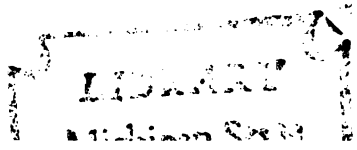

SOCIOCULTURAL FACTORS IN CHILDREN'S EMOTIONAL DISORDERS

by

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THOU I

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CHAPTER I

INTRODUCTION

Social work, as most professional endeavors, has been subject to trends of fashion. Even a casual observation of the profession's history will reveal alternating emphases upon the socio-economic and the psychological aspects of those problems with which the social worker is concerned.

For many years social work appeared to be primarily philanthropic in nature, concerned with the economic needs of the underprivileged. Environmental manipulation only, proved to be inadequate and the treatment of personality difficulties began to be seen as indicated in many situations. Mary Richmond, the most articulate spokesman of the developing profession, in 1922 focused on both aspects of the problem with her comment that "the development of personality through the conscious and comprehensive adjustment of social relationships, and within that field the worker is no more occupied with abnormalities in the individual than in the environment, is no more able to neglect one than the other."[1]

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[1]Mary Richmond, What Is Social Casework (New York: Russell Sage Foundation, 1922), pp. 98-99.

When psychoanalytic knowledge became available a few years later, the profession, therefore, was well prepared to receive it. In fact, there generally seemed a tendency to overemphasize the new approach, frequently to such point that consideration of social factors was almost totally neglected.

During the past few years the trend has been toward rediscovering the "social," combined with an attempt to integrate psychoanalytic factors into a social work approach. The behavioral sciences, through personality-in-culture research, have begun to furnish scientific data concerning the individual's use of his environment and the impact of culture upon his personality.[2] This theory favors an approach which considers the "whole person in his total environment" and serves as a strong reminder that people do not interact and develop personality disorders in a social vacuum.

The need for integration of social and psychological data in social work appears now to be generally recognized by the profession. Perhaps the most comprehensive investigation to date--and that most pertinent to the development of our study--is that of Otto Pollak and collaborators.

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[2]For example: Ralph Linton, The Cultural Background of Personality (New York: Appleton, 1945); Erik H. Erikson, Childhood and Society (New York: Norton, 1950); Abram Kardiner, The Psychological Frontiers of Society (New York: Columbia University Press, 1945).

This was an attempt, supported by the Russell Sage Foundation, to integrate social and psychological data and principles within a psychoanalytically oriented child guidance clinic.[3]

Dr. Pollak's central hypothesis suggests that the diagnostic and therapeutic capabilities in a child guidance clinic would be substantially increased by the effective application of selected social science concepts and approaches. During the first phase of the investigation, the hypothesis was found to be sufficiently plausible to warrant further exploration of these approaches in the diagnosis and treatment of cases assigned to a special therapeutic team. The material secured during a second phase seemed generally to support the hypothesis. As a result of this study Pollak and collaborators found themselves constrained to modify both sets of concepts, those from social science and those from psychoanalysis and to develop a situational-interactional approach.[4]

The present study is a modest attempt to investigate the effects of environmental conditions on children's emotional disorders. The setting is a child guidance clinic in a medium sized midwestern community. The study is based

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[3]Otto Pollak and Collaborators, Social Science and Psychotherapy for Children (New York: Russell Sage Foundation, 1952); and Integrating Sociological and Psychoanalytic Concepts (New York: Russell Sage Foundation, 1956).

[4]Pollak and Collaborators, Integrating Sociological and Psychoanalytic Concepts, op. cit., pp. v-vi.

on case records of children who were subjects of a diagnostic study by the clinic during the year 1956. Inasmuch as extensive behavioral data were not systematically recorded and are therefore not comparable on a case to case basis, the study is necessarily limited to a consideration of such demographic data as are usually included on the face sheet, and the psychiatric, psychological, and social findings of clinic personnel.

Related Research

Studies relevant to our project may be divided into three categories: (1) those concerned with the relation of parental orientations to emotional disorders; (2) those dealing with the effects of socio-cultural factors on parental orientations; and (3) those relating children's disturbances to socio-cultural factors.

Among the first group of studies is that by Shirley Law[5] based on data obtained at the Child Study Center, Institute of the Pennsylvania Hospital, Philadelphia. Law compared two groups of children and their mothers; a clinic group of disturbed children and a group of normal nursery school children. She found that the mothers of both groups demonstrated a capacity for love and warmth for their children; at the same time, both experienced difficulties

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[5]Shirley Law, "The Mother of the Happy Child," Smith College Studies in Social Work, XXV, No. 1 (October, 1954), pp. 1-27.

of one sort or another with their children. However, the mothers of children in the clinic group were blocked and limited in their acceptance of the child, and seemed unsure of themselves. The mother of the "happy child" seemed, by comparison, more able to see her child as an individual, to take pride in his growth and achievements, and to feel comfortable in her role as a mother.

Using a group of much more severly disturbed children, James McKeown[6] made a study of the behavior of parents of schizophrenic, neurotic, and normal children. He found that the parents of the disturbed children were distinguished by "demanding-antagonistic" behavior. The parents of the normal children were much more encouraging and much less "demanding-antagonistic"; they were less "superficial" and "protective-indulgent" than the parents of disturbed children.[7]

A well-known study of the second type--relating parental orientations to socio-cultural variables--is that

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[6]James McKeown, "The Behavior of Parents of Schizophrenic, Neurotic, and Normal Children," American Journal of Sociology, LVI, 1950, pp. 175-179.

[7]See also Melvin L. Kohn and John A. Clausen, "Parental Authority Behavior and Schizophrenia," American Journal of Orthopsychiatry, XXVI, No. 2 (April, 1956), 297-313; Nathan W. Ackerman, "Disturbances of Mothering and Criteria for Treatment," American Journal of Orthopsychiatry, XXXVI, No. 2 (April, 1956), 252-263.

by Allison Davis and Robert Havighurst.[8] These two investigators found, in a large city, significant differences in child rearing practices between parents belonging to the middle and lower classes as well as between white and Negro parents; the same class differences in child rearing practices were found among both the Negro and the white groups. Middle class parents were

> more rigorous in their training of children for feeding and cleanliness habits. They also expect their children to take responsibility for themselves earlier than lower class parents do. Middle class parents place their children under a stricter regimen, with more frustration of their impulses than do lower class parents.[9]

The child rearing differences found to exist between white and Negro families related chiefly to the particular segments of behavior which received the most attention from the parents. Negroes were more permissive in feeding and weaning, but more rigorous in toilet training.

A study of attitudes of middle class fathers (which however lacks any comparison with fathers from other social groups) was done by David F. Aberle and Kaspar D. Naegele.[10] They found that most of the middle class fathers expected their sons to stay within their own occupational status

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[8]Allison Davis and Robert J. Havighurst, "Social Class and Color Differences in Child-Rearing," American Sociological Review, II, No. 6 (December, 1946), 698-710.

[9]Ibid., p. 710.

[10]David F. Aberle and Kaspar D. Naegele, "Middle-Class Fathers 'Occupational Role and Attitudes Toward Children," American Journal of Orthopsychiatry, XXII,No. 2 (April,1952) 366-378.

class. Accordingly, their primary interest was in the socialization of the children, particularly the sons. Almost all of the fathers were concerned with securing obedience and were annoyed at disobedience. However, marked differences were shown to exist in the fathers' expectations regarding boys and girls. Nearly all fathers desired their sons to be responsible, to show initiative, to be competent and to be aggressive and capable of handling competition. While these qualities were not considered undesirable in girls, they were much less important, and the fathers appeared to be much more interested in the girls' generally "nice" appearance and behavior.

Among the studies of the third type--dealing with the relationship between emotional disorders and socio-cultural factors--that by August B. Hollingshead and Frederick C. Redlich[11] dealt with the interrelationship between mental illness and class structure. The authors discovered that, in the community under study, various types of mental illnesses were unequally distributed among social classes. It was found that there was in the lower classes, a higher incidence of mental illness than in the higher classes. The higher classes tended toward phychoneuroses, the lower classes toward psychoses; and the proportion of schizoprenics was larger in the lower than in the higher classes.

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[11]August B. Hollingshead and Frederick C. Redlich, "Social Stratification and Psychiatric Disorders," Mental Health and Mental Disorder, ed. Arnold M. Rose (New York: W. W. Norton, 1955), pp. 123-135.

A similar study is that by Robert M. Frumkin,[12] who investigated the relationship between occupation and incidence of major mental disorders. The study showed a high rate of mental illness among low income, low prestige and low socio-economic status groups. First admissions to Ohio state mental hospitals during the year 1950 were used to compute the relevant indices. Frumkin further found that, among the lower occupational groups, the onset of mental illness was due primarily to sociogenic factors; in the upper occupations, psychogenic factors were more frequently responsible for mental disorders.

Sylvia Stevens,[13] in a study of child guidance intake in Chicago, investigated the relationship between income strata and those symptoms which had led to the child's referral. "Acting out" children were found to be evenly distributed among three income groups, while withdrawn children were found most frequently in the upper socio-economic group.

In a highly suggestive article, Arnold W. Green[14] describes the neuroses typical of the male middle class child. Green thinks that the middle class boy is caught in

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[12]Robert M. Frumkin, "Occupation and Major Mental Disorders," Mental Health and Mental Disorder, ed. Arnold M. Rose (New York: W. W. Norton, 1955), pp. 136-160.

[13]Sylvia Stevens, "An Ecological Study of Child Guidance Intake," Smith College Studies in Social Work, XXV, No. 1 (October, 1954), 73-84.

[14]Arnold W. Green, "The Middle-Class Male Child and Neurosis," American Sociological Review, II, No. 1 (February, 1946), 31-41.

a dilemma which prevents his forming an adequate self-concept. He must placate his parents by compliant behavior in the home; at the same time, aggressive, competitive, achievement-orientated behavior outside the home is also expected of him. This conflict results in "personality absorption," a neurosis consisting in "slavish dependence on the parents."[15]

While the studies cited in the foregoing paragraphs suggest the existence of some relationships between the investigated variables, very little can be said about the precise nature of such relationships. Neither the concepts nor the types of cases used by the various researchers are sufficiently similar to permit the development of generalizations. The only proposition asserted repeatedly in several studies is that middle class parents exert greater pressure to make their children conform and reach a high level of achievement. This is sometimes thought to generate a particular kind of neurotic reaction on the part of the child, but the specific nature of such reactions is not described. Researchers dealing with the more severe types of disturbances fail to establish categories comparable to those applying to less disturbed patients; that is, there is very little similarity between the classification

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[15]See also Paul Barrabee and Otto Von Mering, "Ethnic Variations in Mental Stress in Families with Psychotic Children," Social Problems, October, 1953, pp. 48-53.

systems used to describe disorders of varying degrees of severity. Consequently, it is not possible to generalize from findings which relate types of psychotic disturbances to socio-cultural factors.

