Henry Ford Hospital Medical Journal

Volume 23 | Number 2 Article 5

6-1975

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Henry Ford Hosp. Med. Journal
Vol. 23, No. 2, 1975

Utilization of Mental Health Services for Children Relative to Social Class.

A Pilot Study

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Two groups of children were selected from those evaluated and treated over a two-year period. The study attempted to contrast the mental health care needs and the health care delivery system of children from the uppermost classes against those of the lowest classes.

Very few diagnostic discriminators were found. Prevalence of intellectual dysfunctions in the lower classes and neuroses in the upper classes did not correlate with behavior pattern of "acting out" or "acting in." Autistic psychoses were found almost exclusively among the upper classes; suicidality almost exclusively in the lower classes.

Upper class children were more frequently referred by their private family physicians, lower class children by agencies and particularly by the Emergency Room. An attempt at followup indicated the probability that lower class clients tended to terminate treatment prematurely, a tendency that was totally equilibrated by the tendency of upper class clients not to enter into treatment at all.

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An investigation was undertaken to see if social and economical factors influence the manifestation, care and treatment of mental disorders in children. If correlations exist between psychiatric and socioeconomic variables, they should manifest themselves most clearly in children, who reflect much more directly than adults the influence of the immediate environment.

With this contention, it must be clearly understood, however, that this is not a prevalence or incidence study pertaining to the population at large. It is rather a study of mental health need and mental health delivery as utilized in a large inner-city hospital.

Material, Method

Approximately 500 children had contacts with the Department of Psychiatry of the Henry Ford Hospital between 1970 and 1972. From these, two groups of approximately equal size were chosen for a preliminary examination, 80 belonging to the highest social and economic class and 82 children belonging to the lowest. Socioeconomic group variables were established in close correlation with the Hollingshead and Redlich Rating Scale.[1]

TABLE 1.
SOCIAL CLASS AND DIAGNOSIS

Diagnosis	Standardized Rates Upper Class	Lower Class	x^2	P=
No Psychiatric Disease	12	6		
Mental Retardation	6	20	8.08	.01
Organic brain syndrome	6	2		
Schizophrenia	9	4		
Neurosis	8	5		
Personality disorder	5	12		
Psychosomatic	1	2		
Special symptom reaction	10	7		
Transient adjustment reaction	9	12		
Specific disorders of childhood	13	10		
Social maladjustment reaction	1	2		
Total	80	82		

The "upper class" children (corresponding to Hollingshead and Redlich classification I and II) came from families in which the head of the household was typically an independent professional, executive, or business owner with a college education and usually a college degree, such as a physician, lawyer, or corporation executive. The "lower class" group approximated Class V on the Hollingshead and Redlich Scale. Here, the head of the household was typically unemployed or an unskilled or seasonal laborer with less than full high school education, on some form of social welfare, or, at best, would work intermittently on the assembly line.

Statistically, significance levels were established by calculation of the Chi square with Yates correction. Furthermore, wherever a variable could be related to age or sex, statistical standardization for age and sex was performed (ie, ratios were calculated as if they had occurred in two groups with precisely the same age and sex distribution).

Intercorrelation of Social Variables

Several selected social characteristics discriminated significantly (better than on the .001 level of confidence) between the population groups. Race was clearly a factor, with two thirds of the lower class, but only one-eighth of the upper class being Negro. Equally significant was the place of residence. Seventy-seven percent of the lower classes, but only twenty-one percent of the upper classes lived within the city limits of Detroit. Among suburban residents, the majority of the upper classes (23) lived in Oakland County with its predominant "bedroom" communities, whereas those of the lower classes lived predominantly in the urbanized districts of Wayne County. A relatively sizable number of patients (25) had been referred from outside of the metropolitan Detroit area. Of these, equal numbers of upper class children came from rural and from urban residences; among the lower class, referrals were from urban areas. There were only two "rural poors" in the entire sample.

TABLE 2.
INTELLECTUAL FUNCTIONS

	Group Size	# tested	% tested	IQ Mean	SD	t =	P =
1) Exclusive Mentally Retarded							
Upper Class	56	48	86%	98.71	8.68	8.16	.001
Lower Class	61	27	43%	88.25	7.60		
2) Mentally Retarded Only							
Upper Class	14	all	100%	64.92	4.22	3372	.001
Lower Class	19	all	100%	57.26	10.74		

3) Mental Retardation, by Degree

		Upper Class	Lower Class
Borderline IQ	68-85	6	8
Mild	52-67	6	5
Moderate	36-51	2	3
Severe	20-35	—	2
Profound	under 20	—	1

Family cohesion proved equally class related. Almost all of the children from the upper classes (88.8%) lived in families in which both parents were present. Only 31.8% in the lower classes lived with both parents. Here, 17% were born out of wedlock, 38% had parents who were separated or divorced, 13% had a widowed parent. Interestingly, nine (11.1%) of the upper class children were adopted (as opposed to only three in the lower class).

