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AN EXAMINATION AND DIAGRAMMATICAL DESCRIPTION OF SOCIAL CLASS VARIABLES AT CHILDREN'S PSYCHIATRIC HOSPITAL

by

Steven Louis Padover

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Education)
in The University of Michigan
1970

Doctoral Committee

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Abstract

AN EXAMINATION AND DIAGRAMMATICAL DESCRIPTION
OF SOCIAL CLASS VARIABLES
AT CHILDREN'S PSYCHIATRIC HOSPITAL

by

Steven Louis Padover

Chairman: Matthew J. Trippe

A descriptive study was undertaken at Children's Psychiatric Hospital in Ann Arbor, Michigan, to determine the answer to three major questions: Are there social class differences in the routes by which children are referred to Children's Psychiatric Hospital? Are children's treatment plans related to their social class? And are there any differences in the suggested dispositions of children that might be related to social class?

The population consisted of six hundred and forty-eight children for whom services were requested during the period of July 1, 1967, to July 1, 1968. Social class was considered the independent variable. For statistical purposes, the population was divided into two groups, lower class and middle-upper class. (The term middle-upper class was used to denote a combination of middle class and upper class children).

Chi square tests of significance were utilized to test the hypotheses. In addition to this traditional manner of analyzing data, diagrammatical flow charts were created to graphically illustrate the routes of lower and middle-upper class children through the hospital system. In combination with the flow charts, conditional probabilities were computed. By combining the chi square statistic with the flow charts and conditional probabilities, the researcher was able to examine group differences and similarities, and was also able to bring the "movement" of individual children clearly into focus.

Results indicated that there were significant differences between lower and middle-upper class children with reference to source of referral, locus of the problem, place of residence prior to referral, staff scheduled with, acceptance or rejection for further evaluation, as well as differences in academic and behavioral ratings in the schools. However, the researcher did not find statistically significant differences with regard to diagnosis, prognosis, treatment recommendation, and final disposition of children once evaluated at Children's Psychiatric Hospital.

The study was undertaken to provide some baseline data in the more broadly defined area of social class and mental illness in children. Although the findings may be unique to

the institution studied, the author felt that the presentation and use of the flow charts and conditional probabilities provided a potentially useful methodology that could be utilized by any institution to study itself.

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To Elaine and Erik Hockman I am most grateful for invaluable statistical and methodological consultation inspite of dirty diapers and spit-up pablum. Also special thanks to Joan Pinsky for typing the final draft on rather short notice.

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myself.

And finally this dissertation must be dedicated to my wife, Ann, without whose love, untiring devotion and belief in me, I would never have completed this project or my graduate career. The years I have spent with her have been the happiest I have ever known and in looking forward to the years ahead I know that the best is yet to come.

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CHAPTER I

INTRODUCTION

The Rationale

The problems associated with the care and treatment of emotionally disturbed children are becoming more numerous and more difficult each year. Limited facilities, funds and a lack of skilled practioners are serious handicaps to attempts at providing quality services for mentally ill children.

According to Rosen, Kramer, Redick, and Willner (1968), several surveys have suggested that approximately two to three percent of our school age children are in need of psychiatric care. They also indicate that another seven percent have emotional problems that require some assistance but are not serious enough to require psychiatric intervention.

If census projections (U.S. Department of Commerce, 1967) are combined with the two percent estimate previously mentioned, this would mean that one million four hundred thousand children were in need of psychiatric care in 1966. However, the National Institute of Mental Health estimates that less than five hundred thousand children actually obtained

such care (Rosen et al., 1968).

Looking toward the future and utilizing a conservative population projection (U.S. Department of Commerce, 1967) in conjunction with a ten percent estimate of children having some type of emotional problem ranging on a continuum from mild to serious (Bower, Lourie, Strother, and Sutherland, 1969), one finds that the mental health profession will have to provide services for just under eight million children by 1975.

Manpower projection figures offer little hope that this need can be met. Instead they suggest that by 1972 the mental health profession will be providing fifteen percent less service to children than they are able to provide at the present time (Rosen et al., 1968).

As has been previously documented, these children, many of whom are victims of familial and societal turmoil, will continue to turn up in the wards, out-patient clinics, and day care centers of our hospitals across the nation. Often these children have tried to escape the harsh reality that surrounds them by either turning inward toward themselves or by striking out aggressively at the world that is so threatening to them (Axline, 1947; Berkowitz & Rothman, 1960; and Redl & Wineman, 1951).

Some of these children are deeply disturbed and confused

about themselves and the world around them. But there are also other children who enter mental hospitals not necessarily because they are disturbed themselves, but because they are "disturbing" to others. It is this latter group of children, the ones who are "disturbing" to their environment with which this author is particularly interested.

The problem of the disturbing or deviant child has been well described by a number of people including Kelly (1966), Rhodes (1967), Schafer (1965), and Trippe (1966).

Rhodes (1967) suggests that there is a reciprocal relationship between the culture violator (the disturbing or deviant child) and the culture bearer (society). He further suggests that deviant individuals cause a great deal of anxiety within a social system. In an effort to reduce that anxiety, society's usual response is to either label the deviant or label and remove him from the system.

Both Trippe (1966) and Schafer (1965) have noted the importance of understanding the interaction of the school as a social system with the child. Trippe (1966) states:

> "It is quite possible that today we are dangerously close to viewing difficult, deviant, disturbing children in such a way that the concept of 'emotionally disturbed' is applied when there is no other readily available category, particularly if that behavior disturbed others (pp. 36-37)."

And Schafer (1965) suggests that:

> "When we view deviant behavior interactionally we must concern ourselves with the other parties involved in the labeling process, e.g., schools, agencies, hospital, etc. (p.13)."

The question of how and why some children and not others are labeled as emotionally disturbed is an interesting question when it is viewed from an ecological perspective. Kelly (1966) states that:

> "One of the primary features of an ecological conception of behavior is the redefinition of pathology. Behavior is not viewed as sick or well, but is defined as transactional, an outcome of reciprocal interaction between specific social situations and the individual (p.10)".

From this point of view there must be as much concern for the "responder" as there is for the "excitor" and it is perhaps in the interaction of these two that the most meaningful target for intervention will be found. The ecological perspective refutes the "gremlin" or host organism theory of disturbance (i.e., that there is something wrong with the child). This medically oriented perspective (with its emphasis on treating sickness), suggests that the disturbed individual be taken out of the system, provided with psychotherapy or some other treatment and then be returned to the system. Laing and Esterson (1964), and Lemert (1962) view the medical perspective with some concern and have noted the importance of viewing psychiatric symptoms within

a social system context.

The Problem

The question of what is normal behavior and what is deviant behavior is culturally defined (Becker, 1963). Very often a child's actions and reactions to a situation are viewed as deviant by an individual whose value orientation and socialization are very different from the child he is judging. This lack of cultural communication often results in anger and frustration on the part of both the child and the adult. Schafer (1965) suggests that:

> "The nature of tolerance limits related to deviant behavior is likely to include an individual's 'latent identity' (p. 11)."

Examples of latent identity would encompass such things as sex, race, and social class. It would then seem that the social class of an individual is critical with regard to how he views the world as well as how the world views him in return.

The questions being studied here are: Are there social class differences in the routes by which children are referred to Children's Psychiatric Hospital? Are children's treatment plans related to their social class? And are there any differences in the suggested dispositions of children that might be related to social class?

The value of a study of this nature is not necessarily

dependent upon validating hypotheses through statistical significance. At best these hypotheses can only be suggestive of trends. If this study is to provide a contribution to the broader area of social class and mental illness in children it will do so on an exploratory level. Hopefully it will provide a clear picture of the social system variables that might have resulted in unwitting prejudicial and discriminatory institutional practices at Children's Psychiatric Hospital. It is suggested that, if differences are found in this institution, an awareness of these practices might result in greater sensitivity (i.e., a more comprehensive approach that would consider all aspects of the individual in other institutions as well as Children's Psychiatric Hospital, resulting in better mental health care for all people whatever their social class).

CHAPTER II

REVIEW OF THE LITERATURE

An Overview

The study of social class and mental illness has a fairly substantial literature. One of the most notable contributions is Hollingshead's and Redlich's (1958) study of the New Haven community, which indicated that prevalency rates of mental illness were higher for people in the lower social class. Many other studies have supported this finding including Faris and Dunham (1939), Srole, Langner, Michael, Opler and Rennie (1962), Leighton, Harding, Macklin, Macmillan and Leighton (1963), and Langner and Michael (1963).

While these findings seem perfectly clear for the adult population, there seem to be some discrepancies in the studies related to social class and mental illness in children. In fact, Baker and Wagner (1965) suggest that the relationship of socioeconomic status and mental illness may be different for children than it is for adults.

In an attempt to illustrate this point, Baker and Wagner (1966) found no significant differences between the social class of a child and his chance for acceptance in treatment in an outpatient psychiatric clinic. McDermott, Harrison, Schrager, Lindy and Killins (1967) also found no significant differences in social class status with relation to the

occurrence of diagnosed psychosis in children seen at the University of Michigan Children's Psychiatric Hospital. And lastly, Hunt, Gurrslin, and Roach (1958) found no relationship between socioeconomic status and the length of psychotherapy for children seen in a child guidance clinic.

Routes

One of the major considerations of this study is the possibility of differences between the routes by which children are referred to mental health facilities. Hollingshead and Redlich (1958) have suggested that lower class adult patients are usually referred by the police, courts and social agencies, while middle and upper class adult patients are more likely to be referred by families, self, and private physicians. This finding has been supported by a number of other researchers including Rosengren (1962) in his study of twenty young male psychiatric inpatients and Pfouts, Wallach and Jenkins (1963) in their study of adult outpatient clinics.

Furman, Sweat and Crocetti (1965) in a study of children in New York under the age of eighteen found that almost one half of the low income population served by the clinic had been under some pressure by a semi-authoritative or law-enforcing agency to seek help for their child. Relatively

few families voluntarily sought assistance.

More recently Sabot, Peck and Raskin (1969) in their study of a large urban child psychiatric clinic found that thirty-eight percent of their lower class patients sought help as a result of the advice or insistence of school authorities. When all other sources of referral are taken into account, they found that seventy-five percent of the lower class families brought their children in for help upon the recommendation of some authority in the community.

Finally, in comparing the populations of young patients at the Menninger Hospital and Topeka State Hospital, Hilles (1969) discovered that more than one third of the state hospital patients had been referred by the courts and other public agencies while none of the Menninger patients had been referred in this manner.

Hollingshead and Redlich (1958) have also suggested that far more abnormal behavior is tolerated by the lower class. Shepherd, Oppenheim and Mitchell (1966) indicate that:

> "Clearly the tolerance of disturbed behavior takes its place alongside the nature of that behavior as key factors in deciding for or against referral (p. 381)."

Eisenberg (1961) supports this suggesting that for less severe disorders the major difference between a child who is

referred to a clinic and one who is not:

> ". . .may lie less in the child than in the threshold for discomfort or the diagnostic perception of his parent or his teacher (p.229)."

As a result, this greater tolerance for deviance on the part of lower class families may be indicative of lower class children being referred for treatment much later than middle class children once problem behavior becomes apparent. However, Dohrenwend and Chin-Shong(1967) disagree and suggest that lower status groups are less tolerant of deviance and that the appearance of a greater tolerance for deviance may only be "an artifact of viewing their attitude within a high status frame of reference.

McDermott, Harrison, Schrager, and Wilson (1965) also noted a significantly longer delay for referral of lower class children from the time the problem first became apparent. Baker and Wagner (1966) supported the idea that upper class parents will seek treatment for their children more often while lower class children do not receive treatment until they come to the attention of the school, courts, or police. Furman et al., (1965) offer further support indicating that lower class families do not seek help for their children until after the age of six when the need for psychiatric treatment is brought to their attention by schools and courts.

With regard to causes for referral, McDermott, et al., (1965) indicated that general school maladjustment was the major reason for the referral of lower class children. Bloch and Behrens (1959) supported this finding indicating that most children first expressed their difficulties in school and were referred for this reason. Behavioral difficulties in school were reported for sixty-five percent of their sample of nine hundred and sixty children referred to public residential treatment centers.

Sabot et al., (1969) report that a frequency order listing of presenting problems indicated that anti-social behavior in the school and home was the most frequent cause of referral. Malmquist (1965) offers further support indicating that lower class patients usually arrive at a clinic as a result of referral by an authority figure for "acting out". Hilles (1969) also supports this finding suggesting that lower class patients were more likely to have been found disruptive by the community.

Finally, Roach, Gurrslin, and Hunt (1958) indicate that:

> "Aggressive and acting out behavior apparently comprises the largest single basis for clinic referral, perhaps because such behavior is most disturbing to various cultural agents (p. 186)."

Diagnosis

When considering the problem of diagnosis, Hollingshead

and Redlich (1958) have suggested that adult patients with similar symptoms will receive differing diagnoses that to a great extent are dependent upon their social class. Similarly, Haase (1956) has indicated that the same set of symptoms will be diagnosed more severely when the patient is perceived to be a member of the working class rather than the middle class.

Kahn, Pollack and Fink (1959) in their study of adults in a voluntary mental hospital have noted that diagnosis is not only related to a particular behavior pattern, but is also a "value judgement in terms of social interaction". They too, supported the idea that patients with different social backgrounds and similar symptoms will receive different diagnoses. In summarizing a review of related research, Hunt (1959) stated that:

> "Whether a given patient is classfied as say schizophrenic when diagnosis is uncertain will be in some measure a function of his social status (p. 99)."

While Hilles (1969) did not find any differences in the diagnosis of schizophrenia between patients at the state and private hospital she compared, she did note that a greater percentage of neurotic or characterneurotic diagnoses (i.e., anti-social reaction, addiction to alcohol, etc.) were more prevalent at the state hospital.

Finally, McDermott et al., (1965) in a study of skilled and unskilled blue-collar workers found that personality disorders including borderline psychoses were diagnosed significantly more often for the children of the unskilled workers. However, it is interesting to note, as has been previously indicated, that McDermott, Harrison, Schrager, Lindy and Killins (1967) also found in a later study no significant differences in the occurrence of diagnosed psychoses among the five social class groupings seen at their clinic.

Nature of Treatment

A great deal has been written with regard to the nature of treatment received by mental patients. Hollingshead and Redlich (1958) have reported that upper class adult patients are more likely to receive intensive psychotherapy, while lower class patients are more likely to receive short term psychotherapy, pharmacologic, or custodial care. This finding has been supported by a number of studies, including Schaffer and Myers (1954), Lorr, McNair and Russell(1960), Brill and Storrow (1960) and more recently by Rowden, Michel, Dillehay and Martin (1970).

Robinson, Redlich and Myers (1954) have reported similar findings and indicate that the type of psychotherapy given (i.e., psychoanalysis, analytic psychotherapy, eclectic therapy,

relationship therapy, group therapy, etc.) was a direct function of the patient's social class. As a result if a lower class patient did receive therapy it would more likely be group therapy rather than individual therapy. With regard to children, Harrison, McDermott, Wilson and Schrager (1965) have indicated that the child of an executive had twice as great a chance of being offered intensive psychotherapy as the child of a blue collar worker.

In contrast to these findings, Hilles (1969) was quite surprised to find that there were no significant differences between the percentages of upper and lower class patients receiving psychotherapy in the population of young patients she studied. Baker and Wagner (1966) supported this finding when they indicated that they found no significant relationship between the social class of the child and his chances of being accepted for treatment. More recently, McDermott, Harrison, Schrager, Killins and Dickerson (1970) indicated that they found no differences in the use of "uncovering" or "supportive" therapy.

Hunt (1960) has provided some interesting information regarding the drop-out rate of lower class patients at a child guidance clinic. He noted that seventy percent of the middle and upper class population progressed from the intake phase to the treatment phase, while only thirty percent of the work-

ing class population made similar progress. He further noted that twenty-five percent of the upper and middle class patients completed therapy while only nine percent of the lower class patients did so.

Schaffer and Myers (1954) have suggested that upper class adult patients were more likely to be treated by more experienced staff members. This finding was supported by Hunt et al., (1958), and Baker and Wagner (1966) in their studies of child populations. However, Brill and Storrow (1960) did not find any significant differences in the experiential level of staff members treating upper and lower class adult patients.

Finally, Harrison, McDermott, Schrager and Showerman (1970) found that there was a tendency to assign poorer prognoses to lower class children. Similarly, Cole, Hardin-Branch, and Allison (1962) in an analysis of adult outpatients found that upper class patients had a better chance of being listed as "socially improved" at the time of discharge. In contrast, Hilles (1969) and McDermott et al., (1970) found no significant differences in improvement ratings. Hilles (1969) also noted that one half of the state hospital patients were on pharmacologic care, while less than one third of the Menninger patients were receiving this type of treatment.

Length of Treatment

The findings regarding the length of stay in treatment are interesting. Imber, Nash, and Stone (1955) found that lower class adult patients remained in psychotherapy for significantly shorter periods of time. This is supported by the work of Auld and Myers (1954), Hollingshead and Redlich (1958), and Myers and Schaffer (1954), all of whom indicate that upper socioeconomic adult patients remain in treatment longer than do lower socioeconomic patients. McDermott et al., (1970) in their study of children also found a significant difference in the length of treatment indicating that upper-middle class children remained in treatment longer.

However, Hunt et al., (1958) found no significant relationship between socioeconomic status and the length of psychotherapy for children seen in a child guidance clinic. This work is supported by Tuckman and Ravell (1959) who found no relationship between socioeconomic status and the "maintenance of contact in intake and diagnostic evaluation" for children admitted as psychiatric outpatients.

Length of Stay

The findings with regard to length of stay are also rather inconsistent. Vornbrock and Wenos (1967) in their study of adults at the State Psychopathic Hospital in Iowa

City, Iowa, noted that "social class was not significantly related to the length of hospital stay." These findings were supported by the studies of Wanklin, Fleming, Buck and Hobbs (1956) and Brody and Fishman (1960).

Kahn, Pollack and Fink (1959) have indicated that there is a positive relationship between length of hospital stay and education i.e., adult patients with less education stay a shorter period of time. Hilles' (1969) study of younger patients also supports this finding.

