the deprived group

On only language development, of the five child-based indices studied, did a significant difference emerge between the deprived sub-sample,

as we defined it, and the remainder of the total sample. There was almost no difference in the extent to which the children in the deprived sample suffered from a lack of contact with people outside the family, poor general development and ill health. The children in the deprived sample did show a slightly higher than average number of symptoms of behavioural problems, but this difference did not reach statistical significance.

We have previously reported that children with significant language delay in this sample are likely to come from large families and have fathers with low occupational status (Stevenson and Richman 1978). As language delay is linked to the presence of behaviour problems, there is bound also to be some association between low social status and behavioural disturbance. However, as is the case with older children, the relationships are less marked in this respect.

The mechanisms underlying the links between language development, and low social status and family size, have been reviewed by Rutter and Madge (1976). These authors point especially to the work of Douglas *et al.* (1968) who found that vocabulary level in children decreases as the number of pre-schoolers in the family increases. Possibly the language stimulation provided by other young children is inadequate compared to that provided by adults, and parents who are busy coping with the needs of many children will have less time to spend talking to their offspring.

Results of the path analysis

Perhaps the most striking features of the path analysis is the slender and inconsistent nature of both the links between the various indices of adverse family circumstances, and the relationships between these and the child's status as reflected in general development, language development and behavioural disturbance. By far the highest proportion of the variance remained unaccounted for on each of these child outcomes. In other words, the factors we measured explained only to a small degree the levels of development and the behaviour problems we found.

The large degree of homogeneity in the sample, reflected in the wide spread of isolated disadvantages within the families, may go some way to explain why the measures of family disadvantage accounted for relatively little of the variance in the child indices. An exercise that tries to apportion explained variance to particular aspects of family disadvantage within a relatively homogeneous population may be subject to the effects of chance variation. This possibility, coupled with the presumed measurement error, and the known relative inefficiency of path analysis for explaining social phenomena (Miller and Stokes

1975), perhaps increase the interest and significance of the present findings, despite the large residual variance found when the path analysis was applied to the full sample.

Child status indices were, however, considerably better predicted for the deprived than for the total sample. Family size and birth conditions, in particular, emerged from the second smaller path analysis as of much greater significance for child outcomes among those defined, than those not defined, as multiply disadvantaged. Stress, moreover, appeared to play a greater part in the development of behaviour problems in the deprived than in the total group.

One of our two criteria for defining birth conditions was the age of the mother at the time of the child's birth (scores were weighted both for women who were very young, that is, less than 20 years, or older than average, that is, above 35 years), and the other was the birth-weight of the child. As these characteristics were apparently associated with disadvantage, it might be assumed that improvements in peri-natal care would mean better general and language development in deprived children. However this cannot be taken for granted. Older women who have babies are likely to be near the end of their child-bearing years, and they may have large numbers of children living at home. Very young mothers are likely to be socially disadvantaged because, in general, upwardly mobile women tend to postpone child-bearing at least until their mid-20s. And birth-weight is often related to social class. In other words deficits apparently owing to birth conditions, as measured in this study, may in fact be mediated by social factors. This possibility makes the interpretation of findings from the path analysis less straightforward. Nevertheless the technique itself retains considerable possibilities for clarifying this type of issue, and might well have provided more clear-cut findings if the sample of deprived children had been larger.

Family relationships and family disadvantage

To some investigators in this field, an attempt to distinguish between the effects of material disadvantage, disturbed family relationships and poor parental mental health in a group of deprived children would seem a pointless exercise. It is, after all, well established – at least among problem families – that these types of disadvantage tend to be found together, and indeed that they interact in a highly significant manner.

None the less our findings support the view that, despite their overlap, different types of disadvantage have quite distinct effects on children. Social and material disadvantage are clearly linked to both general developmental delay and to language delay. The quality of

family relationships appear to have rather little influence on general developmental delay, but to contribute significantly to language delay. And, in so far as it is possible to account for the development of behaviour and emotional disorders, it was the quality of family relationships and the presence of external stress factors that seemed largely responsible.

We have shown elsewhere (Richman *et al.* 1982) how the quality of family relationships is not only linked to current levels of language development, but is also predictive of later difficulties in reading. The mechanism of this association remains unexplained, but the demonstration that a child who regularly reads to his parents is likely to be advanced in reading, even when other factors have been controlled for (Hewison and Tizard 1980), may be of significance here. Parents who are preoccupied with their own problems may well have greater difficulty in giving attention to their children's education than those who are better adjusted in their family relationships. It is well known that disturbances in family relationships are of importance in the development of behavioural and emotional disorders, and indeed in the follow-up study of the children described here we have been able to demonstrate that non-disturbed children are much more likely to become disturbed if the quality of their family relationships is poor (Richman *et al.* 1982).

Conclusions

It has been shown that, even though it is possible to identify a deprived group of children living in an urban area, elements of deprivation are spread much more widely in the general population than is sometimes thought to be the case. Moreover deprivation does not necessarily lead to developmental problems: considerable numbers of children appear to manage perfectly well in circumstances deprived in one or two respects, and many of even the small minority who are multiply socially handicapped show little disability in their cognitive or personality development.

Nevertheless multiply deprived children are at more of a disadvantage in terms of language development and behaviour disturbance than would be expected by chance. Such children suffer from many background disadvantages, but our findings suggest that family size and birth conditions might be particularly adverse influences. All the same it is hard to explain such findings and perhaps, more than anything else, our data point to the need for research more specifically designed than was ours to investigate mechanisms underlying the transmission of disadvantage to young children.

Notes

1 Twelve children in the behaviour problems and matched control groups also showed language delay.

2 As no significant differences were consistently found between boys and girls on any of the forty-six basic variables, it was decided to pool the sexes together for all analyses.

3 Since skewness was a feature of many of the distributions of the indices used in the subsequent analysis, a logarithmic transformation was made of all the scores on the indices in an attempt to produce a more normal distribution. However the comparison of path coefficients obtained from the path analyses when these logarithmic transformations and when untransformed variables were used showed there to be only a slight difference, and the transformations were abandoned.

4 Significance tests were also applied to differences in variance on each of the thirteen indices. Contrasts were again found between the deprived sub-sample and the others, the former showing a greater variance on indices of health, behaviour, birth conditions, amenities, family size and parents' income. On one measure – parents' education – the deprived group had a significantly lower variance than the remainder of the total sample. These significant differences mean that subsequent differences in the path analysis between the deprived and the total sample have to be interpreted cautiously. However by using standardised partial regression coefficients, the relative magnitude of the paths obtained with these two samples can be compared.

References

Bloom, B.S. (1964), *Stability and change in human characteristics*, New York: John Wiley.

Brimer, M. and Dunn, L.M. (1962), *Manual for the English Picture Vocabulary Test*, Bristol: Educational Evaluation Enterprises.

Brown, G.W., Sklair, F., Harris, T. and Birley, J.L.T. (1973), 'Life events and psychiatric disorders: some methodological issues', *Psychological Medicine*, vol. 3, pp. 74–87.

Davie, R., Butler, N. and Goldstein, H. (1972), *From birth to seven: a report of the National Child Development Study*, London: Longman.

Doll, E.A. (1947), *Vineland Social Maturity Scale*, Minneapolis: Educational Test Bureau.

Douglas, J.W.B. (1964), *The home and the school*, London: MacGibbon & Kee.

Douglas, J.W.B., Ross, J.M. and Simpson, H.R. (1968), *All our futures: a study of secondary school education*, London: Peter Davies.

Earls, F.E. and Richman, N. (1980a), 'The prevalence of behaviour problems in three-year-old children of West Indian parents', *Journal of Child Psychology and Psychiatry*, vol. 21, pp. 99–106.

Earls, F.E. and Richman, N. (1980b), 'Behaviour problems of pre-school children of West Indian born parents: a re-examination of family and social factors', *Journal of Child Psychology and Psychiatry*, vol. 21, pp. 107–18.

Hess, R. and Shipman, V.C. (1967), 'Cognitive elements in maternal behaviour', in Hill, J.P. (ed), *Minnesota symposia on child psychology, vol. 1*, Minneapolis: University of Minnesota Press.

Hewison, J. and Tizard, J. (1980), 'Parental involvement and reading attainment', *British Journal of Educational Psychology*, vol. 50, pp. 209–15.

Miller, M. and Stokes, C.S. (1975), 'Path analysis in sociological research', *Rural Sociology*, vol. 40, pp. 193–210.

Reynell, J. (1969), *Reynell Developmental Language Scales*, experimental edn, Slough: NFER.

Richman, N. (1977), 'Behaviour problems in pre-school children: family and social factors', *British Journal of Psychiatry*, vol. 131, pp. 523–7.

Richman, N. and Graham, P. (1971), 'A behavioural screening questionnaire for use with three-year-old children', *Journal of Child Psychology and Psychiatry*, vol. 8, pp. 1–11.

Richman, N., Stevenson, J. and Graham, P. (1975), 'Prevalence of behaviour problems in three-year-old children: an epidemiological study in a London borough', *Journal of Child Psychology and Psychiatry*, vol. 16, pp. 272–87.

Richman, N., Stevenson, J. and Graham, P. (1982), *Preschool to school: a behavioural study*, London: Academic Press.

Richman, N. and Tupling, H. (1974), 'A computerised register of families with children under five in a London borough', *Health Trends*, vol. 6, pp. 19–21.

Runciman, W.G. (1972), *Relative deprivation and social justice*, Harmondsworth: Penguin Books.

Rutter, M. (1977), 'Surveys to answer questions: some methodological considerations', in Graham, P.J. (ed), *Epidemiological approaches to child psychiatry*, London: Academic Press.

Rutter, M. and Madge, N. (1976), *Cycles of disadvantage*, London: Heinemann Educational Books.

Rutter, M., Tizard, J. and Whitmore, K. (1970), *Education, health and behaviour*, London: Longman.

Stevenson, J. and Richman, N. (1976), 'The prevalence of language delay in a population of three-year-olds and its association with general retardation', *Developmental Medicine and Child Neurology*, vol. 18, pp. 431–41.

Stevenson, J. and Richman, N. (1978), 'Behaviour, language and development in three-year-old children', *Journals of Autism and Childhood Schizophrenia*, vol. 8, p. 299.

Tonge, W.L., James, D.S. and Hillam, S.M. (1975), *Families without hope: a controlled study of 33 problem families*, British Journal of Psychiatry Publication no. 11.

Wedge, P. and Prosser, N. (1973), *Born to fail?*, London: Arrow Books.

9 The Health Behaviour of Mothers and Daughters

Mildred Blaxter and Elizabeth Paterson

> They just say, don't interfere, Mum, we know what to do! They've got their ways and we've got our ways, they aye seem to know what to do – they take their ain advice.
> And they're usually right.
>
> You seem to follow your ma's footsteps. You seen her daein' it an' you think it's right and you should dae it an' all.

The study described here sought to examine, in an intensive and exploratory way, the connections between 'attitudes' and 'behaviour' in the health care of children, and the similarities or dissimilarities between generations. Despite an elaborate system of child health surveillance and care in Britain, there is a body of evidence to show that successive generations of those in poor socioeconomic circumstances continue to suffer relative deprivation in health. In part, of course, causes may be sought in heredity or the physical environment of poverty, but some of this health deficit is also commonly ascribed to poor health care within families. Neglect can, it is suggested, be the consequence of sub-culturally transmitted beliefs and values.

Explanatory models for this derive largely from the United States where Rainwater (1968), for instance, has been influential in arguing that the 'culture of poverty' results in health-related behaviour characterised by apathy, fatalism and a present-oriented perspective. This model of a self-perpetuating sub-culture has, in recent years, tended to give way to one that emphasises the conditions under which health care is given, stressing the practical barriers to care (e.g. Leacock 1971; Dutton 1978; Rundall and Wheeler 1979). But however it is explained, the fact that those who may most need services tend to use them least is still a matter for concern. This is known to be particularly true of preventive services, but under-use of curative services and delay in seeking medical care have also been demonstrated among poorer social groups, even where the money cost is not a barrier. Very many studies have explored the relationship between varied social, cultural and attitudinal factors thought to be relevant

(e.g. Rosenblatt and Suchman 1964; Zola 1964; Osofsky 1968; Strauss 1969; Rosenstock 1969; Andersen *et al.* 1975).

