Socioeconomic status as defined by income, occupation and education is a determinant in the client's perception and utilization of a mental health facility.

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SOCIOECONOMIC STATUS AS DEFINED BY INCOME, OCCUPATION AND EDUCATION IS A DETERMINANT IN THE CLIENT'S PERCEPTION AND UTILIZATION OF A MENTAL HEALTH FACILITY

by

Lucille Rachael Simmons Colthrust

A Thesis
Submitted to the Faculty of Graduate Studies Through the School of Social Work in Partial Fulfillment of the requirements for the Degree of Master of Social Work at The University of Windsor

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ABSTRACT

The purpose of this quantitative-descriptive research study was to determine what effect socioeconomic status, as defined by income, occupation and education, had on the client's perception and utilization of a mental health facility. The Children's Center of Wayne County, Detroit, Michigan, was the location which this research project was undertaken.

The writer selected seven areas for examination in the review of the literature: Attitude toward mental health services, definition of mental health, community relationship and mental health facilities and services, the delivery of mental health services and the lower socioeconomic classes, treatment approaches in mental health services between the lower and upper classes, dropout rate, and longevity in treatment in the mental health services—contributing factors and the sociological, psychological and psychiatric aspects of mental health.

The population sample in this research project consisted of thirty subjects, twenty-six females and four males ranging in ages from twenty-five to thirty-seven years of age. Forty percent of the population were married, 23.3 percent were divorced, 16.7 percent were single, another 16.7 percent were separated and only 3.3 percent were widowed.
The education level of the thirty subjects were similar. Both fathers and mothers had attained some schooling ranging from grade 9 to university.

The greater percentage of the subjects, 43.3 percent, were receiving public assistance. Those who were employed worked at various jobs. Only 10.0 percent of the subjects were both working in any given household.

The total yearly income for all the subjects showed that 13.3 percent made a yearly income of $3,000. The majority of the subjects, 30.0 percent, received a yearly income of $4,000 to $5,000 from public assistance.

The study showed that 53.3 percent of the parents were involved in the treatment process with their children. The remaining 46.7 percent did not participate in any form of treatment process with their children.

The average age of the children in the research project was eight years. The average length of stay in treatment was one year. The majority of the problems experienced by these children were problems centered in the home and at school. The type of treatment given to the subjects were either individual or group treatment. Eighty percent paid no fee for treatment.

Many of the parents indicated that treatment was helpful to their children. Parents indicated their willingness to utilize the services of the Children's Center in the future. Parents also stated that they saw changes in their children's behavior after treatment.
A summary analysis of the possible relationship among characteristics showed little or no significance in many of the variables.

A hypothesis was developed to examine whether any relationship exists among the variables income, occupation and education, and the client's perception and utilization of a mental health facility. An interview schedule was used to elicit responses from thirty respondents who were actively involved in the treatment at the Center.

The findings of the research indicated that, for this particular population, the use of a mental health facility by clients is not directly related to income, occupation or education.

The writer recommends that a more rigid statistical study with a large sample population and a control group needs to be done in order to determine whether the variables mentioned in the hypothesis are indeed a factor or bear any relationship to the outcome of a person's perception and utilization of a mental health facility.
ACKNOWLEDGEMENTS

The researcher wishes to express her appreciation to all those who have contributed to this research project. Of the many people who have provided the researcher with assistance during the course of this research, several deserve special mention.

Mr. Theodore Lewis, Executive Director of the Children's Center of Wayne County, Detroit, is thanked for approving the undertaking of the research, as is Dr. Paula Journé, my former Field Instructor at the time when this research was first started in 1976, and the other staff members who assisted me with the completion of the interview schedule. The thirty clients who composed the research population will always be remembered by the researcher.

The researcher wishes to express her gratitude to the members of the research committee for their involvement in the research project: Chairperson Professor Valentin Cruz, School of Social Work, for his patient guidance, encouragement and steady push to complete the research; Dr. Wilfred Gallant for his assistance; and Dr. Subhas Ramcharan, Faculty of Sociology, for his words of support and encouragement.

Finally, a special thank you to the typist, Mary Hasegawa, without whose help this project may not have come to fruition. To my husband, Learie, and son, Adrian, and my twin sister, Monica, a special thank you for being so understanding.
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CHAPTER I

INTRODUCTION AND PURPOSE OF THE RESEARCH

It is only recently that clients have the opportunity to express their thoughts regarding the treatment their children receive. Many professionals are more aware that clients no longer take a second place with respect to the kind of treatment rendered to them.

Treatment programs are more action oriented and parents, children and professionals are working together to ensure that their clients receive maximum help.

It is the writer's opinion that in the case of mental health services, more thought and attention should be given to the needs of clients. We need a global and detailed account of treatment services from the standpoint of the client which could prove invaluable to future researchers.

Another relevant point, to the writer, is that it is necessary to determine how clients perceive the treatment process in a mental health facility; the extent to which they feel they have been helped; and what clients feel in their own opinion should be done differently.

Although it may be very difficult to comply with the opinion of clients, the writer thinks that to ignore their perspective could tend to defeat some valuable
therapeutic aims. This could be one reason why there is such a high dropout rate in the treatment process of clients.

An individual's self-concept may play an important role in the interpretation of parents' perceptions about the utilization of a mental health facility.

The writer feels that an individual's self-concept is evidence of that person's awareness of himself which very often tends to influence his behaviour or action.

Since the goal of most mental health services should be the focus of quality service for all people in the community, a research of the literature would try to include the writer's interpretation of the concept that everyone including the poor, unmotivated, as well as the middle class, is entitled to high quality mental health care.

The writer is of the opinion that many poor people are still not getting this kind of care. This may be so because barriers of culture probably prevent many people from making use of any existing mental health service.

It is believed that, in order to shift from such an unfortunate trend, what is required are some innovative methods which may help modify existing treatment services to accommodate the lifestyle of some people and help prepare others to make use of existing treatment facilities which may be valuable to them.
The purpose of this social work research is twofold: First, to evaluate how clients who are presently using the services of the Children's Center of Wayne County, Detroit, Michigan, perceive the services of a mental health facility. Secondly, to determine whether there will be any significant relationships between clients' economic status and their choice of a mental health center.

The writer will also try to develop data to test the premise that socioeconomic status (SES) as defined by income, occupation and education is a determinant in the client's perception and utilization of the services of a mental health facility.

DESCRIPTION OF THE CHILDREN'S CENTER OF WAYNE COUNTY, DETROIT, MICHIGAN

The Children's Center of Wayne County in Detroit is a treatment center for children and adolescents with severe problems. Families are also served by the Center.

The Center provides outpatient services for children, adolescents and adults. Diagnostic and treatment services are offered on a weekly basis and clients are seen either individually or in groups. Clients are referred to the Center either by schools, social service agencies or self referral.

Changes in the mental health statute in the state of Michigan specify that mental health services be designated for specific geographic areas called catchment areas.
The catchment areas assigned to the Center cover a vast area. These catchment areas are as follows: Model cities, East Detroit, North Detroit/Hamtramck, West Central, Central Detroit, North Detroit-Highland Park, West Side/Redford, South-West Detroit, and North Gratiot.

The staff of the Center is composed of personnel representing several disciplines such as social workers, psychologists, psychiatrist, psychiatric nurses, Special Education Teachers, Occupational Therapists, Community Organizers, Child Care Counselors, Speech Therapists, Paraprofessionals, Volunteers, and Vocational Teachers.

The Children's Center programs are presently located in four different facilities. For the purpose of this study the writer will focus upon the program offered by the main center, the Children's Center of Wayne County, Detroit, Michigan, located at 101 Alexandrine E. Michigan, Detroit. This facility was the locus of my field placement. The writer worked in the outpatient department at the Center. It was from this department that the sample population was drawn since the writer had ready access to the files.

The objectives of the outpatient service program as outlined in the Children's Center manual are stated as follows:

To improve the emotional and social adjustments of children and families; to reduce the number of state hospital and institutions admissions of clients from the Center's service areas and to provide aftercare services for children and adolescents returning from institutions; to reduce the incidence of delinquent and pre-delinquent behaviour in the service areas; to provide an emergency response to family crisis;
and to reduce the incidence of child abuse and child neglect.¹

RATIONALE FOR THE STUDY

The Children's Center outpatient services was the base for the writer's field placement for approximately seven months. It was here that the writer had the opportunity to work two days a week. It was during these months that the writer became familiar with the operation of this mental health facility.

The writer's curiosity about mental health, that is, its meaning, the facilities that conduct mental health services, the type of services that are available to the public and its availability for public usage was greatly enhanced by the search for literature which carried various articles on mental health.

A problem arose for the writer in the selection of a population for this study. It did not seem feasible to the writer to try and select a sample from the three outpatient units of the Children's Center.

The difficulty arose in the selection of the population because of the various locations of the Units and outpatient service and because of the complications involved with the administrative policy. The writer chose to get the sample population from the outpatient Unit III, during the field

¹The Children's Center of Wayne County, Detroit, Michigan Orientation Manual, p. 3.
placement. The writer had permission from the Director of Training who was the field supervisor and also from the Director of the Children's Center. The writer also had access to the clients' files.

At first, the writer had decided to select a random sample of two hundred cases, one hundred of which would have been closed cases and the other one hundred from among the active cases in order to determine the relationship, if any, between socioeconomic status as defined by income, occupation, and the client's perception and utilization of any mental health facility.

The writer envisioned some constraints in trying to interview a sample population of two hundred. First, it was possible to assume that many of the clients from among the closed cases may in fact have relocated. Others may have changed their names because of marriage or divorce. Other constraints included the financial cost involved in having to mail the questionnaires. The possibility existed that the return response might not be high even though stamped, self-addressed envelopes are usually mailed out with questionnaires. Another constraint that would have caused some difficulty was the length of time it would have taken to complete a research project of this size.

After much deliberation, it was finally decided to select a sample population of thirty subjects because a small sample was simpler to compute, and its manageability created less problem for the writer. Another reason for
selecting a sample of thirty people was that the writer was only available two days a week at the Center during the field placement which afforded the writer little time to undertake the monumental task of interviewing a large population. A small sample helped to minimize the possibility of analytical complications.

Because the writer only had five cases during the field placement, the writer had to get the remaining sample population of twenty-five from among fellow workers and staff whose caseload was much larger. This random selection of cases helped to protect against any bias within the sample population.

The small sample population made it difficult to generalize about the sample population. Subjects were selected from among the open cases because it provided a homogeneous sample for the research.

The interview was conducted mainly by the researcher with the assistance of other staff members from whom subjects were chosen for the research.