However, these studies must be contrasted with reports by Mason, Tarpy, Sherman and Haefner (1960) and Ziegler and Phillips (1961), all of whom indicated that lower class adult patients tended to have a longer hospital stay. Rosengren (1962) also reported that lower socioeconomic psychiatric inpatient boys' mean length of stay was longer than that of middle class boys.

Generally, a greater consistency in findings is noted with relation to schizophrenic patients i.e., lower socioeconomic patients are hospitalized longer, according to Hardt and Feinhandler (1959), Linn (1960), and Brown (1960. Rosengren (1962) also noted that many of the lower socioeconomic boys did not return to their families after hospitalization. Hollingshead and Redlich (1958) have suggested that once a lower class adult patient is committed to

a mental institution there is little likelihood that he will return to his family.

Summary

What the literature seems to present is a rather clear relationship between social class and mental illness in adults. However, the findings with regard to children do not seem to be as numerous or as clearly defined.

CHAPTER III

METHODOLOGY

The Institution

Children's Psychiatric Hospital is a tax-supported psychiatric facility which is part of the University of Michigan Medical Center. Basic services offered by the hospital include residential treatment, outpatient treatment, day care, and diagnostic and consultative services.

With a commitment to both teaching and training, Children's Psychiatric Hospital combines the disciplines of psychiatry, psychology, social work and education in an attempt to provide services for "disturbed" and disturbing children and their families.

According to Harrison et al., (1965), in the selection of patients an attempt is made to preserve a balance between the "training, research, and service needs" of the hospital.

At intake a social worker generally has the responsibility of tentatively evaluating all referrals. Initial contact with the hospital is usually in the form of a letter, a telephone call or referral from another department within the medical complex. At this point, based on the intake worker's knowledge of the hospital facilities as well as the needs of the patient, some requests for services are referred

to other agencies.

The remaining referrals are presented to an intake screening committee where recommendations for or against further consideration are made. Following an outpatient evaluation another screening committee will make a recommendation regarding the disposition of the patient. Throughout this phase there are waiting periods, and Westman, Vaughan and Zrull (1964) indicated that " a significant number of patients do not reach treatment" i.e., "during one year, one third of the families did not accept treatment when it was offered after a six to twelve month wait." Furthermore, the hospital maintains complete control over decisions regarding the patients they accept or reject for treatment. As a result, the determination of any given population at this hospital is heavily influenced by the training and research needs of the institution.

Population

Coded data (see code manuals in Appendix A) on six hundred and forty-eight children for whom services were requested from Children's Psychiatric Hospital during the period of July 1, 1967 to July 1, 1968, were analyzed. The population consisted of four hundred sixty-two males, one hundred eighty-five females and one child of undetermined sex. The children ranged in age from one to seventeen years.

Social Class

The intake code manual (see Appendix A) provided information concerning the occupational index of the adult responsible for the child who was referred to the hospital. As a result, the determination of an individual child's social class was based on the occupational scale of Hollingshead's Two Factor Index of Social Position. Reiss (1962) had indicated that occupational status correlates well with other indicators of social class. It should also be noted that the vast majority of the studies cited in the review of the literature have employed Hollingshead's index as a means of determining an individual's social class.

The occupational index was coded on the basis of eight occupational categories.

1. Higher executive, proprietors of large concerns and major professionals. N=63
2. Business managers, proprietors of middle sized concerns and lesser professionals. N=34
3. Administrative personnel, small independent businesses, minor professionals. N=64
4. Clerical and sales workers, technicians and owners of little businesses. N=105
5. Skilled manual employees. N=97
6. Machine operators and semi-skilled employees. N=85

7. Unskilled employees. N=50

8. Unemployed, on relief. N=33

For purposes of statistical analysis, categories six, seven, and eight were collapsed into one category and labeled "lower class", with an N of 168. The upper and lower middle class were combined by collapsing categories one, two, three, four and five and labeling that category "middle-upper class" with an N of 363. There were one hundred and seventeen referrals that did not contain any occupational information and therefore could not be assigned to a particular social class. These cases were dropped from further consideration after analysis had determined that their percentages in the various other categories being considered did not differ significantly from the total population.[1]

Research Design

Focus

This study will attempt to describe certain social system variables which, when related to social class, may be significant in the placement and disturbance career[2] of children

---

[1] This was determined by inspection of the variables with significant chi squares to determine if there were any categories where the individuals that did not have an indication of social class represented extremes as opposed to means within a particular category

[2] A disturbance career will be defined in this study as that period of time that begins when the child is first referred and ends when a recommendation for disposition has been made by the hospital

who have been referred to Children's Psychiatric Hospital and have been labeled emotionally disturbed. There will be no attempt to interpret the relationships discovered between the variable in this study, but only to describe them clearly.

General Hypothesis

The main hypothesis is that the child's level of social class will significantly influence:

A. The route by which the child is referred to the hospital

B. The treatment plan that is recommended during evaluation.

C. The suggested disposition of the child as a patient.

Specific Hypotheses

Specific hypotheses with regard to intake:

A. Lower class children will more often be referred to the hospital by courts and other social and governmental agencies, while middle-upper class children will more often be referred by either their families or physicians.

B. From the time that a problem first becomes apparent, lower class children will be referred for treatment significantly later than middle-upper class children.

C. Lower class children will not have been living at home prior to admission to the hospital i.e., they will be more likely to have been living in a foster or juvenile home, while middle-upper class children will have been living at home.

D. Lower class children will be referred more often for acting out and/or anti-social behavior, while middle-upper class children will be referred for withdrawn and/or anxious behavior.

E. Lower class children will be referred as a result of community problems rather than family problems (i.e., the ecological locus of symptomatic behavior will tend to occur in the school and neighborhood for lower class children and in the home for middle-upper class children.

F. Lower class children will be seen for further evaluation by less experienced personnel than middle-upper class children.

G. Lower class children, during the intake phase, will be accepted less often for further evaluation than middle-upper class children.

Specific hypotheses with regard to outpatient evaluation:

Routes

A. Lower class children will exhibit poorer school behavior than will middle-upper class children.

B. Lower class children will exhibit poorer academic performance than will middle-upper class children.

C. Lower class children will be viewed more positively by their parents than will middle-upper class children.

Diagnosis

A. Lower class children will receive more severe diagnoses, including personality disorders and borderline psychosis, than will middle-upper class children.

Treatment

A. Lower class children will be recommended for psychotherapy less often than middle-upper class children.

B. Lower class children will be given a less positive prognosis at the time of evaluation than will middle-upper class children.

Disposition

A. Lower class children will be referred more often to agencies other than Children's Psychiatric Hospital, while middle-upper class children will be recommended for day care or inpatient evaluation.

Statistical Design

Chi-square

Social class was used as the independent variable and was tested for its relationship to the specific hypotheses previously stated. The PSCF Blitz program, which provides joint frequency distributions, percentages and chi square tests of independence were utilized in an attempt to find which relationships were significantly different from chance. (See Appendix B for a technical description of the PSCF Blitz program).

The chi square statistic is useful in determining relationships between qualitative variables. A significant chi square would be indicative of the fact that there is more than a chance relationship among the particular qualitative variables being tested. However, a note of caution in using the chi square should be observed, and that is that a significant chi square is not indicative of causality, but only of the fact that a relationship does exist.

Appendix C provides a graphic example of how the chi square statistic was utilized in this study.

Flow Chart

A descriptive flow diagram has been developed in an attempt to chart the routes of individual patients. The charts provide a visual representation of the route each child takes from the time he is first recognized as deviant within his social system until a final recommendation for disposition is made by the hospital. The diagram will also provide proportional representations indicating the relative prevalence of individuals within each category.

With proportional representations the conditional probability of an individual following a particular path can be easily assessed. According to Mosteller, Rourke and Thomas (1961):

> "the conditional probability of A, given B, is denoted by P(A/B), and is defined by the equation:
>
> $$P(A/B) = \frac{P(A \cap B)}{P(B)}, \text{ if } P(B) \neq 0$$ (p. 88.)"

Conditional probabilities enable the researcher to determine answers to numerous questions which might arise as a result of inspecting the flow chart. An example would be determining the probability of a lower class child being - "A" - accepted for treatment at Children's Psychiatric Hospital given -"B"- a particular diagnosis. Therefore

the conditional probability would be the probability of a lower class child being either accepted or rejected for treatment and given one of seven diagnoses (see Table 1)

TABLE 1

REPRESENTATION OF HYPOTHETICAL CONDITIONAL PROBABILITIES

	B_1	B_2	B_3	B_4	B_5	B_6	B_7
A_1							
A_2							

Where A_1= accept for treatment, A_2= reject for treatment, B_1= brain syndrome, B_2= psychotic disorder, B_3= psychoneurotic disorder, B_5= personality disorder, B_6= mental deficiency, B_7= supplementary diagnosis

The flow diagram is being utilized as a tool to provide an efficient, uncomplicated methodology by which Children's Psychiatric Hospital can examine itself. Diagrams of this nature are undoubtedly an outgrowth of the modern computer age that requires visual representation of the logical structure of systems (Scheff, 1966).

Viewing the hospital systems (e.g., intake, diagnosis and treatment) diagrammatically allows one to see the "flow" or "movement" of a child as he makes his way through the system. In this manner, the flow diagram provides a logical method for examining the interactional or systemic nature of the phenomena that the child is experiencing within the system.

Snyder (1967) used a similar diagrammatical representation in his study of students at the Massachusetts Institute of Technology as they moved through the various curricula. The diagram provided a variety of information concerning the programs that seemed most difficult as well as the semesters that seemed to be most stressful for particular types of students.

The flow chart being utilized in this study was originally developed by a graphics engineer in response to a request that there was a need for useful representation of statistical data that had been gathered. The visual representation employed by Snyder in 1967 and by the author in the present study does not appear to have been employed by other researchers. An intensive search of the literature indicates that most studies have continued to report findings in the more traditional manner of statistical tables and graphs.

The combination of the diagrammatical chart and the chi square test of significance would appear to provide a useful methodology for examining the interaction between the individual and the hospital system. It should be noted that while the labels associated with the boxes of the flow chart are unique to this particular research, the general structure would be applicable to any system.

As has been previously noted the chi square statistic only provides the reader with an indication of whether or not a relationship exists between any two variables. However, when the flow chart is utilized in conjunction with the chi square statistic the reader is then able to view all the variables at one time. Viewing variables within the context of the larger system should help the researcher maintain an ecological perspective so that one particularly significant relationship that might have occurred by chance is not given undue emphasis. In this manner, one can observe the "movement" of an individual through the system and note whether or not his path was random or influenced by social class.

In summary, this particular adaption of the flow chart, utilizing conditional probabilities, is a new one and has not been used extensively previously. Its use, coupled

with statistical data gathered from chi square analyses should help provide the researcher with an opportunity to visually represent what is taking place in a system, to report visually on the outcome of hypotheses (as well as in the traditional statistical manner) and to raise questions that might be studied in later research.

CHAPTER IV

RESULTS

Intake

Source

The first hypothesis was related to the routes by which children found their way to Children's Psychiatric Hospital. Based on the work of Hollingshead and Redlich (1958), Rosengren (1962), Furman et al., (1965), Sabot et al., (1969) and Hilles (1969) it was suggested that lower class children would be referred more often than middle-upper class children by the courts and social agencies while middle-upper class children would be referred more often than lower class children by their parents or a family physician. An analysis of the data supported this hypothesis, (see Table 2)

It is interesting to note that referral by parents was the major route by which most children entered Children's Psychiatric Hospital regardless of their social class. Referral in this manner accounted for thirty-eight percent of all children. Referral by the school social worker (eighteen percent) and private physicians (ten percent) provided the next highest percentages for children without regard to class differences.

TABLE 2

SOURCE OF REFERRAL

	Lower Class	Middle-Upper Class	Total
Parent	.25	.44	.38
School Social Worker	.25	.14	.18
Court	.11	.01	.05
Private M.D.	.07	.11	.10
Social Agency	.08	.05	.06
Pediatrics	.04	.07	.06
School, other	.04	.05	.05
U.M., non Pediatric	.02	.05	.04
Child Guidance Clinic	.05	.02	.03
Other	.04	.03	.03
C.P.H. staff	.00	.02	.02
Relative	.02	.00	.01
Private Psychiatrist	.01	.00	.00
No source	.01	.00	.00

$X^2 = 63.38$, d.f. = 13, $p < .001$

However, an inspection of the data taking into account class differences indicated that while forty-four percent of the middle-upper class children were referred by their parents, only twenty-five percent of the lower class children were referred in this manner. With regard to referral by the social worker, it was found that fourteen percent of

the middle-upper class children were referred as compared to twenty-five percent of the lower class children. It was of interest to the researcher that an equal percentage of lower class children were referred by either their parents or the school social worker while there was quite a disparity between parental and school social worker referrals in favor of parental referrals for middle-upper class children (forty-four percent as opposed to fourteen percent). The hypothesis was further borne out with regard to court referrals, in that eleven percent of the lower class children were referred by the court while only one percent of the middle-upper class children came to the hospital via this route.

Other sources of referral generally indicated that higher percentages of lower class children were referred by non-parent relatives, social agencies, and child guidance clinics, while middle-upper class children were more often referred by school personnel other than the social worker, private physicians or psychologists, the pediatrics department and other medical center departments.

Delay of Referral

The second hypothesis stated that lower class children will be referred for treatment at a significantly later date than middle class children. This was based on the

suggestion by Hollingshead and Redlich (1958) that lower class families have a greater tolerance for deviance, as well as on indications by other researchers that there was a longer delay for the referral of lower class children from the time the problem first became apparent than there was for middle-upper class children (McDermott et al., 1965; Baker et al., 1966; and Furman et al., 1965).

This hypothesis was not supported by the data. Two sections of the code manual provided information regarding this particular hypothesis. The first section was listed in the Intake Code Manual (see Appendix A) as "Length of Time Seeking or Offered Help Regarding this Child" and the possible categories were:

1. under a year
2. one to three years
3. three years and over

The data indicated that while forty-six percent of families had been seeking help for under one year, there was no significant difference between the social classes and the length of time seeking help. The second section of data was gleaned from the Outpatient Evaluation Manual (see Appendix A). This variable was listed as "Duration of presenting Complaint" and provided possibilities for rating complaints of:

1. less than one month
2. one to three months

3. four to six months
4. seven to twelve months
5. one to two years
6. two the three years
7. over three years
8. life long

Again, while thirty-four percent of the patients indicated that the presenting complaint had had a duration of over three years there was no significant difference between middle-upper and lower class patients.

Residence

The third hypothesis suggested that lower class children would not have been living at home prior to their admission to the hospital. Much of this hypothesis is based on an extension of the data from the first hypothesis i.e., involvement of lower class children with courts, social agencies, etc., as well as on the indications by Sabot et al., (1969) and Hilles (1969) of frequent anti-social, distruptive behavior. The Intake Code Manual had a section headed "Child's Type of Residence" under which was listed:

1. Home
2. Foster Home
3. Boarding school
4. Residential placement
5. State Hospital or Institution
6. Detention home

The chi-square analysis of this variable supported the previously stated hypothesis. Table 3 can be examined in order to further clarify the data.

TABLE 3

CHILD'S TYPE OF RESIDENCE

	Lower Class	Middle-Upper Class	Total
Home	.89	.96	.93
Foster Home	.06	.03	.04
Boarding School	.01	.00	.00
Residential Placement	.02	.01	.01
State Hospital	.00	.00	.00
Detention Home	.02	.00	.01
Unknown	.00	.00	.01

$X^2 = 11.29$, d.f. = 5, $p < .05$

Although ninty-three percent of both middle-upper and lower class children had been living at home prior to referral there were significant differences between them. Ninety-six percent of the middle class children had been living at home prior to referral, as compared with only eighty-nine percent of the lower class children. Furthermore, if we combine the other five categories to indicate placement in other than the home, we find that eleven percent of the lower class children were not living at home as opposed to four percent of the middle class children.

Reason for Referral

The fourth hypothesis regarding routes indicated that

lower class children would be referred more often for acting out and/or anti-social behavior while middle-upper class children would be more likely to be referred for withdrawn and/or anxious behavior. Indications regarding the prevalence of acting-out agressive behavior by Roach et al., (1958), Malmquist (1965), Hilles (1969) and Sabot et al., (1969) provided the basis for this hypothesis. An analysis of the data listed under "Major Reason for Referral" in the Intake Manual did not support this hypothesis.

However, some interesting trends were noted. Anti-social behavior (sixteen percent), hyperactive distractible behavior (sixteen percent), and poor academic performances (fourteen percent) comprised the most frequent reasons for referral for all children regardless of social class. There did seem to be a trend indicating that middle-upper class children were more likely to be referred for poor academic performance (sixteen percent vs. nine percent), and that lower class children were more likely to be referred for anti-social behavior (twenty-two percent vs. thirteen percent). Anxiety tended to be more of a problem for the middle-upper class child, while referral for bizarre behavior seems to be reported about equally for both groups.

Locus of Problem

The fifth hypothesis suggested that lower class children

would be more likely to be referred as a result of problems in the community and in the school as opposed to problems within the family. The work of Bloch and Behrens (1959) and McDermott et al., (1965), both of whom indicated that general school maladjustment was the major reason for referral, as well as the studies of Sabot et al., (1969), Malmquist (1965), Hilles (1969) and Roach et al., (1958) formed the background for this hypothesis.

Although the chi square did indicate a significant difference very few actual differences were noted with the exception of the fact that only one percent of the middle-upper class children were referred for problems within the community while five percent of the lower class children were referred because of community problems. (see Table 4 below for an illustration of the outcome of this hypothesis.)

TABLE 4

LOCUS OF THE PROBLEM

	Lower Class	Middle-Upper Class	Total
No Information	.01	.04	.03
School	.39	.41	.41
Home	.30	.29	.29
Community	.05	.01	.02
Combination	.24	.25	.24

$X^2 = 10.55$, d.f. = 4, $p. < .05$

An examination of the data indicates that, as had been suggested in previous studies, the major source of problems was manifested in the school with a total of forty-one percent of all referrals coming from there. A total of twenty-nine percent of the problems seen manifested themselves in the home, while twenty-four percent of the children manifested their problems in both home, the school, and the community. Interestingly, only two percent of the total problems were reported to have manifested themselves in the community.