In 1949, Jules Henry[16] called for "cultural objectification of the case history"; by this he meant that the analysis of case records should be approached in a manner which would minimize the culturally generated prejudices of the investigator. Such analyses would yield a deeper insight into the workings of our own culture and into the hazards to mental health present in our society. Henry is not alone in making such pleas. Yet, the studies of cultural factors in mental disorders are still few in number; they are often limited in scope, segmental in problem formulation, and idiosyncratic in the researcher's choice of categories.

Under these circumstances, it was not possible to formulate precise hypotheses to govern this research. Instead, two broad questions can be formulated:

1. Is parental orientation, that is, the behavior and attitudes of parents toward their children, an intervening variable mediating between broad socio-cultural variables and children's emotional disorders? Or does the

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[16]Jules Henry, "Cultural Objectification of the Case History," American Journal of Orthopsychiatry, XIX, No. 4 October, 1949), 655-673.

culture, as represented by the child's entire social environment, directly generate the types of disorders found in children?

2. Are there invariant relationships between types of environmental factors of a socio-cultural nature and types of disorders? And if so, are there general societal factors which have the same effects as do certain types of parental orientations?

In view of the limited nature of the data available for this study, no complete answer to such questions can be expected. The present study is exploratory in nature, and we can hope for no more than certain indications which might make further researches in this area more fruitful.

The Setting

This study was made at the Lansing Child Guidance Clinic, a joint state and local project serving four counties, Ingham, Clinton, Eaton, and Livingston. The clinic is supported by the State Department of Mental Health and such various local agencies as community chests, boards, of education, and boards of supervisors.

The Clinic, originally known as the Lansing Children's Center, Incorporated, was established in 1938 by the Ingham County Council of Social Welfare. It later became a part of the state mental health program with the function of providing services to children who are suffering from emotional disturbances. These services are currently

divided into two components, the diagnostic study and clinical treatment. During the year 1956, in the total Clinic case load of 486 cases, 257 children received diagnostic study only and 125 received treatment.

After a child has been referred to the Clinic, a diagnostic study is made of his personality and total environment. His parents, who are interviewed by a social worker, furnish information concerning the child's past history and present situation, including much material covering their own personalities and motivations in their relationship with the child. The child is interviewed by the psychiatrist and given psychological tests by a psychologist. Both of these interviews attempt to assess the child's problems and his capacity to gain help through treatment. The various facets of information described above, plus any pertinent material furnished by other sources such as the school or physician, are pooled at a staff conference at which time the staff evaluates the nature of the difficulty and determines whether clinic treatment is indicated for the child and his parents.

When a child and his parents are accepted for treatment, each is seen for weekly appointments. The child is helped both to satisfy his needs in the therapeutic situation and to learn to satisfy these needs in more socially acceptable ways. Parents begin to recognize their own

feelings and the way these affect their relationship with the child. If treatment is successful they become able to modify their feelings to the benefit of both the child and themselves.

CHAPTER II

METHODOLOGY

Selection of Cases for Study

In order that the study might be relatively current, material was drawn from cases opened (or reopened) during the period January-December, 1956. A total of 328 cases was opened. A sample of approximately 150 cases had been planned as it was hoped that such a number would be large enough to produce statistically significant results--although it was realized that such a small number would place severe limitations on the reliability of information drawn from any complex cross tabulations--and yet not be too large to be handled within the allotted time. A sample of alternate cases on a monthly basis was selected. Both new and reopened cases were included in the sample if a diagnostic study had been requested during the year 1956.

A total sample of 168 cases was selected. Of these, twenty-four were later rejected: six because of insufficient information due to parental failure to follow through to the completion of the diagnostic study. The remainder were children living outside their own homes so that information concerning parental social status and orientations toward the children was not available. Adoptive children and

children living in a home situation with a step parent were included in the study since we considered the adoptive parents and step parents to be playing the parental roles. The final sample consisted of 144 cases.

Collection of Data

The data for this study were secured from the case records of the Lansing Child Guidance Clinic. Ideally, it should have been possible to secure all designated information from two sources within the case record, the face sheet and the staff conference notes. The face sheet was expected to supply the demographic data and the staff conference notes the material concerning parental orientations and the children's disorders. However, these two primary sources were frequently so incomplete as to necessitate the use of additional sources, especially the intake interview, the psychiatric evaluation and the psychological report. In a number of cases however, some of the designated material, especially that of demographic nature, was not recorded any place in the case record. Consequently, desired information on specific points often could not be obtained. For some tables presented in this study, therefore, the number of cases dealing with relevant information may be considerably less than the total sample.

The data were coded directly on schedules or code sheets designed for International Business Machines [IBM]

processing. Coded information was then punched on IBM cards and tabulated by means of a counter-sorter.

Preparation of the Schedule

The schedule included 16 different items of information relevant to the study. The first four of these were concerned with the descriptive factors of age, sex, intelligence quotient[1] and number of siblings. The age breaks used were those customarily employed by the Clinic in its statistical reports. IQ was classified according to the Wechler Intelligence Scale. When the IQ was recorded descriptively, for example, "dull normal," we coded it in the appropriate numerical category. The number of siblings category was divided into only child, one sibling, more than one sibling, as a more detailed classification did not appear indicated for purposes of this study.

In classifying children's emotional disorders and parental orientations we have made every effort to adhere as closely as possible to the diagnoses and judgments of the clinicians and to avoid injecting our own evaluations. Only in a small number of cases in which the records did not directly refer to categories used in this study were we forced to interpret appropriately the language of the record.

Classification of the children's emotional disturbances was made originally in two different ways. The first consisted of the simple and frequently employed dichotomy

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[1]Hereafter referred to as IQ.

of "acting out" in which the child's symptoms appear to center in socially unacceptable behavior and "withdrawn" or personality reactions. However, as the schedule was tested we found that the behavior of some of the children seemed characterized by a combination of acting out followed by a period of withdrawal. Since alternating acting out-withdrawn behavior seemed to occur when the child was more severely disturbed this characteristic was added as a third category.

Also, a three point "degree of severity" scale was added as a separate item. The degree of severity was determined from material in the psychological report and the psychiatric evaluation. A child who seemed to be reacting to an unfavorable environment while remaining generally healthy was coded as "essentially healthy." Children whose grasp on reality appeared tenuous, either through withdrawal into fantasy or through inability to control their actions were coded as "severely disturbed." All of those cases in which hospitalization was recommended were coded as 3's. The number 2, or mid point included the majority of children whose behavior disturbances appeared primarily reactive. In order not to weight unduly the number 3 position on the scale, those children for whom hospitalization was recommended because of defects due to organic injury or mental deficiency, were placed in separate code categories.

The second classification of emotional disturbances was based on the American Psychiatric Association classification of primary behavior disorders: habit disturbances, conduct disturbances and neurotic traits.[2] Habit disturbances include such symptomatic manifestations as thumb-sucking, nail biting, masturbation, enuresis, tantrums. Conduct disturbances include such anti-social acts as destructiveness, cruelty, disobedience, setting fires, stealing, etc. Neurotic traits, include such symptoms as stammering, overactivity and fears. Since we believed the majority of children to be referred to the Clinic because of either habit or conduct disturbances, these two categories were employed as defined by the American Psychiatric Association. The category "neurotic traits" however, was expanded, for purposes of this study to include additional nonsurface symptoms, for example, psychosomatic manifestations, and designated in the schedule as "nonsurface symptoms." Moreover, since we knew that many of the children referred to the Clinic displayed more than one type of symptom, categories consisting of combinations of the above simple classifications were added.

There was necessarily a great deal of overlap between the two classifications of children's emotional disorders.

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[2]American Psychiatric Association, Diagnostic and Statistical Manual (Washington: American Psychiatric Association, Mental Hospital Service, 1952).

The extent of this overlap is shown in Table 1.

TABLE 1

CHILDREN'S EMOTIONAL DISORDERS CLASSIFICATION I
BY
CHILDREN'S EMOTIONAL DISORDERS CLASSIFICATION II
(in per cent)

Disorders-Class II		Disorders-Class I		
	Total* (N=134)	Acting Out (N=62)	With-drawn (N=52)	Acting Out Withdrawn Alternating (N=20)
Nonsurface	7	2	15	0
Habit	6	3	11	0
Conduct	7	16	0	0
Nonsurface and habit	24	5	58	0
Habit and conduct	24	37	4	35
Nonsurface and conduct	21	26	8	40
Nonsurface, habit, conduct	10	11	4	20
Not ascertained**	1	0	0	5
Total	100	100	100	100

*Seven defective children and three whose disorders were not ascertained have been omitted from this table.

**Hereafter referred to as N. A.

According to these data, children described as "acting out" most frequently have a combination of habit and conduct disturbances and, in order of decreasing frequency, combinations of nonsurface and conduct disorders or conduct disturbances alone. Children described as "withdrawn" have mostly a combination of nonsurface and habit disturbances,

and much less frequently nonsurface or habit disturbances alone. The observations yield some insight into the meaning of "withdrawn" and "acting out" in terms of somewhat more concrete symptom complexes. The decisive element in the clinician's decision to describe a child as "acting out" or "withdrawn" seems to be the extent to which conduct disturbances are apparent. This can be seen more clearly in Table 2, which shows percentages of children displaying nonsurface, habit and conduct symptoms irrespective of whether these symptoms occur alone or in combinations with other symptoms.

TABLE 2

TYPES OF CHILDREN'S EMOTIONAL DISORDERS BY SYMPTOMS (in per cent*)

Disorders	Acting Out	Withdrawn	Alternately Withdrawn and Acting Out
Nonsurface	44	85	60
Habit	56	77	55
Conduct	80	16	95

*Percentages add to more than 100 since many children had more than one symptom.