Diagnosis

Almost half of the patients in this study had more than one established diagnosis. It was therefore decided to determine as *primary* diagnosis the one pertaining to the problem that most likely had brought the child to the attention of the psychiatric department. (Table 1).

Analysis of the primary diagnoses shows few class related peculiarities. The only statistically significant difference pertains to the frequency of *mental retardation* which is clearly more preponderant in the lower classes. All other diagnoses are fairly evenly distributed.

A considerable number of children in both classes were found to be free of psychiatric disorders. A case-by-case review of these records reveals that, although the children demonstrated no manifest psychopathology, nonetheless the referral to psychiatry indicated considerable family pathology.

Case E.F.: This refreshingly "normal," cheerful, and surprisingly well-adjusted five-year-old child was brought by her mother for evaluation of vague and ill-defined psychological shortcomings. A thorough psychiatric work-up, including psychological testing, revealed no cause for concern. When the mother was informed of these findings, she issued a stream of vituperations, revealing that this is the third agency which she

consulted in order to prove to her husband that the child was "crazy." She threatened to take the child to a state hospital where, she was sure, the physicians would be more obliging and would disprove "all that baloney about my child having a normal IQ."

Behavior Patterns

Even within a given diagnostic category there is considerable leeway for manifestation of divergent psychopathology. Therefore, I attempted to search for possible class-related abnormal behavior patterns by evaluating both primary and secondary diagnoses to see if some specific psychopathological traits would emerge.

The result again was largely negative. A breakdown into diagnostic sub-categories (ie, type of neurosis, type of character disorder, etc) is omitted here, because it was unrevealing. It is true that such a molecular breakdown produced samples that were numerically so small that they can not yield statistically significant results. This observation in itself is noteworthy. Here, at least, one would have expected some clustering relative to social class. If anything, however, this tabulation diminished whatever class related differences could have been suspected. The "neurotic" cases were predominantly diagnosed as "conversion hysteria" (more properly: somatisation) and were equally frequent in both classes. Among the character disorders, there were four cases of drug abuse in the lower classes, as opposed to only one in the upper class. There was little other evidence of class-related *"acting out."* "Unsocialized aggressive reactions" were more frequent in the lower classes and "hyperkinetic" more

TABLE 3.
CAUSE OF INTELLECTUAL DYSFUNCTION

	Upper Class	Lower Class
1) Mental Retardation		
Due to Infection	—	1
Metabolism, growth, nutrition	2	2
Postnatal brain disease	2	2
Prenatal influence	2	2
Prematurity	1	1
Psycho-social deprivation	1	7
Other, unknown	2	8
Total	10	23
2) Organic brain syndrome		
Encephalitis	4	2
Neoplasma	1	—
Epilepsy	1	3
Other	1	—
Total	7	5
All Patients	17	28

TABLE 4.
SOCIAL CLASS AND REASON FOR REFERRAL TO PSYCHIATRY

Cause	Upper Class	Lower Class	X^2
Symptoms manifest after admission to the hospital	1	2	
Psychiatric problems	16	27	2.83
Somatic symptoms	16	14	
Drug Abuse	—	1	
Suicide Attempts	3	13	6.25
School problems	23	10	4.85
Social problems, delinquency	8	10	
Multiple problems	14	6	

prevalent in the upper classes, which may indicate diagnostic bias. The sociopathies (group delinquency, run away, and dyssocial reaction, antisocial personality) were exactly evenly divided. The *"acting in"* disturbances (anxiety state, obsessive and depressive neuroses, schizoid personality, withdrawal, and over-anxious reaction) were presented in nine upper class and ten lower class children.

As in previous investigations, one finding impressed me again as potentially important. Among the psychotic children, seven were diagnosed as autistic, six of them of the upper classes. Since these cases were investigated and diagnosed with utmost scrutiny, it is implausible that this preponderance is due to diagnostic bias (ie, upper class children being diagnosed as autistic, lower class children as mentally retarded). As a rule, there was a consensus of opinion between psychiatrist, psychologist, pediatrician, and audiologist.

Intellectual Dysfunction

Impairment of intellectual functioning, either organically or functionally, appeared to discriminate between the groups. Even if mentally retarded and psychotic children were excluded, there was still a significant difference in intelligence quotient (Table 2).

