1978

Referrals to Mental Health Treatment Facilities

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REFERRALS TO MENTAL HEALTH TREATMENT FACILITIES

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Thesis in partial fulfillment
of the requirements of the
Department of Sociology-Anthropology
honors program.
Oberlin College
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Spring 1978

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The process of obtaining mental health treatment involves several steps of identification and decisions for action (Edgerton, 1969; 49-50, Kadushin, 1969; 12). These are completed either by the potential client or by the person or agency motivating this person to receive treatment. First there must be recognition that something is wrong. The problem must be identified as one which should be dealt with in a psychological manner. Then action must be taken to handle this problem. A decision must be made about the appropriate type of professional to consult, then a specific office must be chosen. This process includes labeling a problem and the appropriate action to take on it before treatment is initiated.

One aspect of this process is the referral to treatment. A client of a mental health facility may have been self-referred, or (s)he may have been referred to treatment through a relative, a friend, the clergy, a physician, a psychiatrist, the schools, police, the court system, or a social service agency (National Institute of Mental Health, 1976). A referral occurs when a person is given the name of a mental health professional or agency by another person or a representative of some type of social agency. This referral may be made on the request of the prospective client or it may be an unsolicited suggestion

(Kadushin;171). The referral may involve various degrees of coercion or it may be a response to a search for help.

The person or agency who is instrumental in motivating someone to receive treatment is an important link between the patient, the treatment center, and the community. In this way the referral source indicates something about the client and it might influence the behavior of the client. The referral source would, as a link with the community, say something to the mental health workers about the client. This could influence treatment and subsequently, the course of the illness.

This research is based on an interest in mental health treatment. The goal of which should be helping a person deal with the situations they are faced with or helping a person learn to change these situations. Mental health care should not be divorced from the client's social situation. One starting point for learning about a client's total environment is learning about the process through which they came to receive mental health treatment.

This paper is organized into three main sections. The first is a review of the literature which serves as a theoretical background for this research. Social context is examined with its implications for defining problems in terms of mental or emotional concerns. Certain personal limitations on seeking help are discussed. The literature dealing with specific referral sources to mental health treatment are examined. The second section contains impressions gained from interviews with mental health professionals about the importance of the referral source

on their evaluations of a client. They responded to questions about what people come to them, what information a person's referral source gives to them and the implications of this information. The third section of this paper deals with information gathered from a community mental health center. These data concern referral source and how it may be a reflection of a client's social contacts and previous experience using mental health facilities.

David Mechanic has written about the importance of the social context in wnich mental health is defined (1962). A person reaches mental health treatment because someone has made an evaluation of his/her mental status. This evaluation may have been made by the future patient, through comparisons between past and present emotional states, it may have been made by the person's social group, family or friends, or by community agencies or psychiatric experts. An evaluation of someone's mental status which results in that person's hospitalization can be made with varying degrees of expertise, in varying social situations and with varying definitions of what constitutes behavior requiring psychiatric treatment.

Mechanic's argument is that when someone is hospitalized, mental illness is assumed. The decision to have someone hospitalized can be made by someone with no knowledge about mental illness; therefore, the diagnosis of mental illness can be given by a layperson. A doctor does not have the necessary time to make a full assessment of the patient's situation, so (s)he assumes illness. The doctor's task is then to apply a label to this illness.

This article is dealing with mental hospitalization. The process of labeling and diagnosis may not be as severe in cases when a person becomes involved with a community mental health center. Hopefully, the labeling consequences are not as severe. This article does serve to emphasize the importance of the persons who recognize and deal with the emotional or mental problems of a person.

An experiment by Coie, Costanzo and Cox (1975) dealt with various "gatekeeper professionals" and whether or not they defined symptoms of mental illness in the same way. A "gatekeeper professional" is someone ". . . who serves as an intermediary between the family or friends of a would-be patient and the mental health agencies of the community"(626).

A sample of gatekeepers were presented with various symptoms and were asked to rate them according to how much concern they would feel about the mental health of the person described. This sample consisted of physicians, clergy, police, social workers, and public health nurses. These professionals rated the symptoms as not evoking concern, evoking some concern, or evoking much concern about the person involved. Their findings showed that the ordering of the severity of the symptoms was basically the same for all groups. The police deviated the most from this pattern. The clergy saw the items as warrenting more concern than the others. They were followed by physicians and nurses. Police and social workers were less likely to see the items as warrenting concern. Though there is a basic agreement concerning the conceptions of mental illness, there are differences in

degree. What is important to note in this study are tne differences in the recognition of mental illness. The clergy are most closely in agreement with psychiatric concepts of mental illness. The authors speculate that social workers and police have a higher threshold for deviant behaviors because

> . . . they are involved in maintaining social order, within the community as a whole and within the family as well, they deal with the more troubled and possibly the more troublesome members of the community. Thus, it may be that as one becomes more familiar with deviance and disorder, one's threshold of concern for deviance would increase (633).

They also speculate that the police and social workers are more likely to deal with persons who have not broken a law, but who are destructive. These are people who are not willing to submit to psychiatric treatment. These gatekeepers might, therefore, be reluctant to label them mentally ill.

It is important to examine the attitudes of these gatekeepers. These are the people who provide helping services and are concerned with moral, legal, and social order.

> (G)atekeepers influence not only the immediate decisions about who will be directed to mental health agencies, but they also indirectly shape the mental health conceptions of the community in which they serve (626).

Once again, the situation in which this behavior is defined as mental illness appears to be very important. The social context is, in part, responsible for who is labeled mentally ill and who receives treatment for mental illness.

Members of the screening unit of a county mental health clinic were observed as they interviewed incoming clients to the clinic (Anderson, 1977). This study identified areas of practical reasoning which occurred in this interview, that is

situations in which the client's problems were redefined and were made to fit into the treatment program available. The staff was responsible for translating the presenting problem into a treatment problem. The presenting problem is what the client says is bothering him or her. The treatment problem involves aspects of the client's real problem, that is what is psychiatrically wrong with the client, that the staff can do something about. This treatment problem becomes the basis for referral. This process involves many judgements, interpretation of the presenting problem into a real problem and then this real problem into the treatment problem. The findings of this study reveal that screening workers shape the problem by asking only certain kinds of questions. The author labels this "the idea of intentionality: the idea that staff members intend things by asking the patterns of questions they do and suggesting referrals for further treatment" (175).

These three studies illustrate the variability inherent in receiving a referral to mental health treatment. The person who makes the judgement that mental health treatment is what is called for is in an important position. The person evaluating problems to define the proper kind of treatment is also performing a vital role.

Charles Kadushin (1969) emphasizes the importance of seeking information about psychiatric help sources and avenues to treatment. He asserts that various avenues to psychiatric treatment affect the types of presenting problems, the type of therapist consulted, and probably the outcome of the request for help. Kadushin's book Why People Go to Psychiatrists deals

with those who have sought psychiatric treatment. In the sample 80 to 90% of those who went to psychiatric clinics had talked with others about their problems (196). Kadushin emphasizes the importance of this figure and relates the importance of conversation to changing attitudes about psychotherapy. The person who acquires a lot of knowledge about psychology and psychological treatment is different from the one with little information. "Although we cannot prove it conclusively with our data, we suspect that the very process of acquiring information changes both the applicant and his self-concept" (249).

Kadushin wrote about three types of clinics (47). The analytic clinic was closely linked with psychiatric sources, therapy was psychoanalytic. The religio-psychiatric clinics had therapeutic goals similar to the analytic clinics but included pastoral counseling. The hospital clinics received most of their patients through other clinics and their own hospital. There was usually less psychoanalytic treatment and more emphasis on chemotherapy. When applicants to these three types of clinics were asked about seeking information about these matters 91% of analytic clinic applicants, as opposed to 53% of the religio-psychiatric and 44% of the hospital clinic applicants "said they had taken some action to get information" (251). These figures indicate some kind of relationship between asking for information and the type of mental health clinic consulted. The author goes on to conclude that those who are more psychologically oriented, i.e. those who go to analytic clinics, talk to others more about their problems.

> Both an orientation to matters psychological and a willingness to see oneself as especially needing help are therefore traits related to asking others for information about psychiatrists and psychiatric clinics (256).

By definition mental illness is beyond the control of the individual (Clark and Anderson, 1967), yet the individual is expected to overcome this condition or seek help in overcoming it. This brings into mental health studies the whole notion of expectancy of control. A person's feelings of efficacy about a situation have been shown to influence the amount of action that person will take to change the situation. This theory might be related to mental illness, those persons who believe they have a certain amount of control over their feelings and emotions might be more willing to ask for help in dealing with them if they feel the need.

Internal-external scales and indexes tapping feelings of powerlessness have been designed to give an indication of how much in control of a situation a person feels to be and the behavioral consequences for these feelings of control. An internal locus of control is the belief that rewards depend on one's own behavior or performance. Each occurance of a reinforcement gives information which is used in assessing the situation and improving one's control over that situation (Gurin, Gurin, Lao and Beattie, 1969, Rotter, Seeman and Liverant, 1962). Chance or luck is the important concept in the external construct. Externality is the feeling that the world is not rational and unpredictable and that control lies in the hands of persons or forces which are stronger than oneself. It implies personal weakness (Gurin et.al., Rotter et.al.).