Among the children who were acting out, 80 per cent displayed conduct disturbances either alone or in combination with other symptoms. Ninety-five per cent of the children who alternated between withdrawn and acting out episodes had the same symptom. But only 16 per cent of the children

classified as withdrawn had some conduct disturbance. While the highest proportions of nonsurface and habit problems occur among the withdrawn children, the differences between this and the other two groups are not nearly so large. It would appear, then, that clinicians tend to classify a child as "acting out" if he displays some conduct disturbance.

The two items, "father's orientation toward child" and "mother's orientation toward child," indicate in general terms the principal parental attitudes toward the child. These categories were developed as concepts of those attitudes described in the case records, and were derived from such material as the child's perception of his parents as shown in his responses, as well as the social worker's impressions of the parental attitudes based on the intake information. The category "accepting" covers those orientations in which the parent seems to have warm feelings toward his child as an individual and accepts the child's right to be himself. "Rejecting" implies that the parent does not like or want the child. "Permissive" as we are using the word may be equated with overindulgent. The "controlling" parent is one who seems to need to regulate his child according to a specific pattern without considering the child's particular personality and needs. The category "inconsistent" refers to any combination of the four categories described above.

The remaining seven items, primary breadwinner, Father's and Mother's occupation and education, parents'

religion and ethnic identification, were those cultural factors of the child's family environment most available for examination. "Primary breadwinner" identifies the major source of income to the family. In order that our categories might be large enough to test for statistical significance the second occupational group was expanded beyond that of the census classification to include all "white collar" personnel who would not fall into the professional and managerial classification, and also persons employed in public or quasi-public service. The category "blue collar" includes all non-white collar factory employees and those persons doing comparable work in other settings. Skilled and unskilled workers are generally classified separately; however, such a division could not be considered in this study as detailed occupational information was rarely available in the case records.

CHAPTER III

ANALYSIS OF DATA

Characteristics of Sample

The sample included 106 boys and 38 girls. In age, these cases varied from pre-school children to high school students. In three of the five age groups, boys constituted about 80 per cent of the total; but in the group of 6-8 year old, boys accounted for only two-thirds of the total, and in the 15-18 year group, the number of boys only slightly exceeded that of girls. [See Table 3]

TABLE 3

CHILDREN'S AGE BY SEX
(in per cent)

Sex	Age					
	Total (N=144)	1-5 (N=22)	6-8 (N=33)	9-11 (N=37)	12-14 (N=35)	15-18 (N=16)
Male	74	82	65	78	80	56
Female	26	18	35	22	20	44
Total	100	100	100	100	100	100

The children's intelligence quotients ranged from defective to superior. In 46 cases the I Q was below average, in 48 it was average, and in 29 above average. Table 4 shows a positive relationship between the IQ's of children

and the social status of the family as described by the occupation of the primary breadwinner. For the 3 x 3 table from which all cases not ascertained have been excluded, chi-square is 20.0, which is significant beyond the .001 level. The contingency coefficient is .39 (the upper limit of the coefficient for the 3 x 3 table being .87).

TABLE 4

OCCUPATION OF PRIMARY BREADWINNER BY CHILDREN'S IQ
(in per cent)

IQ	Total (N=144)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar Farmer (N=73)	Other & N.A. (N=13)
Below Average	32	10	23	42	39
Average	33	36	28	36	31
Above Average	20	46	30	8	15
N. A.	15	9	19	14	15
Total	100	101	100	100	100

Almost all of the children were white of European descent; only two of the children were Negro, and two American Indian.

Parental occupations varied from professional to chronic unemployment, and education from grade school to postgraduate college training. There tended to be a fairly close relationship between the educational levels reached by husbands and wives, as can be seen in Table 5. The

TABLE 5

MOTHERS' EDUCATION BY FATHERS' EDUCATION
(in per cent)

Fathers' Education	Mother's Education							
	Total (N=144)	Less Than 8th (N=0)	8th Grade (N=8)	Some High School (N=33)	High School Graduate (N=27)	Some College (N=12)	College Graduate (N=9)	N.A. (N=55)
Less than 8th grade	7	0	25	12	12	0	0	2
8th grade	10	0	37	24	7	0	0	2
Some high school	15	0	13	30	26	16	0	2
High school graduate	19	0	13	18	37	34	11	9
Some College	3	0	0	3	4	8	11	2
College graduate	12	0	0	3	7	34	78	5
N. A.	34	0	13	9	7	8	0	78
Total	100	0	101	99	100	100	100	100

father's education was generally consistent with his occupational status.

If we count only those whose educational level could be ascertained, we find that 83 per cent of the fathers in the white collar groups had at least a high school diploma, while 74 per cent of the fathers in the blue collar group had not been graduated from high school.

Eleven of the cases were only children, 36 had one sibling, and 97 more than one sibling. The number of children per family varied slightly with the main breadwinner's type of occupation. Two children were most frequent among professional families (41 per cent), while clerical and sales and blue collar families tended to be larger (69 and 66 per cent respectively). [See Table 6.] In our sample, the clerical and sales group had the highest proportion of boys (81 per cent), while the proportion of boys in the other groups tended to be about 10 per cent lower. [See Table 7.]

Thirty-two of the mothers were employed, the remaining 112 being housewives. Gainful employment tended to be somewhat more frequent among mothers of higher educational achievement. The mothers' employment status bears no relationship to the sex of the children or to their intelligent quotients.

Nineteen of the families in the sample were Catholic, 91 were Protestant, one was mixed, and in 33 cases religious

TABLE 6

OCCUPATION OF PRIMARY BREADWINNER BY NUMBER OF SIBLINGS
(in per cent)

Siblings	Total* (N=124)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar (N=66)
Only child	8	5	3	12
1 sibling	27	41	28	21
More than 1 sibling	65	54	69	66
N. A.	0	0	0	0
Total	100	100	100	99

*Twenty cases were omitted from this table. These include 7 farmers, 10 "other" occupations and 3 cases in which occupation could not be ascertained.

TABLE 7

OCCUPATION OF PRIMARY BREADWINNER BY CHILDREN'S SEX
(in per cent)

Sex	Total* (N=124)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar (N=66)
Male	73	73	81	70
Female	27	27	19	30
Total	100	100	100	100

*See footnote to table 6.

TABLE 8

PARENTS' RELIGIOUS PREFERENCE BY NUMBER OF SIBLINGS
(Catholic and Protestant Only*)
(in per cent)

Siblings	Total (N=110)	Catholic (N=19)	Protestant (N=91)
Only child	6	5	6
1 sibling	26	21	26
More than 1 sibling	68	74	67
Total	100	100	100

*Cases in which religion could not be ascertained are not included. The single case of a mixed marriage is also excluded from this table.

preference had not been recorded. As Table 8 shows, religious preference had very little bearing on family sizes. Within occupational groups, there were no differences in the proportion of Catholics (14 per cent), nor was there any appreciable difference in the proportion of working mothers in Protestant and in Catholic families.

The absence of relationships between religious preference and such variables as family size and occupation points to a certain amount of homogeneity in the sample. One might have expected a smaller proportion of small families among Catholics; and it is usually assumed that the Catholic groups, being of southern European origin, would tend toward the lower end of the occupational scale. While

such relationships may apply to the general local population, they do not hold for the Clinic group. Some selective factor may insure a certain amount of homogeneity among families that bring their children to the Clinic. Because of this, religious preference and occupational status can be treated as factors independent of one another.

The ways in which socio-cultural factors may lead to varying types of emotional disorders in children may be direct or indirect. A direct relationship would exist if the type of disorder could be shown to be ascribable to the total social environment of the child, for example, to the character of the neighborhood, of peer-groups, of the extended as well as the nuclear family, and of the school. The relationship would be indirect if disorders were shown to depend chiefly on the attitudes and behavior of the parents and if, in turn, such parental orientations were a result of socio-cultural conditions. Our data do not contain any evidence concerning the general social environment of the children. Such tentative conclusions as we will have to present regarding the direct effects of socio-cultural factors on children's disorders will therefore have to be inferential. We thus turn first to a consideration of the indirect influences of socio-cultural factors on children's disturbances.

Parental Orientations and Emotional Disorders

The question may be raised whether in given families, the orientations of fathers and mothers toward their children, tend to be similar or dissimilar. If the latter, we would have to deal not merely with the effects of various kinds of parental orientations but also with the effects of disparities in the orientations of the two parents. In Table 9 mothers' and fathers' orientations have been related to each other. The most frequent types of orientation

TABLE 9

MOTHERS' ORIENTATIONS TOWARD CHILDREN BY FATHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Fathers' Orientations	Mothers' Orientations				
	Total (N=144)	Rejecting (N=33)	Controlling (N=34)	Inconsistent (N=54)	All Other and N. A (N=23)
Rejecting	27	58	12	24	13
Controlling	26	9	56	19	22
Inconsistent	19	12	3	35	17
All other and N. A.	28	21	29	22	48
Total	100	100	100	100	100

toward the Clinic children by their parents are rejection, over-control, and inconsistency. Other types of orientation (accepting and overly permissive) have been lumped with ten cases of absent fathers, two cases of absent mothers and

seven cases in which the orientations of either or both parents could not be ascertained. The resulting table shows a fairly close relationship between the orientations of fathers and mothers. Chi-square for 9 degrees of freedom is 45.1, and the probability that the two orientation variables are independent of each other is considerably below 1 in 1,000. The contingency coefficient for this table is .49, the upper limit of the coefficient being .87 for the 4 x 4 table.

Aside from the "other" category, in which a strong relationship between the two parental orientations cannot be expected, the largest amount of disparity between parental orientations occurs in the column which refers to inconsistent mothers. One-third of the children with inconsistent mothers have inconsistent fathers, the remaining two-thirds may have fathers with any other types of orientations. This combination between inconsistency and other orientations probably has a similar effect on the child as inconsistency on the part of both parents; in either event, the child lives in a rather unpredictable family environment. Moreover, we will show below that the mothers' orientations tend to have greater effects on children's disorders than do those of the fathers'; consequently, the controlling or rejecting husband of an inconsistent mother is likely to add to the complexity of a child's world rather than to exercise a steadying influence.