Yet one has reason to doubt that this finding in the "normally" intelligent group represents a true difference. As Table 2 shows, almost all upper class children but only half of the lower class underwent psychological testing. One may assume that psychological testing in lower class children, for economic reasons, was reserved for those in whom there was some initial doubt about the actual level of intelligence. This would bias the results in favor of the upper classes. Among those actually mentally retarded, again the mean I.Q. was significantly lower in the lower classes, obviously because "severely" and "profoundly" retarded children were found only in that group.

In regard to the *causes* of intellectual dysfunction one can now discern what appears to be a genuinely class related difference (Table 3).

Taking both primary and secondary diagnosis under consideration, one sees that there is no difference in all categories related to or caused by physical disease. The

preponderance of mentally retarded children in the lower classes is exclusively attributable to *psychosocial deprivation and/or mental retardation from unknown causes*.

Psychosomatic diseases under the disguise of physical illness (bronchial asthma, ulcerative colitis, urticaria) were rare and occurred more frequently in the upper class[7] than the lower class.[2] This was also the case if psychosomatic disease was registered as a primary psychiatric diagnosis. If these cases were added on to each other and some of the special symptom reactions (cephalgia) were included, the total number of "somatic" defenses were 15 in the upper class, but only four in the lower class.

The Referral Process

More than any other variable, the referral process can be expected to reflect the attitudes and idiosyncrasies of the referring agent, and may, therefore, discriminate between social classes. The reason for referral to psychiatry (Table 4) corresponds only to a very limited degree with the ultimate assessment of the underlying psychiatric problem and obviously reflects the areas of concern specific for each social and economic group. There are, indeed, some significant differences, although not where we would have predicted them. School problems and scholastic achievements are of much greater concern to the upper classes (in spite of the fact that the actual number of intellectually handicapped children is much smaller in this group). Clearly defined psychiatric symptoms (such as anxiety, nervousness, withdrawal, etc) lead more frequently to psychiatric referral in the lowest socioeconomic group.

Suicide attempts are significantly more frequent in the lower class. Here, we think that we are dealing with a true and significant difference of incidence in the total population, not merely with a sample bias. It is interesting to notice that true social problems, such as delinquency, are equally frequent in both groups. The number of children referred to psychiatry for problems arising after hospitalization (such as withdrawal, regressed behavior, postoperative psychoses, etc) is unusually small. (The corresponding figure in the adult population is ten times as high). The frequency of referral for physical symptoms which the referring physician considers to be "functional" appears high in both groups, but is low if compared to an adult population.

TABLE 5.
SOCIAL CLASS AND AGENCY CONTACTS

Contact with	Standardized Rates Upper Class	Lower Class	X^2	P=
Psychiatry	32	50	4.56	.05
Psychology	71	52	6.85	.01
Social Work	12	18	0.77	NS

TABLE 6.

RECOMMENDED DISPOSITION

	Upper Class	Lower Class
Hospitalization	2	9
Regular Clinic Visits	20	17
Return only if necessary	4	6
Counseling	10	7
Return to Referring Physician	7	3
School, special education	14	15
Agency	6	2
State Facility	2	10
Foster Home Placement	1	3
No intervention necessary	12	8
Other, unknown	3	2

The source of referral reflects predominantly the organization of the Hospital and of the Department of Psychiatry. The only significant and class-related pattern needs hardly any explanation: Upper class children were referred by their own private physicians, whereas the lower class children were phased into the psychiatric establishment through the emergency room or through agencies, such as schools. The importance of the emergency room as a family health care center for the disadvantaged population cannot be overemphasized.

Agency Contacts

Utilization within the Department of Psychiatry was quite uneven and clearly determined by the social class of the client (Table 5).

The structure of the department may have been decisive, since psychologists and social workers work here independently with their own patient clientele and need not consult with a psychiatrist unless they see a definite reason to do so. The heaviest work load falls thus on psychology which frequently restricts its role to the administration of psychological tests. Less than half of the upper class children were seen by psychiatrists. This clearly is an underutilization, in view of the frequency with which psychiatric diagnoses were established. Psychiatrists, on the other hand, consulted fairly consistently with psychologists and requested psychological testing in upper class children. The result was that significantly more upper class children were seen by psychologists and significantly more lower class children by psychiatrists. The most interesting finding was a negative one, namely, that the social workers were involved in both populations to an almost equal — and equally low — degree.

The Treatment Process

By far the most important variables relate to treatment. They will be discussed last however, because they lend themselves so poorly to statistical analysis. Furthermore, the psychiatric services at the time of this

TABLE 7.

TERMINATION AND FOLLOW-UP

	Upper Class	Lower Class	x^2
Still in treatment	10	4	
Seen for evaluation only	30	31	
Spot counseling	6	2	
Terminated by physician	4	6	
Terminated by client	6	20	7.51
Refused by client *or* consultee	12	7	
Other and unknown	13	11	

study were considerably more active and effective in evaluation than in the treatment of children. Therefore, the data are generally uninformative. But, since the bias applies to both socioeconomic classes, they are still relevant in terms of class-related disposition.