> The emphasis on the situation indicates that the internal-external control construct is not conceived as a typology whereby people can be dichotomously classified but as a hypothetical construct to account for intraindividual as well as interindividual response variations in specified situations (Rotter, et.al.; 499).

The notion of powerlessness, one aspect of alienation, is similar to externality. Powerlessness is

> . . . the expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes, or reinforcements, he seeks (Seeman, 1959;784).

The notion of having some control over one's situation has been empirically linked to the propensity to take direct action on one's environment. Jean Langlie (1977) conducted an experiment which demonstrated a significant relationship between someone's perceptions of control and appropriate health care behavior. The belief that one has some control over one's health and that the benefits of preventative health care behaviors are high (or that the costs are low) accounts for 19-34% of the variance in preventative health care (250). Activity in the civil rights movement has also been positively correlated with feelings of control (Strickland, 1965). Negro college students were compared on degree of activity in civil rights movements and measures of internality-externality, need for social approval, age, and education. Internality was proven to be the most important variable in predicting level of action.

One study by Seeman and Evans (1962) was designed to relate the amount of social learning and the degree of alienation among patients in a tuberculosis hospital. They used matched pairs of male patients, one rated high on the alienation scale and the

other low on the scale. They were matched for previous hospital experience and social background. Alienation was measured by a 12-item forced-choice scale designed to tap feelings of powerlessness. Social learning was operationalized as the patient's score on a 20-item information test about tuberculosis.

Their results supported their original hypothesis that the highly alienated scored significantly lower ($p < .05$) on the learning test than those with low feelings of alienation. The mean knowledge score among those high in alienation was 15.72, among those low in alienation this was 17.21. The actual differences in scores was small. This was believed to be the result of the ceiling on scores at 20, and the items may have been too easy. Intelligence differences were partially controlled for by matching the respondents on educational level. Other information supports the contention that the alienation scale does not measure intelligence.

The authors assert that the causal chain proceeds from alienation to poor social learning (777). They concede that this cannot be directly demonstrated by this data. The two experimental groups differ widely in alienation, but not in length of hospitalization and length of exposure to the illness. The two groups were therefore given approximately equal circumstances under which to learn about tuberculosis, but the more highly alienated did not take advantage of these circumstances to the extent that those low in alienation did. Also, controlled laboratory learning experiments have supported this causal link.

Anotner important aspect of this study deals with the staff members' perceptions of the patients. Staff members were asked to rate patients on their understanding of their illness. A score of 5 indicated very poor understanding and a score of 1 indicated very good understanding. The mean score given by the staff to those who were measured high in feelings of alienation was 2.76, compared to a score of 2.27 for those low in alienation ($p<.02$). "(T)he staff describes the 'highs' in alienation as patients who are relatively low in their medical knowledge, a description that agrees with the patients' objective test scores" (776). The staff rates these two groups differently. This could indicate differential treatment on the wards since the different rankings are due to behavioral differences (seen by the staff) among the two groups.

These results are supported by evidence from two other studies. One was conducted among reformatory residents (Seeman, 1963), relating degrees of alienation with three types of learning. The results indicated that the low alienation group scored significantly higher on a test concerning parole matters than those high in alienation. The two other types of information concerned long-range opportunities and situations over which the inmates had no control. These two types of learning were not related to alienation. Control-relevant information, that which is close in time and can be used for acting on one's environment, is influenced by feelings of alienation. Another study (Bickford and Neal, 1969) dealing with students in a vocational training center confirmed these results. Receptiveness to personally relevant information was inversely related to feelings of alienation.

These studies of internality-externality and alienation are useful in studying referral patterns, particularly in conjunction with the information from Kadushin. His findings state that there is a relationship between asking for help and the type of mental health clinic consulted. The more psychologically oriented talk to others more about their problems and gather more information about their emotional state and about the professionals they will consult. This data states that those who are less alienated or who feel more in control of their situation learn more about the circumstances around them. These studies might serve to equate the psychologically oriented with the less alienated or the internal control personality types.

Those who score high on powerlessness scales or those who are external on internal-external locus of control scales tend to be those in less prestigious positions in society. The inverse relationship between alienation and level of income, education and occupational prestige has been repeatedly established (Otto and Featherman, 1975, Meier and Bell, 1959). This same relationship has been established between externality and social indicators (Gurin, Gurin, Lao, Beattie). "In all of the reported ethnic studies, groups whose social position is one of minimal power either by class or race tend to score higher in the external control direction" (Leftcourt, 1966). Therefore the sense of lack of control is related to objective conditions which would lower a person's ability to control. Externality may be a healthy, realistic adjustment to objective social conditions. Since this externality is related to low degrees of social

learning, we can see the cycle. If one is in a low social position one would tend to put the blame for good or bad occurrences on some force external to oneself. This kind of attitude lowers a person's motivation for obtaining information about his/her conditions, therefore lowering the amount of control he/she has.

Gurin, Veroff and Feld (1960) report some interesting material concerning the location of a person's troubles or worries as internal, weaknesses in the self, or external, located in material things. "Only a minority of the people who went for help (about one in four) explicitly traced the source of difficulty to some defect in themselves . . ."(341). Furthermore, they stated that those with positive or very positive self-images were most likely to describe shortcomings related to achievement. Those with negative or ambivalent self perceptions emphasized shortcomings dealing with internal personal adjustment. While these findings do not directly relate to the internal-external locus of control context, there is some connection. Poor external achievements, in the occupational or educational sphere, for example, can more readily be attributed to external forces, out of the control of the individual. Whereas internal personality problems, can only be traced to one person. It seems apparent that the phenomenon Gurin, et.al. recorded concerns a person's willingness to take responsibility for his/her feelings and emotional states.

These findings, when taken together, give some indication of the variability of paths to mental health treatment. Defining

the problem and treatment source depend on the social context in which this is occurring. Personality factors influence whether or not a person sees any need to take action on these problems. Next is a review of some of the literature concerning specific referral sources to mental health treatment.

Research about various referral sources to mental treatment indicate several differences in the kinds of people they serve, the situations they are asked to help deal with and the amount of influence they have over the person they are referring. The type of person who is exposed to certain referral sources vary, as well as the type of person who would use that agency or person for a referral. Different referral sources encounter the person to be referred in different kinds of social settings. Some sources are utilized only during crises, while others have on-going relationships with the future client and can witness the development of the problem. As a result, referral sources differ in the types of situations with which they are equipped to deal. Finally, referral sources differ in the amount of control they have over the future client's actions to seek help. Some referrals are suggestions that professional help is needed and include information about where this can be obtained, while other referrals involve no degree of choice on the part of the future client. Referrals may be coercive in that the continuance of a marriage or employment is resting on them or they may involve coercion through the legal system.

Some research has investigated specific sources of referral to mental health treatment. Information covered here will deal with how these sources are used by different people and the

different situations they are exposed to and are required to deal with.

The police and court system act as referral sources to mental health facilities primarily for those in the lower social classes and for marginal people with few resources. Hollingshead and Redlich (1958) list the percentage of neurotics in their sample who were referred to psychiatric treatment for the first time by the police or courts (186). They found no respondents in the first two social classes who were referred by the police or courts. In class III 1.3% of the neurotics receiving mental health treatment were referred in this manner. In class IV 5.1% and in class V 13.9% were referred by the police or courts. Miller and Mischler (1964) confirm these findings. Fourteen percent of their sample in class V who were receiving treatment were directed by the police or courts. Hollingshead and Redlich's findings on psychotics were in the same direction. Four point eight percent of their sample in class III was referred to treatment by the police or court. In class IV police referrals accounted for 18.9% of the referrals and in class V they referred 52.2% of the sample. Miller and Mischler's figures were again similar. In class IV, 19% of the psychotics in treatment were referred through the police or courts, in class V, 52% of their sample was referred this way. As is evident, psychotic referrals are more strongly associated with social class than for those clients classified as neurotic. Psychoses are commonly characterized by violent, disruptive, or acting out behaviors. The lower levels of education and smaller financial assets associated with the lower class might serve to increase the proportion of

police referrals because of less knowledge about psychological help sources and less ability to take advantage of them.

In a study of police dealings with the mentally ill, Bittner (1967) was interested in the social context of these referrals. The police have two legal options in handling the mentally ill. The first is a court order to bring someone in for observation, the second is the authority to convey anyone they think is mentally ill to a hospital. This alternative is discretionary freedom similar to making an arrest without a warrent.

Bittner identified features in the immediate environment that the police officer identified as information sources about the mentally ill person and clues in helping to handle the situation (203). The officer took note of available family or friends of the sick person and any indications of previous psychiatric episodes and their outcomes. The practical implications, in terms of time, dealing with a hospital, or notifying relatives, were also important considerations before initiating the process of hospitalization of this person. The officer is called in to some crisis situation and is expected to act on this situation, drawing on any possible sources of information.

The police and courts are involved in managing social situations. They must deal with a mentally ill person in a crisis situation. The courts are involved in this crisis at a later date and in a separate environment. The involvement of the police and courts is the result of some overt, inappropriate behavior on the part of the mentally ill person. Both the police and courts are designed to make referrals on the

basis of behavior, not on the basis of illness.

Coercion and power are symbolized in the police and court system. The person has little choice in accepting or rejecting this referral.

> The courts, after all, are institutionalized representatives of society; decisions are made by them on behalf of society and this symbolized society's rejection of the individual" (Rushing, 1971;512).