Table 10 shows that the children of inconsistent mothers are most likely to display disturbances which we describe as "acting out." Fifty-six per cent of such children fall into this category, while only 28 per cent are withdrawn. There is also a tendency for children rejected or strongly controlled by their mothers to be withdrawn. The difference in proportions of children acting out is at the 1 per cent level of significance[1] between the inconsistently treated and the rejected group, and comes close to the same significant level between the inconsistently treated and the controlled children. For withdrawn children, the significance of the difference in proportions of controlled and inconsistently treated children is also at the 1 per cent level, that between rejected and inconsistently treated children at the 5 per cent level. There are no significant differences in the proportions of children in the controlled and rejected categories.

The orientations of fathers toward their children have effects similar to those of mothers. Among children

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[1]Significance of difference between percentages was tested by means of Vernon Davies' Tables Showing Significance of Differences Between Percentages and Between Means (Pullman: State College of Washington, Stations Circular No. 151, June, 1951). These tables are based on the t-test and are for groups of equal size. Errors resulting from the fact that the groups in our sample were unequal in size are on the "conservative" side, i. e. they result in slight overestimates of minimum differences required for significance. Since our sample was constituted of a large proportion of the total population (50%) a correction for finite population was applied.

TABLE 10

MOTHERS' ORIENTATIONS TOWARD CHILDREN BY DISORDERS
CLASSIFICATION I
(in per cent)

Disorders - Class. I	Total (N=144)	Rejecting (N=33)	Controlling (N=34)	Inconsistent (N=54)	Other* (N=16)	N.A. (N=7)
Acting out	43	33	38	56	44	14
Withdrawn	36	46	50	28	25	14
Acting out--withdrawn alternating	14	12	12	13	19	29
Defective	5	6	0	2	12	29
N. A.	2	3	0	2	0	14
Total	100	100	100	101	100	100

*"Other" includes 10 cases in which the mothers were accepting, 4 with permissive mothers and 2 in which the mothers were absent.

inconsistently treated by their fathers, 61 per cent are acting out, 14 per cent are withdrawn, and 21 per cent alternate between withdrawing and acting out. But there is no clear predominance of the withdrawing or acting out responses among children whose fathers' orientations are rejecting or controlling. As Table 10 shows, about half of the children with rejecting or controlling mothers were likely to withdraw, while about one-third of them tended to act out. There is a slight indication in Table 11 that children of controlling fathers similarly tend to withdraw, but this is not true for children of rejecting fathers. As in the table relating maternal orientations to children's disorders, the differences in proportions of withdrawing and acting out children are significant (most of them at the 1 per cent level), as between the inconsistent group on the one hand and each of the other two groups on the other.

When we consider the relationship between parental orientations and more specific symptoms of emotional disturbance in children, the observed differences are much smaller in magnitude. As Table 12 shows, the children of inconsistent mothers tend to display a combination of habit and conduct disturbances, while overly controlled children are more likely to suffer from nonsurface and habit disturbances. In either case, something over one-third of the children are affected by these particular combinations of symptoms. Table 13 shows that the same prevalence of the

TABLE 11

FATHERS' ORIENTATIONS TOWARD CHILDREN BY DISORDERS
CLASSIFICATION I
(in per cent)

Disorders - Class. I	Total (N=144)	Rejecting (N=39)	Controlling (N=37)	Inconsistent (N=28)	Other* (N=28)	N.A. (N=12)
Acting out	43	44	35	61	43	25
Withdrawn	36	36	41	14	43	58
Acting out--withdrawn alternating	14	8	19	21	10	8
Defective	5	8	3	4	4	8
N. A.	2	5	3	0	0	0
Total	100	101	101	100	100	99

*"Other" includes 14 cases in which the fathers were accepting, 4 with permissive fathers and 10 in which the fathers were absent.

TABLE 12

MOTHERS' ORIENTATIONS TOWARD CHILDREN BY DISORDERS
CLASSIFICATION II
(in per cent)

Disorders - Class. II	Total (N=144)	Rejecting (N=33)	Controlling (N=34)	Inconsistent (N=54)	Other* (N=16)	N.A. (N=7)
Nonsurface	10	9	6	9	13	29
Habit	6	12	3	4	6	14
Conduct	7	9	6	6	12	0
Nonsurface and habit	23	21	38	15	25	14
Habit and conduct	22	9	21	35	13	14
Nonsurface and conduct	20	18	24	20	19	14
Nonsurface, habit, conduct	11	21	3	11	6	14
N. A.	1	0	0	0	6	0
Total	100	99	101	100	100	99

*See footnote to Table 10.

TABLE 13

FATHERS' ORIENTATIONS TOWARD CHILDREN BY DISORDERS
CLASSIFICATION II
(in per cent)

Disorders - Class. II	Total (N=144)	Rejecting (N=39)	Controlling (N=37)	Inconsistent (N=28)	Other* (N=28)	N.A. (N=12)
Nonsurface	10	10	8	7	14	8
Habit	6	13	5	0	4	8
Conduct	7	3	5	7	14	8
Nonsurface and habit	23	15	41	14	18	25
Habit and Conduct	22	21	19	36	18	17
Nonsurface and conduct	20	21	22	25	14	17
Nonsurface, habit, conduct	11	18	0	11	14	17
N. A.	1	0	0	0	4	0
Total	100	101	100	100	100	100

*See footnote to Table 11.

two symptom combinations holds for children of inconsistent and controlling fathers. Among children of rejecting fathers and mothers, habit and nonsurface disturbances, either separately or in combination with each other, tend to prevail. All differences in proportions of children with the symptom combinations just mentioned are significant at the 1 per cent level as between the inconsistently treated and the other two groups, and at the 5 per cent level as between the rejected and the controlled groups.

The incidence of conduct disturbances is evidently highest among children of inconsistent parents. If we lump all code categories referring to conduct disturbances alone or in combination with other disturbances, we find that 72 per cent of the children of inconsistent mothers have some conduct disturbance, while 57 and 54 per cent, respectively, of the rejecting and controlling mothers have such symptoms. The relationship of conduct disturbances to the fathers' orientations is slightly stronger: 79 per cent of all children of inconsistent fathers have some conduct disturbance, as against 46 per cent of the controlled children. However, as many as 63 per cent of children rejected by their fathers have conduct disturbances. With respect to this last finding, it will be recalled from Table 9 that the combination between a rejecting father and an inconsistent mother was not an infrequent one. The fairly high proportion of conduct disturbances among children

of rejecting fathers may be ascribable to the fairly high proportion of inconsistent mothers in this group.

The relationships thus far found between parental orientations and children's disturbances are those one would expect. The child receiving an exaggerated amount of parental control is hindered in self-expression. To the extent that such control is frustrating and harmful, the child's escape is to withdraw into his inner world. The rejected child cannot, by his behavior, affect the behavior of the parent; he has nothing to "gain" from acting out, and withdrawal is therefore a usual reaction. However, he is not as strongly inhibited in expressing himself as is the overly controlled child. We find a somewhat higher incidence of conduct disturbances, especially--it would seem--among children whose father is controlling while the mother is inconsistent. Children of inconsistent parents act out partly because they are able, by so doing, to "get a reaction out of" their parents and partly because the alternation of periods of parental control and permissiveness gives them a chance to express hostilities whenever the parents are in a permissive mood.

As may be seen in Table 14 children of rejecting mothers show, as expected, the greatest amount of disturbance; 52 per cent of such children had to be classified as severely distrubed, while 33 per cent were only moderately disturbed. Among children of controlling mothers, less

TABLE 14

MOTHERS' ORIENTATIONS TOWARD CHILDREN BY SEVERITY OF DISORDERS
(in per cent)

Severity	Total (N=144)	Rejecting (N=33)	Controlling (N=34)	Inconsistent (N=54)	Other* (N=16)	N.A. (N=7)
Essentially healthy	7	6	6	9	6	0
Moderately disturbed	49	33	62	57	38	14
Very disturbed	32	52	32	24	19	29
Defective	11	9	0	9	31	43
N. A.	1	0	0	0	6	14
Total	100	100	100	99	100	100

*See footnote to Table 10.

than one-third were severely disturbed, and among children of inconsistent mothers, less than one-quarter. The differences between the rejected and the inconsistent group are significant at the 1 per cent level of confidence. Those between the rejected and the controlled group are significant at the 5 per cent level.

The effects of paternal orientations on the severity of children's disturbances are not as clear as those of maternal orientations. [See Table 15.] Slightly over one-third of the children rejected or inconsistently treated by their fathers show severe disturbances; and where the fathers' orientation is controlling less than one-quarter of the children have severe symptoms. The significance of the difference between the rejected and the highly controlled children here does not quite reach the 5 per cent level of significance.

On the basis of this evidence, we are inclined to think that the mothers' orientations to the child probably have greater bearing upon the emotional disturbances of the Clinic children than do the fathers' orientations. The reason that rejection by the father does not produce as much disturbance as rejection by the mother is evidently that children who cannot be accepted by their father may receive some support from the mother, even if inconsistently; for about half of the children rejected by the father are not rejected by the mother. This may account for the fact that

TABLE 15

FATHERS' ORIENTATIONS TOWARD CHILDREN BY SEVERITY OF DISORDERS
(in per cent)

Severity	Total (N=144)	Rejecting (N=39)	Controlling (N=37)	Inconsistent (N=28)	Other* (N=28)	N.A. (N=12)
Essentially healthy	7	3	5	11	14	0
Moderately disturbed	49	44	62	50	32	58
Very disturbed	32	36	22	36	39	25
Defective	11	18	8	4	11	17
N. A.	1	0	3	0	4	0
Total	100	101	100	101	100	100

*See footnote to Table 11.

a like proportion of such children is either essentially healthy or only moderately disturbed.

It appears, thus, that parental orientations are associated with specific types of children's disturbances and with the severity of the children's symptoms. While this is far from being a one-to-one relationship, it nevertheless reaches and often exceeds conventional levels of statistical significance. In most cases, the orientations of both parents reinforce one another, either by being alike or by creating a generally unpredictable environment for the child. Generally, the mother's orientation toward the child appears to have greater bearing on the type and particularly the severity of the child's disorder than does the father's orientation.

Parental Orientations and Socio-Cultural Factors

The evidence for any relationships between parental orientations and socio-cultural factors is much less clear. As we will suggest, this relationship is disturbed by a variety of other factors which are not specifically socio-cultural in character.