The study will focus only on clients using the services of the Children's Center at the time the study was undertaken. This study will evaluate how clients view the services rendered by a mental health facility.

The design of the research is quantitative descriptive because it comprises an interview schedule. An interview schedule was used to collect the data to test the following research hypothesis: Socioeconomic status (SES) as defined by income, occupation and education is a determinant in the
client's perception and utilization of the services of a mental health facility.

Despite the size of the population, it is expected that the findings of the research will indicate whether or not the socioeconomic status (SES) of the families presently using the services of the Children's Center of Wayne County, Detroit, Michigan, as defined by their income, occupation, and education is a determinant in their perception and utilization of a mental health facility.

SUMMARY

This chapter described the process of identifying a problem for research in the field of mental health services with regards to a specific facility, the Children's Center of Wayne County, Detroit, Michigan. This chapter also briefly described the Children's Center and its various treatment approaches. A rationale for the study was outlined.

Chapter 2 of this study will present a review of the literature.

Chapter 3 will outline the methodology of the study. Chapter 4 will present the data analysis and findings.

The summary and recommendations will be presented in Chapter 5.
CHAPTER II

REVIEW OF LITERATURE

There exists a great amount of literature which deals with the various aspects of mental health and their theoretical viewpoints. However, the writer will present only material which seems particularly relevant to the present study.

The purpose of this review is to explore the literature for evidence relating to socioeconomic status (SES), as defined by income, occupation and education, as a determinant in the use of mental health services.

ATTITUDE TOWARD MENTAL HEALTH SERVICES

Practically all mental health legislation stands as a part of society's efforts to cope with life situations in which the conduct of certain persons cannot be reconciled with established social and cultural standards.

The writer believes that the issue of mental health is intricately interwoven with other issues of cultural standards and the limitation of individual freedom.

It seems fitting to assume that we have the right to methods and mental health facilities of services that may produce changes in our behaviour.

We cannot solve all the problems of the world but some contribution can be made towards problem solving.
Normand, Iglesias and Payn\textsuperscript{2} state that the essential concept of the mental health movement which they termed the 'third psychiatric movement' is that everyone, poor and unmotivated as well as middle class and psychologically minded, is entitled to high quality mental health care.

The writer feels, despite Normand, Iglesias and Payn's statement, that for many poor people such care is in practice unavailable. It is the writer's opinion that this may be so because, for many people, barriers of culture or language prevent their use of existing services especially with regards to the use of mental health treatment facilities.

The writer believes that in order to translate the present day theory of mental health services into some kind of effective action some form of innovative methods are required both to modify existing treatment to fit the style of some people and also to prepare people to use present treatment modalities which are readily available to them.

An example of this was illustrated in Normand, Iglesias and Payn's\textsuperscript{3} article where they pointed out that a community mental health center was set up to help poor Spanish-speaking people to improve the utilization of mental health services offered to them.


\textsuperscript{3}Ibid., p. 38.
It appears from this article that the aim is to help patients to understand their problems in psychosocial terms and to understand the nature of the services available, not only in the mental health center but also in the community, with the hope that patients will accept further care when indicated.

Lurie⁴ has stated in her article that deficiencies in delivery of mental health services for children are reinforced by parents' attitudes toward their children's problems, and by doubts regarding the relevancy of mental health care.

This was evident in the writer's contact with parents of children who were clients at a mental health facility. The writer feels that in varying ways parents' attitudes reflect socioeconomic differences. This is substantiated in Lurie's article in which she stated that because of these socioeconomic differences

...ways are needed for reaching out to parents and helping them seek and use the services their children need.⁵

For many years various professionals and paraprofessional workers have experimented with different ways of helping people.


⁵Ibid., p. 109.
However, the resultant innovations of these experiments seemed to have stemmed not from the clients' perceptions of the help required but chiefly from the practitioners' perceptions.

**DEFINITION OF MENTAL HEALTH**

The mental health program seems to be an important concept in the field of mental health services. Today, there is a 'movement' towards the improvement of mental health services.

The literature has shown that both professionals and government officials are currently struggling with complex legal, economic and moral issues related to the delivery of mental health services.\(^6\)

Although this 'movement' towards the improvement of mental health services is apparent, the writer still feels that even today the mental health movement is adrift. This is evident in the fact that presently many communities still react with mixed feelings toward discharged mental patients in their community. Such an issue shows the need for renewed attitudes to mental health services.

The literature has revealed that Family Counseling Service is used by some communities as a source of help for clients whose difficulties are of the sort usually defined

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as 'mental health' problems. However,

...the enthusiasm with which many professionals today speak about the achievements of the mental health movement is gratuitous, for it is increasingly clear that community mental health has only partially fulfilled its goals.

COMMUNITY RELATIONSHIP AND MENTAL HEALTH FACILITIES AND SERVICES

The number of people needing and demanding help in our community is constantly on the rise.

Almost ten years ago the Joint Commission on Mental Illness and Mental Health recommended that a national manpower recruiting campaign and concurrently initiate training programs and efforts to stimulate the interest of American youth in mental health careers be launched. 8

The reason for this venture was to initiate training programs and efforts to stimulate the interest of youth in mental health careers.

Despite the affluence of our society, the plight of the poor is worsening. It is a statistical fact that as unemployment increases, the family separation rate also increases, and when unemployment recedes, so does family separation.

The writer sees this as an indication that family problems do have some bearing on the mental state of an individual. It is a fact that mental health problems cut

7 Giordano, "Community Mental Health," p. 6.

across all levels of society. For example, clients seen at the Children's Center come from varied backgrounds with varying problems and are referred for treatment by a number of sources, such as schools and other family and social service agencies.

Brenner's article indicates that there is a close correlation between unemployment levels and rates of admission to mental hospitals—

...mental illness is inversely related to socioeconomic status: the lower the socioeconomic status, the greater the proportion of persons in psychiatric treatment.\(^9\)

We must bear in mind that economic factors produce social and mental health problems that require the services of the helping professions.

On the other hand, though, we must recognize that there is a distinction between demand for services and the need for them. Even today, many people are unhappy, ineffective and suffering from varying degrees of emotional disturbance, yet these same people are not formally identified as having mental health problems.

Studies by Fried\(^10\) and Clausen\(^11\) state that social

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deprivation is related to the incidence of emotional disorders. Both writers feel that the delivery of mental health services is highly disproportionate for various segments of society.

Where help is needed the most, it is typically least available and effective. Many multiproblem families have many psychiatric disorders. Most of the clientele at the Children's Center fall within this category. As such, the children of these families tend to be disabled both emotionally and educationally.

These disabilities are common among people in the lower socioeconomic groups but are not exclusive to this group. It is usually common knowledge that poorer prognoses are more readily assigned to children of blue collar workers than to those of white collar parents. Many of the clientele at the Children's Center come from blue collar workers' homes.

The writer feels that in dealing with mental health and its ramifications it seems fitting to mention that personality and social structure cannot be regarded as independent of each other. In the writer's opinion, there seems to be a connecting link among problems, stresses, adjustments to hardships or disability, and the solution of these problems. All of these problems must be considered in relation to man's social milieu and personality functioning—together they are all part of mental health.
Olga Lurie\textsuperscript{12} explores the attitudes of parents of socially and economically diverse groups towards their children's problems, and toward seeking help, in the light of the utilization of mental health resources.

Lurie feels that, although existing mental health services for children are insufficient to meet many of their needs, there is evidence which shows that parents often fail to seek out and use the resources that are available. The reasons for the apparent reluctance of parents to utilize mental health services show that many factors may contribute to this dilemma.

Some of the reasons cited by the above writer in a study done on the emotional health of children, revealed that emotional impairment of varying degrees of severity was widespread among children from among economic, occupational, religious and ethnic groups.

Lurie further cited that the extent of impairment was related to family structure and functioning, and to the emotional health of the siblings; that children's behaviour patterns and parents' attitudes and practices were interrelated and related to the emotional impairment of the child, and that sociocultural factors influenced parental attitudes.

Further search of the literature shows that although emotionally impaired children were found in all socioeconomic groups, family income proved to be an overriding factor. Many families had incomes of under $6,500 and, in most of the families, mothers were employed.

Comparatively, family income of the clientele at the Children's Center fell within $5,000 - $6,000 range. In many instances, children were from one-parent families and most of the mothers in these families were receiving public assistance.

Sanua made similar related comparision to Lurie with regards to the emotional health of children and their families' economic status. The writer gathered from Sanua's article that usually children from well-integrated homes have very low life-long rates of mental disorder. On the other hand, children from emotionally disrupted families have high subsequent rates of emotional disorders—

...many children were found to live in homes which had been disrupted by death, desertion, separation or divorce.\(^\text{13}\)

Some of the reasons Sanua cited as the apparent causes for the emotional disruption of families which eventually lead to major mental disorders are unemployment, discrimination, broken homes and poor housing.

In another three-year survey done by Gibbs on the use of Mental Health Services by black students, he deduced some—

...similarities and some differences between blacks and other clinic users. He formulated the socio-economic status of the black users at the Mental Health Service from the occupation of the head of the household.\textsuperscript{14}

In so doing, he found that socioeconomic class seems to be positively related to the utilization rates of the mental health services.

Unlike Hollingshead and Redlich\textsuperscript{15} in their discussion of class factors in psychotherapy in which they used the Index of Social Position to designate a person's class position, Gibbs\textsuperscript{16} operationally defined the socioeconomic status of his clientele as upper-middle class, middle class, working class and the lower class.

Hollingshead and Redlich\textsuperscript{17} comparatively use three indicators of status utilized by the Index of Social Position to determine class position:


\textsuperscript{16}Gibbs, "Use of Mental Health Services," p. 432.

\textsuperscript{17}Hollingshead and Redlich, Social Class, p. 66.
(1) the residential address of a household,
(2) the occupational position of its head, and
(3) the years of school the head has completed.

Gibbs went further than Hollingshead and Redlich and outlined specifically the socioeconomic status of his students as follows:

(1) **Upper-middle class** refers to students from households headed by a professional, semi-professional or business executive parent;

(2) **Middle class** refers to students from households headed by a parent in a white-collar, technical or small business occupation.

(3) **Working class** refers to students from households headed by a skilled or semi-skilled parent.

(4) **Lower class** refers to students from households headed by an unskilled, domestic, or unemployed, unskilled parent.\(^{18}\)

A review of the literature indicated that, although such issues as autonomy, financial management and other related problems were experienced by almost all students, it appears that these problems manifested themselves differently, depending on the social class of the students.

Many lower-class black students seemed to be caught in a double bind. They are caught up in a situation of divided loyalty, whereby these students have a desire to please their parents, but on the other hand feel guilty about depriving their other siblings.

