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Family Structure, Child Mental Patients and Length of Hospitalization

Martha Bullock Lamberts

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FAMILY STRUCTURE, 
CHILD MENTAL PATIENTS AND 
LENGTH OF HOSPITALIZATION

by

Martha Bullock Lamberts

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Doctor of Philosophy

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In the preparation of this thesis, I have been aided by many whom I consider friends. This is particularly true of the members of my dissertation committee: Edsel Erickson, Charles Keeley, Ross Eshleman, David Adams and Kenneth Simon. One dear friend, Lois Carl, I consider as an ex officio member of my doctoral committee. To Lois and to Ruth Erickson, another ex officio member, special thanks.

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Most of all, however, this effort has been sustained by the loving faith of certain members of my family; my children, my mother, and M. P., Lucile and Floyd. Without them, I could never have continued.

Thank God . . .

Martha Bullock Lamberts

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CHAPTER I

THE BASIS FOR INVESTIGATION

Introduction

The popular paradigm of family structure continues to be the traditional conjugal, or two parent, family. Yet 1970 census statistics on families in the United States revealed a growing rate of legally dissolved marriages. Divorce, almost unknown in this country until the end of the nineteenth century, became steadily more common during the first half of this century and reached a peak of 3 1/2 divorces per one thousand population in 1945 (the year that marked the end of World War II). By 1960 this rate had declined to 2.2 per thousand, a figure only slightly above pre-war level (Bureau of the Census, 1970). In the early 60's sociologists like Rodman wrote optimistically of the stability of the American family on the basis of a divorce rate in the United States that "had remained somewhat stable" for almost a decade (Rodman, 1969, p. 288).

Even as Rodman's test was being published, a new generation, the progeny of World War II unions, were marrying and divorcing. By 1968 the 2.2 rate per thousand population of 1960 had grown to 2.9, the largest peacetime rise for any comparable period in the century. Two years later, in 1970, the divorce rate equaled the 3 1/2 record rate of 1945. It exceeded the 1945 ratio of divorces to marriages. And the average number of minor children involved per divorce degree had
risen from .9 in 1945 to 1.3 in 1968, representing a total of 2,772,460 children who were affected by divorce during that single year.

During the same period, known illegitimate births were increasing in equally dramatic fashion. In 1940 3.5% of all live births were to unmarried mothers. By 1960 this rate had risen less than two percentage points. Seven years later, however, the 1940 percentage had almost tripled. Nine per cent of all live births were illegitimate. In 1968, the following year, illegitimate births accounted for 9.7 of all children born in the United States, a figure representing a total of 339,200 infants in that single year (Bureau of the Census, 1970).

During the twenty year period from 1940 to 1960, the percentage of children who were orphaned by the death of one or both parents declined. Throughout the decade of the 60's, however, this percentage rose steadily. In 1970 4.8% of all minor children in the United States were orphaned of one or both parents, a ratio which equaled the 1955 level. Over 2/3 of these had lost their paternal parents. In numbers these percentages represent 3,260,000 orphaned children. Of these, 2,300,000 had lost their fathers through death (Bureau of the Census, 1970).

We conclude, therefore, that the family headed by a single adult is a growing trend in American society. In 1970, 10.9% of all families in the United States were defined by the U. S. Bureau of the Census as having a female head. Of these 52.4% included children
whose ages were under eighteen years. The family headed by a single parent has assumed an aspect of regularity in American society.

Simultaneously with the trend toward the single parent family, there has been a rising concern with problems of mental health. The number of patients per thousand of the total population who were treated in facilities offering non-resident psychiatric services increased five-fold during the years from 1955 through 1968. In spite of this increased emphasis on out-patient treatment, however, mental hospitals also admitted growing numbers of patients. In 1940 1.4 persons per thousand population were admitted to mental hospitals as patients. By 1969 admittances to resident psychiatric treatment facilities accounted for 3.2 persons per thousand population, over double the pre-World War II ratio (Bureau of the Census, 1970). These figures, it should be noted, deal in totals, that is with all mental patients of all ages. Readily accessible sources of information seldom indicate numbers of children receiving psychiatric care. Another common characteristic of this information is that it seldom reminds the public of the rise in out-patient and community mental health centers or that treatment facilities of all types (special education, programs, counseling centers, clinics, "half-way" houses, therapeutic membership groups, and private and public hospitals) are more numerous than ever before (Bureau of the Census, 1970).