The power embodied in the referral source and the lack of choice must have some influence on the course of treatment and the motivation of the client.

Physicians are very likely to come into contact with people who need psychiatric help. These may be patients coming for relief of physical complaints resulting from mental or emotional problems. These may be patients who are unable to identify their problem and the appropriate help source, although tney know they should obtain help. Some of these patients may be people who specifically want a referral to a psychiatric agency. Psychiatry tends to be a rather invisible profession (Kadushin;252) so some people may need help finding practitioners.

Physicians are usually presented with isolated symptoms or problems. A study of the wives of psychiatric patients (Clausen, Yarrow, and Robbins, 1955) suggests that the communication between a medical doctor and the wife of a future patient was very important in making a psychiatric diagnosis or referral. The doctor was presented with a purely somatic complaint from the patient and used the information from the wife to fill in the behavioral and situational details.

Clausen, et.al.'s information also supports the notion that physician referrals to mental health treatment are more acceptable to the client than are referrals from friends or family members. The authority and knowledge associated with the position of physician let the client accept this decision more readily. This type of referral might also relieve or prevent any guilt feelings which may haunt a family member or friend who makes the decision for referral. A physician referral may permit the client to make these problems more acceptable or understandable by giving them a physical basis.

The clergy are more likely than the other gatekeepers (such as police, public health nurses, social workers, etc.) to be very concerned about a person presenting symptoms of mental illness (Coie, et.al.). Yet, they are less likely to refer those people who come to them to mental health professionals (Clausen et.al., Gurin, et.al., 1960, Larson, 1965). They are more likely to act as the final therapeutic agents.

> Clergy, the group most alert to the signs of mental illness, see themselves as having a major role in therapeutic activities and are in high agreement with psychiatric definitions of mental illness (Coie, et.al.;633).

The clergy are important help sources in that they are private, no one else has to know that a person asked for help. They are easily accessible. They are also expected to give support and strength, which are what many people want. Of those who went for help, Gurin, Veroff and Feld reported that most chose the clergy or a doctor (341). Most of the clients described the help they received in terms of comfort, reassurance and advice.

When a family member or a friend makes a suggestion that someone seek professional help, the referral is probably based on extensive knowledge of that person. The referral is a decision reached with an understanding of the future client's social situation.

This is the least professional type of referral and, therefore, the reasons for the referral are probably more important. The referral involves not only an assessment of the person's behavior and symptoms, but considerations about what mental illness in the family will mean. The referral may have been made out of concern for the person involved. There is also the possibility that the referral was made because the future client has been causing trouble or is hard to deal with. With family or friend referrals correct interpretation of the reason for the referral is important. The client may have been referred by a caring relative or friend, yet still view the referral as an attempt to get rid of him or her.

A self-referral requires knowledge of psychiatry and insight into one's own problems (Hollingshead and Redlich; 183, Kadushin; 176). A person who is self-referred is motivated to seek relief. Along with greater understanding and knowledge, a self-referred client may have more emotional investment in getting well than one who was brought to treatment by someone else. The self-referred client has taken steps, first to identify his or her problems as psychological and then to alleviate these problems. This self-action might have further implications for treatment and recovery. A study on alcoholics (Chalfant and Kurtz, 1972) indicates that hospital staff is more receptive

to a client who was self-referred.

Americans View Their Mental Health (Gurin, et.al., 1960) contains an extensive section dealing with readiness for self-referral. Their use of the term self-referral does not correspond directly with the definition of that term used elsewhere in this paper. They were interested in some measure of the general acceptance of psychiatry. A distinction was made between intellectual acceptance and personal, or emotional acceptance. Their concept tries to capture whether someone recognizes mental problems as illnesses and views professional sources as the best way to deal with these problems and problems they might encounter in the future. They were then questioned on their uses of help resources. The responses were placed on a continuim ranging from people who have gone for help, to people who did not see help as relevant in the past, but would use it, to people who would never use help.

Those who have gone for help and those who considered help relevant for a past problem were categorized as accepting of self-referral. Several personality characteristics were associated with a readiness for self-referral (275). Distress was more likely to be structured in personal or interpersonal terms for those who had or would have sought help. Feelings of inadequacy or problems in a specific role are were more likely to bring a help-seeking response. These respondents were more likely to engage in self questioning rather than to generalize feelings into dissatisfaction or unhappiness toward life goals. Psychological rather than physical symptoms were more likely to be expressed by those who had a positive view of

helping sources. There was a relationship between introspection and readiness for self-referral. Those who said they had no personal weaknesses as well as those who said they had no strong points tend not to seek help. All of these characteristics are related to increasing levels of education, but when education was controlled for, the relationships still existed.

Certain demographic characteristics were also related to readiness for self-referral. Women, younger people, and the more educated more often have gone for help. These people were less likely to have adopted a self-help position, that someone should handle their own problems alone.

The referral source chosen or the one so imposed reflects, to some extent, the resources of that person, his or her wants and needs, and the desires of others in contact with the client.

Social class is an important determining factor of the referral agencies one will come in contact with. Income limits the range of helping services a person can utilize. Education is an important determinate of someone's ability to recognize certain problems as psychological and then identify the appropriate help sources. Social class is an indicator of social power and therefore, the amount of outside coercion a person is subjected to, or can avoid.

A person's definition of his or her needs is reflected in the type of referral source. If someone wants relief from physical problems while failing to see any psychological origins (s)he will consult a medical specialist. If someone wants comfort and reassurance, but not insight, they are likely to avoid psychoanalytic practitioners and to be dissatisfied with

them if they do go (Gurin, et.al., 1960). Even the acting out behavior of someone taken to a mental hospital by the police may be some expression of a need, the need for help and someone to take charge.

The needs of other people being affected by a person's illness have some implications for the referral source chosen. They may need to have this person's problems defined in somatic terms, which may be easier to understand and deal with. They may need someone to come in and take over a difficult situation. They may be looking for an official diagnosis, an authority figure to relieve guilt.

Referral source reflects certain characteristics of the client and his or her situation, and therefore, should have implications for effective treatment. In an effort to clarify the importance of referral source to mental health professionals twelve area therapists were interviewed about who their clients are and how they came to be clients. They were asked to explain any implications referral source had for their services. Five of the professionals interviewed were in private practive, four were involved in the college psychological services and three worked out of community agencies.

The interviews were conducted in an open format with ample provisions for digression from the questionnaire. The emphasis was on understanding how the professionals use the information of referral source and other factors influencing how a client got to the point of seeking help. This account of the information gathered from the interviews is an attempt to organize the information in a meaningful way. The interviews

were not recorded, so there may be some errors in the quotations. However, I am confident that the informational content has not been misused or misunderstood. This account should be read as an elaboration of previous information and as partial explanation of the results of the quantitative research reported later.

One of the first considerations discussed in the interview was the sex ratio of the clientelle of the therapists. This information helped to clarify some of the questions raised in the literature about utilization of services and willingness to express need. The most important variable in explaining larger numbers of women as clients, is the sex of the therapist. In almost every case in which the clientelle included more women than men, the therapist was female or there were female therapists in the agency. Male therapists were more likely to receive an equal number of men and women. One respondent reported that about 58% of the clients were women. "A few years ago this was closer to 50-50, before that more men came than women. When we added more women to the staff, this increased the women coming in." Another therapist, a woman, reported that her clientelle was "overwhelmingly women". Another female respondent added

> People feel more comfortable talking with someone of the same sex. They may be against seeing a man in the doctor role like they always have been. I assume that men are also looking for men.

The higher percentage of female clients in one agency was explained in another manner, similar to explanations in the literature.

> I believe this is a national pattern (for more women than men to seek psychological help). I think they are a little more willing to admit a need, this is harder for men. When it is a problem with a couple it is sometimes tricky to get the husband involved. . .. I don't know if I can generalize. Women seem to be able to express themselves a little faster. They have less defenses.

Respondents were asked if their clients usually come into the office alone or with someone for their first appointment. This question was intended to determine if physically accompanying someone to the therapist was a sign of coercing that person into treatment, or whether it was a supportive move. The therapists usually agreed that most clients come alone. One therapist elaborated.

> They usually come alone. If someone comes in with someone else their problem involves someone else directly. They will come in with a boyfriend or girlfriend or a roommate. Or if they are having problems in a homosexual relationship they will come with a lover. If they come in alone they have broader scope problems, they are more general.

Another confirmed this opinion. She said that most clients do come alone, but if they are with someone else this person is in a supportive role. This person is "a friend usually. If the client is younger or older it is a member of the family. They come for the support, so they (the client) will come at all if they are very fearful."

Clients who delay seeking mental health treatment could be trying to deny the existence of any problems. They might lack knowledge about where to go, lack motivation, or they may be afraid of asking for help. The duration of a problem and the reasons for delaying treatment could be important

information to the therapist. These interviewees were asked if people tend to delay asking for help, and if so, how they would characterize these clients. They generally agreed that this does occur and they gave several possible reasons.

> They are afraid they have a serious problem. At times this can be a disadvantage (for treatment), their problem becomes so intense, but very few are willing to change until we are hurting. Psychotherapy requires motivation.

This delay in treatment did not affect this therapist's attitude toward the client but affected "assessment of motivation and what could be accomplished. Those who wait are probably not as fully committed." Other information this therapist used to assess the motivation of clients included "their comfort in admitting psychological problems, their openness to different viewpoints and whether they are comfortable with another person." Those who seek treatment early in the course of their problem "may be more open, more sensitive to the development of their problem."