Scheduled With

The sixth hypothesis suggested that lower class children would be seen by less experienced personnel than would other children. This hypothesis was based on the work of Hunt et al., (1958), Schaffer and Myers (1954), and Baker and Wagner (1966) who found differences in the experiential level of staff members treating lower class patients as well as the work of Brill et al., (1960) who did not find any significant differences with regard to this variable. The Intake Code Manual provided an indication of whom the child will be seen by for further evaluation e.g.:

Scheduled with

1. Resident
2. Medical student
3. Senior staff
4. Other C.P.H. personnel

An analysis of the data supported this hypothesis. Unfortunately, the vast majority of cases (forty-four percent) did not have any indication on their records of whom they would be scheduled with.

However, an examination of Table 5 shows that while thirty-seven percent of the middle-upper class children did not have any indication of whom they would be seen by, forty-six percent of the lower class children fell in this category. Almost equal percentages of patients were scheduled with medical students and residents.

TABLE 5

SCHEDULED WITH

	Lower Class	Middle-Upper Class	Total
Resident	.30	.31	.31
Medical Students	.19	.20	.20
Senior Staff	.01	.06	.05
Other Personnel	.06	.03	.05
No Indication	.46	.37	.44

$X^2 = 10.23$, d.f. = 4, p. .05

But it is at the senior staff level, with whom five percent of all patients were scheduled, that we find some differences. Six percent of the middle-upper class children

were scheduled with senior staff, while only one percent of the lower class children were scheduled in this manner. Six percent of the middle-upper class patients were also scheduled with other C.P.H. personnel e.g., psychology, social work, etc., as opposed to only three percent of the lower class children.

Accept-Reject

The seventh hypothesis suggested that during the intake phase, lower class children would be accepted less often for further evaluation than would middle-upper class children. This was mainly based on the work of Hunt (1960), who found a much higher drop-out rate for lower class children than he did for middle-upper class children. The final category of the Intake Code Manual indicates the disposition of the child at that time.

Statistical analysis (see Table 6) supported the hypothesis that there were significant differences in the disposition of lower class children and middle-upper class children.

Three categories under the heading of disposition seem to be particulary significant. The first, "referred to agency previously knowing family or child", indicated that twice as many lower class children (fourteen percent as opposed to seven percent for middle-upper class children) were given

TABLE 6

DISPOSITION

	Lower Class	Middle-Upper Class	Total
Referred to Other U.M. Clinic	.01	.02	.02
Referred to New Agency	.04	.06	.05
Referred to Agency Previously Knowing Family	.14	.07	.09
Advice or Information from Intake Staff	.04	.04	.04
Inpatient Prescreened and Refused	.10	.01	.04
Outpatient Prescreened and Refused	.01	.00	.00
Parents Unwilling to accept Referral	.04	.03	.03
Found other Professional Help	.06	.06	.06
Material Not Received	.05	.06	.05
Referral Changed Mind - No help Sought	.04	.02	.02
No Scheduled Appointments Kept	.01	.01	.01
O.P.E. Incomplete	.04	.03	.04
O.P.E. Complete	.45	.60	.55

$X^2 = 44.13$, d.f. = 15, $p. < .001$

this particular disposition. Analysis of the second category, "inpatient prescreened and refused" indicated that ten percent of the lower class children were given this disposition, while only one percent of the middle class children received a similar disposition. And finally, the last category, which

indicated a recommendation for an outpatient evaluation and accounted for fifty-five percent of all children, indicated that sixty percent of the middle-upper class children received a recommendation for out-patient evaluation while only forty-five percent of the lower class children received a similar recommendation.

Outpatient Evaluation

School Behavior

The eighth hypothesis suggested that of the children accepted for outpatient evaulation, lower class children would be perceived as exhibiting poorer school behavior than would middle-upper class children. This hypothesis was based on previous studies that had been reported by McDermott et al., (1965), Bloch and Behrens (1959) and Sabot et al., (1969), all of whom indicated that behavioral difficulties in the school setting were a frequent source of referral.

The Out-patient Code Manual contained a section entitled "School Behavior Adjustment" with categories indicating:

1. Too good
2. Very good
3. Good
4. Fair
5. Poor
6. Very Poor

Statistical analysis supported this hypothesis (see Table 7.

TABLE 7

SCHOOL BEHAVIOR ADJUSTMENT

	Lower Class	Middle-Upper Class	Total
Too Good	.01	.05	.04
Very Good	.09	.07	.07
Good	.08	.14	.12
Fair	.13	.16	.15
Poor	.33	.33	.33
Very Poor	.25	.08	.12
Change in Behavior	.01	.02	.01
Does not attend school	.04	.09	.07
Other	.03	.06	.05
Unknown	.03	.03	.03

$x^2 = 20.46$, d.f. = 9, $p. < .05$

One third of all the children were rated as having "poor" behavior i.e., "frequent behavioral difficulties with classmates and/or teachers". There was no difference in the percentages of lower class children (thirty-three percent) and middle-upper class children (thirty-three percent) with regard to being rated as having "poor" school behavior adjustment.

However, the differences seem to be quite significant when we consider the third category labeled "good". Four-

teen percent of the middle-upper class children were considered "good" while only eight percent of the lower class children were so considered. An even more significant finding is that twenty-five percent of the lower class children were perceived as having "very poor" school behavior adjustment while only eight percent of the middle-upper class children were perceived in this manner.

Academic Performance

The ninth hypothesis suggested that lower class children would be perceived as exhibiting poorer academic performance than would middle-upper class children. The basis for this hypothesis was found in an extension of the work of Sabot et al., (1969) regarding school achievement, as well as Bloch and Behrens (1959) and Malmquist (1965). The Outpatient Code Manual contained a section headed "Academic Performance" under which there were six possible categories:

1. Very good
2. Good
3. Fair
4. Uneven
5. Poor
6. Very Poor

An analysis of the data supported this hypothesis (see Table 8 for clarification). Approximately thirty-eight percent of the children, regardless of their social class, were preceived as having either "poor" or "very poor" academic performance. There didn't seem to be any

TABLE 8

ACADEMIC PERFORMANCE

	Lower Class	Middle-Upper Class	Total
Very Good	.04	.04	.04
Good	.07	.17	.14
Fair	.13	.11	.11
Uneven	.07	.12	.10
Poor	.21	.21	.21
Very Poor	.29	.13	.17
Underachieving	.14	.10	.11
Compulsive	.00	.01	.01
Does not attend school	.03	.09	.07
Unknown	.03	.05	.04

$X^2 = 19.55$, d.f. = 9, $p. < .05$

real difference in the percentages of middle-upper class (twenty-one percent) and lower class (twenty-one percent) children who were perceived as having "poor" academic performance. There was however, significant difference with regard to those children who were perceived as having "very poor" academic performance. More than twice as many lower class children (twenty-nine percent) were perceived as having poorer academic performance than middle-upper class children (thirteen percent), while twice as many middle-upper

class children (seventeen percent) were perceived as "good" or doing well in school than were lower class children (seven percent).

Home Behavior

The tenth hypothesis suggested that lower class children would be viewed more positively by their parents. This particular hypothesis was an outgrowth of the suggestions by Hollingshead and Redlich (1958) and others that lower class families have a greater tolerance for deviance.

The Outpatient Evaluation Code Manual provided a heading labeled "Home Behavior Adjustment" under which the following categories were found:

1. Too good
2. Good
3. Fair
4. Poor
5. Very Poor

Analysis of the data did not support this hypothesis. Some interesting trends were noted though. Thirty-five percent of the children, regardless of social class, were viewed as being "fair" i.e., somewhat of a behavior problem in the home. Also twice as many lower class parents as opposed to middle-upper class parents rated their child as being "very poor" i.e. completely unmanageable.

Diagnosis

The eleventh hypothesis suggested that more severe

diagnoses would be applied to lower class children than would be applied to middle-upper class children. The studies regarding this particular hypothesis are rather inconsistant in their findings. Hollingshead and Redlich (1958), Kahn et al., (1959), Haase (1956) and McDermott (1965) all suggested that there was a relationship between diagnosis and social class. However, Hilles (1969) did not find any differences in the diagnosis of schizophrenia and McDermott et al., (1967) also did not find any difference in the occurrence of diagnosed psychosis among the various classes of patients seen at their clinic.

During the outpatient evaluation phase, a diagnosis is usually made for each child. For purposes of statistical analysis, diagnosis was broken down into seven major categories:

1. Brain syndromes
2. Psychotic disorders
3. Psychophysiologic, autonomic and visceral disorders
4. Psychoneurotic disorders
5. Personality disorders
6. Mental deficiency
7. Supplementary diagnosis

(for further clarification of the specific diagnoses contained under each heading see Appendix D).

An analysis of the data did not support the hypothesis that there were significant differences in the diagnosis received by lower class and middle-upper class children.

However, there were some interesting trends.

Sixty-nine percent of all the children seen for outpatient evaluation were diagnosed as having either a psychoneurotic or a personality disorder. The trends indicated that middle-upper class children were more likely to be diagnosed as having a psychoneurotic disorder while lower class children were more likely to have a diagnosis of personality disorder.

Treatment and Recommendation

The twelfth hypothesis suggested that middle-upper class children would be recommended for psychotherapy more often than lower class children. The previous research regarding this question is somewhat inconsistant. Hollingshead and Redlich (1958) indicated that upper class patients were more likely to receive intensive psychotherapy while lower class patients were more likely to receive short term psychotherapy, pharmacologic or custodial care. This suggestion was supported by a number of studies including Schaffer et al., (1954), Rowden et al., (1970), Robinson et al., (1954), Lorr et al., (1960), and Brill et al., (1960). In contrast Hilles (1969), Baker et al., (1966) and McDermott et al., (1970) did not find any significant differences in the use of various treatments.

An analysis of the recommended type of treatment at the

time of evaluation did not support the hypothesis that there were significant differences in treatment recommendations made for children.

It is interesting to note that forty-one percent of all the children were recommended for outpatient psychotherapy, although middle-upper class children would seem to be more likely to receive this recommendation. There is also a trend that would seem to indicate that lower class children are recommended for inpatient psychotherapy twice as often as middle-upper class children. However, by combining the percentages of children recommended for either inpatient or outpatient psychotherapy, there are almost equal percentages. Also, lower class children would seem to be recommended for special education more often than middle-upper class children.

Prognosis

The thirteenth hypothesis suggested that middle-upper class children would be given a more positive prognosis at the time of evaluation than would lower class children. This hypothesis was based on the work of Harrison et al., (1970), and Cole et al., (1962), both of whom indicated that there was a tendency to assign poorer prognoses to lower class children. In contrast Hillers (1969) and McDermott et al., (1970) found no significant differences in improvement

ratings.

An analysis of the data indicated that there were no significant differences in the prognosis for improvement ratings. There did, however, seem to be a trend that provided middle-upper class children with a prognosis of "good" while lower class children were more likely to have a prognosis of "fair". Equal percentages of children were assigned a prognosis of "poor".

Disposition

The fourteenth and final hypothesis suggested that lower class children would be referred more often to agencies other than Children's Psychiatric Hospital, while middle-upper class children would be recommended for day care or inpatient evaluation. This hypothesis was based mainly on the work of Hollingshead and Redlich (1958) and others who have indicated that people receive differential treatment based upon their social class.

An analysis of the data did not support this hypothesis. Trends in the data, however, indicated that thirty percent of the middle-upper class children were recommended for outpatient services, while this was true for only twenty percent of the lower class children. Recommendations to Child Guidance Clinics accounted for fifteen percent of the middle-upper class children and only eleven percent of the lower class

children. And finally, recommendation for inpatient service accounted for twelve percent of the middle-upper class children and only seven percent of the lower class children.

A Diagrammatical Delineation of Selected Systemic Variables at Children's Psychiatric Hospital

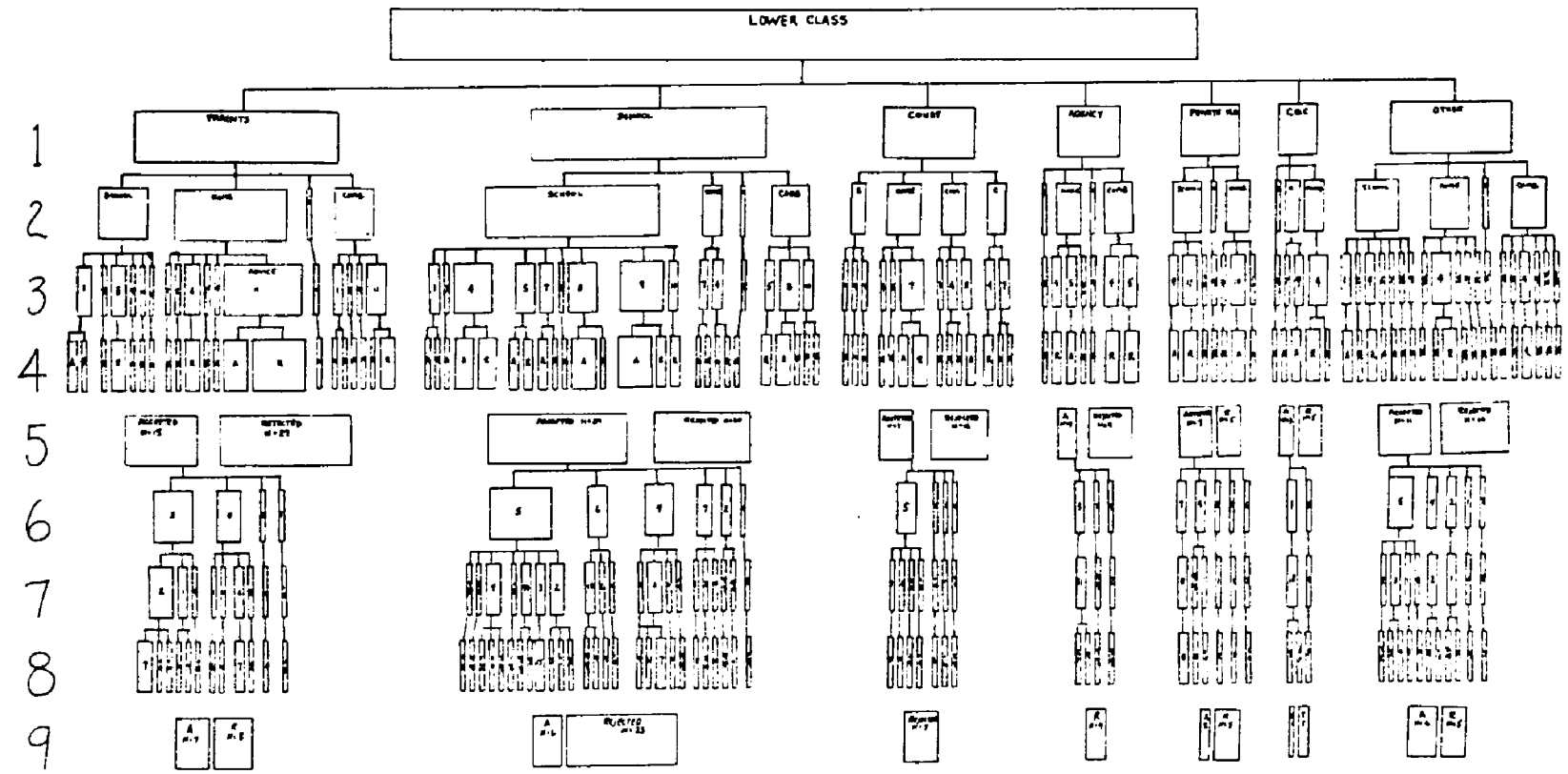
With the information gathered from statistical analysis of the data, the researcher was able to compose two flow charts that provided a diagrammatical representation of the routes through which lower and middle-upper class children passed on their way through Children's Psychiatric Hospital, (see Illustrations 1 and 2).

A study of the charts enables the reader to easily determine the relative prevalence of selected systemic variables and note their relationships to each other. The charts also facilitate the comparison of the routes of lower and middle-upper class children.

Following a thorough inspection of the charts, the author selected specific variables relevant to the hypotheses previously tested. In an effort to examine them in depth, conditional probabilities were computed so that more descriptive information could be gathered concerning the routes of the children through the hospital systems.