\(^{18}\) Gibbs, "Use of Mental Health Services, p. 432."
This double bind in which many blacks find themselves comes about because of their need for independence from parental authority. This urge for independence is complicated by the fact that many blacks feel as though they are depriving their family of any additional income. As such, many feel that this deprivation creates greater financial and social strains for the rest of the family.

Although reference is made here about blacks as having difficulties, the writer feels that the encounter of the double-bind theory may apply to other ethnic minorities who find themselves in similar circumstances. For blacks, though, many of the areas in which they experience undue stress as opposed to their white counterparts are marginally related to their ethnic identity and socioeconomic status, cultural attitudes and behaviour patterns.

Needless to say, the somewhat marginal status among blacks sometimes creates anxiety and dysfunctional psychological problems for the black adolescent.

THE DELIVERY OF MENTAL HEALTH SERVICES AND THE LOWER SOCIOECONOMIC CLASSES

Apart from the need for adequate mental health services in many communities, the literature shows that a problem exists in the area of the delivery of services to members of the lower socioeconomic classes. The review of the
literature reveals that many articles are written about outpatient treatment in mental health services but little is found in the literature pertaining specifically to the delivery of mental health services to the lower socioeconomic classes.

One of the major problems in the development of community mental health services has been the design and delivery of services to members of the lower socioeconomic classes. This section of the review of the literature will be devoted to the kind of services which are available to members of the lower socioeconomic classes.

Cobb in his article on community mental health services establishes a kind of summary in his research on the delivery of outpatient services to the lower socioeconomic class. The research was undertaken in an attempt to uncover findings that would be relevant to program development.

There were few articles in the literature falling within categories other than outpatient treatment. It would appear that such issues as acceptance for therapy, patient expectation, assignment of therapists, dropout from treatment, staff attitudes and treatment approaches need further consideration.

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In the review of the literature, there was little reference to studies designed to assess the effectiveness of the different treatment approaches of serving lower socioeconomic class patients. This may be because there is little evidence in the literature of any attempts to explore the effects of present day treatment of such issues, as stated in paragraph two, upon lower socioeconomic groups.

Throughout the research of the literature, many questions were being asked about the acceptance for therapy among the low and high socioeconomic classes. Cobb indicated that the reason for these questions relates to

...some kind of social class bias in the selection of patients for therapy and this may be due to the irrational factors prejudicial to lower class patients receiving the most beneficial and appropriate treatment.\textsuperscript{20}

Another reason cited with regards to the low acceptance of patients for therapy may be based

...upon the inappropriateness of the types of treatment services available for people of the lower socioeconomic classes.\textsuperscript{21}

Brill and Storrow\textsuperscript{22} pointed out in their study that members of the lower socioeconomic classes were less apt to


\textsuperscript{21}Ibid., p. 406.

be accepted for treatment than members of the upper socioeconomic classes. The reason they gave for this was that there seems to be a tendency to view the lower class patient as less suitable for psychotherapy than the upper class individual.

Another factor to be taken into consideration when facilitating the delivery of mental health services to members of the lower socioeconomic class is the expectation of clients who seek help at mental health facilities. It was revealed, during the review of the literature, that many lower socioeconomic clients most often seek assistance with the hope of getting something in return, for example, relief from their problem.

Overall and Aronson in their study explain that lower class patients predominantly expect a medical-psychiatric interview with the therapists taking a generally assuming and active but permissive role.

In fact, what is being expressed here is the overall attitude of lower socioeconomic class clients who evidently tend not to return to treatment when their hopes and expectations are not fulfilled. Thus, we find a trend developing whereby studies have shown that...

...low socioeconomic status patients are more likely to drop out of treatment than patients of high socioeconomic status.

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However, the writer wishes to add that the above statement is not to be taken at face value, because there are a number of variables that have to be taken into account when considering the issue of client perception of any services. For example, such issues as acceptance for therapy, patient expectation, assignment of therapists, dropout from treatment, and treatment approaches—all require careful attention in order to help define some of the problems that confront members of the lower socioeconomic classes.

Although the research for this study is not geared towards a particular ethnic group, it seems relevant to make reference to the Davis and Swartz study in the review of the literature because it points out some of the difficulties that some blacks face in their attempt to utilize a mental health facility. In looking at the utilization of mental health services by black college students, it was found that most black people do not come in contact with psychiatric clinics unless they are overtly disruptive.

Davis and Swartz gave their reasons for this reluctance or apparent fear of mental health services by indicating that:

Many black people feel that going to a mental health service is a kind of admission of being crazy. Black males feel that any suggestion of mental health service indicates that they are not coping effectively with their lives and this creates a sensitivity that refers to their identity and masculinity. For black women, on the other hand, reference to a mental health clinic creates anxiety over not being able to deal adequately
with problems, handle crises and arrive at appropriate solutions.\textsuperscript{25}

What Davis and Swartz did in their study was to utilize two types of services to encourage black students to use the mental health facilities that were implemented at a city college in San Francisco. There were two types of services used to help students and these services were referred to as Direct Service and Indirect Service.

According to Davis and Swartz, the Direct Service was aimed solely at the students; whereas, the Indirect Service was involved in consultation with student groups, faculty, departments and administrators. What Davis and Swartz were trying to do in the use of these two services was to demonstrate to black students that there was no disgrace in coming to a mental health center.

What these two writers did was to use innovative methods, like self identity, open discussion of personal, family and marital conflicts, in their informal approach in the treatment of their clients. This informal and personal approach became an essential factor in the increasing number of black students who began to use the mental health service.

The main point to be stressed here is the way in which emphasis was placed upon a person's own visibility in the treatment process. By means of informal techniques, the worker

was able to facilitate contact with students and in so doing
was able to reach a sizeable number of the target population.

Baum, Felzer, D'Zmura and Shumaker cite other reasons
why people of the lower socioeconomic group are reluctant to
seek help from a mental health clinic.

Despite this emphasis it is fully recognized that
a low dropout rate is not equivalent to treatment
success.26

A review of the literature shows that there is a
social stigma attached to psychiatric treatment and the
use of mental health facilities. This stigma appears to
be greater in the lower socioeconomic class than in the
upper social classes. The reason for this stigma among
the lower socioeconomic classes may be due in part to the
social class values of both the lower and upper classes.

Reissman and Scribner27 explained it best when they
indicated that, in the content analysis of current mental
health literature, the middle class values and orientations
towards work, problem-solving, adjustment and conformity
continue to dominate the mental health field.

26 O. Eugene Baum, Stanton B. Felzer, Thomas L. D'Zmura

Baum and Felzer\textsuperscript{28} in their article made certain observations about psychotherapy among lower social class patients. What these two writers seem to be saying is that it appears that early, flexible and meaningful activity by a therapist in an initial interview is essential to the establishment of a therapeutic relationship.

However, one must bear in mind that such an activity should be geared to openly discussing the expectation of the client, as well as his lack of understanding of therapy and how it works.

The writer feels that sensitizing the therapist to the special needs and expectations of the client will facilitate communication and form a therapeutic bridge between the client and the therapist. At the same time, by encouraging the therapist to discuss his own expectations and resistances, a more realistic and helpful approach would be developed in the treatment process.

TREATMENT APPROACHES IN MENTAL HEALTH SERVICES
BETWEEN THE LOWER AND UPPER CLASSES

Evidently, the literature shows that some form of relationship exists between a client's social class and whether or not he is accepted for therapy. Writers like Brill and Storrow, Schaffer and Myers and Cole, Branch and Allison all have expressed similar views on the relationship between social class and therapy.

According to Brill and Storrow who cite the Hollingshead and Redlich study as an example of social class bias, the writers point out that patients in the upper social classes who seek psychiatric treatment for any type of psychiatric disorder are more likely to receive intensive, insight-producing psychotherapy. Meanwhile, patients in the lower social classes are more apt to receive short-term supportive psychotherapy, pharmacology, or other somatotherapy, and if hospitalized, simple custodial care.\(^{29}\)

In comparison, Schaffer and Myers report that,

The higher a patient's social class position was in the community, the greater were his chances of being accepted for psychotherapy.\(^{30}\)

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According to Schaffer and Myers, social class still seems to play a role in psychotherapy for patients of lower social classes.

Schaffer and Myers indicate that not only were patients from upper social classes accepted for treatment more often, but their treatment was more apt to be given by a more senior and more experienced member of staff than was the case with patients from lower social classes.

A therapist would tend to select patients who would in some way facilitate his fulfillment of other-originated demands as well as his own general needs. 31

Very similar to Schaffer and Myers' view of patient treatment is Cole, Branch and Allison's 32 idea, that the higher a prospective client's social status, the more likely it is he will be accepted for treatment. Irrespective of class, a patient has more likelihood of being discharged as 'improved' if he remains in treatment. A review of the literature shows a trend towards social class division which seems greater in the lower socioeconomic class than in the upper social classes.

Baum, Pelzer, D'Zmura and Shumaker point out that,

...the lower socioeconomic class patient tends to be crisis-oriented and gets into treatment only


when his problem has created a social crisis for others, i.e., family, community agency, rather than on the basis of personal need.33

Similarly, McDermott, Harrison, Schrager and Wilson indicate that "unskilled" persons from among the blue collar category allowed a longer time to elapse before they sought help.

Despite the greater difficulty of the "unskilled" in making a good school adjustment, a considerably longer time elapses before professional help is requested for them.34

Brill and Storrow35 state that very often interviewers tend to react less positively to the lower class patient, and as such, see him as less treatable in psychotherapy than his upper class counterpart. The reason for this is that there is still the tendency among therapists to view lower class patients as less suitable for psychotherapy than the upper class individual.

Yet another reason for the negative reaction by therapists towards the lower class patient may lie in the inability of patients from the lower social classes to afford the more costly and, therefore, presumably preferred intensive psychotherapy.

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33 Baum, Felzer, D'Zmura and Shumaker, "Psychotherapy," p. 634.


Brill and Storrow\(^{36}\) did a number of analyses to test the relationship of the patient's progress through a mental health clinic with social class. The study showed that if social classes were combined into Upper (I, II and III) and Lower (IV and V), there was a relationship at the 0.05 level of significance between social class and whether or not a patient was accepted for treatment.

Comparative to Brill and Storrow's finding, Schaffer and Myers, in utilizing Hollingshead's Social Index Scale, determined that 64 percent of Class II and 55 percent of Class III patients were accepted for individual psychotherapy, while only 34 percent of Class IV and 3 percent of Class V patients were accepted.