In Britain, there has been less consideration at a theoretical level, but the under-use of services such as antenatal care, immunisation, or dental care by lower social classes (e.g. McKinlay and McKinlay 1972; Davie *et al.* 1972; Cartwright and O'Brien 1976; Miller *et al.* 1974) or by groups defined as socially 'disadvantaged' (e.g. Wedge and Prosser 1973) is well documented. Various versions of the 'culture of poverty' thesis have also been utilised to explain what is held to be 'over-use' – when some groups of the population (particularly the less educated) are castigated for growing 'dependence' and over-frequent use of primary care for trivial complaints. Certainly, the suggestion that groups of families can be identified whose health-care behaviour is open to criticism, and whose attitudes to health are passed down from one generation to another, is frequently met with among service-providers.

The investigation

The sample chosen for the examination of these issues consisted of fifty-eight three-generation families in a Scottish city, in each of which there was a young mother in her 20s with one or more pre-school or primary-school aged children, and a maternal grandmother in her late 40s or early 50s. These age cohorts were chosen in order to take advantage of data on childbearing and early child care that were available for a group of the older generation at the time when their daughters were born; it was possible to obtain about half the sample of families by tracing the daughters of these women. The remaining families were identified through maternity records, and all fulfilled the following conditions: the young mother had had her last child in the city under study, and the family was at that time in Registrar General Social Classes IV or V; the mother had herself been born in the city and in a Social Class IV or V family; and the maternal grandmother was still alive and resident in the city. These were not defined *a priori* as 'deprived' families, but as a group reasonably homogeneous in education, life-style and access to the same local structure of health services, and which was likely to include both the poor and socially troubled and those who (although still in Social Classes IV or V) were secure and in more adequate economic circumstances.

The data collected on these families were of several different types. First, extended tape-recorded interviews were conducted with each 'mother' and most of the 'grandmothers', exploring health and social history, values, attitudes and beliefs concerning health, and perceptions of past and present structures of health services. Secondly, the

health-associated behaviour and service-use of the young mothers in relation to the 139 children of the families were closely and systematically documented for a period of six months, by means of repeated visiting. Thirdly, various sorts of records were analysed – maternity, health visiting, child health clinic – and all the health visitors in contact with the families were interviewed.

The focus was upon the health of the children. We were seeking, first, to document whether or not their health was indeed relatively poor. If – as seemed likely – poor health was found that was in principle avoidable, we wished to examine the ways in which this was the result of the health care behaviour of young mothers. We then wished to look at the relationship of the young women's behaviour to their attitudes to health and the structure of health services, and lastly, to compare these attitudes with those of the previous generation.

Of these four questions, the focus here is upon the latter two, and the first two will be considered only briefly. In this chapter we are concerned primarily with the similarity or differences in attitudes between the two generations, and the consequences for the way children's health is cared for. We are asking: were attitudes the same, and if so did they appear to be directly transmitted by familial or sub-cultural influences? Alternatively, were they simply responses to similar pressures and circumstances? If they were not the same, to what extent did they seem to be responses to *different* conditions? And in either case, in an environment and structure of services that must to some extent have changed over time, did attitudes lead to similar or different behaviour in the two generations?

The relevant comparison is sometimes between the two generational groups, sometimes between mother–daughter pairs, and sometimes between the 'more' and the 'less' disadvantaged of the young families (as distinguished by economic, housing and social circumstances). Several different forms of analysis were used, including various linguistic and content analyses of the tape-recorded interviews. For the purpose of this chapter, some quotations are included as illustrative examples.

The health of the families

There is no doubt that the advances made in child health in the geographical area and the social group studied during the fifty or so years covered by the lifetimes of the three generations have been outstanding. The grandmothers frequently described earlier years characterised by considerable hardship and poverty, with diseases such as scarlet fever, diphtheria or tuberculosis running through whole families. Thus social deprivation and the experience of ill health for

them had begun in childhood:

> When you had to pay for a doctor? Well – to this day my mother still says that was the reason that I took rheumatic fever. 'Cos I took scarlet fever – and I was ill for a few days, and my mother took me to the dispensary. Now, I had to walk there, 'cos my mother didn't have the tram car fare. With the result – I got my chill – we had to walk to the dispensary because it was free there, we couldn't afford to pull in a doctor. 'Cos my mother would have had the doctor in her house – well, at least twice a week because she had eight of us.

> My father had a duodenal ulcer an' a gastric ulcer. Now, when we was little – she had eight, nine kids, twins twice – she got a shillin' to keep twins aff the National Assistance Board 'cos my father was an invalid wi' his ulcer. Now he bore them 25 years in agony, and I mean agony – an' because he couldnae afford to ging into hospital an' get this operation he had to bear that cross until his kids wis up a bit . . . At that time you got fit [what] you cried [called] Parish . . . Now, if you was ill, you didnae pey for your operations and your doctors – but you didnae get your Parish. So therefore your wife an' your kids did without. So therefore my father had to bide an' chop these sticks to keep his kids fed an' dee withoot his operation. Now, when he did get his operation the cancer had been there that long – wi' that – 25 years in agony – We hinna got that worry nowadays.

Such ill health had certainly continued at least through the early years of marriage and childbearing:

> TB . . . well, I called it neglect. I had pleurisy before my twins were born and I cracked my ribs just before A. was born. And I had pleurisy – and I had naebody in, with six of them – I ken what it was, it was really neglect, my own – well, no my own fault, I had to look after my bairns, you understand.

However, by the middle years they now had reached, most of them were in 'comfortable' circumstances, although they reported high prevalences of illnesses such as chest conditions or gynaecological disorders.

The daughters of these women, our mother generation, were accordingly frequently brought up in poverty and in large and troubled families. Though their histories were free of some of the epidemic killers of the previous generation, they nevertheless showed a high prevalence of slight congenital handicaps and – in a group so young – of chronic conditions.

For the children of the third generation, there are few equivalent data documenting *all* health events over an extended period, whether or not they gain medical attention, to provide a comparison by which

the 'normality' of their health can be judged. Nevertheless, certain disadvantages were obvious. These included, first, poor chances at birth. Of the 139 children, 26 per cent had suffered from conditions such as low birth-weight, prematurity, asphyxia, or neonatal jaundice, which had necessitated their being cared for in the Special Nursery of the maternity hospital. The rate of admission to the Special Nursery of *all* babies born in the city (1970) was 14 per cent. A not unrelated fact was that rather high proportions of the sample children were born to mothers 18 years old and younger (16 per cent) and/or were illegitimate (14 per cent). Comparable rates for all children born in the city (1970) were exactly half – 8 per cent and 7 per cent respectively. The children had also suffered high rates of conditions such as measles, pneumonia, gastroenteritis, bronchitis, and 'failure to thrive' in infancy (39 per cent had experienced these or other diseases defined as 'significant' before the age of 2). Of all the children, 24 per cent had been on an 'at risk' register, for medical or social reasons, at some time, and 45 per cent of the families had had one or more children registered in this way.

This early history was associated with high prevalences of chronic conditions, especially ear infections and hearing problems, squint and other eye disorders, chronic chest complaints, epilepsy, speech and behaviour disorders and enuresis. These chronic conditions were not always actively treated or well managed.

The other major cause of health 'deficit' in the children appeared to be the incidence of accidental injury. Here, their record was certainly worse than any reported before (e.g. Davie *et al.* 1972). As many as 80 per cent of boys aged 3 and over at the time of the survey, and *all* of those aged at least 7 years, had received hospital treatment for injuries. For girls the equivalent proportions were 73 per cent and 81 per cent.

The dental health of the majority of the children was undoubtedly poor, and there were some other aspects of preventive health care – for instance, completion of immunisation programmes – that had been neglected in a proportion of the families.

These were, in summary, the aspects of the children's health that might give cause for concern. We would not wish to exaggerate the amount of ill health that was found, however: the children had without doubt experienced, in environmental terms, a better start to their lives than their mothers or grandmothers, and the majority did not appear to suffer from more episodes of acute illness than the national average. Their day-to-day health supervision was certainly not generally neglectful, and almost all the young mothers were very ready to seek medical advice.

Attitudes to 'health and 'illness'

One important theme of the considerable (though rarely empirically based) literature on the concept of 'health' is that the term may be understood in two ways: as a more or less static state of being, where to be healthy is to be in good structural and anatomical condition; or as a description of function, where to be healthy is to be able to carry out one's normal roles (e.g. Erde 1979). Thus one may be 'unhealthy' in the first sense – crippled, diabetic or obese – and at the same time 'healthy' in the second, that is, not ill, and able to carry on in a normal way. In both senses, of course, health is relative to personal or social norms.

It was a notable characteristic of both mother generations in this study that health was defined in terms of function. For both, health meant being able to, or being determined to, decline the role of sickness: the ability to 'carry on', especially with one's work, despite the experience of illness. One grandmother, talking of her husband, said: 'He got a part o' his lung taken oot. But he wis aye healthy enough. There wis niver nothin' the matter wi' him.' Another, whose illness had resulted in major bowel surgery, explained: 'I knew I was really ill because I kept takin' half days off my work. Well, I never did that in my life unless there was somethin' really wrong. But I said, well, I must go to the doctor, if I don't go to the doctor I might lose my job'. Their daughters talked in similar ways of themselves, and even of their children: for instance one, whose son suffered severely from convulsions, said: 'He's definitely healthy. He's not prone to take things'.

There was little evidence of a definition of health in positive terms, as a sense of well-being or a state of physical fitness, in either generation. Health was, of course – as it is for most people – a 'good' quality to lay claim to, and few would wish to describe themselves or their families as unhealthy. However, health as a moral category was more than this. Ill health was a state of spiritual rather than physical malaise, and illness (particularly, of course, in other people) was a product of imagination or a lack of moral fibre. This sturdy moral view was perhaps expressed most consistently by the older generation: 'Some men has pampered their wives, and then they've a headache, and they run for the doctor – nothing wrang wi' them actually. If they rose an' did some work they'd be a' right.' Another respondent said: 'I think if you brood too much on your bitties and piecies, I think you would be ill, you would. Self-analysis every morning – tell yourself, get a move on! Dinna sit an' hang aboot.'

The older generation sometimes explicitly associated stoical attitudes with the difficult circumstances of their earlier lives: 'My mother was aye healthy. I canna mind ever seein' her in bed. We hid such a big

family, you didnae hae nae choice'. And: 'Because I was a widow for six years, I hadn't time to mollycoddle them and run to the hospital or doctors – I was out working, I had my house, I had them'.

However, their daughters often expressed similar views: 'I hate being ill – I canna stand illness. Wi' the result that, if I'm nae well, I think – ugh, don't be stupid, I'm nae really ill'. Another said: 'I think it's put on by a lot. More people like to think they are ill. They moan about it. A lot of it is psychological. They just like a lot of sympathy'.

If, in face of these attitudes, the experience of ill health is inescapable – and for the older generation, in particular, it was – then the obvious refuge is in fatalism and apathy. Thus, for a proportion of the women, 'bad luck' and inevitability were the concepts they had to fall back on, as an alternative to judging others harshly or accepting blame themselves: 'If an illness is there, it's there, ken? And you can either see about it or forget about it. It's up to yourself what you dae'.

A close analysis was made of the ideas of each generation about the cause of both disease in general, and specific diseases. These notions were found to fit very logically with the attitudes to 'health' that have been described. Certain categories of cause were the 'preferred' ones for both older and younger women: infection, agents in the environment, and stress, worry or neglect. The emphasis on these seemed to be a very natural consequence of experience. Heredity and family susceptibility were given, especially by the older generation, much more weight than medical science might give them, which is again a logical conclusion when diseases were known to have run through several generations. In general, thinking about the cause of illness was complex and carefully worked out, and it was a topic of endless interest; 'knowledge' tended to confirm, however, a view of disease as inevitable and beyond personal control, though 'illness' – the reaction to disease – could be overcome by strength of character.