Illustration 1:

ROUTE OF LOWER CLASS CHILDREN THROUGH CHILDREN'S PSYCHIATRIC HOSPITAL



1. Source of Referral

   1. Home
   2. School
   3. Court
   4. Agency
   5. Private M.D.
   6. Child Guidance Clinic
   7. Other

2. Locus of Problem

   1. School
   2. Home
   3. Community
   4. Combination
   5. Unknown

3. Reason for Referral

   0. Unspecified
   1. C.P.H. outpatient
   2. C.P.H. outpatient short term
   3. C.P.H. day care
   4. C.P.H. inpatient
   5. Consultation of professionals
   6. Adoption questions
   7. Placement recommendation
   8. School placement
   9. Differential diagnosis
   10. Personality appraisal
   11. Parent request advice
   12. Other
   13. Unknown

4. Disposition at Intake

   1. Accept for evaluation at C.P.H
   2. Reject for evaluation at C.P.H

5. Disposition Summarized

   1. Accept for evaluation at C.P.H
   2. Reject for evaluation at C.P.H

OUTPATIENT EVALUATION

6. Diagnosis

   1. Brain syndromes
   2. Psychotic disorders
   3. Psychophysiologic disorders
   4. Psychoneurotic disorders
   5. Personality disorders
   6. Mental deficiency
   7. Supplementary diagnosis

7. Recommended Treatment

   0. No recommendation
   1. Psychotherapy - inpatient
   2. Psychotherapy - outpatient
   3. Supportive treatment
   4. Casework treatment
   5. Conjoint therapy
   8. Court custody
   10. Commitment
   11. Out-of-home placement
   12. Disposition left to court
   13. Psychiatric treatment
   17. Follow-up visit
   18. Special education
   20. Environmental change
   99. Other

8. Recommended Disposition

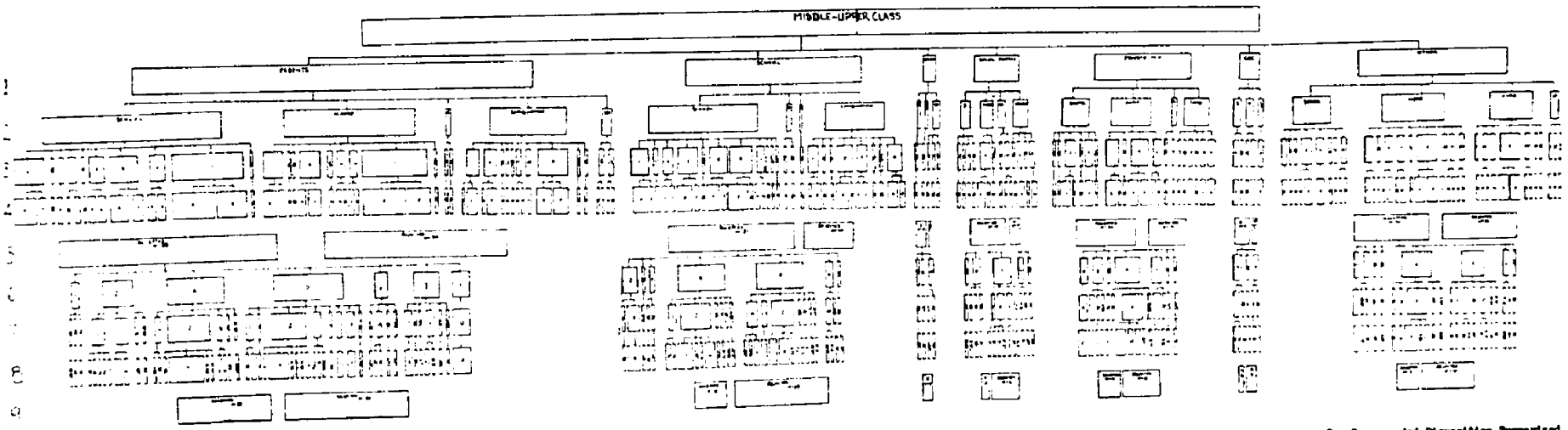
   0. No recommendation
   1. M.P.I. admission (M.P.I., C.P.H., Adol. unit)
   4. State hospital
   6. Transfer to another service other than U.M.M.C.
   7. Outpatient service
   9. Referring clinic continue with the child
   10. Private psychiatrist
   11. Child Guidance Clinic or Mental Health Clinic
   12. Family Service or Catholic Social Service
   14. Family physician
   15. Family care and supervision
   16. Court
   21. Boarding school
   24. Residential child-caring Institution
   99. Other

9. Recommended Disposition Summarized

   1. Accept for treatment at C.P.H.
   2. Reject for treatment at C.P.H.

Illustration 2:

ROUTE OF MIDDLE-UPPER CLASS CHILDREN THROUGH CHILDREN'S PSYCHIATRIC HOSPITAL



INTAKE

1. Source of Referral

   1. Home
   2. School
   3. Court
   4. Agency
   5. Private M.D.
   6. Child Guidance Clinic
   7. Other

2. Locus of Problem

   1. School
   2. Home
   3. Community
   4. Combination
   5. Unknown

3. Reason for Referral

   0. Unspecified
   1. C.P.H. outpatient
   2. C.P.H. outpatient short term
   3. C.P.H. day care
   4. C.P.H. inpatient
   5. Consultation of professionals
   6. Adoption questions
   7. Placement recommendation
   8. School placement
   9. Differential diagnosis
   10. Personality appraisal
   11. Parent request advice
   12. Other
   13. Unknown

4. Disposition at Intake

   1. Accept for evaluation at C.P.H.
   2. Reject for evaluation at C.P.H.

5. Disposition Summarized

   1. Accept for evaluation at C.P.H.
   2. Reject for evaluation at C.P.H.

OUTPATIENT EVALUATION

6. Diagnosis

   1. Brain syndromes
   2. Psychotic disorders
   3. Psychophysiologic disorders
   4. Psychoneurotic disorders
   5. Personality disorders
   6. Mental deficiency
   7. Supplementary diagnosis

7. Recommended Treatment

   0. No recommendation
   1. Psychotherapy - inpatient
   2. Psychotherapy - outpatient
   3. Supportive treatment
   4. Casework treatment
   5. Conjoint therapy
   8. Court custody
   10. Commitment
   11. Out-of-home placement
   12. Disposition left to court
   13. Psychiatric treatment
   17. Follow-up visit
   18. Special education
   20. Environmental change
   99. Other

8. Recommended Disposition

   0. No recommendation
   1. N.P.I. admission (N.P.I., C.P.H., Adol. unit)
   4. State hospital
   6. Transfer to another service other than U.M.M.C.
   7. Outpatient service
   9. Referring clinic continue with the child
   10. Private psychiatrist
   11. Child Guidance Clinic or Mental Health Clinic
   12. Family Service or Catholic Social Service
   14. Family physician
   15. Family care and supervision
   16. Court
   21. Boarding school
   24. Residential child-caring Institution
   99. Other

9. Recommended Disposition Summarized

   1. Accept for treatment at C.P.H.
   2. Reject for treatment at C.P.H.

Conditional Probabilities

Table 9 represents the probability of being accepted or rejected during the intake phase given the child's social

TABLE 9

PROBABILITY OF INTAKE DISPOSITION GIVEN SOCIAL CLASS

	C_1	C_2
D_1	.45	.60
D_2	.55	.40

D_1= accept, D_2= reject: C_1= lower class, C_2= middle-upper class.

class. The table indicates that a lower class child had a probability of .45 of being accepted for intake evaluation, while a middle-upper class child had a probability of .60 of being accepted. With regard to rejection, a lower class child had a probability of .55 while a middle-upper class child had a probability of .40 of being rejected for intake evaluation.

In discussing the remainder of the tables, the reader should be aware that the standard error measurement for this population proportion was .04.[3]

[3]The standard error is reported not for the purpose of hypothesis testing but to set a reasonable criterion for discussing those conditional probabilities which may be more than a chance fluctuation from the population probability. Probabilities containing one or less cells will not be discussed nor will probabilities that fall within two standard errors of the population probability.

TABLE 10

PROBABILITY OF INTAKE DISPOSITION OF LOWER CLASS CHILDREN GIVEN SOURCE OF REFERRAL

	R_1	R_2	R_3	R_4	R_5	R_6	R_7
D_1	.36	.54	.37	.31	.58	.37	.44
D_2	.64	.46	.63	.69	.42	.63	.56

D_1= accept, D_2= reject: R_1= parents, R_2= school, R_3= court, R_4= agency, R_5= private M.D., R_6= child guidance clinic, R_7= other

Table 10 indicates the probability of lower class children being accepted or rejected during the intake phase given their source of referral. For lower class children referred by the school or a private M.D., the probability of being accepted was greater than the probability of being accepted for all lower class children. In contrast, for lower class children referred by their parents, the court, a social agency, or a child guidance clinic, the probability of being rejected was greater than the probability of being rejected for all lower class children.

In Table 11 we note the probability of middle-upper class children being accepted or rejected during the intake phase given their source of referral. For middle-upper class

TABLE 11

PROBABILITY OF INTAKE DISPOSITION OF MIDDLE-UPPER CLASS CHILDREN GIVEN SOURCE OF REFERRAL

	R_1	R_2	R_3	R_4	R_5	R_6	R_7
D_1	.51	.72	.80	.79	.62	.75	.50
D_2	.49	.28	.20	.21	.38	.25	.50

D_1= accept, D_2= reject: R_1= parents, R_2= school, R_3= court, R_4= agency, R_5= private M.D., R_6= child guidance clinic, R_7= other

children whose source of referral was the school, the court, a social agency, or a child guidance clinic, the probability of being accepted was greater than the probability for all middle-upper class children. In comparison, for middle-upper class children referred by their parents and "other"[4] sources the probability of being rejected was greater than the probability of being rejected for all middle-upper class children.

Table 12 shows the probability of lower class children being accepted or rejected during intake, given the locus

[4] "Other" sources of referral included relatives, private psychiatrists, the pediatric department and other medical center departments or staff.

of the problem. For lower class children whose locus of the problem was the home or a combination of the home, school and community the probability of being rejected was greater than the probability of being rejected for all lower class children.

TABLE 12

PROBABILITY OF INTAKE DISPOSITION OF LOWER CLASS CHILDREN GIVEN LOCUS OF THE PROBLEM

	L_1	L_2	L_3	L_4
D_1	.50	.37	.44	.31
D_2	.50	.63	.56	.69

D_1= accept, D_2= reject: L_1= school, L_2= home, L_3= community, L_4= combination

TABLE 13

PROBABILITY OF INTAKE DISPOSITION OF MIDDLE-UPPER CLASS CHILDREN GIVEN LOCUS OF THE PROBLEM

	L_1	L_2	L_3	L_4	L_5
D_1	.45	.58	.60	.48	.75
D_2	.55	.42	.40	.52	.25

D_1= accept, D_2= reject: L_1= school, L_2= home, L_3= community L_4= combination, L_5= unknown

Table 13 represents the probability of acceptance or rejection of middle-upper class children at intake given the locus of the problem. For middle-upper class children whose locus of the problem was unknown, the probability of being accepted was greater than the probability of being accepted for all middle-upper class children. In contrast, for middle-upper class children whose locus of the problem was the school or a combination of the home, school and community the probability of being rejected was greater than the probability of being rejected for all middle-upper class children.

TABLE 14

PROBABILITY OF INTAKE DISPOSITION OF LOWER CLASS CHILDREN GIVEN LOCUS OF THE PROBLEM WITH SOURCE OF REFERRAL USED TO DEFINE THE SUBPOPULATIONS

	R_1		R_2		R_3		R_4		R_5		R_6		R_7	
	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2
L_1	.40	.60	.64	.36	.67	.33	1.00	.00	.33	.67	.00	1.00	.67	.33
L_2	.30	.70	.50	.50	.72	.28	.60	.40	.00	1.00	.33	.67	.37	.63
L_3	.00	1.00	.00	1.00	.40	.60	1.00	.00	.00	1.00	.00	1.00	.00	1.00
L_4	.37	.63	.50	.50	.25	.75	.50	.50	1.00	.00	.25	.75	.28	.72

D_1= accept, D_2= reject: R_1= parent, R_2= school, R_3= court, R_4= agency, R_5= private M.D., R_6= child guidance clinic, R_7= other: L_1= school, L_2= home, L_3= community, L_4= combination

Table 14 indicates the probability of lower class children being accepted or rejected during the intake phase given locus of the problem with source of referral used to define the subpopulations. For lower class children referred by their parents, the probability of being rejected, if the locus of the problem was in the home or a combination of the home, school and community was greater than the probability of being rejected for all lower class children.

For lower class children whose source of referral was the school, the probability of being accepted, if the locus of the problem was in the school, was greater than the probability of acceptance for all lower class children.

For lower class children referred by the court, the probability of being accepted, if the locus of the problem was in the school or the home was greater than the probability of being accepted for all lower class children. In comparison, for lower class children who were referred by the court, the probability of being rejected, if the locus of the problem was a combination of the home, the school and the community, was greater than the probability of being rejected for all lower class children.

For lower class children referred by a social agency the probability of being accepted, if the locus of the problem was in the home, was greater than the probability

of being accepted for all lower class children.

For lower class children referred by a private M.D., the probability of being rejected, if the locus of the problem was in the school, was greater than the probability of being rejected for all lower class children.

For lower class children referred by a child guidance clinic, the probability of being rejected, if the locus of the problem was the home or a combination of the school, the home, and the community, was greater than the probability of being rejected for all lower class children.

For lower class children referred by"other" sources of referral, the probability of being accepted if the locus of the problem was in the school, was greater than the probability of being accepted for all lower class children. In contrast, for lower class children referred by "other" sources of referral the probability of being rejected if the locus of the problem was in the home or a combination of the school, the home and the community, was greater than the probability of being rejected for all lower class children.

Table 15 shows the probability of middle-upper class children being accepted or rejected given the locus of the problem with the source of referral used to define the sub-populations.

For middle-upper class children referred by their parents

TABLE 15

PROBABILITY OF INTAKE DISPOSITION OF MIDDLE-UPPER CLASS CHILDREN GIVEN LOCUS OF THE PROBLEM WITH SOURCE OF REFERRAL USED TO DEFINE THE SUBPOPULATIONS

	R_1		R_2		R_3		R_4		R_5		R_6		R_7	
	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2
L_1	.61	.39	.75	.25	- -	- -	.50	.50	.73	.27	1.00	.00	.47	.53
L_2	.56	.44	1.00	.00	1.00	.00	.80	.20	.63	.37	1.00	.00	.48	.52
L_3	.50	.50	1.00	.00	- -	- -	- -	- -	.50	.50	- -	- -	- -	- -
L_4	.36	.64	.62	.38	.00	1.00	.67	.33	.50	.50	.00	1.00	.65	.35
L_5	.50	.50	- -	- -	1.00	.00	1.00	.00	- -	- -	1.00	.00	.67	.33

D_1= accept, D_2= reject: R_1= parents, R_2= school, R_3= courts, R_4= agency, R_5= private M.D., R_6= child guidance clinic, R_7= other: L_1= school, L_2= home, L_3= community, L_4= combination, L_5= unknown: ---= no occurrence of that category

the probability of being rejected, if the locus of the problem was a combination of the school, the home and the community was greater than the probability of being rejected for all middle-upper class children.

For middle-upper class children whose source of referral was the school, the probability of being accepted, if the locus of the problem was in the school or a combination of

of the home, the school and the community, was greater than the probability of being accepted for all middle-upper class children.

For middle-upper class children referred by a social agency, the probability of being accepted, if the locus of the problem was in the home was greater than the probability of being accepted for all middle-upper class children. In contrast, for middle-upper class children referred by a social agency, the probability of being rejected, if the locus of the problem was in the school was greater than the probability of being rejected for all middle-upper class children.

For middle-upper class children referred by a private M.D., the probability of being accepted, if the locus of the problem was in the school was greater than the probability of being accepted for all middle-upper class children. In comparison, for middle-upper class children whose source of referral was a private M.D., the probability of being rejected if the locus of the problem was in the community or a combination of school, home and community, was greater than the probability of being rejected for all middle-upper class children.

For middle-upper class children whose source of referral was "other", the probability of being rejected if the locus of the problem was the school or the home was greater than

the probability of being rejected for all middle-upper class children.

TABLE 16

PROBABILITY OF INTAKE DISPOSITION OF CHILDREN GIVEN PURPOSE OF REFERRAL WITH SOCIAL CLASS USED TO DEFINE THE SUBPOPULATIONS

		W_0	W_1	W_2	W_3	W_4	W_5	W_6	W_7	W_8	W_9	W_{10}	W_{11}	W_{12}	W_{13}
C_1	D_1	--	.36	1.00	.50	.21	.42	--	.50	.67	.81	.56	.31	.00	.00
	D_2	--	.64	.00	.50	.79	.58	--	.50	.33	.19	.44	.69	1.00	1.00
C_2	D_1	1.00	.59	.00	.67	.47	.64	1.00	.57	.57	.60	.62	.63	.33	.25
	D_2	.00	.41	1.00	.33	.53	.36	.00	.43	.43	.40	.38	.37	.67	.75

C_1= lower class, C_2= middle-upper class: D_1= accept, D_2= reject: W_0= unknown, W_1= C.P.H. outpatient, W_2= C.P.H. outpatient short term, W_3= C.P.H daycare, W_4= C.P.H. inpatient, W_5= consultation of professional, W_6= adoption questions, W_7= placement recommendations, W_8= school placement, W_9= differential diagnosis, W_{10}= personality appraisal, W_{11}= parent request advice, W_{12}= other, W_{13}= unknown

Table 16 indicates the probability of being accepted or rejected given purpose of referral with social class used to define the subpopulations. For lower class children the probability of being accepted if the purpose of referral was school placement, differential diagnosis or personality appraisal was greater than the probability of being accepted

for all lower class children. In contrast the probability of lower class children being rejected if the purpose of referral was a request for outpatient service at the hospital or a parental request for advice was greater than the probability of being rejected for all lower class children.

With regard to middle-upper class children the probability of being rejected was greater if the purpose of referral was inpatient services at the hospital or "other".

Table 17 depicts the probability of lower class children being accepted or rejected at the intake phase given the purpose of referral with source of referral used to define the subpopulations. For lower class children whose source for referral was parents, the probability of being accepted if the purpose of referral was differential diagnosis was greater than the probability of being accepted for all lower class children. However, for children whose source of referral was parents, the probability of being rejected if the purpose of referral was school placement or a parental request for advice was greater than the probability of being rejected for all lower class children.

For children whose source of referral was the school the probability of being accepted if the purpose of referral was placement recommendations, school placement or differ-

TABLE 17

PROBABILITY OF INTAKE DISPOSITION OF LOWER CLASS CHILDREN GIVEN PURPOSE OF REFERRAL WITH SOURCE OF REFERRAL USED TO DEFINE THE SUBPOPULATIONS

	R_1		R_2		R_3		R_4		R_5		R_6		R_7	
	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2
W_1	.50	.50	.50	.50	.00	1.00	--	--	--	--	--	--	.50	.50
W_2	1.00	.00	--	--	--	--	--	--	--	--	--	--	1.00	.00
W_3	--	--	.50	.50	--	--	--	--	--	--	--	--	--	--
W_4	.00	1.00	.50	.50	.18	.82	.18	.82	1.00	.00	.20	.80	.13	.87
W_5	.00	1.00	.33	.67	.67	.33	.50	.50	--	--	--	--	.67	.33
W_6	--	--	--	--	--	--	--	--	--	--	--	--	--	--
W_7	--	--	.60	.40	.50	.50	--	--	--	--	.00	1.00	1.00	.00
W_8	.25	.75	.82	.18	--	--	--	--	--	--	--	--	.00	1.00
W_9	.67	.33	.75	.25	--	--	--	--	.67	.33	1.00	.00	.67	.33
W_{10}	--	--	.25	.75	--	--	1.00	.00	1.00	.00	--	--	.00	1.00
W_{11}	.27	.73	--	--	--	--	--	--	.27	.75	--	--	--	--
W_{12}	--	--	--	--	--	--	--	--	--	--	--	--	.00	1.00
W_{13}	1.00	.00	--	--	--	--	--	--	--	--	--	--	1.00	.00

D_1= accept, D_2= reject: R_1= parents, R_2= school, R_3= court, R_4= agency, R_5= private M.D., R_6= child guidance clinic, R_7= other: W_1= C.P.H. outpatient, W_2= C.P.H. outpatient short term, W_3= C.P.H. daycare, W_4= C.P.H. inpatient, W_5= consultation of professionals, W_6= adoption questions, W_7= placement recommendations, W_8= school placement, W_9= differential

diagnosis, W_{10}= personality appraisal, W_{11}= parent request advice, W_{12}= other, W_{13}= unknown: -- = no occurrence of that category.