The first socio-cultural factor to be considered is that of social status. A rough estimate of social status is possible if occupation is considered as an appropriate indicator. The primary breadwinner's occupation (whether this be the father or the mother) has been taken as such an indicator.

Table 16 suggests that mothers in the two white collar groups (professional and clerical, sales, etc.) tend to accord their children inconsistent treatment; nearly half of the white collar mothers are in the inconsistent category. Less than one-third of the blue collar mothers are inconsistent, and the difference between the white collar and blue collar mothers is significant at the 5 per cent level. Another third of the mothers belonging to the blue collar group reject their children, while only 14 per cent of the mothers in the clerical and sales group evince a rejecting orientation. This difference is also significant at the 5 per cent level.

TABLE 16

OCCUPATION OF PRIMARY BREADWINNER BY MOTHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Orientations	Total* (N=124)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar (N=66)
Accepting	6	0	6	8
Rejecting	24	23	14	30
Permissive	2	0	3	2
Controlling	24	27	25	23
Inconsistent	37	45	47	30
Absent	2	5	0	2
N. A.	5	0	6	6
Total	100	100	101	101

*See footnote to Table 6.

The data relating the occupation of the primary breadwinner to fathers' orientations are more ambiguous yet. [See Table 17.] There is only an indication the professional fathers tend to be more frequently controlling than are other fathers, the 17 per cent difference between professional and blue collar fathers being significant at the 5 per cent level.

TABLE 17

OCCUPATION OF PRIMARY BREADWINNER BY FATHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Orientations	Total* (N=124)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar (N=66)
Accepting	11	9	14	9
Rejecting	27	23	25	29
Permissive	2	5	0	3
Controlling	28	41	28	24
Inconsistent	22	18	19	24
Absent	4	0	6	5
N. A.	6	5	8	6
Total	100	101	100	100

*See footnote to Table 6.

Occupation, as such, is a rather poor indicator of social status. Most serious studies which concern themselves with social status variables employ more complex indices utilizing such variables as income, education, area of residence, participation in voluntary organizations, etc.

Unfortunately most of the information which would enable a researcher to form a better index of social status is only rarely contained in the case records. We can slightly improve on our "measurement" of social status by combining occupation with education, but only at the price of sacrificing 52 cases--over one-third of the sample--for which the father's education had not been recorded. (In an even larger proportion of the cases, the mother's education was missing.)

In view of the small number of cases available for the present analysis, rather crude distinctions had to be made between "high" and "low" occupational status (white collar versus blue collar) and "high" and "low" education (less than high school graduation versus high school graduation and better). Since there were relatively few cases combining a "high" occupation with "low" education, or a "low occupation with "high" education, the two mixed groups had to be merged.

Table 18 reveals that inconsistent treatment of children by their mothers occurs most frequently in the highest social group (49 per cent of the cases), less frequently in the mixed group (35 per cent), and least frequently in the low group (27 per cent). The difference between the high and the low groups is significant at the 1 per cent level. Rejection of children by their mothers takes place among 35 per cent of the mixed status mothers,

the difference with high status mothers being significant at the 5 per cent level.

TABLE 18

FATHERS' OCCUPATION AND EDUCATION BY MOTHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Orientations	Total (N=144)	High (N=35)	Mixed (N=20)	Low (N=37)	N.A. (N=52)
Accepting	7	3	0	19	4
Rejecting	23	17	35	22	23
Permissive	3	0	5	3	4
Controlling	24	23	20	22	27
Inconsistent	37	49	35	27	38
Absent	1	3	0	0	2
N. A.	5	6	5	8	2
Total	100	101	100	101	100

The data concerning the fathers' orientations yield similar information. [See Table 19.] Inconsistent treatment of children, again, is most common among high status fathers, but the significance of the difference between high and mixed status fathers does not quite reach the 5 per cent level. As is the case for mothers, rejection is more frequent among mixed status fathers than among the fathers in the other two groups; and the significance of the difference between the mixed and the other two groups approaches the 1 per cent level.

The use of both occupation and education thus yielded slightly better results with respect to the relationship between social status and parental attitudes.

TABLE 19

FATHERS' OCCUPATION AND EDUCATION BY FATHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Orientations	Total (N=144)	High (N=35)	Mixed (N=20)	Low (N=37)	N.A. (N=52)
Accepting	10	11	10	11	8
Rejecting	27	23	45	24	25
Permissive	3	0	0	3	6
Controlling	26	31	20	22	27
Inconsistent	19	31	15	19	13
Absent	7	0	0	8	13
N. A.	8	3	10	14	8
Total	100	99	100	101	100

The fact that the findings for fathers and mothers are consistent with each other suggests that the relationship is not fortuitous. If a better index of social status could be formed, a closer relationship might have been found. Also, a larger number of cases would be needed for a finer classification. It is doubtful, however, that a very close relationship between social status and parental orientations will ever be found in a population such as that of the Clinic. We have previously cited the researches by Allison Davis and Robert J. Havighurst showing differences in the treatment of children between Negro and white parents; the groups investigated in these studies were culturally divergent in many respects. The population from which the Clinic draws its patients is not nearly so heterogeneous; and while

there may be sizeable differences in occupation, income and education, the majority of the parents partake of the same middle class culture.

Under these circumstances, the differences in orientation which have been found (and such differences as might be discovered by a more thorough study) are by no means easily explained. It is not at all apparent why the parents belonging to the higher social groups should be more inconsistent in the treatment of their children than are the other groups. The frequency of parental rejection in the mixed group may have its root in the equivocal social standing of people whose educational and occupational statuses show some discrepancies. Such people may be under a certain amount of tension which expresses itself in rejection or inconsistency on the part of mothers (it will have been noted that mothers in this category also tend heavily toward inconsistency in orientation).

The relatively high cultural homogeneity of our population is attested by the fact that other social factors have little or no influence on parental orientations. Thus, Table 20 shows no significant relationship between maternal orientations and the mothers' status as a housewife or a gainfully employed person. Table 21 shows Catholic mothers to be controlling slightly more often than Protestant mothers, the difference being significant at the 5 per cent level. There is also a slight, though not

significant, indicated that Protestant mothers tend to be more rejecting. And there is no indication of any relationship between religious preference and paternal orientations toward the children [See Table 22].

TABLE 20

MOTHERS' EMPLOYMENT STATUS BY MOTHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Orientations	Total (N=144)	Employed (N=32)	Housewives (N=105)	N.A. (N=7)
Accepting	7	6	8	0
Rejecting	23	19	25	14
Permissive	3	3	2	14
Controlling	24	22	25	14
Inconsistent	37	44	36	29
Absent	1	0	0	29
N. A.	5	6	5	0
Total	100	100	101	100

TABLE 21

PARENTS' RELIGIOUS PREFERENCE BY MOTHERS' ORIENTATIONS TOWARD CHILDREN
(Catholic and Protestant Only*)
(in per cent)

Orientations	Total (N=110)	Catholic (N=19)	Protestant (N=91)
Accepting	6	10	6
Rejecting	25	16	26
Permissive	3	5	2
Controlling	25	37	22
Inconsistent	35	32	37
Absent	1	0	1
N. A.	5	0	6
Total	100	100	100

*See footnote to Table 8.

TABLE 22

PARENTS' RELIGIOUS PREFERENCE BY FATHERS' ORIENTATIONS TOWARD CHILDREN
(Catholic and Protestant Only*)
(in per cent)

Orientations	Total (N=110)	Catholic (N=19)	Protestant (N=91)
Accepting	9	5	10
Rejecting	26	21	26
Permissive	2	0	2
Controlling	27	32	26
Inconsistent	19	16	20
Absent	7	16	6
N. A.	10	10	10
Total	100	100	100

*See footnote to Table 8.

Socio-cultural Factors and Children's Disturbances

In view of the weak relationship between parental orientations and socio-cultural factors, it would be surprising if the relationship between such factors and children's emotional disorders were particularly high. As Tables 23 and 24 show, relationships between occupations of main breadwinners and children's disorders are virtually absent. There is a slight indication that the children of the white collar groups are more withdrawn than those of the blue collar groups, and that children of blue collar parents tend to act out more often. However, even the largest differences obtainable from the table do not quite

TABLE 23

OCCUPATION OF PRIMARY BREADWINNER BY DISORDERS
CLASSIFICATION I
(in per cent)

Disorders-Class I.	Total* (N=124)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar (N=66)
Acting out	43	36	39	47
Withdrawn	37	41	44	32
Acting out-withdrawn--alternating	15	18	14	15
Defective	3	5	3	3
N. A.	2	0	0	3
Total	100	100	100	100

*See footnote to Table 6.

TABLE 24

OCCUPATION OF PRIMARY BREADWINNER BY DISORDERS
CLASSIFICATION II
(in per cent)

Disorders-Class II	Total* (N=124)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar (N=66)
Nonsurface	10	9	14	8
Habit	6	9	6	6
Conduct	8	9	6	9
Nonsurface and habit	24	27	27	21
Habit and conduct	22	23	27	18
Nonsurface and conduct	20	23	11	24
Nonsurface, habit, and conduct	9	0	6	14
N. A.	1	0	3	0
Total	100	100	100	100

*See footnote to Table 6.

reach the 5 per cent level of significance. When the occupational groups are cross tabulated by the more specific symptoms of disorders, any relationship between the social and psychopathological variables completely dissolves. [See Table 24.] As for the severity of the symptoms, Table 25 suggests that the children of blue collar parents tend to be more disturbed; but there is only one significant difference in the table--that between the proportions of moderately disturbed children in the professional and blue collar groups--and this is only at the 5 per cent level.

TABLE 25

OCCUPATION OF PRIMARY BREADWINNER BY SEVERITY OF DISORDERS
(in per cent)

Severity	Total* (N=124)	Professional Managerial (N=22)	Clerical Sales (N=36)	Blue Collar (N=66)
Essentially healthy	8	9	3	11
Moderately disturbed	50	64	53	44
Very disturbed	32	23	36	33
Defective	9	5	9	11
N. A.	1	0	0	2
Total	100	101	101	101

*See footnote to Table 6.