When therapists were ranked according to their status position within the clinic, the senior staff generally treated patients from classes II and III, while the majority of residents' cases were from classes III and IV, and medical students treated persons primarily from classes IV and V.\(^{37}\)

The writer wishes to explain that Hollingshead's Social Scale Index—

...utilizes the ecological area of residence, occupation, and education to determine an individual's class status. To obtain a class status score on an individual, one must know his address, his occupation, and the


number of years of school he has completed.\textsuperscript{38}  
The highest class is I and the lowest class is V.

Conclusively, both studies reinforce the fact that there is indeed a relationship between social class and whether or not a patient is accepted for treatment.

According to Rosenthal and Frank’s study, psychiatrists mostly refer those patients for psychotherapy whom they feel are most likely to benefit from treatment; for example, patients with relatively higher socioeconomic status and education who are better oriented and motivated toward receiving such treatment.\textsuperscript{39}

Not only do psychiatrists refer patients for psychotherapy who are highly motivated, but we also find that ...
middle class patients are preferred by most treatment agents and are seen as treatable, psychotherapy is more frequently recommended as the treatment of choice and diagnoses are more hopeful.\textsuperscript{40}

There are certain personality characteristics among middle class patients which are referred to as positive indicators of a good prognosis in psychotherapy which may account for this success.

\textsuperscript{38} Hollingshead and Redlich, \textit{Social Class}, p. 37.


\textsuperscript{40} Riessman and Scribner, "Under-Utilization," p. 799.
According to Reissman and Scribner these include such characteristics as psychological thinking rather than magical expectations, internalization of problems and the tendency to self-blame rather than acting-out and projection; a wish to actively change one's environment instead of a passive fatalistic stance towards reality; high motivation and ego strength.\(^41\)

Comparatively, Rosenthal and Frank point out in their study that,

...patients of lowest educational and income levels are most likely to refuse psychotherapy when it became available.\(^42\)

Brill and Storrow report that during the analyses of data obtained at intake which relate to "psychological mindedness" of patients in relation to social class, it shows that:

Low social class is found to be significantly related to lower estimated intelligence, less education, to tendency to see the presenting problem as physical rather than emotional, a desire for symptomatic relief only rather than overall help, lack of understanding of the psychotherapeutic process and lack of desire for psychotherapy.\(^43\)

As a result, Cole, Branch and Allison report that middle class persons are significantly more likely to be rated as "socially improved" than lower class persons, upon discharge from treatment.\(^44\)


However, when both upper and lower class patients are placed into treatment together, the resultant effect of psychotherapy is the same for both groups.

Albronda, Dean and Starkweather indicate that both upper and lower social class patients stood an increasingly better chance of being considered as socially improved if they remained in treatment.

Enrico Jones states in his study that "clinicians believe that the longer the treatment continues, the more favorable the outcome of psychotherapy."

This notion derives from a particular conceptual model of psychotherapy, viz., that therapy is necessarily a prolonged relationship and in order for it to be successful the patient should achieve insight into the connection between his complaints and his past and present interpersonal problems.46

Other writers who support Albronda, Dean and Starkweather and Enrico Jones' points of view are Cole, Branch and Allison. With regards to the relationship between class status and the percentage chance a patient has of being discharged as "socially improved" as a result of psychotherapy, these authors said:

That those patients terminating within the first 5 interviews, both upper and lower classes have a very poor chance of being discharged "improved." At the 10 interview mark, the figures begin to reverse, and therefore, irrespective of class, a patient has more likelihood of being discharged as improved.47


In summary, the writer feels that some therapists should adopt a more supportive and responsive attitude towards the lower socioeconomic class patients.

Overall and Aronson \(^{48}\) similarly suggest a more active role on the part of the therapist working with the lower-class client, especially in the initial interviews when the client's expectation about therapy and how it works should be expressly addressed.

However, it is noteworthy that many findings indicate that irrespective of social class the longer a patient remained in a therapeutic relationship the greater the probability that he would make progress in resolving his emotional problems. \(^{49}\)

Rosenthal and Frank \(^{50}\) also indicate that patients of lower social class and motivation were least likely to accept psychotherapy or remain in it once they tried it; however, they generally do obtain as much benefit from it as those of higher social class and motivation.

**DROP OUT RATE AND LONGEVITY IN TREATMENT IN THE MENTAL HEALTH SERVICES: CONTRIBUTING FACTORS**

Throughout the literature, reports indicate that social status plays an important part in a patient's acceptance for treatment.

\(^{48}\) Overall and Aronson, "Expectations," p. 429.

\(^{49}\) Albronda, Dean and Starkweather, "Social Class," p. 283.

\(^{50}\) Rosenthal and Frank, "Fate," p. 342.
The writer finds that this is not only the case with regards to one's acceptance for treatment but the fact also holds true when dealing with the length of time a person stays in treatment.

According to Yamamoto and Goin,

...there is a significant relation between lower socioeconomic status and failure of a client to keep his initial appointment.51

Similarly, Schaffer and Meyers report in their study that there is a significant correlation between class status and duration of contact with the psychiatric clinic.

They reported that of the 63 patients seen over periods of one week or less 47 percent of 75 percent were from classes IV and V. Conversely, of the 27 patients who maintained contact for more than 25 weeks, 20, nearly 74 percent were from classes II and III.52

It is important to bear in mind that, according to Hollingshead and Redlich's study, status was designated as follows: Classes I, II and III were upper classes and IV and V represented the lower classes.

Studies have shown that the lowest status group, e.g.,...the unskilled and service workers and the chronically unemployed usually have the poorest appointment record re: psychotherapy.53

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53 Yamamoto and Goin, p. 333.
Bailey, Warshaw and Eichler\textsuperscript{54} also show that there is a relationship between social class and continuation of psychotherapy. Their investigation was designed to determine whether such criteria as socioeconomic status, intrapsychic complaints, youth, expressed desire for psychotherapy, recommendations from psychological test evaluation, and previous treatment was related to length of stay in psychotherapy.

In using the chi square test as a means of determining the relationship, they discovered that there is a highly significant relationship between improvement in psychotherapy and length of stay in treatment and low socioeconomic status.\textsuperscript{55}

Baum, Felzer, D'Zmura and Shumaker\textsuperscript{56} also indicate that various factors contribute to the development of dropouts. The variables which are linked to dropout are attributed both to the therapists and to factors characteristic of the patients.

According to Baum, Felzer, D'Zmura and Shumaker, there are five factors related to the therapists' attitudes and behaviors which contributed to dropout among patients in psychotherapy.


\textsuperscript{55} Ibid., pp. 443-444.

\textsuperscript{56} Baum, Felzer, D'Zmura and Shumaker, "Psychotherapy," pp. 632-633.
First, he refers to the term "chuck out" to describe the therapist's rejection towards his patient. The five factors are:

1. The "chuck out" is what we have considered an instance of actual rejection on the part of the therapist who did not want work with this kind of patient, who is labeled as the "worst" kind of case.

2. As a result of insecurity and insufficient understanding of the therapeutic process, the less successful therapist tended to use a rigid, mechanical approach with a "patient" who was not yet a patient.

3. There was "acting out" of resentment on the part of some of the therapists for being involved in the project on a nonvoluntary basis.

4. The unsuccessful therapist's difficulty in communicating with the patient was clearly evident in the "one-way mirror" interviews.

5. There was insufficient and inadequate use made of the social worker and psychologist who were sometimes viewed as competitors, rather than therapy team associates.

These five factors are characteristics of the therapist whose attitude and behavior are influential in producing dropouts in psychotherapy.  

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Similarly, Overall and Aronson point out that lower class individuals, due to cultural factors, may have a different conception of therapy and the procedures involved. This eventually leads to a high dropout rate amongst the lower socioeconomic patients.

Other factors producing dropouts may be present within the therapeutic procedures. Perhaps in viewing therapy from a traditional perspective, the therapist unknowingly rejects the lower-class patient when he does not meet the therapist's expectations.58

Comparatively, we find that those therapists who are more secure, more clinically experienced, task oriented, and aware of the patient's needs and who are able to make use of the broad spectrum of psychotherapy in a flexible way, establish a better relationship with lower socioeconomic patients and have a lower dropout rate.59

On the other hand, when relatively inexperienced resident therapists who are not motivated to work with lower socioeconomic patients are used, a high dropout rate can be expected.60

In looking at those characteristics of the patients which contribute to the high dropout rate among members in the lower socioeconomic group, we find that there are several characteristics and referral processes which are listed as contributing factors.

60 Ibid., p. 634.
According to Baum, Felzer, D'Zmura and Shumaker, these factors are as follows:

(1) Inappropriate referrals, when the patient's problem was not primarily a psychiatric one, increased the possibility of dropout.

(2) The referral source did not adequately prepare the person for referral and did not properly support the therapy during the critical early phase.

(3) A considerable number of people came to the psychiatric interview with unrealistic expectations about what would take place.

(4) Overwhelming reality problems of a social, cultural or economic nature interfered with the possibility of establishing a therapeutic bridge.

(5) The factors of lower intelligence, concrete thinking, minimal phantasy capability and productivity contributed to dropout.

(6) An attitude of resignation and lack of previous accomplishment in many patients raised questions about their motivation.

(7) The social stigma regarding psychiatric treatment appears to be greater in the lower socioeconomic class than in the upper social classes, and these same biases operated in some of the referral sources. The interview was perceived as a threat by the patient who was afraid he would be labeled as "crazy" and sent to a hospital.

(8) The lower socioeconomic patient tends to be crisis-oriented and gets into treatment only when his problem has created a social crisis for others.

(9) Expectation and anticipation of rejection on the part of the patient reinforced the resident therapist's tendency to reject these patients. 61

Since studies have shown that the length of stay in therapy is related to the social position of the patient, it is also possible to predict from the patient's social position how long he will stay in therapy.

The Auld and Myers study showed a consistency with the hypothesis that social position of the patient influences his responses to psychotherapy. The results also revealed that those patients who get the more experienced and more skillful therapists will stay in therapy longer.

Likewise, a study by Sullivan, Miller and Smelser to evaluate the relationship of social status variables to length of stay and progress in psychotherapy, coincides with that of Auld and Myers.

In using the MMPI scales, Sullivan, Miller and Smelser utilized such demographic measures as age, education, occupation and psychological measures, e.g., social status, intellectual efficiency and ego strength to show the relevancy of these variables to length of stay in treatment.

The results of both the demographic and psychological measures show that patients who were better integrated and more successful in life pursuits were the ones who remained in treatment longer. 63

If we were to look at the rate of improvement between those people who survive in therapy and those who drop out, we would find that there is a difference in the general profile of both groups.


Sullivan, Miller and Smelser study points to this difference. They found that all of the clinical scales in their study showed significant differences between the "Improvers" and the "Unimprovers."