The views of both generations, but particularly the elder, of 'normal' health as a state, a characteristic of the individual, were accompanied by low expectations of what it meant to be healthy. One way of reconciling the facts of illness with a presentation as 'normally healthy' was to define certain conditions as not 'illnesses' at all, especially those associated with normal life stages: childbearing, the menopause, or wear and tear over the years. It seemed that accelerated life patterns, with early childbearing and young grandmotherhood, and for many early widowhood, had resulted in an acceptance of ageing and deterioration as compatible with normal health: one grandmother aged 47, who had suffered from a painful and swollen leg since a fracture five years previously, said that she was 'nae really bothered now' because 'I'm getting on in years', and another of the same age explain-

ed her neglect of symptoms: 'Cos as you get older, you just sorta say that's that, just age problems, and I just thought, well, it would be that, and so just let it slide by'.

Their daughters similarly talked as though they were older than their years; for instance, one young woman of 24 said, talking of breast-feeding: 'At first you think about your figure. But it doesn't matter so much with your third if your breasts stretch a little, by that time your figure is pretty far gone anyway'.

These low expectations do not mean that the women of either generation necessarily and always applied strict criteria to the definition of what was to count as a symptom of 'illness'. For children, as for adults, some symptoms were normalised – often those that did not cause disturbance of function, and that were seen as general characteristics rather than symptoms of acute illness. Chronic ear infections were persistently ignored, as were continuous respiratory infections. A 6-month-old baby's cough caused no concern, despite a history of pneumonia, because the young mother 'knew' that it was only the result of teething. At the extreme, and among some mothers, these attitudes might be expressed as a generalised fatalistic sense that illness was inevitable, with a reluctance to seek professional help: 'It's just his normal cough. It's quite usual for him to have a cough'.

For the most part, however, the young mothers – and grandmothers – were quick to identify symptoms in the children. Despite their normalisation of respiratory infections, they had particular fears of anything 'going to the chest' and were much more conscious of the possibility of tuberculosis than a more fortunate social group would be likely to be. They were also very quick to worry about rashes, high fevers, and infectious disease. The medical history of the child or of the family, as perceived by the mother, was important for the recognition of illness. Just as a child's stomach symptoms could be ignored if 'she just has a weak stomach like her father', so symptoms that had proved to be important in the past, or were suggestive of conditions that had handicapped members of older generations, were taken very seriously.

The mothers' perceptions of symptoms in the specific illness episodes that happened during the six-month survey period were, of course, very complex. Many factors not discussed here were relevant, including practical contingencies and domestic circumstances, and the women's experiences in interaction with their doctors. However, it did seem that health attitudes and beliefs which were shared with the older generation also had some relevance, both for the 'neglect' of some symptoms and the over-emphasis of others.

Attitudes to doctors and medical services

The attitudes of the two generations to 'health' as a concept have been shown to have many similarities. Attitudes to doctors and to service-use for the cure of illnesses tended, however, to differ.

The grandmothers often talked at great length about the marvellous advances of modern medicine, comparing the present day with the past that they had known. They rarely applied these advances to their own cases, however, and many had obviously neglected the chronic conditions which they had suffered for many years. Nevertheless, the attitudes to doctors that the majority expressed were trusting rather than sceptical, deferential rather than demanding, and grateful rather than critical. They stressed what 'good' patients they were, and how it was 'other people' who abused the doctors' services 'Cos they ken they dinna have to pay for it'. We have, of course, no independent data on the actual service-use of the older generation at the present time, but certainly the grandmothers presented themselves as reluctant users, apologetic and conscious of the value of the doctor's time. To expect services unless one was seriously ill was morally wrong: 'I dinna think it's right you should bother the doctor if there's nae much a'dee wi' you – some does, for the least little sniff in the nose'.

The majority of grandmothers talked of their doctors in a very proprietorial way, and were proud to tell stories of the 'great man' – usually a well-known family doctor or an important consultant – whom they had known. One displayed amazed gratitude because, long ago, 'The Professor' gave her son five shillings at each clinic attendance: 'That a man o' his profession should *think*, even, of givin' A such a thing!' Another was enthusiastic about the way that: '*Even* the doctors and that, or the surgeons, will sit and talk to you – that Professor M, the way he jist sat an' chatted to you about things to try and find out what was bothering me'.

One of the most remarkable examples was the long story of a young child's death, ending:

> But Dr B, he couldn't have been better – he came up, we didn't have very much at the time, you know, the wages were little and we had the two kids, I wasn't working – and he came up the next morning, you know, after J had died, and said that he was very sorry and he shook hands with my husband and he shook hands with me, and you know – I felt something in my hand, and he just said goodbye and he went away and when I looked he had given me £2. And he just – went away. He was really excellent.

Many of the stories from the past were similarly appreciative, although there were also tales of neglect and inability to get the

services needed. The women's expectations of their doctors had been low, and their trust in professional expertise very passive: 'If he says [the child] is all right, he's all right. It doesn't matter if he's the same after the doctor's gone away, as long as the doctor's been and said it's all right'.

Nowadays, these women felt, medicine might have advanced but the service had deteriorated. Some were fortunate enough to have a 'real family doctor' still, but more felt that the service had changed:

> They just don't seem to have the time they used to have years and years ago . . . but I think it's not the doctor's fault, they're pressured.

> The family doctor has lost contact with the patients. The family doctor days are finished, of course – we're livin' in a different time.

> Chopping and changing from doctor to doctor – just meeting a stranger.

Their reaction was resignation rather than protest, however, and for a proportion of the women, apathy and pessimism: 'I dinna bother askin' him now – just get my pain-killers and that's me happy. I just say, well, if they canna dee nothin' aboot it they canna dee nothin' aboot it – I dinna like to fight with them'.

The attitudes of the younger generation to doctors and the use of services were more varied. A few women – especially those who had retained the same doctor since childhood – were like their mothers in valuing a 'family doctor' relationship. For more, however, the concept no longer seemed appropriate. In several families husband and wife were registered with different general practitioners and yet another doctor who was known to be 'good with children' was used for the children. The majority of the young women said that they did not care greatly about which doctor they saw in a practice (as long as it was not particular individuals whom they disliked), or that they might choose to see different doctors for different purposes. They were frequent users of the accident and emergency department of the children's hospital, and very much appreciated the quick and efficient service they felt that they received there. Many of them saw doctors as interchangeable, and some rejected the 'family doctor' model very explicitly: 'Oh, I wouldn't like that. You don't want someone knowing all about you. I just want a doctor for whatever I want him for – I just want him to say what it is and give you the stuff or whatever'.

Many were much more belligerent and demanding than their mothers had been, and a proportion were apt to relate conversations with doctors and other service-providers in which they presented

themselves (though this may or may not have been actually true) as aggressive in making their wishes clear.

This did not mean, however, that their service-use was necessarily more effective than their mothers' had been; indeed, the older generation's lower expectations and grateful attitudes may have been more in harmony with the service they had experienced. Most of the young women made frequent demands on their general practitioners. Many of them appeared to be receiving excellent service, but some had complaints about problems in getting quick appointments at surgeries, about surgeries being difficult to reach or having inconvenient hours, or about doctors being reluctant to make house-calls. In part, these service problems were inevitable for young mothers such as these, who often worked part time, and who were frequently without access to telephones or cars. In part, they were owing to some maldistribution of medical practices, with few located in the housing estates. For anything other than the routine treatment of more minor illnesses, however, the major problem of the young mothers was the complexity of the system they had to deal with. This might, for chronic or developmental problems or permanent handicaps, involve doctors at child health clinics in addition to their 'own' doctor, school health services, health visitors, specialists at the children's hospital and clinics of many different sorts. For many mothers, the functions of each were not entirely clear: 'If you go to your own doctor he tells you to go to the clinic, they tell you to go to your own doctor – it's a vicious circle'; and if they thought they were receiving conflicting or insufficient information, or if they did not understand the organisational processes or professional etiquette that dictated modes of referral, they became bewildered and angry.

The results of what appeared to these mothers to be a fragmented service were unfortunate in perhaps two ways. One was that anger might lead to conflict and eventually to an avoidance of contact with health services: appointments were missed and conditions neglected because 'they won't tell you anything', 'they just push you around'. And secondly, there were cases where it seemed that a multiplicity of services, involving very many people, might have been one reason why some chronic conditions and minor handicaps, once identified, were never followed up or adequately treated.

Attitudes to preventive services

In the young families, the attitudes to curative medicine that have been described did not differ systematically between the 'more' and the 'less' socially disadvantaged. On some indicators of preventive health, by contrast, there was a clear difference between the two groups.

In considering attitudes to, and use of, preventive health care, it has

to be recognised that for this social group there is really very little that is available which could be called a preventive service – for children, immunisation, developmental checks and assessments to some extent, and perhaps preventive dental care; for younger women, antenatal care; for older women, cervical smear tests. Dental care is a special case, but all the other services were on the whole enthusiastically used, and few women of either generation were actively opposed to any of them. In the different and more difficult circumstances of the past, some of the grandmothers had neglected antenatal care, immunisation and clinic attendance; now, however, they and their daughters agreed that all preventive services were excellent things. Any under-use of preventive services in the young families was the result of slip-ups in supervision by health visitors, and occasionally some inefficiency on the mother's part, but only rarely of any 'apathy' or lack of 'future orientation'. Most women did their best to take advantage of all the preventive services offered.

The special case of dental care must be noted separately. Here, other considerations were operating and there is no doubt that long-standing and well-documented sub-cultural attitudes were being demonstrated. For the most part, both generations placed a low value on the retention of their teeth, and many were antagonistic to preservative treatment; about a fifth of the young women had few or no natural teeth. These attitudes have, of course, often been noted before (e.g. Davie *et al.* 1972; Todd 1975).

The poor dental health of the children was obvious, and many mothers saw dental decay not only as unimportant, but as unrelated to 'health'. About 30 per cent of all the children aged 3 and over had never been to a dentist except in an emergency, and only a handful of mothers had considered any positive action against tooth decay. In one family children of 2 and 3 years were recorded, during the six months, as being in repeated and acute pain for several weeks, and treated only by aspirin. It was notable that the most obvious cases of neglect such as this occurred only in the 'more disadvantaged' group of families.

Poor dental health may also have been associated with diet, and in particular with constant sweet-eating. However, neither this nor the mothers' attitudes was wholly responsible for the situation. At least in part it was caused by a dental service that appeared to be inadequate and which was certainly difficult for the mothers to use. The older children received dental examinations at school, but many mothers had a strong prejudice against the school dental service, and in any case found it inconvenient. Notes were regularly brought home, but rarely acted upon. Because the mothers had no dentist of their 'own', they found it almost impossible to persuade a dentist to accept their child-

ren when they required treatment: eventually, when emergency treatment was achieved, it was likely to be drastic and the mothers tended to be blamed. Thus both child and mother would be reinforced in a determination to avoid dentists, and a true cycle of deprivation would continue.

Preventive health behaviour

Aspects of health-care behaviour considered and talked about included smoking, exercise, being overweight, nutrition and, in relation to children, infant feeding or safety supervision and perhaps family planning. All these were of great interest to both generations, but in order for them to be conceived of as preventive health behaviour, their connection with a concept of 'health' has to be clear. For the older generation, in particular, this connection was never made, or was denied, or events were felt in any case to be outside the individual's control.

For instance, most of the grandmothers smoked and many were overweight. These were topics causing some conflict with their doctors:

> When I went up to the hospital – I niver seem to get ony satisfaction – a' they seem to be interested in is 'you're overweight'. When we wis a' younger, there was hundreds of folk overweight – they niver went on an' on aboot it! Maybe overweight does cause you one or two things, I dinna ken, but I think they mak' an awfu' issue of it . . . instead o' keeping saying 'O you're overweight, you're overweight' – if they really found out, ken, fit your complaint *wis* when you ging up.

Their daughters, sometimes also obese, took an even more aggressive view: if being overweight was (as doctors suggested) a medical problem, then medical means should be available for dealing with it. Some were, indeed, being treated, but others who asked in vain that their doctors should supply slimming drugs became very angry.

Similarly, despite their high rates of bronchial disease, the older women paid very perfunctory lip-service to the idea that smoking harmed their health, or denied it altogether:

> I was put down for chest X-rays. And they told me to stop. But I didn't see the force of it. If after all this time – I've smoked since I was 14 – so if there's anything going to happen to me, it'll happen. I won't go a day before my time's up. [This woman described herself as having 'chronic bronchial asthma', which she blamed on 'the mill fever', e.g. conditions under which she had worked.]