Other therapists emphasized different reasons for delays in seeking help.

> They have talked with people. 'I've run out of everything else, I finally have enough courage.' It takes courage to delve into yourself. I am amazed that people can do that, work it through. It is scary, hard work.

The people who delay treatment were described by another therapist.

> Those who are scared or smart (delay seeking treatment). It is not a good idea to define yourself as a patient too quickly. Some people are over-analized, particularly in this environment. They know how to be a patient, but not how to be a person. . . . There is no reason for therapy unless there is terrible pain. Some people have to feel a little strength to be able to risk treatment.

One therapist indicated that a slightly different approach to therapy is needed for those who delay treatment.

> I am much firmer, less permissive. I tend to be more active. I am a more active therapist in general. You have to prove yourself to them fast. They are asking for someone to take charge.

A different perspective on those who put off treatment was provided by another interviewee. The people who delay are

> . . . mostly minorities. Therapy is not fashionable (to minorities) like it might be in middle class families. They come when they find their extended family can no longer help. It is usually crisis intervention. It takes longer to work through.

Each respondent gave scenerios of the referral patterns of their clients. They gave indications of how different referral sources reflected differences in the people coming to them and any implications this may have had on therapy. The theme of motivation kept recurring in these discussions, as well as support and trust.

> I would say about 85% are self-referred and 5% are referred by their physicians. . . . About 5% are referred by clergy, family or friends. . . . Self-referred are motivated, other referrals are pushed to do this, their coming is related to the other's (the referral source's) problems. In other words, the client is a pain in the neck. You have to deal with why the other person wanted them to come.

In working with clients who are coming to therapy as a part of their parole

> . . . you have to spend time working through what this referral means. A person has to be personally committed to therapy. And usually the person comes to this point.
>
> If they have been pushed, their motivation is less. You must work at getting a prospective patient to work at doing it. You must establish a relationship with the patient. There is no way to do therapy with someone who doesn't

> want to work. They must have the notion of 'I don't have to do it.'

Another therapist deemphasized the method of referral and its importance in treatment. "Actually, it doesn't matter to me how they get to me. The fact that they are there is what is important. I try to treat them all fairly." In regard to physician referrals and what they may mean to the client he said ". . . the effect this has is just to suggest to the person that whatever they are undergoing is mental, not physical." The fact that they were looking for help seemed to be the important factor, not the method of referral. "Their openness might mean they are looking for help. They are usually very open, maybe less knowledgeable."

The motivation to get help seemed to be a very important factor in the influence of referrals.

> Those who come in freely will tell you they are there to work on a problem. If they are with someone they will say that their mother or father told them to come in. Those who come on their own are more likely to work. Those who are doing it for someone else are making a gesture. They are saying 'I did make the effort.' They go through the motions, but there would be no difference in treatment.

This respondent had worked with some clients who were referred through the courts.

> They come as an alternative to jail. They would rather stay in a hospital for 30 days with ground privileges and free movies than in a jail for 30 days. They might not want to be here. They are very honest about their reasons. If they come on their own I assume they want to be there. If they are taking someone's advice, they want to be there. They don't have to come.

Another therapist emphasized motivation and problems with anger over coercion in a referral.

> With those who were coerced to come we must work through that they don't want to be there. I want them to be here. If there is a lot of hostility and anger it has to be vented. You must move them to where you can be helpful. . . . Frequently one is urged extrinsically. That person will identify themselves as being referred. 'Someone else said I should come.' The subtlety of that is that sometimes that person will put the responsibility on the referree. Then if it fails that person will go back to the referral person and say 'see, I tried and it didn't work.'

Other cases are different for this same therapist.

> People are pleased that someone has cared, someone has talked with them. They feel a support system. . . . A self-referral feels a need to come. It is important how people get to you. We prefer voluntary clients, through someone or self-referral.

In regard to agency referrals and how a client feels about them one therapist explained a positive outcome of this kind of referral.

> If they have had a good relationship with the agency, they have more experience using outside help. Help makes them more amenable to more help. There are others who rattle around from one place to another and are hell-bent on proving that they can't be helped.

This therapist also received a lot of referrals from physicians.

> Pediatricians refer a lot. Doctors refer adults with psychosomatic illnesses. Pediatricians refer kids with behavior and psychosomatic problems. Occassionally, they send someone in for an evaluation or diagnosis. They frequently have ruled out everything else. In an area such as this they see it (a referral to a psychiatric agent) as the natural sequence of events.
>
> If there is a lot of resistance (to seeking psychiatric help) medical referrals tend to overcome this. If two parents disagree about treatment for a child, the pediatrician cuts through it. They need an authority person to break in.
>
> The best referrals come on direct recommendation from another patient, who knows me. The next best are from a physician who is trusted and who

> trusts me. They have more realistic expectations of what will happen to them. They have someone else to ask questions. They have overcome initial negative feelings about seeking treatment. They have talked it out. They must ask others if they should get help. They have usually gotten support. Some who come on their own come out of curiosity. I used to get calls from parents to reassure them that their kids were genuises. Now the public is more sophisticated. Some who come on their own are very good. The worst referrals are kids who have been pushed.

Another therapist put the emphasis on trust in making referrals and accepting them.

> People come to a private practitioner (psychologist) because someone they trust recommended the doctor. There is a personal chain. Personal trust is important. That is why it takes a long time to build a private practice. Sometimes personal friends will send someone. This is a difficult thing, you have to have trust in who you recommend.

This therapist was asked about physician referrals to her practice and then she elaborated on what a referral means.

> This happens rarely(physician referrals). We are trying to get the doctors to do this. They won't send the people they should. Doctors do not believe in headwork basically. Even if they do believe the illness is psychological, they don't believe it can be helped. . . . It just doesn't occur to them to refer to a psychologist. It is a shyness on their part, they don't object. You must convince them that you have something to offer.
>
> What is important is more what they are sent for, not who sent them. Agencies notice a problem and point it out and they try to fix it. Personal referrals are all voluntary. . . . You are dealing with people being able to ask for help. I think your premise is right, that the end is in the beginning. I am more concerned with another part. I think the profession is at fault. They concentrate too much on the middle class. They should develop ways to deal with the involuntary patient. They should make themselves available to help, in the patient's definition of help. The profession is too narrow.

Self-referrals were usually spoken of as a positive type of referral. One therapist qualified this by pointing out another reason for a self-referral.

> There are degrees of non-voluntary clients. It takes much more skill from me if they are urged. If people come on their own it may be because they are unhappy and want support for how badly others are treating them. They want to stay the way they are because that is what they know.

Some of the people I talked with had worked with clients who had been referred to them through social service agencies. This type of referral did not seem to be too different from the others.

> In the process of working with that family the agency might find problems that exist, interrelational or one person, a referral would be made. In some cases they are mandatory or optional.

One therapist worked out of a community agency which received clients who had been referred from many different sources. He explained how the clients react to being referred to mental health agency.

> It depends on their level of motivation for getting help. The less motivated they are the more they resent the bouncing around. It depends on how the referral was handled. If it was talked through and explained that they were not capable of dealing with the client's problems and that we could, then it is good. It depends on how it is handled and ambivalence. . . . Those who come from the police and courts are marginal people, economically and socially. They feel marginal. There is a definite pattern there. . . . Doctor referrals tend to be individuals with obvious psychosomatic symptoms, but they are not psychotic. Only several doctors trust us that far.
>
> When they come in by themselves their ego is saying 'yes, I need it.' If others are urging, there is some sense of obligation, a 'should'.

> That 'ought' is super-ego. That is frequently a big barrier. That is a major factor in their life, guilt. They are relying on other's expectations. You have to sort that out initially (in therapy). If it is 'I' you don't have to go through all of that. If they can maintain that you can see home.

Another therapist from a community agency put the same kind of emphasis on client motivation.

> We get referrals if the agency can't handle their problem. They have to terminate with that agency. Welfare sends people with overwhelming problems, that they don't have time to deal with. They (the clients) don't feel rejected, but promoted to a better place. Unless they are from the court. Some people are supposed to come in as a condition of their probation. Nobody is amenable to treatment unless they feel they need help, and then it wouldn't be likely that they would come in through the courts.
>
> Those who are being forced; their wife will leave them unless they come, they will loose their job, the courts sent them, are not amenable to treatment. They need to believe they need to make changes. We are very cautious. . . . If a woman calls in for an appointment for her husband, we make him call in first. We only accept referrals like that from someone else if they are being released from the hospital and then we get all of the information we can from the social worker or whoever calls.

This information helps clarify the point that the actual referral to mental health treatment is part of a process of recognizing a need for help and then obtaining it. Referral source, to be a meaningful piece of information can not be divorced from the reasons for the referral, the relationship between the referral source and the client, the method of referral and the client's own motivation to get help.

Delays in seeking treatment are part of the process discussed. Many of these therapists viewed delays as positive. This delay may be associated with increased client motivation to work in

therapy. When (s)he finally gets to treatment, (s)he knows that this is what was needed. Often this person has been gathering opinions from others about the problem and is ready to act on it. Several therapists, however, recognized times when delaying treatment indicated fear and a reluctance to use help sources. This resistance to treatment was not overcome before the initiation of treatment, so it must be dealt with during the first few sessions.