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ential diagnosis, was greater than the probability of being accepted for all lower class children. In contrast, for children whose source of referral was the school, the probability of being rejected if the purpose of referral was consultation of professionals,was greater than the probability of being rejected for all lower class children.

For lower class children whose source of referral was the court, the probability of being accepted if the purpose of referral was consultation of professionals was greater than the probability of being accepted for all lower class children. In contrast for children referred by the court, the probability of being rejected if the purpose of referral was hospital inpatient services was greater than the probability of being rejected for all lower class children.

For lower class children referred by an agency the probability of being rejected if the purpose of referral was a request for inpatient services at the hospital was greater than the probability of being rejected for all lower class children.

For lower class children referred by a private M.D., the probability of being accepted if the purpose of referral

was differential diagnosis was greater than the probability of being accepted for all lower class children. In contrast, for children referred by a private M.D., the probability of being rejected if the purpose of referral was a parental request for advice was greater than the probability of being rejected for all lower class children.

For lower class children referred by a child guidance clinic, the probability of being rejected if the purpose of referral was a request for inpatient services was greater than the probability of being rejected for all lower class children. Finally, for lower class children whose source of referral was "other" the probability of being accepted if the purpose of referral was consultation of professionals or differential diagnosis was greater than the probability of being accepted for all lower class children. In contrast, for lower class children referred by "other", the probability of being rejected if the purpose of referral was a request for inpatient services at the hospital was greater than the probability of being rejected for all lower class children.

Table 18 indicates the probability of middle-upper class children being accepted or rejected given the purpose of referral with source of referral used to define the subpopulations. For middle-upper class children whose source

TABLE 18

PROBABILITY OF INTAKE DISPOSITION OF MIDDLE-UPPER CLASS CHILDREN GIVEN PURPOSE OF REFERRAL WITH SOURCE OF REFERRAL USED TO DEFINE THE SUBPOPULATIONS

	R_1		R_2		R_3		R_4		R_5		R_6		R_7	
	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2	D_1	D_2
W_0	1.00	.00	--	--	--	--	--	--	--	--	--	--	--	--
W_1	.54	.46	.64	.36	--	--	.50	.50	.83	.17	--	--	.43	.57
W_2	.00	1.00	--	--	--	--	--	--	.00	1.00	--	--	--	--
W_3	.67	.33	1.00	.00	1.00	.00	--	--	--	--	--	--	.67	.33
W_4	.31	.69	.40	.60	--	--	.50	.50	.25	.75	.60	.40	.33	.67
W_5	.50	.50	.80	.20	.67	.33	.83	.17	.75	.25	1.00	.00	.45	.55
W_6	--	--	--	--	1.00	.00	1.00	.00	--	--	--	--	--	--
W_7	1.00	.00	1.00	.00	--	--	1.00	.00	.00	1.00	--	--	.00	1.00
W_8	.40	.60	.75	.25	--	--	1.00	.00	.33	.67	--	--	--	--
W_9	.63	.37	.77	.23	--	--	--	--	.64	.36	--	--	.49	.51
W_{10}	.45	.55	.67	.33	--	--	--	--	.67	.33	--	--	.83	.17
W_{11}	.59	.41	1.00	.00	--	--	1.00	.00	.83	.17	--	--	.75	.25
W_{12}	.00	1.00	.00	1.00	--	--	--	--	--	--	--	--	.50	.50
W_{13}	.00	1.00	.50	.50	--	--	--	--	--	--	--	--	.00	1.00

D_1= accept, D_2= reject: R_1= parents, R_2= school, R_3= courts, R_4= agency, R_5= private M.D., R_6= child guidance clinic, R_7= other: W_1= C.P.H. outpatient, W_2= C.P.H. outpatient short term, W_3= C.P.H. daycare, W_4= C.P.H. inpatient, W_5= consultation of professionals, W_6= adoption questions,

W_7= placement recommendations, W_8= school placement, W_9= differential diagnosis, W_{10}= personality appraisal, W_{11}= parent request advice, W_{12}= other, W_{13}= unknown, W_0= unknown (unpunched): --= no occurrence of that category.

of referral was parents, the probability of being rejected if the purpose of referral was a request for inpatient service at the hospital, consultation of professionals, school placement or personality appraisal, was greater than the probability of being rejected for all middle-upper class children.

For middle-upper class children whose source of referral was the school, the probability of being accepted if the purpose of referral was consultation of professionals, school placement or differential diagnosis was greater than the probability of being accepted for all middle-upper class children. In contrast, for middle-upper class children whose source of referral was the school, the probability of being rejected if the purpose of referral was inpatient services at the hospital was greater than the probability of being rejected for all middle-upper class children.

For middle-upper class children whose source of referral was an agency the probability of being accepted if the purpose of referral was consultation of professionals was greater than the probability of acceptance for all middle-upper class

children. In contrast, for middle-upper class children whose source of referral was an agency, the probability of being rejected if the purpose of the referral was outpatient service at the hospital or inpatient service at the hospital, was greater than the probability of being rejected for all middle-upper class children.

For middle-upper class children whose source of referral was a private M.D., the probability of being accepted if the purpose of referral was outpatient service at the hospital, consultation of professionals or parental requests for advice was greater than the probability of being accepted for all middle-upper class children. In contrast, for middle-upper class children whose source of referral was a private M.D. the probability of being rejected if the purpose for referral was inpatient service at the hospital or school placement was greater than the probability of being rejected for all middle-upper class children.

For middle-upper class children referred by "other" sources of referral, the probability of being accepted if the purpose of referral was personality appraisal or parental request for advice was greater than the probability of being accepted for all middle-upper class children. In contrast, for middle-upper class children referred by "other" sources of referral the probability of being rejected if the purpose of referral was

outpatient service at the hospital, inpatient services at the hospital, consultation of professionals or differential diagnosis was greater than the probability of being rejected for all middle-upper class children.

TABLE 19

PROBABILITY OF DIAGNOSIS GIVEN SOCIAL CLASS

	A_1	A_2	A_3	A_4	A_5	A_6	A_7
C_1	.05	.09	.01	.24	.43	.07	.11
C_2	.03	.11	.01	.36	.35	.06	.09

C_1= lower class, C_2= middle-upper class, A_1= brain syndrome, A_2= psychotic disorder, A_3= psychophysiologic disorder, A_4= psychoneurotic disorder, A_5= personality disorder, A_6= mental deficiency, A_7= supplementary diagnosis.

Table 19 indicates the probability of a child receiving a particular diagnosis given his social class. With reference to diagnosis, lower class children had the following probabilities of diagnosis: 1) brain syndrome - .05; 2) psychotic disorder - .09; 3) psychophysiologic disorder - .01; 4) psychoneurotic disorder - .24; 5) personality disorder - .43; 6) mental deficiency - .07; and 7) supplementary diagnosis - .11.[6]

[6] Supplementary diagnosis included 1) diagnosis deferred 2) no psychiatric testing and 3) testing only.

In contrast, middle-upper class children had the following probabilities of diagnosis: 1) brain syndrome -.03; 2) psychotic disorder - .11; 3) psychophysiologic disorder - .01; 4) psychoneurotic disorder - .36; 5) personality disorder - .35; 6) mental deficiency - .06 and 7) supplementary diagnosis - .09.

TABLE 20

PROBABILITY OF DIAGNOSIS OF LOWER CLASS CHILDREN GIVEN ACCEPTANCE AT INTAKE WITH SOURCE OF REFERRAL USED TO DEFINE THE SUBPOPULATIONS

	R_1	R_2	R_3	R_4	R_5	R_6	R_7
	D_1	D_1	D_1	D_1	D_1	D_1	D_1
A_1	.00	.34	.00	.00	.00	.67	.09
A_2	.07	.69	.14	.00	.14	.00	.18
A_3	.00	.00	.00	.00	.14	.00	.00
A_4	.33	.21	.14	.25	.29	.00	.18
A_5	.53	.45	.57	.50	.00	.33	.45
A_6	.00	.14	.00	.00	.14	.00	.00
A_7	.07	.12	.14	.25	.29	.00	.09

D_1= accept: R_1= parents, R_2= school, R_3= court, R_4= agency, R_5= private M.D., R_6= child guidance clinic, R_7= other: A_1= brain snydrome, A_2= psychotic disorder, A_3= psychophysiologic disorder, A_4= psychoneurotic disorder, A_5= personality disorder, A_6= mental deficiency, A_7= supplementary diagnosis

Table 20 shows the probability of diagnosis of lower class children given acceptance at intake with source of referral used to define the subpopulations. For lower class children referred by parents the probability of being diagnosed as having a psychoneurotic disorder or a personality disorder was greater than the probability of being given these diagnoses for all lower class children.

For lower class children referred by the school, the probability of being diagnosed as having a brain syndrome, a psychotic disorder or a mental deficiency was greater than the probability of being given these diagnoses for all lower class children.

For lower class children referred by the court the probability of being diagnosed as having a personality disorder was greater than the probability of being given this diagnosis for all lower class children.

For lower class children referred by an agency the probability of being diagnosed as having a personality disorder or given a supplementary diagnosis was greater than the probability of being given these diagnoses for all lower class children.

For lower class children referred by a private M.D. the probability of being diagnosed as having a psychophysiologic disorder or being given a supplementary diagnosis was greater

than the probability of being given these diagnoses for all lower class children.

For lower class children referred by a child guidance clinic, the probability of being diagnosed as having a brain syndrome was greater than the probability of being given this diagnosis for all lower class children.

For lower class children referred by "other" sources of referral the probability of being diagnosed as having a psychotic disorder was greater than the probability of being given this diagnosis for all lower class children.

Table 21 (below) indicates the probability of diagnosis of middle-upper class children given acceptance at intake with source of referral used to define the subpopulations. It is interesting to note that, for middle-upper class children referred by a child guidance clinic, the probability of being diagnosed as having a psychotic disorder was the only probability in the table that was greater than the probability of being given a particular diagnosis for all middle-upper class children.

Table 22 describes the final disposition of children given social class. Lower class children had a probability of .14 for being accepted for treatment at the hospital as opposed to a probability of .31 of being given some other recommendation. In contrast, middle-upper class children

TABLE 21

PROBABILITY OF DIAGNOSIS OF MIDDLE-UPPER CLASS CHILDREN GIVEN ACCEPTANCE AT INTAKE WITH SOURCE OF REFERRAL USED TO DEFINE THE SUBPOPULATIONS

	R_1	R_2	R_3	R_4	R_5	R_6	R_7
	D_1	D_1	D_1	D_1	D_1	D_1	D_1
A_1	.02	.01	.00	.00	.00	.00	.03
A_2	.07	.03	.00	.06	.10	.25	.02
A_3	.00	.00	.00	.00	.00	.00	.02
A_4	.14	.27	.40	.17	.26	.12	.20
A_5	.17	.27	.20	.39	.10	.38	.15
A_6	.03	.04	.00	.11	.03	.00	.03
A_7	.06	.01	.20	.06	.03	.00	.02
A_0	.04	.08	.00	.00	.08	.00	.03

D_1= accept: R_1= parents, R_2= school, R_3= court, R_4= agency, R_5= private M.D., R_6=child guidance clinic, R_7= other: A_1= brain syndrome, A_2= psychotic disorder, A_3= psychophysiologic disorder, A_4= psychoneurotic disorder, A_5= personality disorder, A_6= mental deficiency, A_7= supplementary diagnosis, A_0= unknown.

had a probability of .21 of being accepted for treatment at the hospital as opposed to a probability of .39 of being given some other recommendation.

TABLE 22

PROBABILITY OF FINAL DISPOSITION OF CHILDREN GIVEN SOCIAL CLASS

	F_1	F_2
C_1	.14	.31
C_2	.21	.39

C_1= lower class, C_2= middle-upper class: F_1= accept for treatment at C.P.H., F_2= other

TABLE 23

PROBABILITY OF FINAL DISPOSITION OF LOWER CLASS CHILDREN ACCEPTED FOR INTAKE

	F_1	F_2
D_1	.30	.70

D_1= accepted for intake evaluation: F_1= accepted at C.P.H. for treatment, F_2= other final disposition.

Table 23 indicates the final disposition of lower class children accepted for intake evaluation. Lower class children had a probability of .30 of being accepted for treatment at Children's Psychiatric Hospital (once they have been accepted for evaluation), while they also had a probability of .70 of being given some other final recommendation.

TABLE 24

PROBABILITY OF FINAL DISPOSITION OF MIDDLE-UPPER CLASS CHILDREN ACCEPTED FOR INTAKE

	F_1	F_2
D_1	.25	.75

D_1= accepted for intake evaluation: F_1= accepted at C.P.H. for treatment, F_2= other final disposition.

Table 24 represents the final disposition of middle-upper class children accepted for intake. Middle-upper class children had a probability of .25 of being accepted for treatment at Children's Psychiatric Hospital, once they had been accepted for evaluation, as well as a probability of .75 of being given some recommendation other than treatment at Children's Psychiatric Hospital.

TABLE 25

PROBABILITY OF FINAL DISPOSITION OF LOWER CLASS CHILDREN GIVEN DIAGNOSIS

	A_1	A_2	A_3	A_4	A_5	A_6	A_7
F_1	.25	.67	1.00	.35	.24	.20	.22
F_2	.75	.33	.00	.65	.76	.80	.78

F_1= accept for treatment at C.P.H., F_2= other: A_1= brain syndrome, A_2= psychotic disorder, A_3= psychophysiologic disorder, A_4= psychoneurotic disorder, A_5= personality disorder, A_6= mental deficiency, A_7= supplementary diagnosis.

Table 25 shows the probability of the final disposition of lower class children given diagnosis. For lower class children who are accepted for treatment at the hospital, the probability of being accepted, if the diagnosis was a psychotic disorder was greater than the probability of being accepted for all lower class children. In comparison, for lower class children who were not accepted for treatment at the hospital, the probability of being rejected, if the diagnosis was mental deficiency or a supplementary diagnosis was greater than the probability of being rejected for all lower class children.

TABLE 26

PROBABILITY OF FINAL DISPOSITION OF MIDDLE-UPPER CLASS CHILDREN GIVEN DIAGNOSIS

	A_1	A_2	A_3	A_4	A_5	A_6	A_7
F_1	.17	.27	.50	.50	.35	.23	.07
F_2	.83	.73	.50	.50	.65	.77	.93

F_1= accept for treatment at C.P.H., F_2= other: A_1= brain syndrome, A_2= psychotic disorder, A_3= psychophysiologic disorder, A_4= psychoneurotic disorder, A_5= personality disorder, A_6= mental deficiency, A_7= supplementary diagnosis

Table 26 indicates the probability of the final disposition of middle-upper class children given diagnosis. For middle-upper class children who were accepted for treatment at the hospital, the probability of being accepted, if the diagnosis was a psychophysiologic disorder, a psychoneurotic disorder, or a personality disorder, was greater than the probability of being accepted for all middle-upper class children. In contrast, for middle-upper class children who were not accepted for treatment at the hospital, the probability of being rejected, if the diagnosis was a brain syndrome or a supplementary diagnosis was greater than the probability of being rejected for all middle-upper class children.

CHAPTER V

DISCUSSION AND IMPLICATIONS

Discussion

The implications of an ecological model of emotional disturbance that views the child within the context of his social system led the author to formulate specific questions related to social class and mental illness in children seen at a child psychiatric facility. These questions and their answers have been discussed in previous chapters.

The author would now like to attempt to answer three broader questions regarding certain ecological variables that seem to have impact upon the social systems of children seen at Children's Psychiatric Hospital: Are there social class differences in the children that are labeled emotionally disturbed and seen at Children's Psychiatric Hospital? Do personnel there react differently to lower class children than they do to middle and upper class children? And are there predetermined paths that deviant children follow on their way to and through Children's Psychiatric Hospital that are dependent on the social class from which they come?

The review of the literature suggested evidence to the affirmative with regard to the above questions in relation to the adult populations going to and through mental hospitals. However, there were few definitive findings with regard to

children.

The author undertook this descriptive study in order to make a contribution to the sparse literature that presently exists in the area of social class and mental illness in children. A descriptive study was chosen as there appeared to be a need for more studies concerned primarily with providing baseline data. The hope was to provide some answers to the three major questions posed, to contribute data that might be examined more closely in the future by more conceptually oriented studies, and to perhaps provide a methodology that institutions might adapt to their own needs.

As has been indicated previously, the results presented in Chapter IV appear to answer the questions posed by the author in the affirmative. The data demonstrated conclusively that there were social class differences between children labeled as emotionally disturbed who passed through this particular hospital system.

It must be noted at this point, that the particular institution and population studied might be unique to this situation. Children's Psychiatric Hospital is a well known psychiatric facility for children located in a university community. Thus, it is important to understand that the population seeking services at this institution might not be

typical of populations found at more service oriented institutions in communities throughout the state. It could be assumed that people seeking help at Children's Psychiatric Hospital have somewhat more of a background and knowledge of facilities available to disturbed children than do most other people. It would provide an interesting study to determine what variables effect people's choice of an institution. In any event, the results presented and discussed in this paper are made in the light of this fact.

A careful study of the data, in an attempt to answer the first question, indicated that there were social class differences in the children who are labeled emotionally disturbed. (It is assumed that the majority of children referred to Children's Psychiatric Hospital have been tentatively labeled emotionally disturbed by virture of the fact that they have been referred to a psychiatric facility).