This generation, as has been noted, was very ready to accept 'mind over matter' explanations of illness; preventive behaviour consisted of ignoring the possibility, not of taking any particular action: 'I just think if you dee a normal day's work an' just eat an' be relaxed, try an' be happy within yoursel', nae ging aboot moanin' an' groanin' – I think it's up to yoursel', your outlook on life.'

When asked about the health care of children, most talked rather generally of 'good food' (defined as plain meals, 'nae all this snackery'), fresh air, keeping warm and dry. Few talked of specific prophylactic measures, except some elaborate disinfecting and fumigating rituals that had been thought necessary in the past, and most, in connection with children, left the subject of health care very quickly and went on to talk of general upbringing – keeping them happy but disciplined, not 'spoiling' them. And most portrayed any deliberate actions to promote their own health as 'cranky': 'You'll find a' this health food fanatics an' keep fit fanatics nae ony healthier than a person that just does their normal – their normal work, normal meals.' Another said: 'I remember bein' in the Maternity an' watchin' them a' deein' exercises – and they says "Come on now, Mrs B". I says "Away an' dinna annoy me, I niver did exercises in my life!".'

As might be expected, some of the younger generation were, for themselves, more conscious of physical fitness, though few took active steps to promote it; some said things like 'People who play sport and games would be fitter, but we don't,' as if such activities were not for 'people like us'. In general they expressed very similar ideas about not 'lying down to illness': 'A happy personality helps – I never go to bed when I have my periods. You shouldn't feel sorry for yourself. Some of them are hypochondriacs. You need something to occupy your mind.' And concerning any active steps to promote health: 'Well, there's one thing I dinna believe in – this efter you hae a baby in hospital, them makin' you dee a' this stupid exercises. I never did mine. I used to aye go through an' hae a smoke or somethin'.'

They worried a great deal about infection for their children, and about safety. The latter was a topic greatly stressed by health visitors who, typically, criticised unguarded fires; drugs left in accessible places; untrained dogs; and small children up and playing while their parents were still in bed, or left briefly alone in the house. Not many of the accidents that were recorded during the six months' survey occurred within the home, however. Nor was any association found between the incidence of accidents, during the previous six months or in the child's history, and the mother's general attitude to safety. Accidents were not more frequent in one-parent families, nor in those that were most disturbed, those where the mother was working, or

those in the poorest circumstances. Within our sample of families in Social Classes IV and V, the high frequency of accidents already noted was associated clearly with only one social variable: that was a particular type of housing – tenement blocks with stone stairways, unfenced grounds, and nowhere for the children to play in safety. In these blocks and estates the mothers of small children were *all* presented with very difficult problems, and in this area of 'preventive' health the environment appeared to be more salient than the mothers' behaviour.

Family size and family planning

Family size is one characteristic that clearly differentiates the two generations: the average family of the grandmothers was four children, and several had six and more, while almost all the young families consisted of either two or three children (though a few may not yet be complete). In the childbearing years of the older generation, oral contraception was not available and sterilisation and abortion, though probably more commonly performed at that time on grounds of multiparity and general health risk in this part of the country than in most others, were much less freely available. So in comparing the two generations, very different situations are being contrasted.

A proportion of the grandmothers described childbearing histories for which the 'fatalism' and/or practical 'planning problems' often attributed to them seemed appropriate: 'It just happened. We wis actually jist going to have one, an' then we hid another eight!'

The young women were, however, different. For them, lack of control over their fertility was conspicuous only in their teenage years, resulting in the high rates of very youthful or illegitimate births already noted. By the time of survey, the majority presented themselves as entirely in control of their own fertility: 'Two was quite sufficient – a boy and a girl. We can't really afford more with only one wage coming in. I had it all planned. I didnae want any mair.' In almost half of the young families one partner had been sterilised, with an average age for female sterilisation of 24.

When mother–daughter pairs were compared, there was perhaps only one where 'apathetic' or 'fatalistic' attitudes appeared to be shared. Much more common were grandmothers who described unplanned families, and daughters who had no intention of following their example:

> *Grandmother:* It wis jist accidents. We didn't have the contraceptions you have nowadays [three children, with an abortion and sterilisation on medical grounds at the fourth conception].

Her daughter: I'm going to try for another baby when S is two. I think it's soon enough. You don't have time to give them the proper attention otherwise. My mother said she had hers too quickly.

Nevertheless, when family sizes were compared in the two generations, there did appear to be some association between larger than average (for the group) families in the two generations.

Table 9.1 Family size in mother–daughter pairs (50 families on whom there is complete information for the grandmother)

	No. of children born to grandmother	
	1, 2 or 3	*4 or more*
No. of children born to mother (to date)		
1 or 2	18 families	7 families
3 or more	8 families	17 families

There is, however, no evidence that this was the result of any continuity of apathetic attitudes, still less to any influence exerted by the older generation. To a limited extent, it *was* probably the result of teenage pregnancies in some of the higher-parity women of the younger generation, who thus might have been repeating the unplanned childbearing patterns of their mothers. Several of the young families with three or four children were deliberate and planned, however. The limited data of this small sample cannot be more than suggestive, but it seems possible that a positive wish to have more children than average may be associated with having been a member of a large family. The definition of a 'large' family is, however, very different in the successive generations.

Mother–daughter patterns: direct intergenerational influence

So far (except for a brief discussion of family sizes) we have described the attitudes and behaviour of the two generations as groups. The mother–daughter pairs were, of course, also examined, by comparing the attitudes and beliefs expressed by each in the extended tape-recorded interviews, and by noting during the six months' recording of health events whether or not the grandmothers were in fact active or influential in the children's care.

There is a conventional common-sense wisdom of 'like mother, like daughter' to which some of our grandmothers subscribed: [Talking of lay remedies], . . . just what *my* mother used. Just sort of passes on.

And my lot'll pass on what I tell them. Same wi' bringing up their children, they'll just sorta do the things *I* did wi' them, you see'.

Most of these statements sounded more conventional than real, however: in part, they seemed to be another aspect of the appeal to continuity, stability and meaningfulness which had been displayed in the liking for 'heredity' as an explanation for disease. There was little evidence that either generation really believed them.

Service-providers expressed the same views, and appeared to believe them: the health visitors who were interviewed, for instance, certainly described the grandmothers as the most salient source of lay advice and influence in these particular families. They believed that many child-care practices and lay remedies were passed on through the generations: 'Grandmothers are one of our biggest problems. Mums are very receptive to old tips like butter on the nose rather than nasal sprays from the health visitor, because *their* mothers used that!'

In infant feeding – especially the early feeding of solids, which was one of the practices the health visitors felt most strongly about and found it most difficult to combat – they felt that the grandmothers were especially influential: 'She does the same as granny did!' On this particular subject, there was some evidence of a partial truth. For the most part, however, the influence of the older generation did not appear to be nearly as strong as the health visitors supposed.

Family patterns were examined in various ways. Most directly, each grandmother was asked whether she gave advice to her daughter, what that advice consisted of, and how it was received. Daughters were asked the equivalent questions.

It might have been expected that the accounts of a mother and her daughter would frequently disagree, even though each knew that the other was being interviewed. In fact, when the individual pairs of interviews were compared, there was a remarkable consistency of response, as shown in Table 9.2.

In only two families were completely contradictory accounts given. Most often both mother and daughter agreed that the daughter went her own way entirely, although a smaller group agreed that the older generation's influence was important. In the remaining pairs, one or both was equivocal; and it seemed advice was given or accepted to some extent:

Grandmother: Yes, they ask, but I think they still please themselves!
Her Daughter: Oh aye, I listen! I don't say I agree wi' it all, but I listen!

Most of the older generation said that they had been greatly influenced by their own mothers, but things were different now. They

Table 9.2 Grandmothers' and mothers' accounts of advice-giving

	Grandmother's response			
Mother's response	*Yes, gives advice and it is welcomed*	*Equivocal*	*No, never interferes*	*Total*
Yes, grandmother gives advice and it is welcomed	13	3	1	17
Equivocal	2	3	2	7
No, never receives or accepts advice	1	1	20	22
Total	16	7	23	46

could not interfere in the same way that their mothers had done:

> I mean, you'll say, Oh dinna think that I'm interfering, but if I wis *you*, sorta thing. But *my* mother would just have said it. She'd come straight out. But J uses her own – she'll phone, and yet at the same time she knows what she's going to do herself.

Indeed, some said that they were reacting against their own experiences: 'My mother – we lived with her, you see, when the first three were born. And she was inclined to try and take over a bit, you know, do this and do that. So I always said I would never interfere'. Some, of course, were rueful that their daughters scorned their remedies: 'They turn and say, that's old-fashioned now, so I say nothing! M has an awful habit of telling me I'm old-fashioned. But I says old-fashioned ways is the best'. Many emphasised their daughters' independence; indeed, several gave the impression of being surprised at their confidence and capability, in contrast to the dependence and ignorance that they thought they remembered at similar ages: 'I think she's mature for her age, she's been through a lot. I think I rely on her as much as she relies on me. I think she's more capable, actually, than I was'.

The young mothers' accounts matched very closely. They were apt to say, yes, you learned from your mother, and many agreed that they had relied on the older generation when their first child was born – when, of course, they were very likely to be living in the grandmother's household. Others said that they had never listened to their mothers: 'When A was little it would be, don't do this, and do that, but I just said, "Look here, who's bringing up this kid!" And she soon stopped. We have different opinions on bringing up kids'. Or they substantiated what the older women had said about trying not to interfere: 'My

mother had seven kids – she's bound to know something about it . . . but she's never been interfering, or say, dae this and dae that, she'll maybe say, do you think you should?'

Behaviour noted during the six months' survey was perfectly in accordance with these accounts. Though the grandmothers often in fact had the care of the children (as babysitter during the evening, or during the day when the mother was working or out shopping), they went to considerable lengths to avoid 'interference' in their upbringing. It was notable that they always thought it necessary to ask the mother's *permission* before calling a doctor to a sick child, or trying any but the simplest of remedies. Sometimes this involved bringing the mother home from work, or delaying consultation for an obviously sick child, or getting a seriously ill child transported home so that a doctor could be called.

Although members of the older generation presented themselves as infrequent users of doctors' services, their advice, as far as children were concerned, was usually confined to recommending that the doctor should be consulted. Sometimes, for trivial conditions, lay remedies might be suggested, but these were usually scorned and the lists of home remedies recounted by each generation were very different – a long list of sometimes exotic remedies from the grandmothers, and a shorter list confined largely to proprietory medicines from the young mothers. Sometimes the young women appealed to their mothers' greater knowledge for the diagnosis of ailments: 'I usually phone Mum up and say, what's this? She's been through most of the illnesses, after all'. They were also observed, during the survey months, to be very likely to telephone their mothers or go to see them if they were worried about a child. This seemed to be simply in order to talk, however, rather than for the seeking of actual advice. And if they *were* given advice, it would usually be to call a doctor:

> *Grandmother:* I worry maybe more about the grandchildren. I mean, I wis aye worried about my own, but you've time to *see* their things and what's going on, whereas wi' your own you're too busy.
> *Her daughter:* If I don't know what to do I just phone my mother. Mind you, she's a bittie over-protective, the least little thing, she says, you'd better go to the doctor. [The same mother, later describing a specific incident]: I phoned my mother and she said, you'd better get the doctor, just to be on the safe side.

Similar findings emerged for other aspects of child care. Sometimes it was claimed that daughters were copying mothers: one grandmother asserted that 'a dirty needle' had been used when *her* mother had had

some of her children vaccinated, and as a result she had not been vaccinated herself and consequently neither she nor her daughter had been in favour of immunisation. 'You see?', she said, 'It's going in – runs in the family'. Similarly, one or two mothers explained that they 'got the idea' to breast-feed from their mothers, or that they decided against it because 'nobody in my family did'. The early supplementation of infant feeding with solids was certainly one area where grandmothers claimed to give advice:

> E was ten weeks old and sometimes she'd cry before her feed's due and I'll say, why don't you give her a rich tea biscuit rolled with some hot milk and a half teaspoon of sugar? She's ten week, I feel maybe now she wants something more solid.