As in the preceding investigation of the relationship of parental orientations to social status, somewhat better results are obtained when a social status index based

on the fathers' occupation and education is used. Table 26 shows a consistent increase of the proportion of children who are acting out as their social status declines. The 15 per cent difference between the highest and the lowest group approaches significance at the 5 per cent level. In this instance, however, as may be seen in Table 27 tabulation of more specific symptoms yields larger differences. Parents from high status families tend to have the highest incidence of children with a combination of nonsurface symptoms and habit disturbances; the difference between this group and the mixed status group is significant at the 5 per cent level. Thirty per cent of the children in the mixed status group have a combination of nonsurface symptoms and habit and conduct disturbances; and the difference between this group and the two others is significant at the 1 per cent level. Table 28 shows that the children from the mixed status group have the highest proportion of very disturbed children (40 per cent); there is an 18 per cent difference between this and the low status group, which is significant at the 5 per cent level. We have suggested previously that the mixed status groups, with their combination of high and low status characteristics, are under particular social tensions; this may account for the high incidence of severely disturbed children in this group.

Admittedly, the differences are small and they do not form any consistent pattern; nor can they be easily

TABLE 26

FATHERS' OCCUPATION AND EDUCATION BY DISORDERS
CLASSIFICATION I
(in per cent)

Disorders-Class. I	Total (N=144)	High (N=35)	Mixed (N=20)	Low (N=37)	N.A. (N=52)
Acting out	43	34	45	49	44
Withdrawn	36	40	40	32	34
Acting out-withdrawn Alternating	14	20	15	11	12
Defective	5	6	0	5	6
N. A.	2	0	0	3	4
Total	100	100	100	100	100

TABLE 27

FATHERS' OCCUPATION AND EDUCATION BY DISORDERS
CLASSIFICATION II
(in per cent)

Disorders-Class.II	Total (N=144)	High (N=35)	Mixed (N=20)	Low (N=37)	N. A. (N=52)
Nonsurface	10	9	5	8	13
Habit	6	3	10	11	4
Conduct	7	3	5	8	10
Nonsurface and habit	23	34	15	22	19
Habit and conduct	22	23	20	22	23
Nonsurface and conduct	20	23	15	24	17
Nonsurface, habit, conduct	11	6	30	5	12
N. A.	1	0	0	0	2
Total	100	101	100	100	100

TABLE 28

FATHERS' OCCUPATION AND EDUCATION BY SEVERITY OF DISORDERS
(in per cent)

Severity	Total (N=144)	High (N=35)	Mixed (N=20)	Low (N=37)	N. A. (N=52)
Essentially healthy	7	9	0	11	4
Moderately disturbed	49	51	57	49	50
Very disturbed	32	34	29	22	34
Defective	11	6	14	13	12
N. A.	1	0	0	5	0
Total	100	100	100	100	100

interpreted. It is not at all clear, for instance, why most of the children displaying a combination of all three types of disturbances should be concentrated in the middle group. On the other hand, the greater incidence of non-surface and habit disturbances among the higher status children is consistent with the other data collected in this study. At the very least, the present analysis suggests that a refinement of the index of social status might yield stronger relationships between social status and children's disorders.

The socio-cultural factor of religion also shows very little relationship to children's disorders. There is a suggestion, in Table 29 that Catholic children have a tendency to act out, but the 15 per cent difference between Catholic and Protestant children does not quite reach the 5 per cent

level of significance. Similarly, religious preference appears to have little relation to any particular type of symptom or symptom combination, except that the combination of habit and conduct disturbances is slightly more frequent among Protestants than among Catholics, the difference being significant at the 5 per cent level. As for severity of the disturbances, religious preference appears to have no bearing upon it.

TABLE 29

PARENTS' RELIGIOUS PREFERENCE BY DISORDERS CLASSIFICATION I
(Catholic and Protestant only*)
(in per cent)

Disorders-Class. I	Total (N=110)	Catholic (N=19)	Protestant (N=91)
Acting out	41	53	38
Withdrawn	40	37	41
Acting out--withdrawn alternating	13	10	14
Defective	5	0	6
N. A.	1	0	1
Total	100	100	100

*See footnote to Table 8.

Other Factors Related to Parental Orientations and Children's Disorders

We must ask why the relationships between socio-cultural factors and the emotional disorders of children are so weak--if not nonexistent--although there were some fairly substantial relationships between parental orientations

and children's disturbances. We have already pointed to the weakness of the relationship between socio-cultural factors and parental orientations. In the present section we will show, further, that such relationships as may exist could well have been obscured by the operation of other factors which affect either parental orientations or children's disturbances. These are the factors of intelligence of the child, age, and sex. We did not select these factors on any theoretical grounds but for the sole reason that information concerning them was available in the record.

Parental orientations are, to some extent, related to the children's intelligence as measured by the tests administered at the Clinic; yet there are no relationships between IQ and types or severity of disturbances. As Table 30 shows, mothers of children with high IQ's tend to be more frequently inconsistent than the mothers of children with average and below average intelligence; the 19 per cent difference between the above-average and each of the two other groups is significant at the 5 per cent level. Mothers of children with average intelligence tend to be controlling, the 22 per cent difference between this and the below-average group being significant at the 1 per cent level. Fathers, whose orientations are shown in Table 31 become more controlling as IQ's increase, the differences between the below-average and each of the two higher IQ groups being significant at the one per cent level.

TABLE 30

CHILDREN'S IQ BY MOTHERS' ORIENTATIONS
TOWARD CHILDREN
(in per cent)

Orientations	Total (N=144)	Below Average (N=46)	Average (N=48)	Above Average (N=29)	N. A. (N=21)
Accepting	7	13	2	3	10
Rejecting	23	26	23	14	28
Permissive	3	7	0	3	0
Controlling	24	13	35	24	19
Inconsistent	37	33	33	51	38
Absent	1	0	2	3	0
N. A.	5	9	4	3	5
Total	100	101	99	101	100

TABLE 31

CHILDREN'S IQ BY FATHERS' ORIENTATIONS
TOWARD CHILDREN
(in per cent)

Orientations	Total (N=144)	Below Average (N=46)	Average (N=48)	Above Average (N=29)	N. A. (N=21)
Accepting	10	15	2	14	10
Rejecting	27	24	25	21	48
Permissive	3	4	2	3	0
Controlling	26	15	33	38	14
Inconsistent	19	24	19	17	14
Absent	7	4	6	7	14
N. A.	8	13	13	0	0
Total	100	99	100	100	100

These findings parallel those reported previously concerning the relationship between occupation of the main breadwinner and parental orientations. The similarities between the two sets of findings are probably to be explained by the closeness of the relationship between IQ's and occupations of main breadwinners. The higher the occupational status of the family, the greater the chance that the child will be above average in intelligence. The higher the occupational status, the higher the proportion of children toward which the mothers have an inconsistent and the fathers a controlling orientation. The same thing is true of the orientations of parents toward children with high IQ's.

This is to say that occupational status produces more than parental orientations toward children; it also influences level of intelligence. Level of intelligence, in turn, may have considerable effect on the course of an emotional problem. The relationships between intelligence and the specific types of pathological adjustments which children may make is no doubt a very subtle and complex one; while emotional disorders may affect the level of performance in the intelligence test, intelligence may also affect the manner of a child's dealing with his problem. If this is kept in mind, it will be realized that intelligence can easily affect the nature of relationships between parental orientations and children's disturbances and thus reduce

considerably the strength of such statistical relations. For the same reason, it is not surprising that no relationship can be found between IQ and emotional disturbances.

Two rather fundamental variables--those of age and sex have some relationship to the types of children's disorders, but very little or none to parental orientations. The relationship between children's ages and mothers' orientations is shown in Table 32. Controlling orientations tend to become more frequent as children become older, reaching their highest point during puberty. Inconsistent orientations decline correspondingly and become particularly low during the same period of the child's life. Sudden changes are particularly noticeable at the beginning of puberty, between the 9-11 and 12-14 age groups, the differences being significant at the 1 per cent level. However, no such trends can be observed among fathers. It may be noted, however, that fathers tend to be most likely to reject their children during puberty and are least likely to display inconsistent treatment during that same period.

While relations between parental orientations and the ages of the children are, at best, weak, we discover much stronger associations between the children's ages and the types of disorders which they display. [See Table 33.] The proportion of acting out children drops rather abruptly at the age of six, then increases gradully and reaches its former level of 56 per cent in the group of the 15-18 year

TABLE 32

CHILDREN'S AGE BY MOTHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Orientations	Total (N=144)	Age				
		1-5 (N=22)	6-8 (N=33)	9-11 (N=37)	12-14 (N=35)	15-18 (N=16)
Accepting	7	9	6	8	9	0
Rejecting	23	14	24	27	23	25
Permissive	3	0	3	0	9	0
Controlling	24	14	21	16	37	25
Inconsistent	37	55	36	43	20	44
Absent	1	0	0	3	3	0
N. A.	5	9	9	3	0	6
Total	100	101	99	100	101	100

TABLE 33

CHILDREN'S AGE BY DISORDERS-CLASSIFICATION I
(in per cent)

Disorders-Class. I	Total (N=144)	Age				
		1-5 (N=22)	6-8 (N=33)	9-11 (N=37)	12-14 (N=35)	15-18 (N=16)
Acting out	43	55	33	39	43	56
Withdrawn	36	23	52	39	29	31
Acting out--withdrawn alternating	14	13	9	18	14	13
Defective	5	5	6	3	9	0
N. A.	2	5	0	0	6	0
Total	100	101	100	99	101	100

olds. Correspondingly, the number of withdrawn children increases by 29 per cent when they reach school age and then levels off to about 30 per cent. At the critical point of the beginning of school, all differences are significant at the 1 per cent level.

Table 34 shows a similar relationship between age and specific symptoms. Between the 1-5 and the 6-8 age groups, there is a 16 per cent increase in the incidence of nonsurface and habit disorders, and a corresponding 21 per cent decrease in the combination of habit and conduct disturbances. A similar drop occurs in the proportion of cases displaying all three types of symptoms. The over-all trends are very similar to those previously described. All differences mentioned in this paragraph are significant at the 5 per cent level.