Motivation to change and deal with problems is one of the most important factors in the therapeutic relationship, and may be related to a person's referral to treatment. "Motivation is the most consistent variable, the more motivation, the more positive the outcome." Referral source may reveal some information about a client's motivation, but generalizations are difficult. A client could have been pushed to seek treatment by one type of referral source, yet another client may have been given encouragement and information by the same type of referral source. Referral source is important, but only insofar as it reflects other qualities of the reasons for seeking treatment. Trust in the referral source is important. The more trust in the original relationship, the better the referral will be. If a referral is understood as the "natural sequence of events" in help seeking and receiving, there is more of a chance of a positive outcome. If the referral was not explained, one of the first objectives in therapy is to deal with any negative feelings about a referral.

> If a client is pretty unsure about the referral then the initial task is to establish rapport and trust so that they are comfortable. This takes up most of the first interview.

The referral seems to be something the therapist has to get around, if it was a negative experience. Any hostility towards the referral must be worked out before therapy can start. The client has to be to the point of working for him or herself. "They feel less responsibility for their own changes if they are pushed." "They can't be a passive recipient. They have to learn how to help themselves." Several of the therapists identified this need for the client to take responsibility for overcoming the problem.

The previous review of the literature illustrates the complicated set of social influences which impinge upon who becomes a client and how this is accomplished. Various social factors relate to how the person deals with his/her problems, whether the problems warrent treatment and what kind of treatment to seek. Various attributes of a person will determine the people (s)he associates with and whether or not this person talks about problems which might require help. Social class and education have a lot to do with the recognition of possible sources of help. The important questions here concern who becomes a client of mental health services, how the person becomes a client and what effects these processes have on the course of treatment.

The information from the professionals in the mental health field indicates that the way a person gets to treatment is important in that it gives an indication of that person's

motivation to change and willingness to take responsibility for his or her actions. Referral source is only one part of the way a person gets to help and it must be understood as such. Again, the relationship between the referral source and the client, the reasons for the referral and any feelings about the referral must be considered.

This next section will deal with information gathered about clients receiving treatment at a community mental health center. The main emphasis of this analysis will be on clarifying the information revealed by someone's referral to this center. The organizational approach taken will try to approximate social network studies. A social network approach to referral emphasizes the actual opportunities of someone to receive information about psychiatric help sources and the opportunities to receive a referral from a person or agency (Horwitz, 1977). A social network is defined as ". . . a specific set of linkages among a defined set of persons, with the additional property that the characteristics of these linkages as a whole may be used to interprete the social behavior of the persons involved" (J. Clyde Mitchell, as quoted in Horwitz;87).

The household composition of the client, marital status and occupational status are the three variables used to give an indication of the persons the client will be in contact with prior to treatment, as well as the role the client plays in these relationships.

Household composition gives some information about the client's contact with kin. The clients were recorded as living in conjugal homes, parental homes, with relatives (other than

spouse or parents) or friends, or living alone. These four categories give an indication of the people available to react to the client's illness or problems (or conversely the people the illness or problems are a reaction to) and the people who are available to make a referral. In addition, household composition gives some indications of the roles the client has to deal with, that is whether the client is reacting like a child or a parent, a friend or a spouse.

Marital status, like household composition, would be some indication of the persons who would be in a position to react to someone's illness and the persons available to provide referrals. It is also an indication of the roles the client has to handle.

Employment status measures whether someone was employed, not employed or a housewife at the time they initiated treatment. This is the third indicator of contact with others. A housewife's illness or problems would probably have the most direct effects on her nuclear family. Someone who is employed would come into contact with others while working. Illness would have important effects on one's ability to work and could be identified through the work situation.

These three variables also give a limited amount of information about the degree of control the client would have in their social environment. An adult living in a parental household would seem to be less in control than an adult in a conjugal or relative-friend household or living alone. The state of being married implies more familial responsibilities than the state of being single. An employed person probably would

feel more efficacious than someone who is not employed. A housewife would be more like the employed. These speculations about the implications and information contained in these three variables are only specualtions. We will examine how they fit with the data.

This research is exploratory in nature and is not based on any firm hypotheses. There are several expectations however. Household composition, marital status, and occupational status should be related to the referral source of the client. Those clients who have kin contacts and friends available, as indicated by these variables, will be more likely to be referred by relatives or friends. Those clients who are more isolated from others will either tend to be self-referred more often, or referred through more formal types of agencies. Those clients who are in more equal, responsible relationships with the persons they come in contact with will more likely be self-referred than those who appear to be in more dependent situations. Referral source will be an indication of the client's social circumstances.

This research was conducted at the Lorain Outcare Division of the W. G. Nord Centers, a part of the Mental Health Services of Lorain County, Inc.. This is a community based mental health center. At the time this information was gathered there were 6 full time therapists. The sample consists of clients who initiated treatment with the center in 1976. This year was chosen because it was the most recent time period in which one could expect a large number of terminated cases. A systematic

sample of the client's files from the storage cabinets was taken. Those clients under 18 were excluded from the analysis because they would not be expected to have much control over whether or not they got to treatment. This method of sampling may have excluded some cases when the first intake date was prior to 1976, but started treatment again in that year. It may have also excluded some open cases which were being consulted and were not in the file cabinets. The total sample consists of 183 cases out of the 421 cases (including children) which were opened in 1976.

The information about the clients came from four main areas in the case file; the call-in sheet was filled out by a staff member when a person called in for a first appointment, the client form was filled out by the client on the day of the first appointment, treatment notes kept by the therapist, and the termination record. Most of the background information came from the client form. The call-in form and treatment notes gave the most information about the presenting problem and the client's motivation. Information about the treatment was obtained through the treatment notes and termination records. Referral source was one of the most important variables recorded. This was taken from the client form.

This research is limited in its scope and representativeness. The measure of referral source gives no indication of the influence, relationships, or feelings of that person or agency towards the client. No attempt was made to control for psychological symptoms. A lot of reliance was put on information

gathered from the client, with no ability to replicate it. Many times the information in the files was incomplete, each therapist kept track of different information about his/her clients. The sample is of people who have already been referred, and more specifically, people who have been referred to this particular mental health center. Keeping these limitations in mind, this research is important as a starting point. This should be examined as an exploratory study dealing with the relationships between information about the client and his/her referral source.

findings

The frequency distributions of the referral sources used by the respondents show that self-referrals are the most prevalent. Physician referrals are the second most frequent,

Table 1 about here

followed by friend and then relative referrals.

Referral source and household composition are not statistically related (X^2=13.86, df=9, p=.127, V=.175). However, many

Table 2 about here

of the percentages are in the predicted direction and warrent some attention. Those living alone are the most likely to be self-referred. They are less likely to have others close to make a referral. Those in parental homes are the least likely to be self-referred. This is probably due to the lack of control implied by the condition of an adult living with his/her parents. Living in a parental home might also be an indication of ill

health or inability to act responsibly. Those living with relatives or friends are the most likely to receive referrals from relatives or friends. These types of referrals are readily available. Those in conjugal homes are the next most likely to receive these referrals from relatives or friends. Those living alone are the least likely to receive these referrals. These results seem to be due to the availability of friends or relatives to give referrals. Professional sources are used least by those living alone. Those living alone and those in parental homes are the most likely to use health facility referrals. This might be an indication of higher rates of illness associated with these living arrangements.

The relationship between referral source and marital status is statistically significant, although it is not very strong (X^2=15.02, df=9, p=.07, V=.181). The divorced and widowed

Table 3 about here

groups are the most likely to use self-referrals. These two groups are the least likely to have relatives to help with the recognition of problems and action on them. The married group is the most likely to use relative-friend referrals. In this relationship referrals by spouses are probably very common because of the closeness of the marital relationship. Professional sources are the least-used sources of referral for those who are divorced. The health agency users are about equally distributed across marital status categories.

Referral source is not statistically related to occupational status (x^2=5.06, df=6, p=.54, V=.125). The percentage dif-

Table 4 about here

ferences are not very large. The most striking differences occur among those who are relative-friend referred. The unemployed are the least likely to be referred in this way (25.71%) when compared to the employed (34.48%) and housewives(32.35%). The state of being unemployed might imply limited contacts with friends. There is also a difference among those referred by health agencies. Those not employed are the most likely to be referred in this manner (44.29%). Of the employed, 29.31% are referred through health agencies as are 26.47% of the housewives. The unemployed seem to be the most isolated in terms of friends and family. Unemployment could be attributable to health problems or could result in problems increasing the usage of health agencies.

None of these relationships is as strong as expected, although the general trends are consistent with the earlier arguments. Further examination of the interrelationships among these variables might specify the conditions under which these variables relate to referral source.

The three main independent variables being examined are all statistically related to one another, as one would expect. The relationship between household composition and marital status is strong (X^2=153.02, df=9, $p<.001$, V=.549). Ninety-six percent of the respondents who are married, live in conjugal households. Of those who are divorced, 45% are in conjugal homes and the rest are almost equally split between relative-friend homes and living alone. Most of the widows live alone (about 56%), the rest live with relatives-friends or in conjugal homes. Most of the single respondents live in parental homes (about

67%). The next largest group of single respondents live alone (16%).

The relationship between marital status and employment are significantly related (X^2=56.34, df=6, p<.011, V=.394). Most housewives are married (82.5%). Most of the unemployed are single (46.75%), followed by a large percentage who are divorced (27.3%). Most of the employed clients are married (47%) followed by a high percentage who are divorced (31%) and a large group who are single (20%).