Significant differences between lower and middle-upper class children were found with regard to: source of referral, residence prior to being referred, locus of the problem, the staff member the child was scheduled with, behavioral and academic ratings in the school setting, and whether or not the children would be accepted or rejected for an outpatient evaluation. The researcher found no statistically significant differences between classes with regard to delay of

referral or reason for referral to the hospital.

The data indicated that lower class children were referred significantly more often to Children's Psychiatric Hospital by courts and social agencies than were middle-upper class children. In contrast, middle-upper class children were referred by their parents significantly more often than were lower class children. As has been previously noted, one of the basic premises of an ecological approach to emotional disturbance is that deviant behavior is culturally defined, and that the child is often viewed as deviant by individuals whose value orientations are different from the child's. One could further investigate these differences in another study that would be an effort to determine how such differences seem to effect specific variables. Perhaps lower class parents simply tolerate more deviance or have a higher threshhold for discomfort than middle class parents. Perhaps lower class parents do not know where to go for help and thus asked agencies to provide the needed assistance. Or perhaps agencies may have had to initiate action on their own because society could not tolerate the deviant child even though lower class parents could. On the other hand, the parents of middle-upper class children might have tried other sources of help prior to a request for services at C.P.H. and may have had less of a tolerance for deviance,

than did the lower class parents. This would be an interesting area to study, particularly because the data did not indicate a difference in the reasons for referral, so that one cannot easily attribute these differences in source of referral to differences in types of problem behavior noted.

That significantly more lower class children lived away from home prior to referral to the hospital might be attributed to agencies concerned with the maintenance of societal values intervening on their own or with parental support. It might be interesting to explore the perceptions of people concerned with the child prior to his placement, outside the home.

Because significantly more lower class children had problems in the community than did middle-upper class children, one might use this finding in conjunction with the findings concerning residence prior to referral for further support to investigate the reasons for placing the children outside the home. Was the community able to exert a great deal of pressure on agencies and/or the parents? Was the community concerned with maintaining its own system of values and did lower class children tend to violate the values of these subsystems more often than middle-upper class children? Again, one is faced with numerous questions which can only be answered by further study.

Interestingly, the study indicated that people involved with referring deviant children acted quickly, independent of social class, once the problem was apparent. Thus, to someone involved with the child, regardless of social class, the problem was cause enough for concern to act within a one year period. It is reassuring to note that problems of lower class children will be acted upon quickly, though perhaps by different people i.e., law enforcement agencies, than will act upon the problems of middle-upper class children.

On the way to the institution, children tended to be referred for "disturbing" types of behavior. The majority of children referred, no matter what their social class, were referred for anti-social, hyper-active, distractible behavior, and for poor school behavior, both academic and behavioral. Lower class children were referred significantly more often than middle-upper class children for academic and behavioral problems. Because the schools are generally oriented toward middle-upper class values, one might speculate that lower class children posed quite a threat to the schools with their attitudinal conflicts. Such behaviors, more than bizarre, psychotic type behavior might be viewed as more threatening to social systems within a child's life space. It would be of further interest to study the perceptions of the various

referral sources to discover just what was most disturbing to them about the children they sent to Children's Psychiatric Hospital.

Finally, the data indicated social class differences with regard to acceptance and rejection for further evaluation at Children's Psychiatric Hospital. Significantly more middle-upper class children were accepted for evaluation at the hospital than were lower class children. The researcher is not aware of what other variables interacted to place the children at this point but one can speculate as to some reasons. Upper-middle class children might have been viewed more favorably by the intake workers because they could identify more easily with them than with lower class children. Both Hollingshead et al., (1958) and Srole et al., (1962) have indicated that therapists often feel more comfortable working with patients from the same social class. Parents and agencies working with middle-upper class children might have more sophistication concerning the hospital and the type of children who are seen there than would the parents and other agencies dealing with lower class children, and thus refer children who were good treatment candidates in the first place.

This finding, in combination with the results that more middle-upper class children were seen by senior staff and other personnel at the hospital than were lower class children

might point out more bias on the part of the institution which could possibly feed into the selection process at the hospital. One might assume that the majority of the senior staff had a middle-upper class orientation, would prefer to work with and actually might work better with, middle-upper class children and because of status and expertise have more of say at screening committee meetings than would the residents as to who would be rejected or accepted. This of course is merely speculative, as such biases would be dependent on the individuals involved.

The study has dealt thus far with the social class differences in children labeled emotionally disturbed and seen at Children's Psychiatric Hospital. Up to the decision to accept or reject a child for intake evaluation, the study has dealt mainly with social system variables which made a difference in the route of the children to the intake decision point. One may say, then, that there seemed to be social system variables within a child's social context that differentiated lower from middle-upper class children. Up to the intake decision point, such variables appeared to bias the chances in favor of a middle-upper class child being accepted for evaluation at Children's Psychiatric Hospital.

The second question this study dealt with was in regard to people reacting differently to lower class children than

they do to middle and upper class children. This answer is also to the affirmative. One finds that at the decision point, because of factors working for or against the children, personnel at Children's Psychiatric Hospital reacted more favorably to middle-upper class children than to lower class children in that more middle-upper class were accepted for evaluation.

One might also speculate here that within a child's social system agencies, parents, etc., react differently dependent on social class. This study did not deal with these particular variables in any depth. It can only be hypothesized that agencies might have stepped in and taken action more often with regard to lower class children than regarding middle-upper class children perhaps because they did not get cooperation from the parents of the lower class children. Schools and social agencies might have been able to work more closely with parents of middle-upper class children or might have viewed these parents as more competent to handle their children's problems than the parents of lower class children. The affective or perceptual feelings of parents would be another interesting area to explore in a case study analysis.

Once the children were accepted at Children's Psychiatric Hospital, however, the data indicated that there were no differences in the way they were treated that might be attributed

to social class. Thus, there were no differences in diagnoses, prognosis, treatment recommendations, or final disposition at the completion of the outpatient evaluation.

These findings might be indicative of several things. They might imply that, while there were differences in treatment of children before they reached this phase, the personnel working at this level have been able to overcome their social class biases and have been able to work with children without regard to value and attitudinal conflicts. It might also imply that there are no social class differences between children who, according to McDermott et al., (1970) represent the 'best treatment risks', regardless of social class.

This would have implications for a facility that is a tax-supported institution. That Children's Psychiatric Hospital is not reacting differently to children once they have gotten to the point of evaluation might indicate that they are meeting the needs of the public more than is often assumed. It could also indicate that the screening out process before this point is quite efficient and thus only children who are treatable are even evaluated.

The final major question that was considered in this study was with regard to the existence of predetermined paths that deviant children might follow in their way to and through an

Children's Psychiatric Hospital that might be dependent on the social class from which they come. At this point, the researcher was able to utilize extensively the diagrammatical flow charts and the conditional probabilities constructed from the charts.

An examination of the charts indicated the relationships between variables. With the flow chart and the conditional probabilities the author was able to better understand the interrelatioships of variables reported previously, and in this manner to view the children within the total context of their social system and their route through the hospital. This was of paramount importance as the researcher was concerned with the ecological, and therefore, systemic implications of the children's disturbance careers.

In addition, the use of the charts enabled the researcher to bring the individual back into the picture. It seems quite apparent that much of the research presently being done tends to mask the individual through the use of mass and traditional statistics. Thus, a more personal innovative look at individuals, combined with the traditional statistical methods enabled the author to view the interaction of variables within the system and to note some possible implications of such findings.

As mentioned previously, the author hoped to provide a

clear picture of social system variables that might have resulted in unwitting prejudicial and discriminatory institutional practices in the mental health field. Thus an attempt was made to determine if such unwitting practices occured within the system of Children's Psychiatric Hospital.

We have already noted that, (when observing variables traditionally), while the social systems of the children themselves seemed to differentiate between middle-upper and lower class children. there were no observable differences in the treatment of children related to social class once children were accepted for evaluation.

After examining the flow charts, the researcher decided to explore further the interaction between source of referral and other variables in the system. Parents as source of referral were chosen to illustrate the potentials of examining a system with the conditional probabilities in combination with the chart.

The author chose parents as source of referral, as that seemed an important source for both lower class and middle-upper class children, (see Illustrations 1 and 2 in previous chapter). An attempt was made to find out if parents as source of referral interacted with the other variables in the system similarly for both lower and middle-upper class children. Using the information from the chart, the condi-

tional probabilities were computed that allowed the author to examine the interactions of parents as source of referral for the children referred to Children's Psychiatric Hospital, (see Tables 10, 11, 14, 15, 17, 18, 20 and 21 in Chapter 10).

Interestingly, lower class children, if they were referred by their parents to Children's Psychiatric Hospital, had a greater probability for being rejected for intake evaluation at the hospital. A similar decrease in probability of acceptance for intake evaluation was discovered for middle-upper class children. At this point, the researcher was able to formulate tentative questions to be studied. Why are children more likely to be accepted for evaluation at this institution if their parents do not refer them? Do the parents not understand the function of the hospital? Does the hospital not think highly of parents as a source or referral and prefer more professional sources of referral?

When lower class children were referred by their parents, their probability of being rejected was higher than the probability for all lower class children if the locus of the problem was in the home, or in a combination of the home, school, and community. Similar findings were reported for middle-upper class children. Might this indicate to an institution that they might be "cooling out" parents as a source of referral? Or again, is it that parents refer

children for the wrong reason? This would be unlikely as previous hypothesis testing demonstrated that there were no significant differences in reasons for referral. In any event, there is still room for further study of the interaction of parental referral and social system variables within the institution.

When lower class children were referred by their parents, the probability of being rejected if the purpose of referral was school placement or a parental request for advice was greater than the population probability. For middle-upper class children, when the source of referral was parents, the probability of being rejected if the purpose of referral was a request for inpatient service at the hospital, consultation of professionals, school placement, or personality appraisal, the probability was greater that they would be rejected for intake evaluation than was the probability of being rejected for all middle-upper class children.

In contrast, lower class children had a better chance for acceptance at intake if their parents were the source of referral and the purpose of referral was for differential diagnosis, while middle-upper class children thus referred did not increase their chances for acceptance based on parental referrals.

Again, the parents seemed to be getting a "brushoff" at

first glance. Lower class parents referring their children actually decreased the child's chances for acceptance particularly if theywere requesting advice. Middle-upper class parents seeking advice are not as likely to be rejected.

One might then summarize what has been found with regard to conditional probabilities thus far. An inspection indicates that parents as a source of referral seemed to play an important role in the initial contact with the institution. An examination of the conditional probabilities showed that for some reason, in combination with other variables, as well as by itself, that parental referral was not particularly successful in obtaining help for children. Questions for further study might consider whether or not parents understand what the functions and services of the hospital are? Perhaps they tend to not present their problem coherently or persuasivily enough? Or perhaps they are referring their children under pressure from other sources and are really not very interested in securing services?

To continue examining the route of children through the system the researcher wondered whether or not parental referral could be predictive of diagnosis of children.

The data indicated that lower class children referred by their parents had a greater probability of receiving a diagnosis of psychoneurotic disorder or personality

disorder than did the general population. A parental source of referral for middle-upper class children was not predictive of diagnosis.

Further study could lead the researcher to discover, through examination of the charts and related probability tables which variables, in contrast to parental referral, might possibly increase probabilities of acceptance for lower and/or middle-upper class children.

The author has demonstrated briefly the application of the conditional probabilities reported previously. Obviously, the comparisons and examinations that an institution might make about itself are numerous. That they can be made must be noted and that they lead to further speculation and tentative directions for study is more than useful.

Other Implications for Further Study

While implications for further research have been noted throughout this chapter, the author would like to re-state some of his own feelings concerning the value and future of such studies.

The combination of traditional statistics with more individually oriented methods enabled the researcher to examine social system variables singlely and in interaction with each other. The return of the individual child in the system, particularly in today's world of mass numbers was

meaningful to the researcher in that the reader could then follow disturbance careers of groups and individual children.

With the variety of information gathered, more data can be added to the literature on social class and mental illness in children.

More importantly however, is that the author feels he has identified a method, that though simple, is complete in its demonstration of specific variables at work within a system. There is nothing inherently good in complex and numerous statistical tables. With the diagrammatical charts and the conditional probabilities an institution can examine itself to understand what is happening within its own system. In combination with traditional statistical tests, an institution will be getting more information than usual, and much of it can be useful. In reality, more people will look at a concise chart, and react to what they discover if the information is immediately available.

There is a demand today for institutions to become more accountable. If the author has provided a simple model for data presentation, which could assist some institutions in examining themselves, he feels this study has been of value.

APPENDIX A

CODE MANUALS

INTAKE CODE

1 Code Card Number

2 - 8 Registration Number

9 - 10 Month of Referral

11 - 12 Day of Referral

13 - 14 Year of Referral

15 - 16 Month of Scheduling First Appointment

17 - 18 Day of Scheduling First Appointment

19 - 20 Year of Scheduling First Appointment

21 - 22 Month of First Appointment

23 - 24 Day of First Appointment

25 - 26 Year of First Appointment

27 First Appointment
1. Social History
2. Psychology
3. Main Hospital
4. OPE
5. Pre-screening
6. Other_____

28 - 29 Age of Patient in Years

30 - 31 Grade Level of Patient
1. Grade 1
2. Grade 2
3. Grade 3
4. Grade 4
5. Grade 5
6. Grade 6
7. Grade 7
8. Grade 8
9. Grade 9
10. Grade 10
11. Grade 11
12. Grade 12
13. Nursery or pre-school
14. Kindergarten
15. Type A (Educable)
16. Type B (Trainable)
17. Emotionally Disturbed
18. Ungraded
19. Homebound
20. Excluded

32 Sex of Patient

1. Male
2. Female
3. Undetermined

33 - 34 Geographical Area of Patient Name of City or County of Residence_____.
(See Separate List)

35 - 36 Source of Referral

1. Parent
2. Relative, non-parent or guardian
3. School Social Worker
4. School, other
5. Court
6. Social Agency
7. Private psychiatrist
8. Private M.D., D.O., or psychologist
9. Child Guidance Clinic
10. Pediatric Department
11. UM Non-Pediatric
12. CPH staff
13. Other

37 Impetus for Referral

1. Direct
2. Indirect

38 Referral Person's Involvement

1. Referral person treating emotional problem, willing to continue
2. Referral person treating, reluctant to continue
3. Referral person not presently treating
4. Referral person not treating, unwilling to
5. Not applicable

39 Length of Time Seeking or Offered Help

1. Under 1 year
2. 1 to 3 years
3. 3 years and over

40 Child's Type of Residence

1. Home
2. Foster Home
3. Boarding School
4. Residential Placement
5. State Hospital or Institution
6. Detention Home

41 - 42 Purpose of Referral

1. CPH Services - Out-Patient
2. CPH Services - Out-Patient - short term
3. CPH Services - Day Care
4. CPH Services - In-Paitnet
5. Consultation of Professionals and Agencies
6. Adoption Questions
7. Placement Recommendations
8. School Placement
9. Differential Diagnosis
10. Personality Appraisal
11. Parent Request for Advice
12. Other_____
13. Unknown

43 - 44 Major Reason for Referral

1. Poor academic performance
2. School refusal
3. Anti-social behavior
4. Hyperactive, distractible behavior
5. Bizarre behavior
6. Withdrawn behavior
7. Delay in development
8. Anxiety and related symptoms (See 1)
9. Somatic symptoms (See 2)
10. Suicidal threat or attempt
11. Child abuse
12. No major symptoms
13. Other (Specify)
14. Unknown

45 Major Problem Manifested In

1. School
2. Home
3. Community
4. Combination

46 - 47 Intake Impression at Appropriate Disposition, if scheculed for OPE

01. In-Patient
02. Day Care
03. Out-Patient
04. DOS (Short term treatment with termination,

05. Drug therapy - DOS or LMD
06. Private psychiatrist
07. M.D. or D.O.
08. School (VT or special class)
09. Special school

10. Court
11. Child Guidance Clinic
12. Other social agency
13. Placement out of home
14. Other (Specify)_____
15. State Hospital
16. Unknown

48 - 49 Occupational Index of Responsible Adult

01. Higher executive, proprietors of large concerns and major professionals
02. Business managers, proprietors of middle-sized concerns and lesser professionals
03. Administrative personnel, small independent minor professionals
04. Clerical and sales workers, technicians, and owners of little businesses
05. Skilled manual employees
06. Machine operators and semi-skilled employees
07. Unskilled employees
08. Unemployed, on relief
09. Not applicable
10. Unknown

50 Race

1. White, caucasian
2. Negro
3. Yellow, Asiatic
4. Red, American Indian
5. Mixed
6. Unknown

51 Scheduled As

1. Emergency
2. Urgent
3. Routine
4. Not scheduled

52 Scheduled With

1. Resident
2. Medical students
3. Senior staff
4. Other CPH personnel only

53 Patient Status

1. New Patient
2. New to CPH, previously registered at Main Hospital
3. Second intake, no previous evaluation
4. Three or more intakes, no previous evaluation
5. Re-evaluation
6. Ex-inpatient
7. Ex-outpatient
8. Otherwise old to CPH

54 Filled Out By:

1. Elizabeth B. Killins
2. Donna Bredlow
3. Other (Specify)

55 - 56 Disposition

01. Referred to other UM clinic
02. Referred to new agency outside UM
03. Referred to agency previously knowing family or child
04. Advice or information from Intake staff
05. In-patient pre-screened and refused
06. Day Care pre-screened and refused
07. Out-patient pre-screened and refused
08. Parents unwilling to accept referral
09. Parents or referral source found other professional resource
10. Material not received
11. Referral source changed mind, no other help sought
12. No scheduled appointment kept, specify reason_____
13. OPE incomplete: Social Service contact only
14. OPE incomplete: Psychology contact only
15. OPE incomplete: Other, specify_____
16. OPE complete

Name_____

PSYCHIATRIC OUT PATIENT CODING OUTLINE

1 Code Card Number

2 8 Registration Number

9 Service
1. CPH
2 ff Not applicable

10 - 11 Day of Month

12 Month of Evaluation

13 - 14 Year of Evaluation (19 -)

15 - 18 Examining Physician (See separate list)