On the other hand, daughters were just as likely to react against their own mother's practices. With regard to immunisation, one said: 'It wis jist my mother was too auld-fashioned to think o' havin' needles at a' – I tried to prove it to her, which I did, through the bairns'. Even the few who thought dental care was important might be reacting against their own upbringing: 'I think that's why I started taking M. My mother was feart o' the dentist, and I think she passed that fear on to us. So I thought "I'm nae gaun tae dee that til mine". So I taen him from about 3.'

For the most part, however, daughters went their own way and made their own decisions, as the grandmothers had said. Far fewer of the younger generation breast-fed their infants, for instance, not because of any influence from their mothers, but because they found it inconvenient and distasteful (a very common attitude) and were not, they said, subjected to the pressure from doctors and nurses that had been their mothers' common experience. According to the grandmothers, ideas about children's diet had changed – as they thought, for the worse – but the types of food available were of course very different, and with many mothers working, or husbands away or working on shifts, the concept of a regular 'proper' family meal was not always appropriate. More young mothers used clinics regularly, but then the organisation of clinics was different. Times had changed, and the older generation's experience was not necessarily felt to be relevant.

Conclusions

In summary, it has been shown that health deprivation has, to some extent and in specific ways, been perpetuated through generations in this small sample of families. To a limited degree the health behaviour of the mothers *is* implicated. But any simple theories of the relation-

ship between attitudes and behaviour, or of 'transmission' through families, are inadequate as explanation.

True 'transmission' is seen at its clearest in health conditions around the time of birth, when a health deficit in the mother, combined with poor socioeconomic circumstances at the time of childbearing and a pattern of early and often unplanned births, combine to offer the children a poor start. In other areas of health (such as accidents) it is the environment of poverty that was clearly indicted, rather than the mother's behaviour: any similarity was a result of continuity in a disadvantaged environment. In yet other areas (immunisation, dental care) behaviour was clearly implicated to some extent, and was related to attitudes, but the clearest influence was the structure of available services.

There was some evidence of the perpetuation of familial or subcultural ideas about health (from the fear of 'chest' complaints to the stoic belief in 'not lying down' to illness), though also many changes. The attitudes of the two generations to curative service-use were conspicuously different. For the grandmothers, low expectations of present-day services were reported to be, and appeared to be, associated with low service-use and a degree of fatalism. On the other hand, the younger generation – though their standards of 'normal health' continued to be low – had high expectations of curative medicine and were usually high service-users. Where the environment had changed least – that is, where the young families remained in the poorest circumstances – one set of attitudes and behaviour had also changed least: an apathy towards preventive behaviour, and a lack of any positive concept of health maintenance.

Thus attitudes were related to behaviour sometimes in the same way in the two generations, and sometimes differently. There was little evidence of *direct* mother–daughter transmission of ideas, and almost none of direct influence on behaviour. It is clear that a version of the 'culture of poverty' model of health behaviour fits the older generation quite well, but the younger generation to only a very limited extent.

We would offer two general conclusions. The first is that the individual/structural debate about the persistence of disadvantage is, in this area of life at least, not helpful in any practical way. However over-burdened or inefficient the individual parent, the health of the children is society's responsibility: it should not be *possible*, whatever the circumstances, for children to remain unimmunised (without conscientious objections) or to suffer the unnecessary worsening of chronic conditions.

Secondly, we would draw attention to the practical, as well as the theoretical or academic, dangers of applying out-of-date concepts of

social processes to changing societies. Service initiatives based on the 'culture of poverty' model, appropriate though they may have been for a previous generation, are not in harmony with the attitudes of the young mothers of this sample: of course, individuals differ, but in general they could not be described as characterised by low self-esteem and feelings of powerlessness.

The paternalistic model of 'good' medical care may also be out of date for this generation and this social group. There was in fact considerable congruence between the 'family doctor' model and the service that the grandmothers liked to think they remembered: their ideal fitted very well to the professional ideal. The younger generation, however, often rejected this model: they had adopted new attitudes to meet a changing structure of health services. The services they now had to deal with were, however, very complex, so that in some ways the young mothers were even more at a disadvantage than their mothers had been. They still lacked the skills, the education, or the 'enabling factors' of time, mobility, and a predictable social environment, that would have made dealing with the system easy. High expectations and assertive behaviour could readily lead to conflict. Changed attitudes had led to different behaviour, but the result – troubled service-use and some neglect of health – was often the same.

References

Andersen, R., Kravits, J. and Anderson O.W. (eds) (1975), *Equity in health services: empirical analyses in social policy*, Cambridge, Mass.: Ballinger.

Cartwright, A. and O'Brien, M. (1976), 'Social class variations in health care and the nature of general practitioner consultations', in Stacey, M. (ed), *The sociology of the NHS*, Sociological Review Monograph no. 22, Keele University.

Davie, R., Butler N. and Goldstein, H. (1972), *From birth to seven: the second report of the National Child Development Study (1958 cohort)*, London: Longman.

Dutton, D. (1978), 'Explaining the low use of health services by the poor: costs, attitudes or delivery systems?', *American Sociological Review*, vol. 43, pp. 348–68.

Erde, E.L. (1979), 'Philosophical considerations regarding defining "health", "disease", etc., and their bearing on medical practice', *Ethics in Science and Medicine*, vol. 6, pp. 31–48.

Leacock, E.G. (1971), *The culture of poverty: a critique*, New York: Simon & Schuster.

McKinlay, J.B. and McKinlay, S.M. (1972), 'Some social characteristics of lower working class utilisers and underutilisers of maternity care services', *Journal of Health and Social Behaviour*, vol. 13, pp. 369–82.

Miller, F.J.W., Court, S.D.M., Knox, E.G. and Brandon, S. (1974), *The school*

years in Newcastle upon Tyne, London: Oxford University Press for the Nuffield Foundation.

Osofsky, H.J. (1968), 'The walls are within: an exploration of barriers between middle-class physicians and poor patients', in Deutscher, I. and Thompson, E.J. (eds), *Among the people: encounters with the poor*, New York: Basic Books.

Rainwater, L. (1968), 'The lower class: health, illness and medical institutions', in Deutscher, I. and Thompson, E.J. (eds), *Among the people: encounters with the poor*, New York: Basic Books.

Rosenblatt, D. and Suchman, E.A. (1964), 'Blue-collar attitudes and orientation towards health and illness', in Shostak, A. and Gomberg, W. (eds), *Blue collar world*, Englewood Cliffs, N.J.: Prentice-Hall.

Rosenstock, I.M. (1969), 'Prevention of illness and maintenance of health', in Kosa, J., Antonovsky, A. and Zola, I.K. (eds), *Poverty and health: a sociological analysis*, Cambridge, Mass.: Harvard University Press.

Rundall, T.G. and Wheeler, J.R.C. (1979), 'The effect of income on the use of preventive care: an evaluation of alternative explanations', *Journal of Health and Social Behaviour*, vol. 20, pp. 397–406.

Strauss, A.L. (1969), 'Medical organisation, medical care and lower income groups', *Social Science and Medicine*, vol. 3, pp. 143–77.

Todd, J.E. (1975), *Children's dental health in England and Wales, 1973*, London: HMSO.

Wedge, P. and Prosser, H. (1973), *Born to fail?* London: Arrow Books and the National Children's Bureau.

Zola, I.K. (1964), 'Illness behaviour of the working class', in Shostak, A. and Gomberg, W. (eds), *Blue collar world*, Englewood Cliffs, N.J.: Prentice-Hall.

10 Identifying Families at Risk
Nicola Madge

Tolstoy is well known for remarking that all unhappy families are very different, and his wisdom on this point – even if he did, more controversially, suggest that all happy families are much the same – is not in doubt. There are many faces of deprivation and disadvantage, and the variation in individual characteristics, attitudes and life-styles shown by families in difficulty means that they are not always easy to identify.

Predicting families least likely to provide 'good enough parenting' (CCETSW 1978) for their children is further complicated by the less than straightforward association between experiences and their effects. Not only is it rare for single influences to have single outcomes, but it is also common for significant events to have an impact only after a considerable time-lag – for instance, people may not show the effects of their upbringing until they become parents a generation later. Such limits to perfect prediction are important to recognise, but they do not mean that the task of identifying families at risk should be abandoned. The aim of this final chapter is to pull together knowledge helpful in this task – focusing on the new data presented earlier – and to develop some guidelines for predicting the families in which children are most likely to suffer. First, the significance of family history is discussed, and then five features of family life that often provide good clues to family functioning are examined. These first five indicators in an alphabet of risk will not always signify difficulties in individual families, just as problems will sometimes be found in families that are 'normal' in these respects. All the same, a check-list can be a useful adjunct to professional experience and personal intuition in the assessment of family stress.

Cycles of family difficulties

The possibility that family problems and troubles are concentrated in a small number of families generation after generation gave rise to most of the research reported in earlier chapters. It is useful at this point, therefore, to stop and ask whether families at risk can be predicted with any degree of accuracy simply by knowing something of their origin.

Over all, and following exhaustive searches of the literature and a not inconsiderable expenditure of research energy, it must be said that there is mixed support for the 'cycle of deprivation' thesis (see Rutter

and Madge 1976; Brown and Madge 1982). On the one hand there are plentiful examples of family continuities and good evidence of greater than expected family resemblance across generations in income level, housing circumstances, socioeconomic status, criminality, educational attainment, and so on. But, on the other hand, there are always many exceptions to this pattern. In other words family history, on its own, is probably not a very good predictor of family difficulties. Some children may in adulthood resemble their parents, but many others will not.

The original focus of the cycle of deprivation thesis was on how *experiences* of parenting during childhood would affect *styles* of parenthood a generation later. It was hypothesised that parents who had difficulty in coping, and who were severely disadvantaged in many ways, would not be good parents and that their children would suffer as a result. Not only would youngsters be set a poor model of parenthood, but they would tend to do poorly at school, and subsequently get poor jobs and receive only low incomes. In turn they would bring up their own children amid difficulties and chaos, and in this way a cyclical process would be set in motion.

The notion of a cycle of deprivation was intended to apply to families in the greatest adversity and was not necessarily thought to have direct implications for parent–child resemblance across the social spectrum. In this sense it gains some support in that there are much clearer indications of continuities in the most severely depriving forms of child-rearing than in parenting more generally (Rutter and Madge 1976).

Most of the research reported in earlier chapters has focused on the family, and particularly on patterns and relationships across generations. Not all studies have defined family risk in the same way and not all have adopted similar methodologies. Nevertheless the findings combine to confirm and illustrate these general conclusions on cycles of deprivation. The research has verified that, under certain conditions, some family members display consistent patterns. This indicates that like *can* beget like. At the same time, however, it has provided convincing evidence of widespread discontinuities, which suggests that 'rags to riches' and other family contrasts are also found.

In Chapter 2 Coffield, for example, gave evidence of some clear instances of intergenerational similarities among four severely disorganised families, but at the same time he pointed out that there was no inevitability that parents and their children would have particular difficulties in common. Indeed, and bearing in mind that the families were selected because they were expected to exhibit intergenerational continuities, it is worth noting that Coffield felt that parent–child similarities were not all that marked and that family resemblance

would be even less over three generations. Perhaps even more hopeful was that some children from very adverse home backgrounds appeared to be doing rather well at school.

In Chapter 3 much the same conclusion was drawn by Tonge, Lunn, Greathead, McLaren and Bosanko who examined whether children brought up in multiple problem families were more likely than others growing up under less stress, but in the same locality, to have problems when they formed their own families in adulthood. It emerged that children from troubled homes *did* tend to be less well off and more unstable in their patterns of employment, and that they were also more likely to have criminal records, to be in contact with social agencies and to display inconsistent and permissive child-rearing behaviour. But again there was no inevitability that parents and their children would show similarities. In some cases very strong common patterns were found, but in many others they were not. Sometimes quite severe problems in the older generation were followed by very favourable outcomes in the next, and occasionally there were quite marked contrasts in the adult circumstances of brothers and sisters brought up in the same household.