The relationship between household composition and employment status were not quite as strong as the other two relationships (X^2=38.29, df=6, p<.001, V=.336). Most of the housewives live in conjugal homes (87.5%). Thirty-five percent of the unemployed live in parental homes, 30% live in conjugal homes and 19% live with relatives or friends. Those who are employed are most likely to live in conjugal homes (64%). There are equal percentages in parental homes or living alone (13%) and about 10% live with relatives and friends.

The relationship between referral source and household composition is statistically significant only for those who are divorced or separated (X^2=17.24, df=9, p<.05, V=.340). There was only one case of a respondent who was divorced living in a

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Table 5 about here

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parental home, so this category of household composition will be left out of the discussion. Those in conjugal homes (living with non-adult children) are the most likely to be self-referred.

Those living alone are the least likely. The patterning across household categories for self-referrals is not at all similar to that in the original relationship between referral source and household composition. In the original relationship (see Table 2) those living alone were the most likely to be self-referred, followed by those in conjugal and relative-friend houses who were about equally likely to be self-referred. This change from the original relationship may be the reflection of the responsibilities of a single parent (a divorced person in a conjugal home). This person would be in charge of a household and would have to take action on problems. This sense of responsibility might be stronger in this situation. This might also indicate that these persons are isolated from other help sources. The situation of being divorced might also be an easily recognizable reason for counseling, divorce might be seen as a good excuse for seeking help.* The relationships in the relative-friend and health agency referral categories are similar to that in the original, uncontrolled relationship. Only one divorced client was referred through professional sources.

The relationship between referral source and household composition for those who are single may not be statistically significant because of the small sample size (n=42), 27 of these respondents are living in parental homes. For those clients who are married, 60 out of the 63 respondents are living in conjugal households. This small spread of the sample precludes any analysis.

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*This idea is thanks to the therapists at the Nord Center.

The relationship between referral source and marital status is significant only for those living in conjugal households (X^2=24.31, df=9, p<.004, V=.314). The main difference in the

Table 6 about here

usage of referral sources is between the married and divorced goups. There is a very small number who are widows or single (n=5). Those who are divorced are over 4 times as likely to be self-referred as the married group. These findings confirm the earlier idea that the role of being a single parent involves self action, a good reason for seeking help, or a certain amount of isolation from other sources of referral. The percentages of relative-friend referrals is similar between the married and the divorced. Eighteen percent of the married respondents were referred through professional sources while none of the divorced group was. The married group has three times the number of health agency referrals as the divorced.

Sample size and distribution of the sample are probably the main reasons for lack of significant relationships for other household groups. For those in parental homes only 3 out of the total of 30 are not single. The sample sizes for those living in relative-friend homes (n=17) and those living alone (n=20) are quite small.

These comparisons paint a picture of inaccessibility to outside referral sources for the divorced client living in a conjugal home, based on the high percentages of self-referrals. Further research will be needed to determine if the high number

of self-referrals among this group is due to isolation from other sources or an ability to identify problems as those dealing with mental health and the ability to act on these problems. The low number of referrals from professional sources might be some indication of the invisibility of the problems for this type of client. The professional sources includes police and schools, basically public control organizations, and would tend to act as referrals towards those who are publically displaying problems.

The relationship between referral source and household composition controlling for employment status is significant only for those who are not employed (X^2=18.31, df=9, p<.05, V=.314).

Table 7 about here

This is a moderately strong relationship. Among those who are not employed, those living alone are the most likely to be self-referred. The conjugal living group follows in percentages of self-referrals, but this is about half the percentage of those alone. Those living with relatives or friends are the most likely to be referred through relatives or friends. Those in conjugal homes follow far behind. Professional sources are not used extensively by those who are not employed. What is very striking in this whole relationship is the high percentage of health agency referrals. The unemployed living in relative-friend homes are the least likely to use these referrals, but the percentages for the other categories range from 44.44% of those in conjugal homes, to 54.55% in parental homes.

The lack of relationships in the other two occupational categories are due to the lack of spread of the distribution. For those who are housewives, only 5 out of a total of 34 are not in conjugal homes. Most of the employed sample are in conjugal homes (35 out of 54).

The relationship between referral source and occupational status is significant only for those respondents in parental homes (X^2=11.19, df-6, p=.083, V=.425) and it approaches significance for those respondents in relative-friend homes (X^2= 5.96, df=3, p=.113, V=.592). The sample is small for those in relative-friend homes (n=17) which probably holds the Chi-squared value down, but the strong measure of association indicate an important relationship. It is hard to tell whether the lack of a significant relationship between referral source and occupational status for those living alone is due to the small sample (n=20) or to a true lack of relationship. There is no relationship for those in conjugal homes.

For those living in parental homes, only three respondents

Table 8 about here

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were classified as housewives. They will be excluded from the analysis. Between those who are employed or not employed, there are not large percentage differences in usage of self-referral (about 3% difference) and relative-friend referral (about 2% difference). The important findings are for those who are referred through professional sources or health agencies. Among those clients who are employed, 33.33% were referred through

professional sources while 13.64% of those who are not employed were referred in this manner. This finding is unexpected and unexplainable. I would have expected those who were unemployed to have more access to professional sources since these sources are usually more likely to deal with overt, more visible displays of illness or problems. A very striking finding is the high percentage of health agency referrals among those in parental homes, as was reported earlier. Among those who are not employed 54.55% are referred through health agencies. Among those who are employed 33.33% are referred in this manner. This difference between employed and unemployed was evident in the bivariate relationship without controlling for household composition. This high percentage of health agency referrals by the unemployed could be due to three influences. First, community agencies (such as welfare, family services etc.) are included in the health agency category and the unemployed would be more likely to use these agencies. Second, maybe the unemployed are more likely than the employed to somatisize; they may be less willing to identify emotional problems and instead identify physical problems, or they may be less knowledgeable about mental or emotional problems and be less able to identify them or go to the right help source. Third, the unemployed may be unemployed because of health problems, so they would have more contact with these sources of referral. The relationship needs to be further explored with a larger sample size and a more detailed breakdown of referral sources.

The relationship between referral source and employment

status approaches significance for those living with relatives or friends. In this relationship the main differences between the unemployed and the employed is among those who were self-referred and those who were relative-friend referred. (Although the measure of association is strong the sample size, n=17, is quite small, so this relationship should be examined carefully.) Among those who are employed 60% were self-referred while only 8.33% of the not employed were self-referred. The higher percentage of self-referrals among the employed could be due to one of two factors. It is possible that this group is isolated from other referral sources or that this group is more likely to act on problems and feels more efficatious in doing so. I would tend to reject the former reason because the employed are very likely to have friends on the job, increasing the liklihood of friend referrals and these respondents are living with relatives or friends, another source of exposure to this type of referral. I would attribute this high percentage of self-referrals to the ability to acknowledge problems as due to mental or emotional causes, the ability to identify appropriate help sources, and/or the increased ability to act on problems. For those who are employed, 20% were referred through family or friends while 58.33% of the unemployed were referred through family or friends.

The differences in referral patterns between those who are employed and those who are unemployed seem very important when compared between those living in parental homes and those living with relatives or friends. The important differences between

the employed and unemployed living in parental homes were for professional and health agency referrals. For those living in relative-friend homes, the important differences were in self and relative-friend referral categories. This addresses question about the living arrangements and what they say about the client. Self-referrals and relative-friend referrals are the most self-initiated. Professional or health agency referrals imply less control over seeking help and less knowledge about doing so. Those living with relatives or friends would have to be more responsible than those in parental homes. For those living in conjugal households, occupational status is not an important indication of referral source. This might be because conjugal living is a more important indicator of referral source or that the state of being married, so closely correlated with conjugal living, is a more important indicator.

The relationship between referral source and marital status, while controlling for employment status is significant only for

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Table 9 about here

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those who are employed (X^2=14.63, df=9, p<.002, V=.292). There is no relationship for housewives because so few (7 outof 34) are not married. The relationship is not significant for those who are not employed. For those who are not employed marital status is not an important indicator of referral source.

Over 42% of the divorced clients who are employed were self-referred. Eighteen percent of those who are single were self-referred while only 8% of the married were self-referred.

Those who are married are much more likely to be relative-friend referred. About equal percentages of the divorced and single clients were relative-friend referred. Once again, none of the divorced clients used professional referrals. The single clients were the most likely to use health agency referrals and the married clients were the least likely. These results are similar to the ones already discussed and support the ideas recorded earlier.

The state of being unemployed must be more important than marital status. The relationship between referral and marital status is not significant for those who are not employed.

The relationship between referral source and employment status is not significant when no controls were used.

The relationship between referral source and household composition is significant. The relationship remains significant for those who are divorced and those who are not employed. In all three cases those who live in parental households are one of the least likely groups to be self-referred. Those living in relative-friend homes are the most likely to be referred through relatives or friends. For the original relationship and for those who are divorced, those in conjugal homes are the next most likely group to be referred through relatives or friends. Those who live in parental homes are very likely to be referred through health agencies. Many of these relationships seem to be due to proximity or exposure to the referral source, particularly the differences in self and relative-friend referrals. Some of these findings, particularly the differences in health

agency referrals may be due to the health, or psychiatric condition of the client and how this might relate to choice of household.