As far as treatment recommendations were concerned, one significant class-related discriminator emerged (Table 6).

The recommendation of at least temporary separation of the child from its family (ie, hospitalization here or elsewhere, foster home care) was consistently more frequent (significance level better than .001) in the lower classes, if all the recommendations are pooled. All other treatment recommendations are surprisingly uniform. One notices again the seeming underutilization of counseling in the lower classes.

On the other hand, looking not at what has been recommended, but what actually happened, we notice the technical shortcomings of the study. Follow-up studies were notoriously difficult. In a sizable number of cases we could not find out what happened. In others, the child was seen for the purpose of evaluation only, without treatment. Thus, the groups were uncomfortably small. Statistically significant differences hardly emerge (Table 7).

The only seemingly significant difference pertains to the frequency with which lower class children terminated treatment (in other words: did not show up after a few appointments).

This is almost entirely balanced by the frequency with which upper class families either refused treatment recommendations or were not informed of these treatment recommendations. This rather disquieting pattern occurred fairly frequently whenever the consultee was a physician. The hesitancy of the family physician to inform a parent that psychiatric treatment for the child had been recommended was clearly class related. Apparently there is more sensitivity to broach such a delicate issue with a rich client.

Case L.M.: This bright, energetic, and outgoing 8-year-old boy with limitless energy was referred under the tentative diagnosis of "hyperkinetic child." Thorough evaluation revealed no evidence of the hyperkinetic syndrome, but in view of the fact that both parents are exceedingly high strung and nervous some rather serious family pathology emerged. The psychiatrist recommended a series of counseling sessions with the entire family. The family physician ignored the

psychiatric report and subsequently placed the child on Ritalin. We may encounter the child again in a future study under the diagnosis of "drug addiction."

Discussion

When we consider the enormous gulf that separates rich, white, upper class children in the suburbs from deprived inner-city children growing up in the midst of the ghetto, we are amazed that the two groups can be compared at all. Intuitively, we doubt that any health — and specifically any mental health — parameter would be shared by the two groups. The fact that only a very few real differences emerge must, therefore, be regarded as a truly significant result which justifies the reporting of our findings.

We recognize that much of the paucity of class related discriminators is due to methadological problems, that the samples were very small, and that sample bias and lack of hard core-evaluation criteria would have blurred real contrasts. I have emphasized my awareness of these limitations by calling this a pilot study.

As in the case of any pilot study, one wonders into which direction it points. Some real discriminators have been found which need further investigation and elaboration. Furthermore, the need appears established to enlarge this study and to go ahead with a full-scale investigation of the total patient sample. A repeated investigation, using more contemporary material and more refined investigative methods, may well provide important clues about the permanency or the changing picture in health care and health care delivery.

Summary

Two groups were selected out of the children evaluated and treated at our psychiatric department during a two-year span. It was attempted to contrast the mental health care needs and the health care delivery system of children from the upper-most classes (Hollingshead and Redlich Scale I and II) against those of the lowest classes (Hollingshead and Redlich Scale V).

Upper class children were predominantly white, lived in the suburbs, and came from intact families. Lower class children were usually Negro, lived in the inner-city ghetto, and came from broken families.

Very few diagnostic discriminators were found. Predominant was the prevalance of intellectual dysfunctions in the lower classes, almost entirely attributable to the categories of "mental retardation due to socioeconomic deprivation or to causes unknown." Neuroses were most frequent in the upper classes. Character disorders more frequent in the lower classes. But, this did not correlate with behavior pattern of "acting out" or "acting in", which showed no relationship to class. Autistic psychoses were found almost exclusively in the upper classes.

Analysis of patient movement provided evidence that concern over scholastic failure dominated the motivation for psychiatric evaluation in the upper classes, whereas more clearly defined psychiatric symptoms prevailed in this respect in the lower classes. Suicidality was clearly class related, and was found almost exclusively in the lower classes. Upper class children were more frequently referred by their private family physicians, lower class children by agencies and particularly by the Emergency Room. There was evidence that upper class children were more frequently seen by psychologists, lower class children by psychiatrists. Separation from the family was rec-

ommended predominantly for lower class children. An attempt at followup indicated the probability that lower class clients tended to terminate treatment prematurely, a tendency that was totally equilibrated by the tendency of upper class clients not to enter into treatment at all.

References:

1. Hollingshead, A and Redlich, F: *Social Class and Mental Illness,* New York, Wiley & Sons, 1958.