Perhaps the strongest indications of cycles of disadvantage arose from the research reported by Rutter, Quinton and Liddle in Chapter 4. First, these investigators found that reception into care in the older generation increased the risk of similar experiences in the younger: on the one hand a quarter of mothers with children currently in care, as compared with no mothers in the general population comparison group, had been in care themselves in childhood, and 18 per cent of the mothers who had been reared in institutions, again as contrasted with none in the comparison group, had children who had been fostered, placed in Children's Homes or otherwise removed from parental care. Second, and more generally, the *experience* of adverse parenting greatly heightened the likelihood of *becoming* a poor parent – for instance, poor parenting (as defined by the investigators) was five times as common among families where parents were reared in institutions as for other families. Over all it seemed that such patterns were the result of persistent psychosocial problems that influenced parenting, rather than because of the direct transmission of parenting styles. It appeared that early adversity sometimes led women to conceive early, to select a spouse who also had psychosocial and other problems, and to end up in poor social circumstances and lacking marital support. However in other cases it seemed that early adversity meant that women were particularly susceptible to later stress. In both instances parenting was affected and intergenerational similarities were apparent. Nevertheless, as in other studies, Rutter, Quinton and

Liddle found that childhood circumstances did not always predict characteristics in adulthood, and it is noteworthy that about one in four of the mothers brought up in institutions were rated as 'good' parents.

It is likely that the strength of cycles of deprivation varies, and one possibility, as already mentioned, is that family similarities are most common among the most severely deprived of families. Whether or not this is the explanation, McGlaughlin and Empson – whose sample was more disadvantaged than the average on a range of indices, but yet did not show the level of problems found in the studies already referred to – found less evidence of problems running in families than did other investigators (Chapter 5). In their study, McGlaughlin and Empson adopted the unusual strategy of comparing pairs of sibling mothers and their young children. As sisters and cousins were no more like each other than unrelated pairs of mothers and infants, it seemed that the mothers' own parents had had a negligible influence on styles of child-rearing a generation later. All the same there was a small core of families in which sisters (and in some cases also their children) were very alike.

The chances that parents will become like their own parents probably depend on the aspect of family life in question. Blaxter and Paterson found, despite the common conventional wisdom among service providers that family generations often share attitudes to health, that mothers and grandmothers generally showed few similarities in beliefs and behaviour regarding health. In Chapter 9 they reported how there were some mother–daughter pairs who were very alike, and some issues on which intergenerational resemblance was fairly high, but how these similarities were not marked enough to be able to say that familial transmission took place.

The main conclusion, overall, is that parents and their adult children are sometimes very similar in circumstances and styles of coping, but that intergenerational similarities are neither frequent enough nor strong enough to mean that family background *on its own* can predict with any certainty families at risk. Sometimes factors within the family, factors acting in society or in the community, or the interactions between these two types of influence, lead fairly directly to parent–child resemblance. Sometimes, too, children's experiences of deprivation may be so severely disadvantaging that life chances in adulthood are damaged and intergenerational similarities are again apparent: for instance, impoverished and overcrowded home conditions, plus limited educational opportunities and little parental encouragement, may result in poor progress at school, entry into the labour market at a young age and with no qualifications or training and, in turn, a poor-status job with few prospects and low pay. *But*,

equally, deprivation very often does not seem to persist within families. Some children may grow up seemingly unscathed by their background, while deprivation may arise quite spontaneously, and without earlier precedent, in other families. This variety of pathways to deprivation makes it essential to look beyond family history when assessing the life chances of individuals.

An ABC of risk

The main purpose of this book is to identify families in difficulty. So, whether problems stem from personal shortcomings, from the structure of society or from some combination of these two broad influences, the focus must be on the family and on signs that something is likely to be 'wrong'. Certain areas of family functioning are particularly useful for predictions of this kind. These features of family life – which, it should be re-emphasised, are indicators of, rather than the reasons for, problems – include the *A*ge and maturity of parents, the *B*urdens carried by a family, *C*onsistency and change in the lives of children, *D*ynamics and support within the family, and the *E*xperiences and characteristics of individual family members. No guide is infallible, and the list is not complete, but these first five items in an alphabet of risk both singly and cumulatively help to establish the probability that individual families will be under stress.

Age at parenthood

A first sign of family risk is parental age and maturity. This is not to say that children will necessarily suffer just because they are born to young mothers – almost one in ten births are to mothers aged between 15 and 19 years (OPCS 1979) and it is likely that the majority of children in these cases will be brought up perfectly satisfactorily (an observation supported by Kruk and Wolkind's findings reported in Chapter 6) – but there is none the less an increased risk for both mother and infant from early parenthood, especially if the mother is already disadvantaged in other ways.

One cause of concern for young mothers and their children is the high risk they run that the family unit will at some stage contain only one parent. There are two main reasons for this. The first is that illegitimacy and lone parenthood at the time of the birth are much more common for mothers who conceive at an early age. And the second is that, for those who *are* married at the point of parenthood, very early marriages break down much more often than those contracted at an older age. The highest rate of divorce occurs between the ages of 25 and 30 years (OPCS 1979), and a tendency for marriages by teenagers, or those following conception, to fail was

confirmed for the mothers in the small sample studied by Kruk and Wolkind. Concern for children in these families is not because children cannot function perfectly well with only one parent – they undoubtedly can – but because single parenthood in our society is linked to a high risk of severe material disadvantage.

For those who do marry early, whether or not separation or divorce later occurs, there are often restrictions placed on the choice of a partner. Ineichen (see Brown and Madge 1982), among many others, has clearly shown how early marriages tend to take place between young people growing up in the same locality, whereas partners selected for later marriages are drawn from a much larger geographical and social context. If young people from disadvantaged homes choose spouses from their own neighbourhood and social circle, the chances that they will marry partners who have problems rather like their own are considerable.

Another disadvantage commonly faced by young parents is a shortage of financial resources. Mothers on their own are particularly likely to have low incomes and, if married or cohabiting, they or their partners will tend – if employed at all – to be at the bottom end on any earnings scale (see Brown and Madge 1982). At the same time, as pointed out in Chapter 1, the costs of children are high. The combined effect of these tendencies is that young parents are often relatively poor and living under bad housing conditions. The possible effects on their children need not be spelled out.

Young parents may also be at a disadvantage emotionally. Women become pregnant for different reasons and with varying degrees of intention, and earlier chapters have shown how early pregnancy is quite often associated with adolescent difficulties. Rutter, Quinton and Liddle, for instance, found that both mothers who at the time had children in care, and those who had been in care themselves during childhood, were more likely than others from similar, but more stable, social backgrounds to have had their first child at a young age. Furthermore three-quarters of the 'in care' mothers in the first group, but less than one in five of the rest, seemed to have married or entered a relationship in order to escape from a troubled home background, and in two-thirds of cases these young mothers chose partners who also came from a difficult home background and/or who were displaying symptoms of psychiatric disorder or criminality. In other words the age of marriage and parenthood of these women reflected a constellation of adversity, and it seems likely that the outcome was often a somewhat unsatisfactory emotional family environment.

Early marriage as a 'compensation', in some sense, for an unsatisfactory upbringing also seemed implicated when Rutter, Quinton and

Liddle looked at the patterns of childbearing of mothers who had been in care during childhood. Two-fifths of these mothers in the sample, as compared with none at all in the comparison group, had become pregnant by the time of their nineteenth birthday. Moreover the children in these families were affected: almost two-thirds of these young mothers, relative to less than a third of the rest, were rated as poor parents.

In other chapters, too, it has been suggested that early relationships and conception may sometimes be the result, in the main, of a wish to escape from a stressful home situation. Coffield discussed this possibility, and Kruk and Wolkind noted that the young women in their sample often seemed unaware of the long-term implications of motherhood. These authors stressed that the teenagers they talked to, whether married or not, were on the whole far less prepared, in terms of their attitudes and expectations, for parenthood than older mothers and – in line with other research findings – they more often came from families with marked problems. In Chapter 7 Kolvin, Miller, Garside and Gatzanis showed that the more deprived mothers in their sample were the most likely to have been married by the age of 19. Moreover, whereas no illegitimate children were born to members of the control groups, the rates of illegitimacy in the deprived and multiply deprived groups were 10 and 17 per cent respectively. Finally, Stevenson and Graham reported that mothers in their deprived sample were more disadvantaged than others in the conditions surrounding the birth of their infants, and this took into account the age of the mother.

Despite increasing concern voiced by social workers, and by the media, about the numbers of girls from deprived backgrounds who apparently *choose* to have a baby almost as soon as they leave school, even though they may not have a stable partner (quite apart from those who become pregnant 'accidentally'), there is at present no way of knowing how widespread this behaviour is. It has been suggested that the motives precipitating early pregnancy are partly financial (that is, it is recognised that motherhood brings in an income from the state – although the costs of a child are probably not so readily appreciated); partly emotional, in that the young mother may be seeking the 'love' she has so far lacked; and partly to do with status, as having a child is one achievement that does not depend upon doing well at school or finding a good job. Certainly these suggestions are alarming, and they should be investigated in greater depth.

The evidence discussed so far suggests that age at parenthood is an indicator, although not a perfect indicator, of difficulties at the time of childbirth and later. The children of younger mothers are more likely to be or become members of single-parent families, and to live in

poorer households with fewer household amenities and lower household standards; they may also have been less planned, and their mothers less prepared for them, than other youngsters. The important question, however, is whether their development and well-being are affected. The answer is less than straightforward. On the one hand, Kruk and Wolkind suspect that age and marital status are not useful predictors of later problems for children, and they themselves found no difference in the rate of either behaviour problems in infants up to $3\frac{1}{2}$ years, or concern expressed by interviewers, between children of mothers who had or had not conceived when still teenagers. Although some other investigators have presented similar findings (e.g. Burd 1980), there are on the other hand, as Kruk and Wolkind pointed out, some observations that suggest that children of teenage mothers are more likely than others to show behaviour problems and poor intellectual development (e.g. Oppel and Royston 1971).

It seems, too, that children may, in some circumstances, be disadvantaged in other ways if born to young mothers. Blaxter and Paterson, for instance, noted that infants may have early physical health problems if their mothers are young and unprepared for parenthood – especially if the mother herself has poor health and comes from a relatively deprived socioeconomic background. More seriously, perhaps, it is also well documented that higher proportions of young than older parents physically abuse their infants (Helfer and Kempe 1968; Creighton 1980). Although it applies to only a very small minority of the population, Scott (1973) claimed that non-accidental injury was especially likely if 'young unstable, deserted and unhappy women associate with young, psychopathic and criminal men, and have babies they do not want'.

To sum up, age at parenthood is the first index in an alphabet of family risk not because it always predicts problems but because it can reflect a lack of preparation for parenthood, immaturity, a greater risk of lone parenthood or an unstable marriage or cohabitation, and fewer material resources. Moreover, and crucially so far as cycles of deprivation are concerned, it can reflect a loveless and stressful childhood of the mother herself – which, incidentally, may increase the risk of parenting difficulties. All these factors are likely to contribute to the well-being of growing children even if the precise way in which infants are affected remains relatively uncharted. The majority of children of young mothers will develop just as well as most of their peers who have older parents, but, statistically, it remains true that parental age increases the risk of a variety of family troubles.

Burdens

The more that families have to contend with, the more severely the quality of their family life will be affected. Material hardship, poor housing, large families with few resources, unemployment, ill health, limited opportunities, and so on, are not only debilitating in their own right but they also affect both a family's ability to cope generally and the style and manner in which children are raised and socialised.

The force of this conclusion has been emphasised strongly in earlier chapters. Coffield laid particular emphasis on the significance of family stress for family failure and listed the defeating complexity of multiple problems, and a lack of material, emotional and social resources, among the main features of families known to service agencies and labelled as public problems. His main conclusion was that 'it was the dense network of overlapping psychological, social, medical and economic factors which overwhelmed the families and perpetuated their problems'.

The effects of stress cannot be minimised, and any examination of the circumstances of a family thought to be 'at risk' should take into account income levels, overcrowding, work patterns, health and so on. Indeed there is good evidence that the relative deprivation and poor development of children from certain families are in large measure *the result* of such socioeconomic disadvantage. This conclusion applies to single-parent families, and it seems that the low attainments of children of unmarried mothers (Crellin *et al.* 1971; Lambert and Streather 1980) may be partly because of family disadvantage in income and housing. Lambert and Streather found that when social class, sex, family size, housing and financial differences were allowed for, the children in these families no longer did less well at school than expected.