The "Improvers" and the "Unimprovers" were the terms used to differentiate between those groups of people who stayed in treatment and those who did not remain in treatment.

Sullivan, Miller and Smelser also indicate that the "Improvers" have generally lower profiles than the "Unimprovers," and this suggests that those who improve in psychotherapy are less sick from the outset.

As the psychological findings indicate that the improved were less disturbed at the outset of therapy than the unimproved, findings on the demographic variables show that they also held better positions and were employed in capacities more closely in keeping with their higher educational achievement.

Conclusively, this study shows that, when patients who were rated improved in psychotherapy were compared with those rated unimproved, patients with higher occupational achievement and less psychopathology proved to be more successful in treatment.

64 Sullivan, Miller and Smelser, "Factors in Length of Stay," p. 5
65 Ibid., p. 5.
66 Ibid., p. 8.
Apart from those factors which contribute to a high dropout rate among the lower socioeconomic patient, there are certain relevant factors which are to be taken into account when considering the gap between the upper class patients and the lower classes during psychotherapy.

There are certain external factors which are cited as the reasons why people in the upper classes survive psychotherapy longer than those in the lower classes. According to Cole, Branch and Allison, the possible relationship between social class and attrition in psychotherapy can be divided into two categories. The first category includes those factors which are external to a therapeutic situation. These external factors as indicated by Cole, Branch and Allison are as follows:

(1) The selection process of the waiting list, for those who are accustomed to instant gratification or relief, the waiting list can serve as a barrier.

(2) Usually, the time concept of the poorer people is in terms of "here" and "now" and "immediately," any idea of postponement and future rewards emerges with movement up the social scale.

(3) The waiting list can bias in favor of the upper classes.

(4) Distance from the clinic and loss of time from work may unwittingly bias in favor of the upper classes.

(5) The loss of earnings involved in meeting the clinic schedule may be a considerable burden on the family economy.

(6) Babysitters can create insurmountable problems for lower class groups who have no access to helpful relatives.
(7) Lower classes tend to view agencies with hostility and defensiveness.67 When we compare these external factors with factors that are internal to the success of longevity of psychotherapy among the upper classes, here again we find a difference in the characteristics between patients who terminate prematurely from treatment as against those who remain in treatment.

In support of this idea, we find that Lorr, Katz and Rubinstein study, like that of Sullivan, Miller and Smelser, was based on the comparison between "terminators" and "remainers" in treatment. They found that "remainers" tend to be more anxious, more self-dissatisfied, and more willing to explore personal problems with others.

Remainers also are less likely to have a history of antisocial acts and are more dependable, more controlled and more persistent, in tasks undertaken than terminators.68

There are certain patient characteristics which are related to success and longevity in psychotherapy. Cole, Branch and Allison refer to these as internal factors and list them as the reasons why members of the upper classes survive psychotherapy longer than members of the lower classes. These internal factors are:


(1) Social status, based upon education, economic social standing.

(2) Orientation toward behavior, rather than medication.

(3) Active participation in therapy, rather than passive cooperation.

(4) Internalization of problems and a tendency to self-blame, rather than acting out and blaming the environment.

(5) Self-dissatisfaction - a wish to change things.

(6) Possessing the traits of dependability, control and persistence.

(7) Social integration.

(8) Having less confusion about sexual role.

(9) Fluctuating illness, with manifest anxiety.

(10) A strong need for people to relate to, to feel worthwhile.

(11) A desire to talk with others concerning problems.

(12) Subject to influence and amenable to authority. 69

If we were to look closely at Lorr, Katz and Rubinstein study, along with the previously mentioned factors, we find similarities in the characteristics of both groups of patients.

Lorr, Katz and Rubinstein point out that the "remainder" in the study is thus seen as an anxious, self-dissatisfied individual with some psychological insight who is willing to explore his personal problems with others. He has some sense of loyalty to others and tends to persist in activities he undertakes. He is not likely to have been involved in antisocial acts. 70


On the other hand, the "terminator" either is not anxious or does not admit to being anxious and self-dissatisfied. He is likely to have had a history of anti-social acts, he admits to being undependable and impulsive, and may be authoritarian or rigid in his social attitudes.  

THE SOCIOLOGICAL, PSYCHOLOGICAL AND PSYCHIATRIC ASPECTS OF MENTAL HEALTH

Many of the studies investigated so far have shown that there is a link between the class differences and our value system.

We have seen that middle class values are centered around self-direction, while lower class values are based on conformity to external characteristics. It seems fitting to add then, that these differences in values may in fact stem from differences in the conditions of life of the various social classes.

Middle class occupations require a greater degree of self-direction, working class occupations, in larger measure, require that one follow explicit rules set down by someone in authority.  

Our values tend to form a bridge between social structure and behavior. This behavior pattern then becomes a part of our mental processes which eventually influences our way of thinking and our attitude towards mental health.

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From a sociological perspective, if we were to examine the effects of social class upon parent-child relationship, we find that social class as a concept, not only refers to education, occupation or any of the other variables, but it entails a reality that the intricate interplay of all these variables create different basic conditions of life at different levels of social order.

Members of different social classes, by virtue of enjoying (or suffering) different conditions of life, come to see the world differently—to develop different conceptions of social reality, different aspirations and hopes and fears, different conceptions of the desirable.73

It seems possible then, that from people's conceptions of things whether it be desirable or otherwise, anyone can discern certain objectives in parent-child relationships.

One writer refers to this conception as value, which forms the bridge between position in the larger social structure and the behavior of the individual. He further describes Value as the following.

A value is a conception, explicit or implicit, distinctive of an individual or characteristics of a group, of the desirable which influences the selection of available modes, means, and ends of action.74

Reference has already been made to the under-utilization of psychiatric resources by low income groups. Evidence from many of the studies has shown that the amount of psychiatric care is differently distributed throughout the population by social status and income level.

The mere fact that lower status groups get less psychiatric care has become a major social problem. Reissman and Scribner gave seven factors that account for the present low use of psychiatric facilities by lower status groups. These factors are:

1. Cost of services.
2. Availability of services.
3. Failure to the general practitioner to refer cases for psychiatric treatment.
4. Failure to define distress in psychologically relevant terms.
5. Attitudes towards mental illness.
6. Fear of institutionalization.
7. The middle class character and the associated inappropriate nature of the services offered to low-income people.\textsuperscript{75}

It appears then, that the critical factors limiting effective use of mental health facilities by low-income people are negative attitudes and inadequate services.

Even today, a large part of the population and the lower socioeconomic groups in particular still equate mental illness with severe forms of disorders.

\textsuperscript{75}Reissman and Scribner, "Under-Utilization," p. 798.
Individuals in these groups often delay efforts to secure treatment until the illness conforms to this concept. Their view that mental illness is the extreme opposite of "normality" has other unfortunate consequences as well: not infrequently it carries with it rejection of the person who has become mentally ill and a hopeless, defeatist attitude about the possibility of his recovery and future reinstatement into society. 76

These attitudes and feelings are often viewed by the mental health movement as an indication of the backwardness and ignorance of our culture.

However, this way of thinking should not be regarded as a myth but as a fact since studies have confirmed that we do indeed treat lower class individuals differently than the upper classes.

All recent treatment censuses confirm the fact that the overwhelming bulk of blue-collar and low-income individuals are institutionalized when they exhibit mental and emotional disturbances, and are commonly relegated to custodial care rather than active treatment programs within the institutions. 77

Presently, organized mental health treatment is not congenial to low income clients and is poorly understood by them. Many of these clients are alienated from treatment and are still fearful of mental illness and its consequences.


77 Ibid., p. 799.
SUMMARY

Many aspects of the mental health services that were significantly relevant to this study were discussed. Such issues as parents' attitudes towards mental health services; definitions of mental health; community relationship and mental health facilities and services; the delivery of mental health services and the lower socioeconomic classes; treatment approaches in mental health services among the lower and upper classes; dropout rate and longevity in treatment in the mental health services, and the sociological, psychological and psychiatric aspects of mental health were referred to.

It was revealed that many of the deficiencies in the delivery of mental health services for children were reinforced by parents' attitudes towards their children's problems and by their doubts about the relevancy of mental health care.

We discovered that impairment among children differed among diverse social and economic groups, and that this impairment was often related to the family structure and functioning.

Mental health was defined as a "movement" in which virtually every agency and organization was concerned. Nevertheless, there was still the need for further development of adequate services to meet the needs of all.
It was demonstrated that members of the lower socioeconomic groups, especially blue collar workers, have poorer prognoses than those of white collar workers.

Mental health services among the lower socioeconomic classes indicated that black children were greater mental health risks than their white counterparts. However, in comparable income groups, there was no significant difference in the overall impairment levels between black and white children.

Unemployment, discrimination, broken homes and poor housing were major causes of emotional disorders.

The literature revealed a high dropout rate among the lower socioeconomic group. Studies have shown that the unskilled and service workers and the chronically unemployed usually have the poorest appointment records.

It was pointed out that the variables both external and internal which contributed to dropout were attributed both to the therapists and to factors characteristic of the patients.

Mention was also made about the types of patients who remained in treatment, and those who dropped out. One writer referred to them as the "improvers" and the "unimprovers" while another referred to them as "remainers" and "terminators."

In both instances, though, there was a distinction in the profiles of both groups. The "improvers" had a generally lower profile than the "unimprovers." The "improvers" were less disturbed at the outset of therapy than the "unimprovers."
They were also employed in capacities more closely in keeping with their higher educational achievement.

Likewise, the "remainers" and the "terminators" showed distinctive characteristics. The "remainers" were portrayed as being anxious, self-dissatisfied individuals who were willing to explore their personal problems with others.

The "terminators," on the other hand, did not admit to being anxious or self-dissatisfied. They were more likely to have experienced a history of being antisocial and admitted to being undependable and impulsive.

Finally, it was felt that there was a great need for further research in many of the areas discussed. There was a need for further research aimed at identifying those factors that are relatively conducive to the delivery of effective mental health services to members of the lower socioeconomic classes.

It was felt that some changes ought to be made in procedures whereby patients attend therapy. Even a modification of present services to meet the needs of lower class patients would be in order.

Inadequate professional services and fears of mental illness and its consequences, cited as the principal causes of the under-utilization of mental health facilities by clients in the low income groups, should not be regarded as independent factors. Since they are so closely interwoven, change in one area requires a movement towards change in the other.
Having briefly reviewed the literature with regard to treatment approaches, utilization of services, socioeconomic status, the writer has undertaken to develop a hypothesis to test for the possible association between and among these concepts. This hypothesis and the framework within which they were tested appear in the following chapter.
CHAPTER III
THE RESEARCH DESIGN

In accordance with the stated rationale for this study, the writer sought to collect and analyze data related to the following hypothesis.