19 Patient Status
1. New patient
2. New patient, re registration
3. Refer, in-patient
4. Refer, out-patient
5. Refer, emergency, out patient
6. Refer, emergency, in patient
7. Emergency, walk-in
8. Refer, bedside
9. NPI (CPH) re-registration
0. Other
x. Unknown
y. Return visit for re-evaluation

20 Amount of Fee (* used at CPH)

1. $?	7. $?
2. $?	8. $?
3. $?	9. $30.00*
4. $.?	0. Other or no fee*
5. $16.00*	x. Unknown
6. $?	y. $50.00*

21 Source of Fee
1. Patient and/or family
2. County and/or State guarantee
3. Workmen's Compensation
4. Private insurance guarantee
5. Court
6. School
7. Family Service or Catholic Social Service
8. MCI
9. Other social agency guarantee

22 - 23 Source of Referral (See separate list)

24 Purpose of Referral

1. Diagnostic evaluation with recommendations
2. Out-patient psychotherapy
3. Hospitalization at CPH (or NPI)
4. Commitment to a state institution
5. Recommendations regarding disposition
6. Admission to Day Treatment Service
7. Remedial Instruction (e.g. Reading Therapy)
8. Determination of legal responsibility, Sanity, etc.)
9. Follow-up
0. Other. Please specify_____
x. Unknown

25 Major Reason for Referral

1. Maladjustment in Community
2. Maladjustment in school (incl. school refusal)
3. Maladjustment in home
4. Suicidal threat or attempt
5. Bizarre or psychotic behavior
6. Neurotic symptoms
7. "Psychosomatic" symptoms
8. Abnormal development
0. Other. Please specify_____
x. Unknown

26 Sex of Patient

1. Male
2. Female
3. Undetermined

27 - 28 Age of Patient (In years)

29 Race

1. White, Caucasian
2. Negro
3. Yellow, Asiatic
4. Red, American Indian
5. Mixed
6. Unknown

30 Marital Status

1. Single
2 ff. Not applicable to children

31 Religion

1. Protestant
2. Catholic
3. Jewish
4. None
5. Other
6. Unknown

32 - 33 Residential Area (See separate isit)

34 Occupational Index of Patient (If responsible).

35 - 36 Relationship of Patient to Responsible Relative

01. Natural child
02. Adopted child
03. Foster child
04. Step-child
05. Sibling, natural
06. Sibling, half- step- or foster

37 Occupational Index of Responsible Relative

1. Higher exectutive, proprietors of large concerns, major professionals
2. Business manager, proprietors of middle-sized concerns, lesser professionals
3. Administrative personnel, small independent businesses, minor professionals
4. Clerical and sales workers, technicians and owners of little businesses
5. Skilled manual laborers
6. Machine operators and semi-skilled employees
7. Unskilled employees
8. Unemployed, on relief
0. Not applicable
x. Unknown

38 Education Index of Responsible Relative

1. Graduate professional training with a degree
2. Standard college or university graduation
3. Partial college training (at least one year)
4. High school graduate
5. Partial high school (completed 10th grade or more)
6. Junior high school (7th ro 9th grade)
7. Less than 7 years of school
x. Unknown

39 Social Class - Responsible Relative (Multiply Occupational Index by 7 and the Educational Index by 4 and add resulting figures

1. Class I (11-17)
2. Class II (18-27)
3. Class III (28-43)
4. Class lV (44-60)
5. Class V (61-77)

40 Income Level of Responsible Adult

1. Less than $5,000 annually
2. $5,000 to $10,000 annually
3. $10,000 tp $15,000 annually
4. $15,000 to $20,000 annually
5. Over $20,000 annually
6. Unknown

41 - 42 Educational Level of Patient

01. Pre-school
02. Kindergarten
03. 1st Grade
04. 2nd Grade
05. 3rd Grade
06. 4th Grade
07. 5th Grade
08. 6th Grade
09. 7th Grade
10. 8th Grade
11. 9th Grade
12. 10th Grade
13. 11th Grade
14. 12th Grade
15. Ungraded school
16. Does not attend school
17. Does not attend school

00. Other. Specify_____
xx. Unknown

43 Educational Degree (Not applicable at CPH)

44 Contact with other than psychiatrist (Includes family)

1. Medical students
2. Psychologist
3. Social Worker
4. Medical students and psychologist
5. Medical students and social worker
6. Psychologist and social worker
7. All of above
8. None of above
0. Other (Incl. senior staff)

45 - 49 Diagnosis (More than one, if necessary, in order of priority).

50 - 54 (See separate sheet for code numbers)

55 - 59

Recommendation - Agency

60 - 61
62 - 63
64 - 65
66 - 67

00. No recommendations
01. NPI Admission (NPI, CPH, Adol)
02. Day Treatment Service
03. Private psychiatric hospital
04. State Hospital
05. Transfer to another service at UMMC
06. Transfer to another service other than UMMC
07. Out-patient Service (CPH, NPI, Adol.)

08. Intensive Treatment Center (NOB)
09. Referring clinic continue with patient
10. Private psychiatrist
11. Child Guidance Clinic/Mental Health Clinic
12. Family Service/Catholic Social Service
13. Department of Social Welfare/Bureau of Social Aid (MCI)
14. Family physician
15. Family care and supervision
16. Court
17. Boys Training School
18. Girls Training School
19. Juvenile Detention Home
20. Youth Home
21. Boarding School
22. Military School
23. Psychiatric Social Service
24. Residential Child-caring Institution (Dewing Hall, Don Bosco, Starr Commonwealth, etc.)
25. Visiting Teacher Service
27. U of M Psychological Clinic
30. Florence Crittenton Hospital or other maternity home
32. State Hospital out-patient clinic
99. Other. Specify_____

Recommendation - Type (More than one, if necessary, in order of priority)

00. No recommendation
01. Psychotherapy, in-patient
02. Psychotherapy. out-patient
03. Supportive treatment
04. Casework treatment
05. "Conjoint" therapy
06. Group therapy
07. Court custody
08. Court custody, permanent
10. Commitment
11. Out-of-home placement
12. Disposition left to Court
13. Psychiatric treatment
14. Continued medical treatment
15. Referred for specialized medical treatment
16. Drug treatment
17. Follow-up visit
18. Special education
20. Environemtnal change
21. Vocational planning
22. Physiotherapy
23. Custodial care
24. Occupational therapy
25. Supervision by law enforcement agency (probation officer)
99. Other. Specify_____

Name_____

CHILDREN'S PSYCHIATRIC OUT-PATIENT CODING OUTLINE

2	1	Code Card Number
___ ___	2 - 8	Registration Number
1	9	Service
___ ___	10 - 11	Day of Month
___ ___	12 - 13	Month of Evaluation
___ ___	14 - 15	Year of Evaluation 19___

HISTORY SECTION

___ 16 Who Actually Originated the Idea of Referral?

1. Family
2. School (Incl. Visiting Teacher)
3. Child Guidance Clinic
4. Court
5. Other Social Agency
6. Outside physician
7. U-M physician
8. Self (the child)
0. Other. Please specify_____
x Unknown

___ 17 Duration of Presenting Complaint

1. Less than 1 month
2. 1 to 3 months
3. 4 to 6 months
4. 7 to 12 months
5. 1 to 2 years
6. 2 to 3 years
7. Over 3 years but not lifelong
8. Lifelong
0. Other. Please specify_____
x Unknown

18 Number of Patient's Siblings:

1.	1	6.	6
2.	2	7.	7
3.	3	8.	8 or more
4.	4	9.	None
5.	5	x	Unknown

19 Sibling Position

1.	First	5.	Fifth
2.	Second	6.	Sixth
3.	Third	7.	Seventh or more (exc. as in 8)
4.	Fourth	8.	Mutiple birth (twins, etc.)
		x	Unknown

20 Economic Activities of Mother

1. No economic activities outside home.
2. Works full time outside the home currently.
3. Works part time outside the home currently.
4. Unemployed now, but has worked full time outside the home during the patient's life.
5. Has worked part time outside the home
0. Other. Please specify_____
x Unknown

21 Special Environmental Stresses

1. None
2. Separation from parent or parents (Incl. by divorce)
3. Unstable, conflict-ridden home.
4. Lived with relatives.
5. Foster home or insitution.
6. Death of father or mother.
7. Illness or acciddnt requiring hospitalization,
8. Extreme poverty, e.g. having to go hungry.
0. Other. Please specify_____
x. Unknown

22 Abnormalities of Mother's Pregnancy with Patient

1. None
2. Unwanted pregnancy
3. Conceived out of wedlock
4. Hemorrhage during course of pregnancy
5. Hyperemesis gravidarum (prolonged vomiting)
6. Intercurrent physical illness of mother, i.e._____
7. Toxemia of pregnancy.
9. Unusual emotional instability of mother
0. Other. Please specify_____
x Unknown

23 Circumstances of Birth and Neonatal Period

1. No abnormalities
2. Prolonged labor
3. Interference with function of umbilical cord
4. Placenta previa

5. Erythroblastosis fetalis (parental Rh factor incompatability)
6. Complications (e.g. mid-forceps, deep general anesthesia etc.)
7. Significant anoxia of infant
8. Unusual emotional instability of mother
9. Other. Please specify_____
0. Unknown

24 Timing of Birth
1. Full term birth (birth weight over 5 pounds)
2. Birth premature (birth weight under 5 pounds)
3. Birth significantly delayed
0. Other. Please specify_____
x. Unknown

25 Feeding Problems of Infancy and Childhood
1. None
2. Insufficient intake with underweight
3. Reported insufficient intake but not underweight
4. Idiosyncratic eating habits
5. Overeating with obesity
6. Colic
7. Persistent vomiting
8. Rumination
0. Other. Please specify_____
x. Unknown

26 Judgment of Motor Development
1. Normal
2. Crawling significantly delayed
3. Sitting significantly delayed
4. Standing significantly delayed
5. Walking alone significantly delayed
6. Temporary loss of ability to walk
7. More than one of above
8. Onset of speech and ability to walk widely separated
0. Other. Please specify
x. Unknown

27 Sleeping Problems (Past or Present)
1. None
2. Insufficient or restless sleep
3. Difficulty going to sleep
4. Frequent nightmares or night terrors
5. Sleepwalking
6. Excessive sleepiness or drowsiness
7. Frequent sleep talking
8. Night wandering
0. Other. Please specify_____
x. Unknown

28 Speech and Language Problems (Past or Present)
1. None
2. Delayed onset of speech but speech not abnormal
3. Disorder of articulation (e.g. babytalk, dyslalia)
4. Stuttering

5. Mutism (incl. selective mutism)
6. Disturbance in child's understanding of speech (receptive aphasia, deafness)
7. Incoherent purposeless speech
8. Echolalia (imitative speech)
0. Other. Please specify_____
x. Unknown

29. Special Body Manipulation Problems (Past or Present)
1. None
2. Prolonged finger sucking(incl. thumb sucking)
3. Nailbiting
4. Lipsucking or biting
5. Hair pulling
6. Excessive or public masturbation
7. Head banging, rocking
8. Habitual self-injury (auto-agressive acts)
9. Other. Please specify_____
0. Unknown

30 Special Impulse Control Problems (Past or Present)
1. None
2. Enuresis (nocturnal and/or diurnal)
3. Encopresis
4. Enuresis and encopresis
5. Frequent temper tantrums
6. Physically aggressive toward others
7. Fire setting
8. Frequent temper tantrums, aggressive toward others
9. Other. Please specify_____
0. Unknown

31 Running Away from Home (Past or Present)
1. None
2. Occasional
3. Frequent
9. Other. Please specify_____
0. Unknown

32 School Behavior Adjustment
1. "Too good" - behavior exemplary because of inhibition and limited interaction
2. Very good - gets along well with teachers and classmates; popular
3. Good - #2 is generally true with some exceptions
4. Fair
5. Poor - frequent behavioral difficulties with classmates
6. Very poor - frequent behavioral difficulties with teachers; often truant; has been suspended
7. Recent dramatic change in school behavior
8. Child does not attend school
9. Other. Please specify _____
0. Unknown

33 Academic Performance
1. Very good - outstanding scholarship
2. Good - does well scholastically
3. Fair - average student
4. Uneven - does well in some sub,ects, poorly in others; may have specific learning problems in math, reading etc.
5. Poor - does poor work in one or more sub ects
6. Very poor - failed one or more grades; unable to keep up
7. Underachieving
8. Compulsice perfectionistic
9. Child does not attend school
0. Unknown

34 Home Behavior Adjustment
1. "Too good" - extremely conforming - "model child"
2. Good - child comfortable in home with average behavior
3. Fair - child viewed as somewhat of a behavior problem
4. Poor - child and parents continually at odds
5. Very poor - parents view child as completely unmanageable
9. Other. Please specify _____
0. Unknown

35 "Delinquency Status" of Child (Based upon worker's knowledge; check the iowest numbered iten possible)
1. Child known to have legally been declared delinquent by Court
2. Parents believe child is "legally delinquent"
3. Community complains about child as delinquent
4. Parents not sure about child's status but know that he has been apprehended by authorities
5. Child definitely not delinquest
9. Other. Please specify_____
0. Unknown

36 Physical Health History
1. Very good; has generally been in good health
2. Good; has generally been in good health but with occasional complaints with visits to doctor
3. Moderately good' has had frequent illnesses of a minor nature
4. Fair more than 6/year
5. Poor; has had severe illness or injury with residual impairment of health or bodily function
6. Has chronic non-debilitating disease, e.g. diabetes
7. Frequent accidents and injuries
8. Very poor; has severe chronic or debilitating disease at present
9. Other. Please specify_____
0. Unknown

37 History of Central Nervous System Insult (Post natal)
1. None
2. History of CNS infection (encephalitis)
3. History of significant head injury with loss of consciousness
4. History of significant head injury or injuries

5. History of both infection and trauma
9. Other. Please specify_____
0. Unknown

38 - 39 Physical Disorder

1. None
2. Visual defect producing definite handicap
3. Hearing defect producing definite handicap
4. Neurological defect
5. Psychosomatic disease (asthma ulcerative colitis,
6. Chronic disease (diabetes, etc.)
7. Convulsive disorder
8. Acquired body deformity
9. Congenital body deformity
0. Physical disability or deformity other than above
x. Unknown

40 Family History of Psychiatric Illness

1. None
2. One parent has received psychiatric treatment
3. Both parents have received psychiatric treatment
4. One or more siblings has received psychiatric treatment
5. One or more siblings believed to have a classifiable mental illness
6. One or more blood relatives
7. One or both parents believed to have a classifiable mental illness
8. Two or more of above choices apply
9. Other. Please specify_____
0. Unknown

41 Unusual Sexual Experiences

1. None known (and possibly considered unlikely)
2. Rare bed-sharing with parents
3. Persistent bed-sharing with parent
4. Covert sexual relationship with parent
5. Persistent overt sexual behavior with peers
6. Homosexual exposure with older person
7. Heterosexual intercourse in childhood
8. Transvestism, fetishism
9. Other. Please specify_____
0. Unknown

42 Previous Psychiatric Treatment of Child

1. None
2. Out-patient supportive treatment local physician
3. Out-patient drug therapy local physician
4. Out-patient treatment private psychiatrist
5. Out-patient treatment clinic or agency
6. Out-patient treatment CPH
7. In-patient treatment other than CPH
8. In-patient treatment CPH

Continued. . . . . .

9. Other. Please specify_____
0. Unknown

43 This Section (History) Filled Out by:
1. Medical Student III
2. Medical Student IV
3. Resident I
4. Resident II
5. Resident III
6. Resident IV
7. Senior staff psychiatrist
8. Staff social worker
9. Student social worker
0. Other, Please specify_____

MEDICAL SECTION

Use the following code to mark the severity of the following symptoms at the time of evaluation.

1. None or slight
2. Mild (between slight and moderate)
3. Moderate
4. Severe
5. Predominant (use this item once only)
6. Suspected by history but not confirmed
7. Not known

44 Depression

45 Phobic symptoms

46 Obsessive and/or compulsive symptoms

47 Conversion symptoms

48 Anxiety

49 Dissociative episodes (fugue states, amnesias, sleepwalking etc.)

50 Feelings of depersonalization strangeness unreality estrangement and loss of identity of self

51 Autism (dominated by sub ective self-centered trends of thought or behavior) - does not relate

52 Bizarreness

53 Regression infantile behavior etc.

54 Distrubance of thought processes

___ 55 Affective disturbance

___ 56 Paranoid symptoms (suspiciousness, ideas of reference, etc.)

___ 57 Hypoactive symptoms (negativism, catatonic symptoms)

___ 58 Hyperactive psychomotor activity (excitement, hyperactivity, agitation, etc.)

___ 59 Manipulative and/or seductive

___ 60 Impulsivity

___ 61 Low frustration rolerance

___ 62 Open hostility and/or aggressive, sadistic and destructive

___ 63 Covert hostility (passively resistant, stubborn, negativistic)

___ 64 Constricted, overly conforming, pseudo-mature behavior

___ 65 Passivity and/or masochistic behavior (marked dependency)

___ 66 Subjective guilt, shame, diminished self-esteem

___ 67 Untrustworthy, lying, stealing, malingering

___ 68 Behaviorally and apparently callous, unsympathetic

___ 69 Disturbed sexual identification, i.e. effeminate

___ 70 Disturbance of food intake (anorexia, bulimia, bizarre eating, nausea and/or vomiting, etc.)

___ 71 Early puberty

___ 72 Delayed puberty

___ 73 Neurologic-like symptoms (dizziness, weakness, tremors)

___ 75 Prognosis for Improvement

1. Good
2. Fair
3. Poor

___ 76 How Do You Feel About the Patient?

1. Irritated with him
2. Like him
3. Feel sorry for him
4. Neutral
5. Other. Please specify_____

___ 77 This Section (Medical) Filled Out by:

1. Medical Student III
2. Medical Student IV
3. Resident I
4. Resident II
5. Resident III
6. Resident IV
7. Senior staff psychiatrist
8. Staff social worker
9. Student social worker
0. Please specify_____

___ 78 - 80 Name of Supervisor, if actively involved in evaluation

_____

APPENDIX B

PSCF BLITZ PROGRAM

COMPUTING CENTER MEMO #41 April, 1970

PSCF BLITZ - Bivariate Frequency & Percentage Tables, & Statistics

Written by: David L. Ross, Institute of Social Research, University of Michigan, May 1965.