The relationship of the child's sex to parental conduct and to types of disorders is similar to that of age. The child's sex appears to have much less effect on the parents' orientation than one would expect. Table 35 shows fathers to be slightly more inconsistent toward boys than girls--the 12 per cent difference being significant at the 5 per cent level. But there is no relationship between children's sex and mothers' orientations. Yet, Table 36 shows girls to be more withdrawn than boys (the difference is significant at the 1 per cent level), and boys to act out more frequently than girls (difference significant at the

TABLE 34

CHILDREN'S AGE BY DISORDERS - CLASSIFICATION II
(in per cent)

Disorders--Class. II	Total (N=144)	Age				
		1-5 (N=22)	6-8 (N=33)	9-11 (N=37)	12-14 (N=35)	15-18 (N=16)
Nonsurface	10	5	9	16	6	13
Habit	6	9	12	5	3	0
Conduct	7	0	3	8	9	19
Nonsurface and habit	23	23	39	16	20	13
Habit and conduct	22	36	15	16	20	37
Nonsurface and conduct	20	0	15	29	31	13
Nonsurface, habit and conduct	11	23	6	11	11	6
N. A.	1	5	0	0	0	0
Total	100	101	99	101	100	101

TABLE 35

CHILDREN'S SEX BY FATHERS' ORIENTATIONS TOWARD CHILDREN
(in per cent)

Orientations	Total (N=144)	Male (N=106)	Female (N=38)
Accepting	10	10	8
Rejecting	27	29	21
Permissive	3	2	5
Controlling	26	24	32
Inconsistent	19	23	11
Absent	7	6	11
N. A.	8	7	13
Total	100	101	101

TABLE 36

CHILDREN'S SEX BY DISORDERS
CLASSIFICATION I
(in per cent)

Disorders - Class. I	Total (N=144)	Male (N=106)	Female (N=38)
Acting out	43	47	31
Withdrawn	36	30	52
Acting out--withdrawn alternating	14	18	3
Defective	5	3	11
N. A.	2	2	3
Total	100	100	100

5 per cent level). It may be noted that, in our sample, the clerical and sales group has a slightly larger proportion of boys than do the other groups and that therefore the proportion of acting out children among the clerical and sales people may be unduly high. This may reduce the difference in the proportion of withdrawn children from this and other groups, which might be larger if sex were controlled. Table 37 tells substantially the same story. Girls tend to be subject to nonsurface symptoms and habit disturbances more often than boys, while boys tend more frequently to have a combination of habit and conduct disorders. Both differences are significant at the one per cent level.

If such variables as age and sex have little effect on parental orientations, but relatively larger effects on

TABLE 37

CHILDREN'S SEX BY DISORDERS
CLASSIFICATION II
(in per cent)

Disorders - Class. II	Total (N=144)	Male (N=106)	Female (N=38)
Nonsurface	10	8	16
Habit	6	7	5
Conduct	7	6	11
Nonsurface and habit	23	18	37
Habit and conduct	22	27	8
Nonsurface and conduct	20	22	16
Nonsurface, habit, conduct	11	12	8
N. A.	1	1	0
Total	100	101	101

children's disorders, how can the effects of such variables be interpreted? It would certainly be unrealistic to regard age and sex simply as biological or demographic variables. While biological differences due to age and sex no doubt contribute to the form which a child's problems may take, we must also consider the socio-cultural significance of age and sex. The culture provides for certain important differences in the treatment of individuals according to their sex and age. The differences in children's disorders which we have observed to take place between ages 1-5 and 6-8 are no doubt ascribable to the fact of the children's reaching the school age. Children with a tendency to withdraw will experience difficulties in adjusting to the school

situation and their predispositions will at that point emerge as a social as well as an emotional problem. Since girls appear to be socially so conditioned as to evince withdrawing symptoms the number of girls developing emotional complications at the beginning of their school years tends to be particularly large. We are thus led to believe that some of the factors which affect the types of children's disorders are broadly social and cultural and have very little connection with the specific family situation of the children.

Direct Effects of Socio-Cultural Factors

In a somewhat different way, the relationship between the mothers' employment status and the children's disturbances illustrates the point we are trying to make. We have shown previously that the mothers' employment status as a housewife or as a member of the labor force has no bearing on their orientation toward the children. Yet, as Table 38 shows, children of employed mothers act out more frequently than children of housewives; and the latter are withdrawn more often than the former. Both differences are significant at the 1 per cent level. Similarly, children of employed mothers have more conduct disturbances than those of housewives, while children of housewives tend to display a combination of nonsurface and habit complications.

If such differences are not generated by parental orientations toward the children, they can be ascribed to the

total social environment of the child. The child of an employed mother evidently spends a proportionately larger amount of time than do other children with people outside the nuclear family, such as peer groups in school and neighborhood. His emotional problems may be largely related to his experiences in such environments. There is, thus, a suggestion of the importance of the total social environment for the emotional problems of the child.

TABLE 38

MOTHERS' EMPLOYMENT STATUS BY DISORDERS CLASSIFICATION I
(in per cent)

Disorders - Class.I	Total (N=144)	Employed (N=32)	Housewives (N=105)	N.A. (N=7)
Acting out	43	50	40	57
Withdrawn	36	25	42	0
Acting out--withdrawn alternating	14	25	10	29
Defective	5	0	6	14
N. A.	2	0	3	0
Total	100	100	101	100

If it were desired to test for the direct effects of the social environment upon the child, this might be done by controlling parental orientations. In view of the small number of cases in our sample, it is difficult to introduce such controls. In Table 39 we have, nevertheless, attempted such a procedure. We have taken the occupational

TABLE 39

OCCUPATION OF PRIMARY BREADWINNER AND MOTHERS' ORIENTATIONS TOWARD CHILDREN BY DISORDERS CLASSIFICATION I
(in per cent)

Disorders-Class. I	Total* (N=107)	White Collar		Blue Collar	
		Rejecting and Controlling (N=25)	Inconsistent (N=26)	Rejecting and Controlling (N=36)	Inconsistent (N=20)
Acting out and Acting out-withdrawn Alternating	59	48	58	53	85
Withdrawn	41	52	42	47	15
Total	100	100	100	100	100

*Cases with accepting, permissive or absent parents and cases not ascertained have been omitted from this tabulation.

classification used previously as a rough index of social status and compressed it so as to distinguish only between white collar and blue collar groups. We have, further, combined the controlled and rejected children into one classification, chiefly in order to make the cells sufficiently large for the purposes of statistical tests; the present combination appeared to be justified on the ground that, as was shown previously, the types of disturbances of rejected and controlled children tended to be similar. In the process of these consolidations, we were forced to relegate to a miscellaneous group 33 cases for which all or part of the necessary information was missing.

The result shows only one large difference between blue and white collar groups. Eighty-five per cent of all inconsistently treated blue collar children act out or alternately withdraw and act out; only 58 per cent of the inconsistently treated white collar children display the same types of disturbances. The difference between the two proportions is significant at the 1 per cent level. The fact that no similar differences occur between white collar and blue collar children whose parents display controlling or rejecting attitudes may be explained by the heterogeneity of the cases lumped together in this category.

It is noteworthy that the relationship between occupational status and children's disturbances, which we have previously shown to be extremely weak, gains in

strength when parental attitudes are held constant. This result was obtained in spite of the fact that the smallness of the sample compelled rather crude combinations of groups into heterogeneous classes. The present finding strongly suggests that the direct effects of the child's total social environment may be quite powerful. The child, as much as the rest of our urbanized society, may have ceased to be contained in the nuclear family; and psychologically important influences may impinge upon him from all sides. While we would hesitate to minimize in any way the great importance which parental orientations must have for the child, we believe that these have become closely entwined with other experiences in the child's world. A more complete understanding of children's emotional problems may thus call for a broad inquiry into the particular culture or subculture in which the child gains his experiences.

CHAPTER IV

SUMMARY AND CONCLUSIONS

An analysis of the records of a sample of children for whom a diagnostic study was completed at the Lansing Child Guidance Clinic yielded the following findings:

1. There is a fairly clear relationship between parental orientations and children's disorders. The children of inconsistent parents, particularly of inconsistent mothers, tend to act out. Rejected and controlled children tend to be withdrawn.

2. There is a weak relationship between socio-economic status of the parents and children's disorders when occupation is used as an index of social status. Mothers in the white collar group tend to treat their children inconsistently; mothers in the blue collar group tend toward rejection of the children more often than white collar mothers. The relationship between social status and parental orientations is stronger when occupation and education are combined into an index. It then appears that rejection of the children occurs most frequently in that intermediate status group whose social position is somewhat ambiguous.

3. It was not possible to demonstrate any relationship between parental occupations and types of children's

disorders. The use of an index based on occupation and education of the father produces a slight amount of association between social status and children's disorders. The proportion of children acting out increases as social status decreases.

4. Other socio-cultural variables which have no demonstrable relationship to parental orientations also have effects upon children's disorders. Among these are age and sex of the child, which must be regarded as socio-cultural factors because they imply culturally determined relations between the child and the social world. Boys tend to be acting out. Children with a tendency to withdraw tend to develop problems upon reaching the school age. Children of working mothers tend to act out, although gainful employment has no demonstrable effect on the mothers' obligations toward their children.

5. When parental orientations are held constant, a fairly strong relationship is found between occupational status of the parents and types of disorders of children receiving inconsistent treatment from their parents.

6. Children rejected by their parents are most likely to be severely disturbed; those controlled by their parents less likely, and those inconsistently treated least likely to be severely disturbed. Rejection is most frequent among blue collar workers and inconsistency least frequent. The largest proportion of severely disturbed children is found in the blue collar group.

While the evidence is by no means clear on all points, and the small number of cases in this study as well as the deficiencies of the records prevented our making finer classifications of data as might have been desirable, four conclusions may be tentatively drawn:

1. The type of emotional disturbance appears to be a function of both parental orientations and of the child's total social environment. Some of the environmental factors operate independently of parental orientations. That is the relationship between such factors and types of emotional disturbances is to some extent direct.

2. It is probable that emotional disturbances also are indirectly related to socio-cultural variables, that is, parental orientations also operate as an intervening variable. However, this relationship could not be clearly demonstrated in the present study, partly because the association between social status and parental orientations proved to be extremely weak. There is some evidence that improvements in the measurement of social status might make it possible to discover stronger indirect associations between social status and emotional disturbances.