Specifically, the hypothesis was:

(1) Socioeconomic status of clients with respect to their income, occupation and education as a determinant in the client's perception and utilization of a mental health facility.

As was stated previously, several experiences contributed to the writer's interest in developing this research hypothesis. It was from those experiences that a research question was developed.

The writer felt that the concept of mental health was too broad to attempt any detailed review of the literature on the subject. Hence, the writer chose to investigate instead whether there is any existing association between the socioeconomic status of clients and their perception and utilization of a mental health facility.

A quantitative descriptive study was chosen to help the writer in relating the outcome of this research design.

By collecting data related to the stated hypothesis, the writer hoped that some answers to the study would be partially answered. In so doing, it is also hoped that
by means of the collection and analysis of this data some
conclusion can be made based on this research project.

The writer decided to use an interview schedule for the
data collection instrument because the population of the study
was small. The writer pretested the design questionnaire
prior to the formal testing. This was done to help clarify
any issues that may have arisen during the formal testing,
to try and reduce ambiguity, redundancy or duplication which
may have made the formal testing difficult to understand.

The statistical analysis of the findings would be
presented by means of some simple statistics since the
population size in this research project was very small.

PROBLEM FORMULATION

There were many aspects about mental health which could
possibly have been investigated. The writer had intended to
look at certain factors, for example, culture, socioeconomic
status, to see what correlation there is, if any, between
these factors and what influence, if any, they may have on
a person seeking help from a mental health facility.

The writer’s interest in the area of mental health
eventually materialized during the field placement at the
Children’s Center of Wayne County in Detroit. The writer’s
interest in mental health became a reality during this
period from September 1976 to April 1977. It was from this
Center that the writer acquired the thirty subjects used
in this research.
The writer eventually formulated the hypothesis that socioeconomic status as defined by income, occupation and education is a determinant in the client's perception and utilization of a mental health facility.

This study was not aimed at contributing to the proof or disproof of anything, but rather was aimed at contributing to the research knowledge of the positive or negative relationship between socioeconomic status of clients and their perception and utilization of a mental health facility with a view to suggesting further or other areas of needed investigation.

FOCUS OF THE RESEARCH

This research was centered on the socioeconomic status of clients and their perception and utilization of the Children's Center as a mental health facility.

The interview schedule was divided into two sections. Section I dealt with the socioeconomic status of the clients. Section II dealt with direct services.

THE RESEARCH QUESTION

The research question used in this quantitative descriptive study is summarized in the following hypothesis: Socioeconomic status as defined by income, occupation and education is a determinant in the client's perception and utilization of a mental health facility.
OPERATIONAL DEFINITIONS

The definitions of terms used in this study are as follows:

Mental health - the ability of the individual to adjust to new situations and to handle personal problems without marked distress, and still have enough energy to be a constructive member of society. 78

Facility - the actual premises in which specialized services are offered to help people in the community.

Clients - the recipients of the agency services and their families.

Perception - the capacity of a person to gain insight and/or knowledge about himself and his life situation.

Utilization - the actual use made of a particular service by clients.

Service - a particular kind of function carried out by trained personnel to help other people in need.

SOCIOECONOMIC STATUS:

Income - any money a person receives through employment or other sources, such as welfare, pension or social security.

Occupation - any type of work for which money is paid for services rendered.

Education - any type of formal schooling: for example, public, secondary or post secondary.

Status - occupying a certain position or rank in relation to other people in the community.

The following section describes the nature of the population examined in this study.

THE POPULATION

For the purposes of this study, only thirty subjects from the Children's Center of Wayne County, outpatient department, were used as the population. These were parents of children who were currently being seen at the time in treatment by the outpatient department.

The reason for this small population sample was based simply on the fact that the writer was unable to secure a larger population sample because of the time factor involved in trying to work with too large a sample.

It was first planned to mail a questionnaire to parents of the children using the services of the Children's Center. Later this idea was changed because of the apparent low return rate for mailed questionnaires and because of time limitations; therefore, the writer chose instead to conduct an interview schedule which proved most convenient to the writer fulfilling the field placement at the Center.
Only thirty families were used as the population research, and this became the sample for the study and the 'N' was, therefore, thirty. The findings of this study were limited to this population.

**METHODOLOGY**

An interview schedule was the instrument used in this study in order to test the stated hypothesis. (See Appendix 'A', Interview Schedule.) The advantage that the interview had was that it offered the writer an opportunity to clarify what was being asked of those who participated in the study.

Therefore, the interview schedule was the writer's guide. This method of testing the hypothesis also served to standardize the order in which the questions were asked as well as the wording of the question.  

The writer made use of this interview guide from which certain items of information were obtained from the respondent about his socioeconomic status and his perception of the use of the Children's Center as a mental health facility.

Goode states that the guide allows the interviewer to rephrase the question in keeping with his understanding of the situation. This permits the interviewer to express the question in such a fashion that the respondent can understand it most easily.  

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This was one of the advantages of using this type of instrument (the interview schedule). As Goode stated, it allowed for "a more adequate interpretation of the answers to the questions."

In formulating the questions, the writer used the "fixed-alternative question." The response alternatives were limited. According to Selltiz, this type of question had the advantage of being "standardizable," simple to administer, quick and relatively inexpensive to analyze.

The writer formulated twenty-one questions using the fixed-alternative question method.

THE PRETEST

The pretest was conducted on five workers at the Center. This pretest was used to help determine whether the questions were understood and could be answered.

The pretest gave the writer an opportunity to correct errors. Some adjustments were made after the pretest. Some questions were also rearranged to help to eliminate redundancy. Other questions were eliminated completely because they were not relevant to the study.

The writer avoided using lengthy questions in an attempt to reduce the likelihood of asking 'leading questions' which

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81 Selltiz, Jahoda, Deutsch and Cook, Research Methods, p. 257.
could have appeared to the readers that the writer was trying to give her own opinion.

After the pretest the writer outlined the schedule into two sections. The first section dealt with socio-economic factors of the clients. The second section was related to direct services.

By means of the pretest, the writer had the experience of being able to practice asking the questions so that they were asked in the same order. The time factor involved in the questioning was also modified from the pretest.

The pretest also provided the writer with experience in recording the content of the replies from the respondents.

The data was collected in a series of interviews over a five-day period.

The method of data analysis is the next area of the methodology considered.

**THE METHOD OF DATA ANALYSIS**

The thirty families in this study constituted the sample of the study.

Some simple graph charts were used in analyzing the data collection.

However, the writer chose to present most of the findings in the study in the form of a discussion because it was more practical and easy for the writer to manage.
LIMITATIONS

The writer had gathered from readings that it was important to be aware of the limitations that may be inherent in any study. Such limitations must be viewed both from the standpoint of the writer and also from that of the consumer of the research. This study had some limitations.

This study was classified as a Hypothesis-Testing Study\textsuperscript{82} because it represented one subtype of a major category of research studies known as Quantitative-Descriptive Studies. This classification system was developed and outlined by Tripodi, Fellin and Meyer in their book, The Assessment of Social Research.

The major purpose of hypothesis-testing studies is the testing of hypotheses which are somewhat related to, or derived from theory. This study sought to test the previously stated hypothesis by the use of an interview schedule.

In the writer’s opinion, practical and ethical considerations prevented the use of control groups in this study. Because of these factors, the hypothesis-testing design framework was chosen, even though the hypothesis outlined could have been applied to other design types and applications.

The hypothesis attempted to test for the existence of an association among the independent variables, without suggesting any causal relationship.\textsuperscript{83}


\textsuperscript{83}Ibid., p. 34.
The literature describing hypothesis-testing designs make reference to the limitations of such frameworks. The limitations which were applicable to this study were as follows.

Since there were no control groups in this study, one has to assume that the results of the testing may have been contaminated. This limitation was unavoidable because of the nature of the study.

Another limitation in this study was related to the writer's tendency to generalize from the study's findings. Readers must keep in mind that these findings only related to the thirty subjects that comprised the study. Therefore, the results of the study may be exaggerated or distorted.

Another limitation was related to the lack of both theoretical and practical knowledge about people's perception and utilization of a mental health facility.

Much literature is written about mental health per se but few articles consider this aspect of the research.

Yet another limitation in this study was that this research did not intend to report on what a mental health facility was or how it operated. It sought, or attempted instead, to try and determine whether there was any existence of an association among independent variables and the socioeconomic status of clients and their use of a mental health facility.

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These were the anticipated limitations in this study.

**SUMMARY**

This chapter presented the research design and problem formulation of this study. A focus of the research and research question were outlined. In addition, operational definitions used in the study were presented.

Discussions regarding population sample, methodology and pretesting were also stated. The method of data analysis and the limitations of the study were presented. The analysis of the data obtained from the study's procedures appears in the following chapter.
CHAPTER IV

ANALYSIS OF DATA

The analysis of the data, related to the stated hypothesis, is presented in the following manner.

The first section of the chapter described the sample population under the following socioeconomic headings:

(A) Sex
(B) Marital Status
(C) Age
(D) Education
(E) Employment Status, i.e. Income

The presentation of the above listed variables will indicate a description of the population with regard to frequency and related percentages.

It must be mentioned at this point that in this chapter, both Section I and Section II, the analysis will be done through statistical charts and in the form of a discussion. The reason for presenting parts of this chapter in a discussion form will be in support of portions of the data that is not indicated by charts.

Section II interview schedule of the analysis of data deals with Direct Services. Through the use of an interview schedule, data was obtained from thirty clients at the Children's Center of Wayne County. Responses were analyzed and tabulated in most cases except as was mentioned before where parts of the analysis will be presented in the form of a discussion.
Section I

SOCIOECONOMIC FACTORS: DESCRIPTION OF THE POPULATION

(A) Sex

The sample consisted of twenty-six females that represented 86.7 percent (26) of the population and four males that represented 13.3 percent (4) of the population as indicated by Table 1 (page 67).

(B) Marital Status

Subjects who were single represented 16.7 percent (5) of the sample, while 40.0 percent (12) were married. This 40.0 percent represents only those subjects interviewed in the sample. A widowed person was represented by 3.3 percent (1) of the sample. Subjects who were separated represented 23.3 percent (7) of the sample and those who were divorced comprised 16.7 percent (5) of the total sample. Table 2 (page 67) indicates an analysis of the subjects varying marital status.

(C) Age

The thirty subjects that comprised this research ranged in age from twenty-five (25) years to thirty-seven (37) years of age. This was evident for both males and females. This represents a fairly young group but is not typical of the population served by Wayne County, Detroit, Michigan.