Modified by: David G. Karpinski, Institute of Social Research, University of Michigan, January 1966.

Transposed from IBM 7090 MAD to IBM 360 FORTRAN IV by: Dan N. Perkuchin, School of Education, University of Michigan, March 1968.

GENERAL DESCRIPTION:

BLITZ is designed to mass produce bi-variate frequency tables which compare all spread variables with all control variables. The spread variable is always considered to be the columns where as the control variable is always considered to be the rows of the frequency table. The many features of this program will be explained within the context of the control card requirement and set up. The following is a list of the included features:

1. Up to 30 data cards per subject are permitted.

2. Missing data can be eliminated from the computed statistics by specifying the valid limits for both the spread and the control variables.

3. Many optional statistics are available:

   (a) The cells of the frequency table can be percentaged by either the columns, rows or from the table's total frequency count (corner).

   (b) Pearson Chi-Square test of association (Hays, W. L.; Statistics for Psychologists, New York: Holt, Rinehart and Winston, 1965. Chapter 17).

   (c) Cramer's Statistic (Hays, 606).

   (d) Indices of predictive association (Hays, 606-610).

   (e) Means and the unbiased estimate of the standard deviations for the spread variable columns (Hays, 161 & 207).

   (f) Difference between means tests on the spread variable columns (Hays, 315-319).

4. The option to label the spread and/or control variables.

5. An option to identify each data card of a subject by some code other than its order in the subject's data deck.

CONTROL CARDS' SEQUENCE AND SET UP:

1. TITLE CARD: Any title desired to be printed on the output sheet punched in columns 1-80.

2. PARAMETER CARD:

Columns	Program Symbols	Information
3-5	NOCV	The highest numerical value that any control variable will contain. If left blank, as will usually be the case with single column control variables, this will be set to "9". If any control variable is double column or triple column and NOCV is not specified, NOCV is set automatically to "99" or "999" respectively.
10	IFLAB	1 - User will supply variable label cards. 0 or blank - otherwise.
15	CELENT	Indicates the percentage option selected in addition to the raw frequency table. A separate table provides the percentaged information. 0 - No percentage table requested. 1 - Rows percentaged. 2 - Columns percentaged. 3 - Corner percentaged. **NOTE** Percentages are computed only for those cells that are within the spread and control limits. Also, if no subjects have a particular row value on the control variable then that row is not printed out for either the raw frequency or percentage tables.
19-20	NOSV	The highest numerical value that any spread variable will contain. If left blank and all spread variables are single columns, this will be set to "19". NOSV must not be set higher than "19". **NOTE** If the user has a spread variable that has a value greater than 19 and if the control variable does not have a value greater than 19, then it is only necessary to switch the spread to a control and the control to a spread. Caution must be taken in doing this as all spread are run against all controls.

Columns	Program Symbols	Information
25	CHISQ	1 - Pearson Chi-Square, Cramer's Statistic, and indices of predictive association will be computed for all tables. 0 or blank - otherwise. **NOTE** The degrees of freedom printed out for frequency tables is the number of rows -1 times the number of columns -1. Only the rows and columns contained within the minimum and maximum limits for the control and spread variables are considered. CMIN, CMAX, SMIN, and SMAX specify the inclusive limits.
30	IFJECT	1 - All data cases with any control value greater than NOCV or any spread value greater than NOSV will be eliminated from the sample of subjects considered for the computations on all tables. The number of such subjects is indicated by the label "REJECTS - " found immediately after the title on the first table printout sheet. "POP. N = " is the number of subjects that are remaining from the total number placed into the program after the REJECTS are excluded. The rejected subjects will be printed out. 0 or blank - otherwise. **NOTE** Usually the user will elect this option only if he desires to eliminate some subjects that may have had their data punched incorrectly. If the user desires a frequency count of values above the maximum limits for each table (described later) then he should make sure NOCV and NOSV are equal to or greater than the largest value possible for each variable, including the missing data values.
40	IFMEAN	1 - Means and the unbiased estimate of the standard deviations will be computed for each spread variable column for all tables. 0 or blank - otherwise.
45	DFMEAN	1 - Difference between means tests will be performed on each pair of spread columns for all tables with the following restrictions. No spread column is compared if it has zero or only one subject within it, and if the standard deviation of both spread columns are zero. 0 or blank - otherwise.

Columns	Program Symbols	Information
46-50	NMIN	The degrees of freedom for the difference between means tests can be determined by a special correction formula when one cannot assume equal column variances and the column sizes are unequal and when the column sizes are small. See Hays, 322 for correct application. If either column size is smaller than the value punched in this column, 50, then the correction formula is used. If both columns are greater than NMIN then the degrees of freedom will be the sum of the two columns being compared minus 2.
55	SQUEEZ	1 - If more than one table is produced for each spread variable this option will print them out contiguously. 0 or blank - Each table will start at the top of a new page and the title and the first line after the title will be duplicated.
57-58	DDC	The number of Data Description Card(s). Not to exceed 30.
60	CONMIN	1 - If Variable Range Specification Card(s) is included by the user. 0 or blank - otherwise. **NOTE** If a 1 is punched then that card must appear in this order in the control cards' sequence. If 0 is punched then no card should be placed in the control cards' sequence for the respective specification card.
62	CONMAX	
64	SPRMIN	
66	SPRMAX	
68	DECKSN	1 - If Decksnamed Identifier Card(s) is used. 0 or blank - otherwise.

3. DATA DESCRIPTION CARD(S):

This set of cards contains information as to the location of the spread and control variables. There must be as many data description cards as there are cards per subject with 30 cards being the maximum number possible. The number of such cards must be specified in columns 57 & 58 of the parameter card. The letter "S" is punched in the columns where single column spread variables are found in a subject's set of data cards. The letter "C" is punched in the columns where single

column control variables are found. A "+" is placed after the "S" to indicate a double column variable. The spread variable can have no value greater than 19. "+" or "++" is placed after the "C" to indicate a double or triple column control variable, respectively. The only limiting value of the control variable is NOCV as specified by the user. Spread variables are limited also by NOSV if the user chooses to designate it.

4. VARIABLE RANGE SPECIFICATION CARDS:

(Optional) Any or all of the following four cards may be used to set the minimum or maximums of the control or spread variables. If used then the cards must occur in the order indicated below and the appropriate columns on the parameter card must be punched "1". If any or all the cards are not used then the appropriate cards must be omitted from the control cards' set up. If a minimum card is omitted then all variables of that type will be assigned a minimum value of "0". If a maximum card is omitted then all maximums for the spread variables will be equal to NOSV and for the control variables NOCV. Because all statistics are based on the values contained within the specified limits it is usually desirable to specify such limits on the variable range cards. If a specification card is used then every variable has to have limits specified on that card.

Columns: (three columns per variable right justified)

1-4	7 - 9	10 - 12	13 - 15	---- 75 - 78
CMIN	Minimum of 1st control vari.	Minimum of 2nd control vari.	Minimum of 3rd control vari.	etc.
CMAX	Maximum of 1st control vari.	Maximum of 2nd control vari.	Maximum of 3rd control vari.	etc.
SMIN	Minimum of 1st spread vari.	Minimum of 2nd spread vari.	Minimum of 3rd spread vari.	etc.
SMAX	Maximum of 1st spread vari.	Maximum of 2nd spread vari.	Maximum of 3rd spread vari.	etc.

If there are more than 24 spreads or 24 controls, the minimums or maximums should be continued on a card immediately following the appropriate one above, starting again in columns 7 - 9.

5. VARIABLE LABEL CARDS:

(Optional) These cards are present only if IFLAB on the parameter card is punched "1" (Column 10). There must be as many label cards as there are C's and S's on the Data Description Cards, and in the same order. Punch labels only into columns 1 - 24 of each card.

APPENDIX C

ILLUSTRATIVE CHI SQUARE DESIGN

Chi Square Statistic

Illustrative example:

In an attempt to determine if there is a statistically significant relationship between social class and referral by either family, court, or school, the chi square statistic was utilized.

The table shown below illustrates how the data can be arranged when using the chi square statistic.

HYPOTHETICAL CHI SQUARE TABLE

2 WAY ANALYSIS AND A 3 x 2 TABLE

Source of Referral		LOWER CLASS	MIDDLE-UPPER CLASS	Total No. Referred by each agency
	Court	A*	a	A + a
	Family	B	b	B + b
	School	C	c	C + c
	Total Number of children in each	A + B + C	a + b + c	A+B+C+a+b+c

$$X^2 = \frac{(o-e)^2}{e}$$**

Each hypothesis will be subjected to the chi square analysis in a manner similar to the one illustrated above.

* All entries are joint frequencies

** o = observed frequency
e = expected frequency under chance conditions

APPENDIX D

DIAGNOSTIC CLARIFICATION

45-59

DIAGNOSIS

1- Brain Syndromes (300-317)

3 0 0 Acute brain syndrome associated with infection

- 300.0 Epidemic encephalitis
- 300.4 Other intercranial infection
  - Requires: writing exact infection, if more specificity is desired and it is not indexed separately
- 300.9 Systemic infection NEC
  - Requires: writing exact infection, if more specificity is desired and it is not indexed separately

3 0 1 Acute brain syndrome associated with intoxication
(Excludes: alcohol or drug addiction (326.3-326.9)

- 301.0 Acute hallucinosis, alcoholic
- 301.1 Delirium tremens (alcohol)
- 301.2 Other alcoholic intoxication
  - Includes: acute recoverable brain syndrome resulting from the use of alcohol, except as above (301.0, 301.1) simple drunkenness
- 301.9 Other drug or poison intoxication
  - Requires: writing exact drug or poison, if more specificity is desired and it is not indexed separately.

3 0 2 Acute brain syndrome associated with trauma

- 302.0 Birth trauma
- 302.9 Other trauma
  - Includes: brain surgery
    other operative trauma

3 0 3 Acute brain syndrome associated with circulatory disturbance

3 0 4 Acute brain syndrome associated with convulsive disorder
Excludes: epilepsy without brain syndrome (353.0-353.9)

3 0 5 Acute brain syndrome associated with metabolic disturbance

3 0 6 Acute brain syndrome associated with intracranial neuplasm

3 0 7 Acute brain syndrome of other or unspecified cause

3 0 8 Chronic brain syndrome associated with diseases and conditions due to prenatal (constitutional) influence

- 308.0 Congenital cranial anomaly
- 308.1 Congenital spastic paraplegia
- 308.2 Mongolism
- 308.3 Prenatal maternal infectious disease

3 0 9 Chronic brain syndrome associated with central nervous sustem syphilis

309.0 Meningocephalitic
309.1 Meningovascular
309.9 Other

3 1 0 Chronic brain syndrome associated with intracranial infection

310.0 Acute infectuous encephalitis
Requires: additional code, if it is desired to index together late effect of acute infectious encephalitis (083)

310.9 Other intracranial infection
Requires: writing exact infection, if more specificity is desired and it is not indexed separately

3 1 1 Chronic brain syndrome associated with intoxication
Excludes: alcohol or drug addiction without brain syndrome or psychosis (326.3-326.9)

311.0 Alcohol intoxication
Includes: all degrees of permanent brain damage resulting from the use of alcohol
Korsakoff's psychosis unless specified as non-alcoholic polyneuritic psychosis
Excludes: alcohol addiction without brain syndrome or psychosis (326.3)
simple drunkenness (301.2)

311.9 Other drug or poison intoxication
Excludes: drug addiction without brain syndrome or psychosis (326.4-326.9)
Requires: writing exact drug or poison, if more specificity is desired and it is not indexed separately

3 1 2 Chronic brain syndrome associated with trauma

312.0 Birth trauma
312.1 Brain trauma, gross force
312.2 Brain operation
312.3 Electrical brain trauma
312.4 Irradiational trauma
312.9 Other trauma

3 1 3 Chronic brain syndrome associated with circulatory disturbance

313.0 Cerebral arteriosclerosis
313.9 Other

3 1 4 Chronic brain syndrome associated with convulsive disorder

3 1 5 Chronic brain syndrome associated with disturbance of metabolism, growth of nutrition

315.0 Senile brain disease
315.1 Presenile brain disease
315.9 Other
Includes: familial amaurosis
glandular disease
pellagra

3 1 6 Chronic brain syndrome associated with intracranial neoplasm

3 1 7 Chronic brain syndrome of other or unspecified cause

317.0 Multiple sclerosis
317.1 Huntington's chorea
317.2 Pick's disease
317.8 Other unspecified cause
317.9 Unspecified cause

2 - PSYCHOTIC DISORDERS (318-322)

3 1 8 Involutional psychotic reaction

3 1 9 Affective reactions

319.0 Manic depressive reaction, manic type
319.1 Manic depressive reaction, depressive type
319.2 Manic depressive reaction, other type
319.3 Psychotic depressive reaction

3 2 0 Schizophrenic reactions

320.0 Simple type
320.1 Hebephrenic
320.2 Catatonic
320.3 Paranoid
320.4 Undifferentiated, acute
320.5 Undifferentiated, chronic
320.6 Schizo-affective
320.7 Childhood type
320.71 Autistic type
320.72 Symbiotic type
320.73 Mixed autistic-symbiotic type
320.74 Borderline psychosis of childhood
320.8 Residual type
320.9 Other and unspecified

3 2 1 Paranoid reactions

321.0 Paranoia
321.1 Paranoid state

3 2 2 Other psychotic reaction

3- PSYCHOPHYSIOLOGIC AUTONOMIC AND VISCERAL DISORDERS (323)

3 2 3 Psychophysiologic autonomic and visceral disorders

Requires: additional code to index specific condition, as:
Dermatitis factitia (artefacta) (708.4) (also 323.0)
emotional blindness (781.0) (as well as 323.9)
emotional deafness (781.3) (as well as 323.9)
hyperventilation (783.2) (as well as 323.2)
neurasthenia (790.1) (as well as 323.8)
neurocirculatory asthenia (790.1) also 323.3)
paroxysmal tachycardia (433.3) (also 323.3)
pylorospasm (784.2) (as well as 323.5)

323.0 Skin reaction
323.1 Musculoskeletal reaction
323.2 Respiratory reaction
323.3 Cardiovascular reaction
323.4 Hemic and lymphatic reaction
323.5 Gastrointestinal reaction
323.6 Genitourinary reaction
Excludes: enuresis (327)
323.7 Endocrine reaction
323.8 Nervous system reaction
Excludes: learning disturbance (327)
somnambulism (327)
stammering and stuttering (327)
other speech disturbance (327)
323.9 Reaction of organs of special sense

4-PSYCHONEUROTIC DISORDERS (324)

3 2 4 Psychoneurotic disorders

324.0 Anxiety reaction
324.1 Dissociative reaction
324.2 Conversion reaction
324.3 Phobic reaction
324.4 Obsessive-compulsive reaction
324.5 Depressive reaction
324.9 Other and unspecified

5- PERSONALITY DISORDERS (325-328)

325 Personality pattern and trait disturbance

325.0 Inadequate personality
325.1 Schizoid personality
325.2 Cyclothymic personality
325.3 Paranoid personality
325.4 Other personality pattern disturbance
325.5 Emotionally unstable personality
325.6 Passive-aggressive personality
325.7 Compulsive personality
325.9 Other and unspecified personality trait disturbance

326 Sociopathic personality disturbance

326.0 Antisocial reaction
Includes: psychopathic personality
326.1 Dyssocial reaction
326.2 Sexual deviation
326.3 Alcohol addiction
Includes: chronic alcoholism not otherwise specified
Excludes: alcohol addiction with chronic brain syndrome or psychosis (311.0)
alcohol intoxication (301.0-301.2)
326.4 Addiction to opium or opium derivatives
Includes: chronic poisoning, codeine, diacetylmorphine, diamorphine, dilaudid, heroin, metopon, morphine, pantopon, paregoric
Excludes: acute poisoning (970.0)
addiction with chronic brain syndrome or psychosis (311.9)
intoxication (301.9)
326.5 Addiction to synthetic substitutes for opium
Includes: chronic poisoning, demeral, dolophine, meperidine, methadon, pethidine
Excludes: acute poisoning (970.0)
addiction with chronic brain syndrome or psychosis (311.9)
intoxication (301.9)
326.6 Addiction to barbiturates
Includes: chronic poisoning
Excludes: acute poisoning (972.0)
addiction with chronic brain syndrome or psychosis (311.9)
intoxication (301.9)
326.7 Addiction to cannabis
Includes: chronic poisoning, Indiana hemp, hashish, marihuana
Excludes: same as 326.6
326.8 Addiction to cocaine
Includes: chronic poisoning
Excludes: same as above

(continued)

(3 2 6 cont'd)

326.9 Other and unspecified addiction
Includes: chronic poisoning from narcotic, soporific, and analgesic drugs
Excludes: same as above

3 2 7 Special symptom reactions
Requires: additional code to index specific symptoms, as:
enuresis (768.2)
learning disturbance (781.6)
somnambulism (780.7)
stammering and stuttering (781.5)
other speech disturbance (781.6)

327.01 Primary reading disability
327.02 Secondary reading disability

3 2 8 Transient situational personality disorders

328.0 Gross stress reaction
328.1 Adult situation reaction
328.2 Adjustment reaction of infancy
328.3 Adjustment reaction of childhood
328.4 Adjustment reaction of adolescence
328.5 Adjustment reaction to late life
328.9 Other and unspecified

6- MENTAL DEFICIENCY

3 2 9 Mental deficiency

329.0 Familial or hereditary, mild or unspecified degree
329.1 Familial or hereditary, moderate
329.2 Familial or hereditary, severe
329.3 Idiopathic, mild or unspecified degree
329.4 Idiopathic, moderate
329.5 Idiopathic, severe
329.6 Type unspecified, mild
329.7 Type unspecified, moderate
329.8 Type unspecified, severe
329.9 Type unspecified, unspecified degree

7- Supplementary diagnosis

Y979 Suicide and self-inflicted injury

PLUS:

930 Diagnosis deferred
940 No psychiatric diagnosis
980 Testing only

LIST OF REFERENCES

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