3. The severity of emotional disturbances appears to be chiefly a function of parental orientations. There is not evidence that general cultural factors have any influence upon the severity of symptoms; and insofar as the blue collar groups are found to have the largest proportion

of severely disturbed children, this is largely a result of the frequency of rejecting and controlling parents among the blue collar groups. It may be said, then, that social status is indirectly related to severity.

4. While there is no specific information in this study regarding the effects of general environmental factors on the child, it can be inferred that some of these must be operating in the same fashion as do parental orientations. Acting out behavior seems to appear when either the child is inconsistently treated at home, or when there is reduced contact with parents and consequently greater contact with other social groups, presumably peer groups. The crucial factor in determining the nature of a child's disturbance thus might be the amount and the consistency of the control to which the child is subjected. While control--or absence thereof--by parents is no doubt of great importance, experiences of being controlled or uncontrolled in other situations may also have considerable effects on the child's disorder.

These findings contain an apparent contradiction. Since children from the white collar groups most frequently receive inconsistent treatment and since inconsistenly treated children tend to act out, one would expect children from the higher status groups to act out more frequently than other children. In actual fact the highest proportion of children who act out is found among the blue collar groups. One reason for this was discovered when parental

orientations were held constant. Among children of the higher status groups inconsistent treatment was less strongly related to acting out behavior than among children of the lower status groups. To some extent the effects of socio-cultural variables tend to cancel each other. Insofar as parental attitudes intervene between status and children's disorders, they tend to lead to acting out behavior among the higher status groups and to withdrawal among the lower status groups. Insofar as social factors operate directly they tend to have the reverse effect. This may, in part, account for the relative smallness of the differences found in our tables. Since the relationship between status and parental orientation is relatively weak it is easily overcome by the much stronger association which appears to exist between directly operating socio-cultural factors and children's disorders.

Our tentative conclusions, however, should not be accepted without further investigation. It would be most instructive if a study could be made with a larger number of cases (and, one would hope, more complete records); it would then be possible to develop better indices of socio-economic status and of other socio-cultural variables. The socio-cultural groups so constituted could then be broken down by types of parental orientations and by types of disorders; and the precise connections between these three variables could thus be more conclusively described. It would also be

possible, in such a design, to hold constant all types of parental orientations toward their children and thus to assess whether our conclusion that there is a direct effect of the social environment on the child's disorder is true for inconsistently treated children only, or also for children of parents with other types of orientations.

If our conclusions were confirmed by further research, certain consequences for diagnosis and treatment would flow from them. The diagnostician might then pay greater attention to the total socio-cultural environment of the child. He might give more careful consideration not only to the child's relations with members of the nuclear family, but also to those with teachers, friends and the like. As for treatment, it might be found indicated to work more toward concrete changes in the child's environment. For one of the still unsolved problems of social workers is, we think, to find the proper combination between techniques of individual therapy and of social action.

APPENDIX

SCHEDULE

1. Case Number

_____

2. Age

1. 1 - 5
2. 6 - 8
3. 9 -11
4. 12 - 14
5. 15 - 18

___

3. Sex

___ 1. Male 2. Female

4. IQ

1. 65 & below
2. 66-79
3. 80-90
4. 91-110
5. 111-119
6. 120-127
7. 128 & above
8. N. A.

___

5. Siblings

1. Only child
2. 1 sibling
3. More than 1 sibling
4. N. A.

____

6. Disorders--Classification I

1. Acting out
2. Withdrawn
3. Acting out--withdrawn, alternating
4. Defective
5. N. A.

____

7. Disorders--Classification II

1. Nonsurface symptoms
2. Habit
3. Conduct
4. 1 & 2
5. 2 & 3
6. 1 & 3
7. 1, 2, 3,
8. N. A.

____

8. Father's Relation with Child

1. Accepting
2. Rejecting
3. Permissive
4. Controlling
5. Inconsistent
6. Absent
7. Other
8. N. A.

9. Mother's Relation with Child

1. Accepting
2. Rejecting
3. Permissive
4. Controlling
5. Inconsistent
6. Absent
7. Other
8. N. A.

10. Primary Breadwinner

1. Father
2. Mother
3. Other
4. N. A.

11. Father's Occupation

1. Professional, Indep. bus., Manag.
2. Clerical, sales, services
3. Blue collar
4. Farmer
5. Chronic unemployed
6. Other
7. N. A.

12. Mother's Occupation

1. Professional, Indep. bus., manag.
2. Clerical, sales
3. Services, factory
4. Housewife
5. Other
6. N. A.

13. Father's Education

1. Less than 8th grade
2. Completed 8th grade
3. Some H. S., did not complete
4. H. S. graduate
5. Some college, did not complete
6. College graduate
7. N. A.

14. Mother's Education

1. Less than 8th grade
2. Completed 8th grade

3. Some H. S., did not complete
4. H. S. graduate
5. Some college, did not complete
6. College graduate
7. N. A.

15. Parents' Religion

1. Catholic
2. Protestant
3. Mixed
4. Other
5. N. A.

16. Ethnic Identification

1. White--old family
2. White--first generation
3. Indian
4. Oriental
5. Negro
6. Mixed
7. N. A.

17. Severity of Disorders

1. Essentially healthy
2. Moderately disturbed
3. Very disturbed
4. Defective
5. N. A.

BIBLIOGRAPHY

Books

Bendix, Reinhard, and Lipset, Seymour Martin (eds.). Class, Status and Power. Glencoe, Illinois: The Free Press, 1953.

Erikson, Erik H. Childhood and Society. New York: W. W. Norton, 1950.

Hamilton, Gordon. Psychotherapy in Child Guidance. New York: Columbia University Press, 1947.

Kardiner, Abram. The Psychological Frontiers of Society. New York: Columbia University Press, 1945.

Kluckhohn, Clyde and Murray, Henry A. (eds.). Personality in Nature, Society, and Culture. New York: Alfred A. Knopf, 1948.

Linton, Ralph. The Cultural Background of Personality. New York: Appleton, 1945.

Lowrey, Lawson G., M.D. Psychiatry for Social Workers. New York: Columbia University Press, 1950.

Pollak, Otto, and Collaborators. Integrating Sociological and Psychoanalytic Concepts. New York: Russell Sage Foundation, 1956.

_____. Social Science and Psychotherapy for Children. New York: Russell Sage Foundation, 1952.

Richmond, Mary. What is Social Casework. New York: Russell Sage Foundation, 1922.

Articles

Aberle, David F., and Naegele, Kaspar D. "Middle-Class Fathers' Occupational Role and Attitudes Toward Children," American Journal of Orthopsychiatry, XXII (April, 1952), 366-378.

Ackerman, Nathan W. "Disturbances of Mothering and Criteria for Treatment," American Journal of Orthopsychiatry, XXXVI (April, 1956), 252-263.

Barrabee, Paul, and Von Mering, Otto. "Ethnic Variations in Mental Stress in Families with Psychotic Children," Social Problems, October, 1953, 48-53.

Bettelheim, Bruno, and Sylvester, Emmy. "Notes on the Impact of Parental Occupations: Some Cultural Determinants of Symptom Choice in Emotionally Disturbed Children," American Journal of Orthopsychiatry, XX (October, 1950), 785-795.

Cass, Loretta Kekeisen. "An Investigation of Parent-Child Relationships in Terms of Awareness, Identification, Projection and Control," American Journal of Orthopsychiatry, XXII (April, 1952), 305-313.

Davis, Allison, and Havighurst, Robert J. "Social Class and Color Differences in Child Rearing," American Sociological Review, 11 (December, 1946), 698-710.

Frumkin, Robert M. "Occupation and Major Mental Disorders," quoted in Arnold M. Rose (ed.) Mental Health and Mental Disorder. New York: W. W. Norton, 1955, 136-160.

Garrett, Annette. "Historical Survey of the Evolution of Casework," in Kasius, Cora (ed.). Principles and Techniques in Social Casework. New York: Family Service Association of America, 1950, 393-411.

Green, Arnold W. "The Middle-Class Male Child and Neurosis," American Sociological Review, 11 (February, 1946), 31-41.

Henry, Jules. "Cultural Objectification of the Case History," American Journal of Orthopsychiatry, XIX (October, 1949), 655-673.

_____. "Family Structure and the Transmission of Neurotic Behavior," American Journal of Orthopsychiatry, XXI (October, 1951), 800-818.

Hollingshead, August B., and Redlich, Frederick C. "Social Stratification and Psychiatric Disorders," in Rose, Arnold M. (ed.). Mental Health and Mental Disorder. New York: W. W. Norton, 1955, 123-135.

Kohn, Melvin L., and Clausen, John A. "Parental Authority Behavior and Schizophrenia," American Journal of Orthopsychiatry, XXVI (April, 1956), 297-313.

McKeown, James. "The Behavior of Parents of Schizophrenic, Neurotic and Normal Children," American Journal of Sociology, LVI (1950), 175-179.

Newburger, H. "Social and Cultural Conditioning of Pre-Delinquency," The Nervous Child, 11 (October, 1955), 12-15.

Stone, Fred H., M. D. "A Critical Review of a Current Program of Research into Mother-Child Relationship," in Caplan, Gerald, M.D. (ed.). Emotional Problems of Early Childhood. New York: Basic Books, 1955, 95-116.

Studies and Reports

American Psychiatric Association. Diagnostic and Statistical Manual. Washington: American Psychiatric Association Mental Hospital Service, 1952.

Davies, Vernon. Tables Showing Significance of Differences Between Percentages and Between Means. Pullman: State College of Washington, Stations Circular No. 151, June, 1951.

Lansing Child Guidance Clinic. Eighteenth Annual Report, 1956. Lansing, Michigan: Lansing Child Guidance Clinic, 1956.

Law, Shirley. "The Mother of the Happy Child," Smith College Studies in Social Work, XXV (October, 1954), 1-27.

Maas, Henry S., and Others. "Socio-cultural Factors in Psychiatric Clinic Services for Children: A Collaborative Study in the New York and San Francisco Areas," Smith College Studies in Social Work, XXV (February, 1955).

Stevens, Sylvia. "An Ecological Study of Child Guidance Intake," Smith College Studies in Social Work, XXV (October, 1954), 73-84.

Unpublished Material

Wright, Jean. "A Study of School Referrals to a Child Guidance Clinic for the Year 1954." Unpublished Master's Research Project Report, School of Social Work, Michigan State University, 1956.