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### TABLE 1

**SEX**

<table>
<thead>
<tr>
<th>SEX</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>26</td>
<td>86.7</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### TABLE 2

**MARITAL STATUS**

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
<td>40.0</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Separated</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
(D) Education

The educational achievement level for both fathers and mothers was the same; namely, ranging from grade nine (9) to university. However, seven (7) of the fathers in the research had attained at least some schooling somewhere at grade nine (9) and the bulk of the subjects in the sample population had attained a level of education in grade nine to grade eleven (11) category. None of the mothers in the sample population went on to attend university. Nevertheless, of the sample population, only one father indicated that he attended university for one (1) year.

(E) Employment Status i.e. Income

The employment category showed that of the sample population the largest proportion of the subjects in this sample earned their income by means of public assistance, a total of 43.4 percent (13). The heads of the households or major wage earners represented 23.3 percent of the sample. The analysis also showed that out of the sample population 10.0 percent of the parents were two-income families. 23.3 percent of the fathers were employed and worked as skilled workers doing such jobs as machinists and assembly line workers. Table 3 (p. 69) indicates the employment status of both parents.
TABLE 3

EMPLOYMENT STATUS: INCOME

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father Employed</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Mother Employed</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Both Employed</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>Public Assistance</td>
<td>13</td>
<td>43.4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Further analysis of the employment status of both parents indicated that the total yearly income of the families were well below the poverty level. The largest proportion of the families, approximately 43.4 percent (13), received their total yearly income from public assistance.

Among the total sample, the largest proportion of subjects were classified as unskilled workers, many of whom worked at such jobs as maintenance workers, store clerks, and cashiers.

Section II

DIRECT SERVICES

Section II of the analysis of data deals with Direct Services to clients or the perception and utilization of services and the type of treatment offered at the Children's Center of Wayne County, Detroit.

The writer sought to determine whether any other Mental Health sources were used prior to the start of treatment at the Children's Center.

The data showed that only 6.7 percent (2) of the subjects had been treated at Detroit Psychiatrist Institute before their start of treatment at the Children's Center. Another 3.3 percent (1) was serviced by Protective Services; 6.7 percent (2) were treated at Children's Hospital; the same percentage of subjects 6.7 percent (2) were treated by the Ypsilanti Community Services; the remaining 76.7 percent (23) subjects were not treated by any other mental health service prior to their treatment at the Children's Center.
of Wayne County. See Table 4 (p. 72) for an analysis of the treatment services.

The writer then sought to determine how many parents were actively involved in the treatment process with their children. In this instance the term "treatment process" refers to the involvement of parents who were participants in their children's treatment. This process is the only means of helping parents to become more aware of their own role as parents, within a helping relationship whereby the parent-child relationship can be strengthened.

An analysis of the parents' involvement in their children's treatment showed that 53.3 percent (16) were in treatment with their child or children. In other instances only the children were involved in treatment.

Coincidentally, there were more male than female children being treated at the Children's Center. Because of the limitation of this sample, this result should not be seen as representative of the male-female child ratio of children in treatment at the Children's Center. Perhaps, if we were to look at a larger sample population, the outcome might be reversed.

The research showed that the minimum length of stay in treatment for the children was approximately one year. However, in specific diagnostic categories, treatment would be for a shorter period of time.
<table>
<thead>
<tr>
<th>MENTAL HEALTH SERVICES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detroit Psychiatric Institute</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Protective Services</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Children's Hospital</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Other Services</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>No Prior Services</td>
<td>23</td>
<td>76.6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
This research revealed that the diagnostic problems of the children were either related to problems within the home or at school. Of the thirty (30) subjects in this research 6.7 percent (2) were being treated for behavioral problems in the home. Another 50.0 percent (15) were in treatment for school-related problems; 23.3 percent (7) were diagnosed as hyperactive and were receiving treatment for this problem. There were 6.7 percent (2) subjects in treatment whose problems were diagnosed as a learning disability. Ten percent (3) were being treated for acting out behavior both in the home and at school. Only 3.3 percent, one (1) child, was in treatment because of behavioral problems in the home and diagnosed as hyperactive.

Table 5 (p. 74) describes the behavioral problems of the sample population.

The writer also tried to ascertain what kind of treatment the children of the respondents in the sample were receiving at the Children's Center of Wayne County. An analysis of this showed that the majority of the subjects, 63.3 percent (19), were receiving individual treatment. Another 36.7 percent (11) were in group treatment.

On the other hand, an analysis of the parents in treatment showed that only 8.3 (1) was receiving individual treatment. The remainder, 91.7 percent (11), were in group treatment. The remaining eighteen (18) subjects in the population were not actively involved in any form of ongoing treatment.
<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acting out behavior in home</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Acting out behavior in school</td>
<td>15</td>
<td>50.0</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Acting out behavior at home</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>and school</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>Hyperactivity and behavior problems at home</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Other problem—learning disability</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
The writer felt that it was important to establish how much time elapsed from the point of initial contact with the Children's Center until the actual start of treatment.

The writer was of the opinion that this factor was important because it would try to indicate just how much emphasis is placed on trying to effect treatment at the earliest time of contact. This time-lapsed factor could be crucial from the clients' perception regarding the type of services they receive. This factor may also play a part in the rationale behind the assumption that triggers "dropout" and "no-shows" during the treatment process. However, the responses indicate that this was not a factor for this particular group because there was not a long waiting gap between the first contact and the actual start of treatment.

The charging of fees was another area which the writer investigated. The following data showed that the thirty subjects in the population sample, 80.0 percent (24), paid no fee for treatment. Another 10.0 percent (30) were paying between one and two dollars for fees; 6.7 percent (2) were paying between three and four dollars in fees, while 3.3 percent (1) was paying five dollars. Table 6 (p. 76) gives the details on fee payment for the subjects in this research. In conclusion, fee payment was not a factor in the utilization of treatment at the Children's Center of Wayne County, Detroit.
### TABLE 6

**FEE PAYMENT**

<table>
<thead>
<tr>
<th>FEES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No fee</td>
<td>24</td>
<td>80.0</td>
</tr>
<tr>
<td>1 - 2 dollars</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>3 - 4 dollars</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Over 5 dollars</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
A comparison of the number of treatment interviews the respondent and their child had at the Center revealed that in the sample, children were seen once weekly for treatment. This trend as indicated by the population sample (30) may not necessarily be the norm at the Center as far as ongoing treatment is concerned.

Other parents, on the other hand, were seen once weekly and others twice weekly. The analysis showed that 8.3 percent (1) was seen twice a week, while 91.7 percent (11) were seen in treatment only once a week. This frequency of interviews had little or no significance on the outcome of the analysis which indicated that the respondents were satisfied with the treatment they were receiving at the Center.

Finally, the writer sought to find out the subjects' opinions on the treatment their children were receiving. The writer also tried to investigate whether the subjects in the sample population (30) would make use of the Children's Center in the future and whether they had observed any significant changes in their children's behavior.

First, the data on the subjects' opinions of the treatment their children were receiving showed that 33.3 percent (10) individuals strongly agreed that treatment was helpful to their children. The remaining 66.7 percent (2) simply agreed that treatment was helpful. None of the respondents indicated any negative response to treatment.
Because the researcher wanted to determine whether the respondents were satisfied that their children's behavior had improved with treatment, the writer concludes from these responses that a significant proportion agreed that treatment was helpful.

The data on the respondents' future use of services at the Children's Center showed that 36.7 percent (11) strongly agreed that they would continue to use the services at the Children's Center. The other 63.3 percent (19) agreed that they would continue to make use of the services at the Center in the future. Once again, there were no negative responses from the respondents regarding the future use of the services at the Children's Center of Wayne County, Detroit.

When respondents were asked whether they observed any changes in their children's behavior, 80.0 percent (24) said that their children's behavior had improved. 3.3 percent (1) said that their child's behavior had worsened and 16.7 percent (5) said that they noticed a variety of changes in their children's behavior; for example, two respondents said that they had seen only slight improvement in their child's behavior. One respondent said that there was some improvement; another respondent was not certain whether her child's behavior had changed or not; and yet another respondent said that there was just a little change in her child's behavior. Nevertheless, the writer concludes
from this finding that the majority of respondents were satisfied that their child's behavior had improved.

In order to test for possible relationships between the previously described characteristics or variables, the writer attempted to complete a series of crosstabulations. However, in analysing the data it became apparent that there was no significant relationship between the variables. Hence, the crosstabulation was not undertaken because the information was the same—the variables bore no outstanding significance on the outcome of the research; that socioeconomic status as defined by income, occupation and education is a determinant in the clients' perception and utilization of a mental health facility.

A comparative look at the income guide represented in the Orientation Folder at the Children's Center in 1976-1977 showed some of the characteristics of the Center clientele categorized as follows—Family Annual Income:

0 - $3,600 = 20 percent
$6,000 - $10,000 = 26 percent
$10,000 - over = 18 percent.86

(This data is dated 1976 - 1977 and may no longer be applicable since the income trend may have changed by now.)

86 The Children's Center of Wayne County, Detroit, Michigan, Orientation Manual, p. 1.
Comparatively, a look at the income status of the respondents in this research along with the fees they were paying for services at the Children's Center showed that many of them were dependent on the State for their income.

Like the family annual income just outlined, the income of individuals in this research was marginal and indicative of mere existence at the subsistence level. As a result, many clients received free services and those who did pay were only charged a minimum fee. Table 7 shows the employment status - income.

<table>
<thead>
<tr>
<th>INCOME</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000 and under</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>$4,000 - $5,000</td>
<td>13</td>
<td>43.4</td>
</tr>
<tr>
<td>$6,000 - $7,000</td>
<td>6</td>
<td>20.0</td>
</tr>
<tr>
<td>$8,000 - $9,000</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>$10,000 and over</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30</td>
<td>100.0</td>
</tr>
</tbody>
</table>
SUMMARY

The writer attempted to see what effect or relationship certain variables would have upon one another in this research hypothesis. The data analyzed in the beginning of Chapter 4 was sufficient evidence to indicate that it was not feasible to make any attempt to crosstabulate for further variance or relationship between the variables because the net result would be the same.

The results obtained from the data analysis showed no significance. All variables were relatively independent.

There was no evidence in the research to show that any of the variables analyzed can determine a client's perception and utilization of a mental health facility.
CHAPTER V

SUMMARY AND CONCLUSION

The purpose of the research project was to determine what effect socioeconomic status such as income, occupation and education had on the client's perception and utilization of a mental health facility. The Children's Center of Wayne County in Detroit was the location in which this research project was undertaken.