Large families are another 'at risk' group whose troubles often seem in part attributable to socioeconomic disadvantage. An above-average number of children increases the chances of a low income (Layard *et al.* 1978) and overcrowding (Department of the Environment 1979), and these factors, as well as the tendency for parents with more children to have less spare time to play and talk, appear to contribute to the poor language development and the slow progress at school typically found among children from large families. Nevertheless a large family size is often associated with other forms of deprivation – Kolvin, Miller, Garside and Gatzanis found this among the Newcastle Thousand Families – and large families are probably sometimes at risk because of the attitudes and lack of planning they reflect and not simply because of the greater socioeconomic disadvantage they suffer. All the same, as indicated by Tonge, Lunn, Greathead, McLaren and Bosanko, even

extremely disorganised families can be helped to break out from a cycle of deprivation that might otherwise have trapped them if contraception and advice on family planning are freely available.

The effects of burdens on individual families can be very varied and difficult to specify, and McGlaughlin and Empson found inconsistent reactions to unemployment, rehousing, ill health, and personal and financial difficulties. Moreover different types of burden may have contrasting effects on children, as intimated by both Stevenson and Graham (Chapter 8), and Blaxter and Paterson (Chapter 9). Nevertheless it has been clearly documented that the effects of *multiple* disadvantage can be cumulative and pervasive (Brown and Madge 1982). This is vividly illustrated by a study of children in an inner-city area reported by Wilson and Herbert (1978). Family burdens meant that 3- and 4-year-olds with high social handicaps were lagging behind other children in language development while older children were, according to teachers, behaving badly and attaining poorly. These children also suffered in other ways. Those from large families often had rather shortened childhoods as they were, from quite an early age, expected to look after younger brothers and sisters. Many others were restricted in their play because of the poor environment in which they lived and the dangers of traffic, demolition sites, vacant houses and the like that were ever present.

The common denominator underlying family burdens is stress. Many writers have emphasised the debilitating effects of chronic and current stress (e.g. Dohrenwend and Dohrenwend 1974) and this impression was also conveyed in some of the earlier chapters. Blaxter and Paterson hinted at the apathy created by family stress and the effects this could have on how parents cared for their children's health, while Rutter, Quinton and Liddle pointed to the importance of current circumstances for psychosocial functioning and, in turn, styles of parenting. In addition, McGlaughlin and Empson very clearly demonstrated how family stress, when combined with little and poor-quality contact between parents and children, put children at a considerable disadvantage. It was found that infants who talked and played a lot with low-stressed mothers had a four to one chance of developing well (according to the study criteria), while children who interacted little with highly stressed mothers had a twelve to one chance of developing poorly. It seems from these findings that the presence or absence of stress makes a difference to what mothers and children do together and that in this way it affects infant development.

In summary, burdens of all kinds make a difference both to the circumstances under which families live and to the ways in which they are able to function. In this way they can be a good indicator of families at risk.

Consistency and change

There are many independent pieces of evidence to suggest that too much inconsistency and change in a child's upbringing can be unsettling and may lead to disturbance. Sometimes it seems that it is the lack of stability that is responsible for the development of problems, but at other times it appears that constant change reflects family disorganisation and difficulty. Inconsistency can arise in many spheres of a child's life, and this section will illustrate briefly some of the outcomes that may accompany instability and inconsistency in caretakers and family composition, discipline and patterns of child-rearing, attitudes to education between home and school, and area of residence.

Consistent parents or substitute parents are probably more important to children than is stability in any other context. It was concluded in Chapter 1 that infants do not need to be in the constant physical presence of their mothers, although they do need to feel secure and to have that security maintained by regular contact with their principal caretaker(s). In Chapters 4 and 6 both Rutter, Quinton and Liddle, and Kruk and Wolkind, reporting on women institutionalised during childhood, showed how parents who had experienced extreme disruption in their early years had a far greater risk of difficulties in bringing up their own children, who in turn became particularly prone to emotional and behavioural problems. In both these studies it is likely that emotional insecurity, reflected in a lack of stable caretakers and other unsatisfactory conditions, was at least one of the factors implicated in the transmission of family problems from generation to generation.

Less drastic changes in household composition can also be unsettling, even if effects are more temporary. Not much direct evidence on this issue is provided in earlier chapters, although some of the families described by Coffield and by Tonge, Lunn, Greathead, McLaren and Bosanko were unstable in terms of membership and also characterised by multiple problems. Changing household composition in these instances was no doubt influenced by the disorganised lifestyle of the families, but there were probably additional adverse effects on the children. It is well established that the loss of a parent following divorce and family separation quite often produces disturbance in children (Wallerstein and Kelly 1980) and, although there is not good evidence on the question, it seems likely that changing substitute parents can be unsettling too. Other additions to the family may also be upsetting, and it has been shown that the birth of a sibling, at least in the short term, can lead to emotional and behavioural problems because of changes in the mother–child relationship (Dunn *et al.* 1981). Families are social units and members are inevitably affected as their character changes.

Besides consistency in the composition of the social unit, consistency in the experiences and interactions found within the family are likely to affect well-being and development. Patterns of behaviour are learned within the family context, and what exactly is learned will depend very much on what is taught. Both Coffield and Tonge, Lunn, Greathead, McLaren and Bosanko observed the inconsistency of discipline and child-rearing in families marked by their problems and disorganisation, and it seems likely that these practices may contribute to the intergenerational perpetuation of families at risk. These findings accord with a large body of evidence that suggests that consistent and firm discipline and supervision typically characterise well-organised families. Under these conditions children are offered the best protection against antisocial behaviour and delinquency, and they are most likely to become resilient to stress (Rutter 1981; Werner and Smith 1981).

As well as consistency in attitudes and approaches *within* the home, a child will benefit from consistency across environments, especially between home and school. The issues have not been discussed in this volume, but other reports indicate that scholastic progress is best where attitudes stressing the value of educational achievement are common to both parents and teachers (Douglas 1964; Mortimore and Blackstone 1982). Essen and Wedge (1982) have recently demonstrated how even very severely disadvantaged children can do much better at school than expected if their parents encourage them in their educational aspirations. Similar findings have emerged at the preschool level, and the most successful compensatory education programmes tend to be those that involve parents (see Rutter and Madge 1976).

Finally, family risk may be indicated by a very high rate of geographical mobility. Again, however, disadvantage may be either the effect or the cause. On the one hand, moving house can in and of itself be disruptive, especially if it disturbs social and family relationships (Fried 1963), and it does seem likely – although the evidence is inconclusive – that there will be at least short-term effects on educational progress where rehousing means changing schools. On the other hand, however, geographical mobility is a good index of family risk because it so often results from severe socioeconomic disadvantage. Wilson and Herbert (1978) found such a high degree of mobility among fifty-nine deprived families in an inner city area that thirty-three had moved between three and eight times since marriage, thirteen had moved twice and only ten had changed address not more than once. These writers placed the blame for this instability on the families' disadvantaged position in the housing market and maintained

that it was badly affecting social integration and the children's educational development. Other groups, too, seem at similar risk. Crellin *et al.* (1971) pointed to the high geographical mobility of illegitimate children by seven years, and this pattern was confirmed for the same group of children between 7 and 11 years by Lambert and Streather (1980). As, socially, these illegitimate children were less well adjusted than other children, even when their disadvantaged background was taken into account, Lambert and Streather suggested that continual mobility, via its impact on anxiety, aggression and social relationships, may have had an impact.

Not only socioeconomic, but also emotional, deprivation is associated with geographical mobility. In Chapter 4 Rutter, Quinton and Liddle noted far more changes of address among families where a parent had been in care during childhood than among the rest. So marked was this contrast that only half the 'in care' families, as compared with more than eight in nine of the general population group, had lived in the same place for at least a year. Quite what precipitated such mobility is unclear.

Over all, then, inconsistency, instability and change to an unusual degree may be either the cause or the effect of family difficulties. Probably the patterns of association are in fact circular, so that one type of instability both reflects and accentuates another. Certainly it has been argued that too much change is conducive to mental ill health (Dohrenwend 1973; Rahe 1969), although it has also been stressed that this is so only if change involves some long-term threat (Brown and Harris 1978). Whatever the interplay between these various factors, it does seem that the stability or otherwise of family life can provide a useful guide to the likely well-being of parents and their children.

Dynamics and support

The nature of family dynamics and the level of moral and emotional support offered to family members are very important influences on well-being. And of foremost importance as an index of family dynamics is, where two parents are present, the quality of the marital relationship. Not only has it been well documented how children are at particular risk of poor performance at school, emotional disturbance and behavioural disorders if there is severe parental discord and family separation (Rutter 1981); but also there is widespread evidence that a good parental relationship can protect against the effects of family troubles. Elder (1979), for instance, found that boys suffered far less from the material hardships imposed by the Great Depression of the 1930s if their parents had a close relationship than if they did not, and

it also seems that paternal unemployment disrupts family life far less where a high degree of mutual sympathy and support precedes the loss of a job (Madge 1983).

The tendency for families to be happier if parents are mutually loving and supportive gains further weight from earlier chapters. Coffield observed that the four families in his study could be separated into three that appeared quite overwhelmed by their problems and a fourth that was struggling hard, with some success, to reduce its burdens. Interestingly, it appeared that these families could also be distinguished according to another criterion: none of the first three showed any evidence of a close confiding parental relationship whereas the fourth did. Much the same impression was conveyed by Tonge, Lunn, Greathead, McLaren and Bosanko. These writers described how marital stability seemed to help a family cope with difficulties whereas marital problems tended to be found where a family situation was getting worse.

Whatever the nature of the association, marital instability and other forms of family disadvantage are frequently found together. Kolvin, Miller, Garside and Gatzanis showed that a large proportion of the children in their samples of deprived families, but relatively few in the control groups, experienced parental conflict during their first year. Moreover it seemed that interpersonal problems often persisted over long periods of childhood: over half the children exposed to marital instability at 5 years had witnessed discord since their first year of life.

The significance of the quality of the marital relationship for family functioning was also emphasised by Rutter, Quinton and Liddle. These investigators found that mothers who had been reared in institutions were indeed as likely as comparison mothers to be rated as 'good' parents *if* they had supportive relationships with spouses who were relatively free of psychosocial problems. In addition, Stevenson and Graham used a path analysis technique to show that family relationships were better predictors of child behaviour than were any of the other variables they looked at, and that children's language development was better explained by a combination of family relationships and family disadvantage than by the latter index alone.

It has often been demonstrated that children thrive well on a high level of good-quality interaction with their parents or others, and the message of this discussion is that children are most likely to receive this if they come from homes with good family relationships and hence low levels of stress. The importance of this mixture was demonstrated convincingly by McGlaughlin and Empson who found *no* exceptions, within a group of relatively disadvantaged families, to the rule that a lot of interaction and little family stress led to good development by 2½

years and that little interaction but considerable stress resulted in much poorer development.

The focus, so far, has been on the conventional nuclear family, but similar conclusions apply in the case of families without two parents present. Emotional climate is always important, and the nature of relationships experienced by lone mothers, as well as current satisfactions with their circumstances, will no doubt influence the course of family life. The increased chances of depression among mothers lacking an intimate confiding relationship have been demonstrated (Brown and Harris 1978), and it seems likely that lone mothers and their families may be at particular risk of emotional distress.

Support from *outside* the family can also serve a protective function, particularly if family relationships are poor or lacking. It has just been noted in relation to single parents how a significant confiding relationship, not necessarily with a spouse or even a member of the opposite sex, can be a great source of support to adult women and, in addition, the compensatory effects at all ages of good relationships outside the family are well known (Brown and Madge 1982). Sometimes such relationships may be with peers, and sometimes they may be with relatives or with teachers, neighbours or others. Hinde (1980) has pointed out how the evidence for the importance of human peer–peer relationships is now considerable, and it is possible that a particularly good relationship, if initiated early enough, might provide at least some compensation for the lack of a supportive parental relationship.

Relationships outside the immediate family have not been examined in any detail in earlier chapters, although the value of external support for parents has been referred to on several occasions. First, Coffield noted how the family in his study that was managing to overcome its earlier deprivation seemed to be helped by support from relatives who had already achieved circumstances to which this family aspired, while the less successful families were very socially isolated. And second, Kruk and Wolkind pointed to the probably important role of the mothers of single parents. It seemed that young lone mothers who coped best had the support of their own mothers during the early years of child-rearing, but that those who had greater difficulties with their infants did not have a mother they could turn to.