Referral source and marital status are significantly related. This relationship is still significant for those living in conjugal homes and those who are employed. Those who are divorced are the most likely to be self-referred. In the original relationship and for those who are employed, the married groups were the most likely to be relative-friend referred. For those in conjugal homes the single clients are more likely to be relative-friend referred. This could be a group composed of young adults referred by their parents. Those who are divorced are rarely referred through professional sources. The relationships with health agencies change among the three groups. Information about the health of the respondents and how that relates to marital status will help specify this relationship.

The relationship between referral source and occupational status is not significantly related. This relationship does become significant, however for those in parental homes or those living with relatives or friends. For those in parental homes, the employed are more likely to use professional referrals and the unemployed use more health agency referrals. There seem to be little difference between the usage of self or relative-friend referrals. This pattern is also reflected in the original relationship. The relationship between referral and occupational status is different for those in relative-friend homes. The differences between the employed and not employed are among those

who are self and relative-friend referred. Those who are employed are more likely to be self-referred while those who are unemployed are more likely to be relative or friend referred.

These relationships could be more fully explained if there was a larger sample. In several of the controlled relationships it is hard to tell whether the small number of cases is keeping the significance low or whether there is no relationship. Examination of the client's willingness to take responsibility, as indicated by scores on an internality-externality measure would also add immensely to the explanatory power of this research. Finally, these relationships could be further analized in relation to the severity of illness or the problem and if this has any relationship to the client's household composition, marital, or occupational statuses. The only measure in this data which may approximate this is whether or not the client has had prior psychiatric treatment. These relationships will be examined with information about the client's prior psychiatric experience to understand more about these relationships.

The relationship between referral source and prior psychiatric experience is moderately strong (X^2=19.01, df=3, p<.001, V=.352). Those with and without prior psychiatric experience

Table 10 about here

are almost equally likely to be self-referred. This is an unexpected result. One would expect that knowledge of mental health facilities, through experience, would increase one's ability to make a self referral. It might be that prior

psychiatric experience indicates illness or problems which prevent these clients from being able to self refer. Also, prior psychiatric treatment may have been a negative experience, lowering the willingness to self refer. Those with no prior psychiatric care were more likely to receive referrals from relatives or friends than those with prior psychiatric experience (41% of those with none, 24% of those with some). These differences seem contrary to labeling theory (See Gove,1970, Scheff, 1974, Gove and Howell, 1975). which states that once a person has received treatment for mental illness, others would tend to keep reapplying this label of mental illness. One would expect those with prior psychiatric experience to be more readily referred by relatives or friends. Twenty-one percent of those with no prior psychiatric care, as opposed to 8% of those with some, were referred through professional sources. Once again, this seems contrary to labeling theory.

The relationship between household composition and prior psychiatric care is not significant (X^2=3.68, df=3, p=.30, V=.153).

Table 11 about here

The only relationship which seems worth note is that those with some prior psychiatric experience are more likely to live alone than those with no prior experience.

The relationship between marital status and prior psychiatric experience is significant, although weak (X^2=6.32, df=3, p .10, V=.194). Those with no prior experience are more likely

Table 12 about here

to be married than those with a psychiatric background. Those with some psychiatric experience are somewhat more likely to be divorced than those without. Those without previous experience are somewhat more likely to be single. All of the widows in the sample had prior psychiatric experience. Although these percentage differences are slight, they may have some effects on the other relationships.

The relationship between occupation and prior psychiatric experience is significant (X^2=8.26, df=2, p<.02, V=.220).

Table 13 about here

A greater percentage of those with no prior experience are housewives than those with some experience. A greater percentage of those with some previous psychiatric experience are not employed. Those with no previous experience are more likely to be employed.

These relationships indicate that the relationships found between referral source and these three variables could be due to the relationships between these variables and the presence or absence of prior psychiatric experience.

The relationship between referral source and household composition is not significant for either those with no prior

Table 14 about here

psychiatric experience or those with some prior psychiatric experience. However, the low Chi-squared values may be attributable to the uneven distribution of the sample in both instances. The relationships appear to be moderately strong.

For those with no prior psychiatric care there are few respondents living with relatives or friends, or living alone. The relationship is very likely to have occurred by chance, so it must be examined with caution (X^2=12.88, df=9, p=.17, V=.268). Those living alone or with relative-friends are very likely to be self-referred. Those living in parental homes are very likely to be referred through relatives or friends, followed by those in conjugal homes. None of the clients living alone were referred through relatives or friends. Those in parental homes are much more likely to be referred through professional sources than those in conjugal or relative-friend homes. Half of the respondents living alone were referred through health agencies. The relationship for those with some prior psychiatric treatment is closer to being statistically significant (X^2=14.57, df=9, p<.11, V=,245). Across self-referrals, the differences among household composition groups is not as large as they were for those with no prior psychiatric experience. Those living alone are the most likely to be self-referred. Those living with relatives or friends are the least likely. Those living with relatives-friends are the most likely to be relative-friend referred while those in parental homes are the least likely to be relative-friend referred. This is a reversal of the pattern for those who had no previous care. Those in parental homes are the least likely to use a professional referral, while they are the most likely to use this referral if they have not had previous experience. Those in parental homes, living alone, or in conjugal households all show a high incidence

of health agency referrals. None of the sample living in parental households with no prior psychiatric experience were referred through health agencies while 68% of those with some prior psychiatric treatment were referred in this way.

When prior psychiatric care is controlled for there is a big difference in the type of client living in parental homes. It seems that among those with no prior psychiatric care those in parental homes are young adults, probably still students. The large percentage of professional referrals are probably from school officials. Those in parental homes with prior psychiatric experience are very likely to be referred through health agencies. These are probably clients who live with their parents because of an inability to live alone. This conjecture is given support by the fact that the relationship between referral source and prior psychiatric care is significant for those living in parental homes. (X^2=16.87, df=3, $p<.001$, V=.750). This relationship is not significant for any of the other living arrangements.

The knowledge of a client's household composition gives some information about this person's referral source. Some of this information is due to the connection between living arrangements and prior psychiatric care.

The relationship between referral source and marital status is significant only for those with no prior psychiatric care

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Table 15 about here

Those who are divorced are much more likely to be self-referred than either those clients who are married or those who are single. The divorced clients are the least likely to be relative

or friend referred. Those who are single are slightly more likely than those who are married to have used professional referrals. Those who are married were more likely to use health agency referrals than the single or divorced clients. In comparing this relationship with the uncontrolled relationship we see an increase in the percentages of relative-friend referrals and a decrease in health agency referrals. The relationship between referral source and marital status is not significant for those with prior psychiatric experience (X^2=8.81, df=9, p=.45, V=.182). Prior experience using psychiatric help sources overrides the importance of the relationship between referral source and marital status.

The relationship between referral source and prior psychiatric experience is not significant for the married clients (X^2=4.41, df=3, p=.22, V=.267). The relationship does appear significant, however for the divorced clients (X^2=7.24, df=3, p<.07, V=.431) and for those who are single (X^2=12.82, df=3, p<.006, V=.540). This relationship for divorced clients much more closely resembles the original, uncontrolled relationship, in a more extreme form. Among the divorced the percentage of self-referrals is twice as large for those with no prior psychiatric care as it is for those with some prior experience. Those with some prior psychiatric care are slightly more likely to be referred through relatives or friends. The relationship between referral source and prior psychiatric care is different for the single clients. Those with some prior psychiatric experience are over twice as likely to be self-referred as those without. Those with no previous mental health treatment are almost four times as likely

to be referred through relatives or friends. Prior psychiatric experience influences choice of referral source for those clients who are divorced or single. For married clients, prior psychiatric treatment is not an important indicator of referral source.

The relationship between referral source and occupational status is not significant when prior psychiatric experience is controlled for (for clients with none X^2=1.58, df=6, p=.95, V=.112; some prior psychiatric care X^2=3.12, df=6, p=.79, V=.132).

Table 16 about here

Information about prior psychiatric experience does not specify any significant relationships between referral source and occupational status.

The relationship between referral source and prior psychiatric treatment is significant, however for those who are not employed (X^2=9.67, df=3, p<.03, V=.377). Fourty-three percent of the unemployed sample, with no prior psychiatric background were referred through relatives or friends while only 19% of those with some prior psychiatric care received these kinds of referrals. Those with no psychiatric history received a higher percentage of professional referrals. Fifty-five percent of those who have received psychiatric treatment in the past were referred through health agencies, while only 19% of those with no past treatment were referred in this way.

Some of the relationships we have seen between referral source and household composition, marital status, and occupational status were due to the relationship between these variables and prior psychiatric experience. Any relationship

between household composition and referral source does not seem to be due to any influence of prior psychiatric experience. Prior psychiatric care is related to the referral source of those living in parental households. This relationship seems to be distinguishing between two different types of persons who would be living in a parental household, those who are young and have not left home yet and those who are too dependent or ill to leave. Marital status is significantly related to referral source only for those with no prior psychiatric experience. For those who are married, prior psychiatric experience is not related to referral source, but it is related to referral source for those who are divorced or single. Prior psychiatric care does not specify any significant relationships between referral source and occupational status. It is significant however for those who are unemployed. This seems to be some kind of division between those who are seeking psychiatric help because of unemployment and those who are unemployed because of psychiatric problems.