The Children's Center of Wayne County, Detroit, began as a Child Guidance Clinic in 1930. Its emphasis then was to treat emotionally disturbed children. At present, there has been a growing emphasis on relatively new treatment methods, such as group, family and behavior therapy. 87

The rationale for investigating the effect on these socioeconomic factors was based solely on two purposes. First, the writer hoped to evaluate how clients who are presently using the services of the Children's Center of Wayne County, Detroit, Michigan, perceive the services of a mental health facility. Secondly, the writer wished to determine whether there will be any significant relationships between clients' economic status and their choice of a mental health center.

Through the use of an interview schedule, the data was obtained from thirty subjects who were still in treatment.

87 The Children's Center of Wayne County, Detroit, Michigan, Orientation Folder, p. 1.
at the Center when the research was done. The schedule examined the socioeconomic factors and the kind of direct services provided by the staff at the Center to the thirty subjects who were interviewed.

Data was obtained by means of a small sample population (30). Several demographic variables such as sex, marital status, age, education, employment were included in the data collection. The subjects' responses to the treatment services their children were receiving and the changes in their children's behavior after treatment were obtained in the responses to Section II of the interview schedule.

The sample population was described and evaluated, from the analyses of the information obtained from the instrument which attempted to compare various factors.

The demographic variables were considered important in describing the characteristics of the population.

SUMMARY AND FINDINGS AND LIMITATIONS

This study set out to evaluate how clients who were presently using the services of the Children's Center of Wayne County, Detroit, Michigan, perceived the services of a mental health facility. Secondly, the study sought to determine whether there will be any significant relationships between clients' socioeconomic status; that is, income, occupation and education; as a determinant in the clients' perception and utilization of a mental health facility.
A sample population of thirty (30) subjects were questioned by means of an interview schedule. Data was obtained from respondents who were still in treatment at the Center when the research was undertaken. The schedule examined the socioeconomic factors and the kind of direct services provided by the staff at the Center.

The outcome of the finding of the analysis did not support that the variables income, occupation and education were determinants in a client's perception and utilization of a mental health facility. Since the test of this hypothesis did not show any relationship between the variables in this sample, the researcher cannot make a definite conclusion or generalize from the size of this small sample population. Further research and more in-depth investigation is required to produce a more conclusive result.

Some major limitations exist in this study. The first limitation centers mainly around the lack of planned control in administering the interview schedule. Since there was no way to control the responses posed by the respondents, it became necessary to accept responses at face value.

Because the questions asked were not disguised, they were easily made available for manipulation by the respondents.
Another limitation concerns the overall generalizability of the findings. There were subjective indications that the use of a mental health facility may be related to a client's income, occupation and education. However, because of the small sample population, one cannot generalize from the findings in this research. Also, because of the nature of the selection of the respondents, there was no comparative analysis to draw upon, and this limits the possibility of a replicability of this study.

Additionally, the skewness of the population, mainly with regard to the sex of the population; for example, there were twenty-six females and four males in the study; also limited the potential comparison of the results of the research.

RECOMMENDATION FOR FURTHER RESEARCH AND STUDY

The writer recommends that attempts be made to conduct an extensive and more detailed study of a similar nature as the one presented in this research.

The writer recommends that a more rigid statistical study with a large sample population and a control group needs to be done in order to determine whether the variables mentioned in the hypothesis are indeed a factor or bear any relationship to the outcome of a person's perception and utilization of a mental health facility.

Since the writer's study did not indicate any comparative association among the variables, the writer
suggests that further research be conducted in an attempt to ascertain any possible associations among such variables as employment status, occupation and education in the use of a mental health facility. A single research project does not settle this issue and more research needs to be done.

Further research of this kind may lead to more insights into people's choice of the kind of mental health facility they will utilize.

The writer believes that this research shows that the population at the Children's Center of Wayne County may not be easily distinguishable in terms of problems related to mental health.

There are many complex reasons why people choose a particular agency as a source of help. Some may utilize the service of the agency because it is readily available and fees are low. This seems to be the case with the clients at the Children's Center.
INTERVIEW SCHEDULE

RESPONDENTS:

SECTION I

SOCIOECONOMIC FACTORS:

A. Sex
   (1) Female
   (2) Male

B. Marital Status
   (1) Never Married
   (2) Married
   (3) Widowed
   (4) Divorced
   (5) Separated

C. Present Age
   (1) 20 years and under
   (2) 21 - 22 years
   (3) 23 - 24 years
   (4) 25 - 26 years
   (5) 27 - 28 years
   (6) 29 - 32 years
   (7) 33 - 36 years
   (8) 37 years and over

    Mother
    Father

... 1/2
D. Please state the number of children in the family:

(Specify)

E. Educational background of father, specify the highest grade completed.

1. Grade 0 - 5
2. Grade 6 - 8
3. Grade 9 - 11
4. Grade 12
5. High school graduate
6. University
7. Other

F. Educational background of mother, specify the highest grade completed.

1. Grade 0 - 5
2. Grade 6 - 8
3. Grade 9 - 11
4. Grade 12
5. High school graduate
6. University
7. Other
INTERVIEW SCHEDULE

G. WHAT IS THE FAMILY'S PRESENT SOURCE OF INCOME
(CHECK ONLY ONE ANSWER)?

(1) Father employed
(2) Mother employed
(3) Both employed
(4) Public assistance
(5) Other

H. HOW MUCH IS YOUR TOTAL AMOUNT OF INCOME FOR THE YEAR?

(1) $3,000 and under
(2) $4,000 - $5,000
(3) $6,000 - $7,000
(4) $8,000 - $9,000
(5) $10,000 and over

I. WHAT KIND OF WORK DO YOU DO WHEN EMPLOYED?

(1) Skilled worker
(2) Unskilled worker
(3) Professional
(4) Retired
(5) Other

Mother          Father
SECTION II

DIRECT SERVICES:

J. STATE WHETHER ANY OTHER MENTAL HEALTH SOURCES WERE USED PRIOR TO THE START OF TREATMENT AT THE CHILDREN'S CENTER.

(1) DETROIT PSYCHIATRIC INSTITUTE
(2) PROTECTIVE SERVICES
(3) LAFAYETTE CLINIC
(4) CHILDREN'S HOSPITAL
(5) OTHER
(6) NONE

K. WERE BOTH PARENTS INVOLVED IN TREATMENT AT THE CHILDREN'S CENTER?

(1) YES
(2) NO
(3) NONE

L. GIVE THE NUMBER OF CHILDREN WHO WERE SEEN AT THE CENTER AND STATE THEIR AGES.

(1) CHILDREN (SPECIFY)

(2) AGE
**INTERVIEW SCHEDULE**

**M. GIVE LENGTH OF STAY IN TREATMENT.**

1. **LESS AND 1 YEAR**
2. **1 YEAR**
3. **2 - 3 YEARS**
4. **OVER 4 YEARS**

**N. WHAT KIND OF PROBLEM(S) WAS YOUR CHILD DISPLAYING AT HOME OR SCHOOL?**

1. **PARENT - CHILD CONFLICT**
2. **SIBLING RIVALRY**
3. **ACTING OUT BEHAVIOR IN HOME**
4. **ACTING OUT BEHAVIOR IN COMMUNITY**
5. **ACTING OUT BEHAVIOR IN SCHOOL**
6. **HYPERACTIVITY**
7. **OTHER**

**O. WHAT KIND OF TREATMENT IS YOUR FAMILY PRESENTLY RECEIVING AT THE CHILDREN'S CENTER?**

<table>
<thead>
<tr>
<th>Child</th>
<th>Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) INDIVIDUAL</td>
<td>(4) INDIVIDUAL</td>
</tr>
<tr>
<td>(2) GROUP</td>
<td>(5) GROUP</td>
</tr>
<tr>
<td>(3) OTHER</td>
<td>(6) OTHER</td>
</tr>
</tbody>
</table>

.../6
INTERVIEW SCHEDULE

P. Please give the length of time which elapsed between your first contact with the agency and the start of the actual treatment.

1. 1 - 2 months
2. 3 - 4 months
3. 5 - 6 months
4. 7 - 8 months

Q. State whether a fee was charged for services given by the center.

1. No fee
2. 1 - 2 dollars
3. 3 - 4 dollars
4. Over 5 dollars
INTERVIEW SCHEDULE

R. How often were you seen for treatment at the Children's Center?

<table>
<thead>
<tr>
<th>Child</th>
<th>Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) 3 times a week</td>
<td>(5) 3 times a week</td>
</tr>
<tr>
<td>(2) 2 times a week</td>
<td>(6) 2 times a week</td>
</tr>
<tr>
<td>(3) Once a week</td>
<td>(7) Once a week</td>
</tr>
<tr>
<td>(4) Once every two (2) weeks</td>
<td>(8) Once every two (2) weeks</td>
</tr>
</tbody>
</table>

S. The treatment given by the Children's Center is helpful.

<table>
<thead>
<tr>
<th>(1) Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) Agree</td>
</tr>
<tr>
<td>(3) Disagree</td>
</tr>
<tr>
<td>(4) Strongly disagree</td>
</tr>
</tbody>
</table>

T. In future I would make use of the services at the Children's Center.

<table>
<thead>
<tr>
<th>(1) Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) Agree</td>
</tr>
<tr>
<td>(3) Disagree</td>
</tr>
<tr>
<td>(4) Strongly disagree</td>
</tr>
</tbody>
</table>
U. Do you think your child's behavior changed after treatment at the Children's Center?

(1) Improved
(2) Remained the same
(3) Worsened
(4) Other

Thank you for your cooperation
BIBLIOGRAPHY

BOOKS


ARTICLES


ARTICLES continued


ARTICLES continued


ARTICLES continued


UNPUBLISHED MATERIAL

VITA AUCTORIS

Lucille Rachael Simmons Colthurst was born April 18, 1942, in Trinidad, West Indies. She completed her elementary education at Hardbargain Government School and her secondary education at St. Stephen's College in Trinidad.

She came to Canada in 1966 and worked with the Ministry of Revenue until she entered the University of Windsor in the undergraduate social work program in September 1970. She received her Bachelor of Social Work Degree in 1974.

After graduation, Mrs. Colthurst was employed with Metro Social Services as a Welfare Worker. In September 1976 Mrs. Colthurst enrolled in the Master of Social Work Program. During her graduate work at the University, Mrs. Colthurst's field practicum was at the Children's Center of Wayne County, Detroit, Michigan. This same Center became the focus of her research, which finally culminated in the production of this research project.

During the academic year, she was also a Teaching Assistant for the fourth year B.S.W. class at the School of Social Work.

For reasons that are too complex to describe, Mrs. Colthurst is just now completing her Master's Thesis. She expects to graduate in October 1985. Mrs. Colthurst has for the past six years been employed as a Family Service worker with the Children's Aid Society of Metropolitan Toronto.