Family dynamics and support can, in these ways, provide clues as to whether or not the welfare of a family is at risk. Parents with a good relationship are usually much better able to deal with difficulties and troubles than couples who also have to cope with interpersonal conflict, and single mothers will probably gain the greatest satisfactions from parenthood if they are emotionally settled and supported. The

presence or absence of relationships outside the family – for both parents and children – provide an additional index of family support.

Experiences and characteristics

Experiences and characteristics are the fifth and final item in this short check-list of indicators of family risk. These are important because it is individual differences that largely explain why people vary so enormously in their responses to stress and in the circumstances they find stressful.

The role and possible effects of experience have already been partly examined. The 'cycle of deprivation' thesis suggests that experiences in childhood help to shape experiences in parenthood, and it was shown that there is at least partial confirmation of this notion. It seems that severely depriving experiences, especially if these prevent the development of good interpersonal relationships or effective coping strategies, may well have intergenerational repercussions. Nevertheless it was also found that there is no inevitability that problems will run in families. Other experiences may indeed be more important. Opportunities for stimulation, learning, forming friendships, establishing relationships, and for parental employment, and a reasonable standard of living, for instance, can make considerable difference to family burdens and to children's scholastic attainment, peer groups and well-being in general.

Experiences depend very much on personal characteristics. The very fact that some people succumb to adversity while others survive or flourish in similar circumstances suggests that part of the strength of survivors may lie in their personal make-up. More and more attention has recently been directed towards investigating just what seems to promote invulnerability in this sense. Besides optimal opportunities and experiences, Brown and Madge (1982) listed some of the factors associated with greater resilience as sex – females often manage better under stress than males – a 'coping' temperament, single-minded persistence, an awareness and acceptance of values commonly associated with success, and good personal and social relationships.

The course of family life is also affected by the experiences of members. Ill health of parents may, for instance, influence child welfare and development. Quite apart from occasional risks of contracting illnesses, children of the physically sick may suffer because of effects on parental employment and income, parental absence from the home, or parental preoccupation with their own condition and a lack of time and inclination to share activities with them. Some of these patterns would seem likely to characterise a few of the families described by Blaxter and Paterson. More seriously still, particularly

extreme cases of ill health may lead, even if only temporarily, to the child's removal from the family and consequent distress. Certainly in March 1978 7 per cent of all children and young people in care of the local authority in England and Wales were there because of parental illness (House of Commons 1980).

Mental illness of parents can also take its toll within the family, and it is apparent that infants often suffer emotionally from regular contact with an unhappy or disturbed mother. Main (1980) recently showed that, even during their first year, infants of rejecting, aggressive and non-socially interactive mothers could come to show very much the same characteristics, even if they had not differed appreciably from the children of non-disturbed mothers in their first months of life. Kruk and Wolkind also reported on the importance of maternal mental health for the prognosis of children. Whereas they detected no over-all significant differences between the behaviour of infants of single and non-single mothers, they did find, albeit for only a very small number of mothers, that psychiatric disorder before pregnancy was predictive of behaviour problems in infants at $3\frac{1}{2}$ years, and that this was the case whether or not women were married.

As children grow older, the parental experience of emotional instability may continue to have effects. It has been shown that children of depressed mothers are much more likely to have accidents than other children (Brown and Harris 1978), and it is well documented, whatever the cause of the association, that there is a greater than chance relationship between psychiatric disturbance, especially conduct and personality disorders, in parents and in their children (Rutter and Madge 1976).

Child development depends on children's own personal characteristics and experiences as well as on those of their parents. Infants vary enormously physically (Rapoport 1980) and temperamentally (Dunn 1980), and personal make-up will affect both behaviour and psychological and intellectual development. As Dunn pointed out, individual differences influence the course of child development because of the differential effects of different characteristics, such as physical attractiveness or verbal skills, on caretakers and others, because they affect likely experiences and reactions to experiences, and because they can signal varying susceptibility to stress.

Children are also highly variable in their needs for certain experiences. Some are physically weaker than others and so require more care and protection, and some are particularly accident-prone and so must be given greater supervision. Needs for physical and intellectual stimulation are also highly variable. It has been shown, for instance, that physically active children are much better at compensating for a

period of immobility and understimulation, such as following a spell in hospital, than are the less active and mobile (Schaffer 1966), and in much the same way it is likely that bright children find ways of gaining intellectual stimulation that duller youngsters do not.

Emotional needs also vary from child to child, and whereas some are quite easily satisfied, others can be very demanding. And while some children are, relatively speaking, easy to control and discipline, others are less 'conformers' than 'rebels'. Over all some children are just more fun to be with and do things with than others, they are easier to love and they bring greater emotional satisfaction. It is inevitable that personal characteristics of this kind will influence how children and their parents talk and play.

Finally, not all children have the same material needs. Those with expensive hobbies, who break things and wear out their clothes quickly, and who have apparently insatiable appetites, can be very expensive to keep happy. In this sense child characteristics may again determine the degree of disadvantage that is experienced within the family.

In many ways patterns of family life depend on how well parents and children get on together and how far they have wishes and characteristics in common. Frustration is particularly likely if members of the two generations are not highly compatible. For instance, an excessively demanding child, or parent, may be resisted by the other member of the pair – and the original abnormal behaviour intensified. Similarly a very withdrawn child or parent may attract less attention than a more active member of the family, and in this way withdrawal could become more marked. More positively, however, easy-going children and parents are likely to encourage attention and interaction so that 'good' behaviour is reinforced. In these ways parents and children can mutually affect each other's actions and reactions, and set chains of causes and effects in motion (Wolff 1981).

In conclusion, it is apparent that human diversity is marked and that parental and filial experiences and characteristics can provide help in identifying families in trouble. The most risk is likely to exist where severely adverse experiences, extremely abnormal personal characteristics in parent or child, and marked parent–child discord, are apparent.

A final word

Identifying families at risk, even if helpful practical guidelines are available, is no easy task. As all unhappy families have their own characteristics, as human reactions to adversity differ enormously, and as perceptions of 'difficulty' vary both among professionals and be-

tween professionals and possible clients, providing any once-and-for-all definition of families in trouble is not possible.

Nevertheless there are various signs that point to increased family risk. Among these – which are *symptoms* rather than causes of problems – are family history, age of parents, family burdens, consistency of circumstances, family dynamics and support, and experiences and characteristics of family members. Individually these indices can signify difficulties that exceed those commonly faced by families, and in combination they can reflect a tangle of stresses and strains that are long term and pervade most spheres of day-to-day living. Concern is heightened in all these cases by the possible effects on children. Some youngsters are permanently scarred by their early experiences and many more suffer during childhood even if they 'survive' in the longer term.

Prediction of risk is, none the less, merely a stepping-stone between concern for the most disadvantaged families and action on their behalf, and, once families in difficulty can be readily identified, attention should be directed towards means of prevention and intervention. It is quite apparent that the causes of family difficulties are just as likely to originate within society or the community as within the family itself and, accordingly, action needs to take place on several fronts. Some clues have been given in this tale on ways in which families might be helped, and about the characteristics and circumstances that seem to allow children and adults to withstand the effects of deprivation and disadvantage. Proper examination of this area, however, demands detailed consideration and discussion of many important questions and issues – and it is, unfortunately, another story.

References

Brown, G.W. and Harris, T. (1978), *Social origins of depression: a study of psychiatric disorder in women*, London: Tavistock.

Brown, M. and Madge, N. (1982), *Despite the welfare state*, London: Heinemann Educational Books.

Burd, M. (1980), quoted by Sue Kruk and Stephen Wolkind in chapter 6.

CCETSW (Central Council for Education and Training in Social Work) (1978), *Good enough parenting*, London.

Creighton, S.J. (1980), *Child victims of physical abuse, 1976. The third report on the findings of NSPCC Special Units' registers*, London: NSPCC.

Crellin, E., Pringle, M.L.K. and West, P. (1971), *Born illegitimate: social and educational implications*, Slough: NFER.

Department of the Environment (1979), *English house condition survey, 1976. Part 2: report of the social survey*, London: HMSO.

Dohrenwend, B.P. (1973), 'Life events as stressors: a methodological inquiry', *Journal of Health and Social Behavior*, vol. 14, pp. 167–75.

Dohrenwend, B.P. and Dohrenwend, B.S. (1974), *Stressful life events; their nature and effects*, New York: John Wiley.

Douglas, J.W.B. (1964), *The home and the school*, London: MacGibbon & Kee.

Dunn, J. (1980), 'Individual differences in temperament', in Rutter, M. (ed), *Scientific foundations of developmental psychiatry*, London: Heinemann Medical Books.

Dunn, J., Kendrick, C. and MacNamee, R. (1981), 'The reaction of first-born children to the birth of a sibling: mothers' reports', *Journal of Child Psychology and Psychiatry*, vol. 22, pp. 1–18.

Elder, G.H. Jr (1979), 'Historical change in life patterns and personality', in Baltes, P.B. and Brim, O.G. Jr (eds), *Life-span development and behavior vol. 2*, Academic Press (UK edn: London).

Essen, J. and Wedge, P. (1982), *Continuities in social disadvantage*, London: Heinemann Educational Books.

Fried, M. (1963), 'Grieving for a lost home', in Duhl, L.J. (ed), *The urban condition*, New York: Basic Books.

Helfer, R.E. and Kempe, C.H. (1968), *The battered child*, Chicago: University of Chicago Press.

Hinde, R.A. (1980), 'Family influences', in Rutter, M. (ed), *Scientific foundations of developmental psychiatry*, London: Heinemann Medical Books.

House of Commons (1980), *Children in care in England and Wales, March, 1978*, London: HMSO.

Lambert, L. and Streather, J. (1980), *Children in changing families*, London: Macmillan.

Layard, R., Piachaud, D. and Stewart, M. (1978), *The causes of poverty*, Royal Commission on the Distribution of Income and Wealth. Background Paper no. 5, London: HMSO.

Madge, N. (1983), 'Unemployment and its effects on children', *Journal of Child Psychology and Psychiatry*, vol. 24.

Main, M. (1980), 'Abusive and rejecting infants', in Frude, N. (ed), *Psychological approaches to child abuse*, London: Batsford Academic.

Mortimore, J. and Blackstone, T. (1982), *Disadvantage and education*, London: Heinemann Educational Books.

OPCS (Office of Population Censuses and Surveys) (1979), *Birth statistics, 1977*. London: HMSO.

Oppel, W. and Royston, A. (1971), 'Teenage births: some social, psychological and physical sequelae', *American Journal of Public Health*, vol. 61, pp. 751–6.

Rahe, R.H. (1969), 'Life crisis and health change', in May, P.R.A. and Winterborn, J.R. (eds), *Psychotropic drug responses: advances in prediction*, Springfield, Illinois: C.C. Thomas.

Rapoport, J.L. (1980), 'Congenital anomalies, appearance and body build', in Rutter, M. (ed), *Scientific foundations of developmental psychiatry*, London: Heinemann Medical Books.

Rutter, M. (1981), *Maternal deprivation reassessed*, 2nd edn, Harmondsworth: Penguin Books.

Rutter, M. and Madge, N. (1976), *Cycles of disadvantage*, London: Heinemann Educational Books.

Schaffer, H.R. (1966), 'Activity level as a constitutional determinant of infantile reaction to deprivation', *Child Development*, vol. 37, p. 595.

Scott, P. (1973), 'Fatal battered baby cases', *Medicine, Science and the Law*, vol. 13, pp. 197–206.

Wallerstein, J.S. and Kelly, J.B. (1980), *Surviving the breakup: how children and parents cope with divorce*, London: Grant McIntyre.

Werner, E.E. and Smith, R.S. (1981), *Vulnerable, but invincible: a longitudinal study of resilient children and youth*, New York: McGraw-Hill.

Wilson, H. and Herbert, G.W. (1978), *Parents and children in the inner city*, London: Routledge & Kegan Paul.

Wolff, S. (1981), *Children under stress*, 2nd edn, Harmondsworth: Penguin Books.

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