This research does indicate interconnections between a person's referral source to the Nord Center and those available to make a referral and prior psychiatric experience. Referral source is not significantly related to age, sex, education, or income of the client. The small sample size may be a factor in this. Further analysis is needed to determine if any relationships are hidden by intervening factors.

Through my research I have attempted to highlight the importance of the process of seeking mental health treatment. The referral source of a client was examined as one aspect of this process. This vital piece of information can help to reveal the reasons a client seeks treatment, the motivation or lack of motivation to improve during treatment, and the resources the client is able to draw upon as an aid to his/her treatment. Through a study of the literature on the subject, class differences clearly emerge as a variable in the usage of referral sources. Other studies have indicated that there are situational differences in what is defined as a mental health problem and what each referral source is equipped to deal with. One model, the internal-external personality construct, may be able to predict certain help seeking patterns, particularly those concerning self-referrals. The professionals I interviewed, in part, confirmed the significance of help seeking behaviors, specifically how the patient was referred. This information plays a particularly relevant role in indicating the client's level of motivation in receiving treatment, and the client's subsequent readiness to accept responsibility in improving his/her condition. Information culled from the Nord Center points to the fact that there exists an interconnection between a person's referral source, the people who are available to make such a referral, and prior psychiatric experience.

The implications of sociological research which examines the methods by which a client reaches psychiatric treatment

can have an impact of the field of mental health. The mental health professional should be fully cognizant of the environment from which a person comes, the people this person associates with and deals with daily, the reasons for seeking help, and any connections between the patterns of help seeking and the needs of the client. The process of obtaining mental health treatment is one possible link in a complex set of interrelated variables relating to mental health treatment in this country. The research I have completed is a starting point. It is an effort to recognize that there is much to be gained from a more complete examination of the referral process. Further research on this topic is needed to specify the information available.

Table 1: Frequency Distributions of Referral Sources

		recoded	
Self	21.5%	Self	21.5%
Relatives	14.2	Relative-friends	30.2
Friends	16.0		
Police or courts	4.3		
Professional sources (schools, clergy, etc.)	0.6	Professional sources	13.0
Community agencies	9.2		
Doctor	19.6		
Hospital	6.1	Health agencies	35.2

n=162

Table 2: Referral source by household composition of the client

Referral	Conjugal	Parental	Rel-Frnd	Alone
Self	23.17%	12.90%	23.52%	35.00%
Rel-Frnd	31.71	25.81	47.06	15.00
Prof Source	15.85	16.13	11.76	--
Health agency	29.27	45.16	17.65	50.00
(n)	(82)	(31)	(17)	(20)

X^2=13.86, df=9, p=.127, V=.175

Table 3: Referral source by marital status of the client

Referral	Married	Divorced	Widow	Single
Self	12.50%	38.10%	37.50%	17.39%
Rel-Frnd	35.94	28.57	12.50	28.26
Prof source	17.19	2.38	12.50	15.22
Health agency	34.38	30.95	37.50	39.13
(n)	(64)	(42)	(8)	(46)

X^2=15.801, df=9, p=.07, V=.181

Table 4: Referral source by Occupational Status

Referral	House-wife	Not employed	Employed
Self	23.52%	20.00%	22.41%
Rel-Frnd	32.35	25.71	34.48
Prof sources	17.65	10.00	13.79
Health agencies	26.47	44.29	29.31
(n)	(34)	(70)	(58)

$X^2=5.06$, df=6, p=.54, V=.125

Table 5: Referral source by Household composition and Marital Status

Referral	for clients who are divorced			
	Conjugal	Parental	Rel-Frnd	Alone
Self	58.82%	--	33.33%	22.22%
Rel-Frnd	29.41	100.00	44.44	11.11
Prof sources	--	--	11.11	--
Health agencies	11.76	--	11.11	66.67
(n)	(17)	(1)	(9)	(9)

X^2=17.24, Df=9, p<.05, V=.400

Table 6: Referral source by Marital Status and Household Composition

Referral	for clients living in conjugal homes			
	Married	Divorced	Widow	Single
Self	13.33%	58.82%	50.00%	--
Rel-Frnd	31.67	29.41	--	66.67
Prof sources	18.33	--	50.00	33.33
Health agencies	36.67	11.76	--	--
(n)	(60)	(17)	(2)	(3)

X^2= 24.31, df=9, p<.004, V=.314

Table 7: Referral source by household composition and Occupational Status

	clients who are not employed			
Referral	Conjugal	Parental	Rel-Frnd	Alone
Self	22.22%	13.64%	8.33%	50.00%
Rel-Frnd	22.22	10.18	58.33	--
Prof sources	11.11	13.64	16.67	--
Health agencies	44.44	54.55	16.67	50.00
(n)	(18)	(22)	(12)	(10)

$X^2=18.31$, df=9, $p<.05$, V=.314

Table 8: Referral Source by Occupational Status and Household Composition

Referral	Clients living in Parental homes: House-wife	Not employed	Employed	Clients living with Relatives or Friend: House-wife	Not employed	Employed
Self	--	13.64%	16.67%	--	8.33%	60.00%
Rel-Frnd	100.00%	18.18	16.67	--	58.33	20.00
Prof sources	--	13.64	33.33	--	16.67	--
Health agencies	--	54.55	33.33	--	16.67	20.00
(n)	(3)	(22)	(6)	--	(12)	(5)

X^2=11.19, df=6, p=.083, V=.425

X^2=5.96, df=3, p=.113, V=.592

Table 9: Referral Source by Marital Status and Occupation

Referral	clients who are employed			
	Married	Divorced	Widow	Single
Self	7.69%	42.11%	100.00%	18.18%
Rel-Frnd	46.15	26.32	--	27.27
Prof sources	19.23	--	--	18.18
Health agencies	26.92	31.58	--	36.36
(n)	(26)	(19)	(1)	(11)

X^2=14.63, df=9, p<.102, V=.292

Table 10: Referral source by Priorpsychiatric Experience

	Prior Treatment	
	None	Some
Referral		
Self	22.22%	20.00%
Rel-Frnd	41.27	24.44
Prof sources	20.63	7.78
Health agencies	15.87	47.78
(n)	(63)	(90)

$X^2=19.01$, df=3, $p<.001$, V=.352

Table 11: Household Composition by Prior Psychiatric Experience

Household Composition	Prior Treatment None	Some
Conjugal	63.24%	50.56%
Parental	20.59	22.47
Rel-Frnd	10.29	13.48
Alone	5.88	13.48
(n)	(68)	(89)

$X^2=3.68$, df=3, p=.30, V=.153

Table 12: Marital Status by Prior Psychiatric Experience

Marital Status	Prior Treatment None	Some
Married	48.57%	37.76%
Divorced	21.43	28.57
Widow	--	6.12
Single	30.00	27.55
(n)	(70)	(98)

$X^2=6.32$, df=3, $p<.10$, V=.194

Table 13: Occupational Status by Prior Psychiatric Experience

Occupation	Prior Treatment None	Some
Housewife	29.58%	17.17%
Not employed	30.99	52.53
Employed	39.44	30.30
(n)	(71)	(99)

$X^2=8.26$, df=2, $p<.02$, V=.220

Table 14: Referral source by Household Composition and Prior Psychiatric Experience

	No Prior Psychiatric Care				Prior Psychiatric Care			
	Married	Divorced	Widow	Single	Married	Divorced	Widow	Single
Referral								
Self	21.05%	9.09%	42.86%	50.00%	22.50%	15.79%	10.00%	33.33%
Rel-Frnd	42.11	54.55	28.57	--	25.00	10.53	60.00	16.67
Prof Sources	18.42	36.36	14.29	--	12.50	5.26	10.00	--
Health Agencies	18.42	--	14.29	50.00	40.00	68.42	20.00	50.00
(n)	(38)	(11)	(7)	(4)	(40)	(19)	(10)	(12)

$X^2=12.88$, df=9, p=.168, V=.268

$X^2=14.57$, df=9, $p<.11$, V=.245

Table 15: Referral Source by Marital Status and Prior Psychiatric Experience

	No Prior Psychiatric Care				Prior Psychiatric Care			
Referral	Married	Divorced	Widow	Single	Married	Divorced	Widow	Single
Self	13.79%	57.14%	--	10.53%	12.12%	28.00%	16.67%	24.00%
Rel-Frnd	44.83	28.57	--	47.37	30.30	32.00	16.67	12.00
Prof Sources	20.69	7.14	--	26.32	12.12	--	16.67	8.00
Health Agencies	20.69	7.14	--	15.79	45.45	40.00	50.00	56.00
(n)	(29)	(14)	--	(19)	(33)	(25)	(6)	(25)
	X^2= 13.07, df=6, p .05, V=.325				X^2=8.81, df=9, p=.45, V=.182			

Table 16: Referral Source by Occupational Status and Prior Psychiatric Experience

	No Prior Psychiatric Care			Prior Psychiatric Care		
Referral	House-wife	Not employed	Employed	House-wife	Not employed	Employed
Self	23.53%	19.05%	24.00%	23.53%	19.15%	19.23%
Rel-Frnd	35.29	42.86	44.00	29.41	19.15	30.77
Prof sources	29.41	19.05	16.00	5.88	6.38	11.54
Health agencies	11.76	19.05	16.00	41.18	55.32	38.46
(n)	(17)	(21)	(25)	(17)	(47)	(26)

X^2=1.58, df=6, p=.95, V=.112

X^2=3.12, df=6, p=.79, V=.132

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