In Michigan, the state providing services to the children who are the subjects of this study, the joint Michigan Mental Health Agencies estimate that one-fourth of the state's mentally ill are
children under eighteen years of age. In 1970 some 55,000 school-aged Michigan children were receiving help for mental or emotional conditions other than mental retardation from publicly supported programs like state hospitals, clinics, courts, and schools. During the same year, an estimated 145,000 children who needed special help were not reached by public programs despite state and local expenditures of over $110,000,000 for mental health services (Michigan Mental Health Facts, 1971).

Increases in both in-patient and out-patient numbers may simply reflect modern diagnostic efficiency and/or enlightened societal policies. Perhaps they can be explained by sources of stress within society like the threat of war, particularly of atomic war; the noise and speed of modern life; or the rapid urbanization of the second half of the twentieth century. All of these popular explanations may be valid factors in the increased pre-occupation with mental health and with mental illness.

Statement of Theoretical and Methodological Problems

The parallel trends toward one parent families and increased mental illness suggests the possibility that a relationship between the two phenomena may be involved. This study undertakes to investigate this possibility. Its general thesis suggests that children from one parent families are not only more likely to be allocated to deviant roles within society but also will tend to retain deviant master status roles for longer periods of time than will children...
from traditional two parent families who experience similar role allotment. Specifically, its research objectives are based upon the hypothesis that child mental patients from one parent families will be hospitalized for longer periods of time than will those from two parent families, when controlling for diagnosed illness, social class and other sociological and psychological factors generally considered relevant to forecasting length of hospitalization.

As a first step in this undertaking, it seems proper to consider the problems of theory and method which have limited past attempts to test an assumed relationship between family structural variables and deviant outcomes for children, particularly outcomes which involve allocation to the role of mental patient.

The Concept of Mental Illness

One major limitation of past investigations in this area has been that of definitional obscurity. A number of criteria of varying levels of abstraction and generality have been used to define the concept of mental illness.

The fact of psychiatric treatment has been one popular way of operationally defining mental illness. This was the criteria used by Hollingshead and Redlich in choosing sampling procedures for their investigation of the effects of social class on mental illness. Their approach was distinguished for its inclusion of subjects under the care of private psychiatrists on an out-patient basis (Hollingshead and Redlich, 1958). More often the definition of mental illness has
referred to persons receiving in-patient psychiatric treatment (Wahl, 1954; Yarrow, et al., 1955; Lemert, 1959; Swanson and Spitzer, 1970).

It may be argued that neither of the above definitions possesses the precision demanded by scientific standards of research clarity. Both approaches define an unknown proportion of a population which might be included under the global concept of mentally ill. The procedures used by Hollingshead and Redlich are made further suspect by their inclusion of private out-patient subjects; for, one surmises, such a sample is intrinsically biased by a disproportionate number of upper-class subjects. Lower and middle-class persons who suffer comparable mental disorders of equal severity may be excluded for out-patient samples because they cannot afford private psychiatric care.

Another approach to the problem of defining mental illness has used degree of conformity to social norms, or "social adjustment," as its sampling criterion. While this approach seems more likely on surface examination to encompass a full range of the mentally disturbed, it too contains ambiguity when it is used to specify and operationalize mental illness as a global concept; for it cannot satisfactorily answer the question, "Whose judgements of social adjustment, whose norms, constitute a valid standard from which to measure deviation in terms of mental illness?"

There is an ethnocentric value judgement built into this definitional approach which pervades even the use of psychiatric diagnoses as the criteria for defining mental illness. While this method of
definition is legitimized by the use of professional opinion, it is nonetheless obscured by cultural considerations. Perhaps the most famous illustration of this type of definitional ambiguity is to be found in the work of Eaton and Weil (1953). Their investigation utilized the services of trained professionals who examined the members of nineteen Hutterite communities for symptoms of mental aberrations. The professionals reached the conclusion that 23.2 of every 1,000 members of the sect had some form of mental disorder. Mental and emotional states which were labeled "neurotic" illness by psychiatric diagnosis were considered "normal" conditions of exultation or temptation within the religiously oriented Hutterite culture, however. What to the psychiatrists was mental illness was to the Hutterites a not unusual vicissitude of Godly living.

Other operational definitions which have attempted to encompass the entire range of disorders implied by the concept of mental illness have utilized both subjective test measures and objective enumerations of psychological symptoms and self-actualization evaluations. Each effort attempts to cope with the conceptual scope of mental illness. Each is limited more by the complexity and gamut of the concept than by lack of methodological ingenuity.

The Langner and Michael report, for example, is based upon the heavily funded Midtown Manhattan Study, a circumstance which allowed a "triangulation approach" to their operational definition of mental illness. The "triangulation" approach utilized a questionnaire derived from such instruments as the "Cornell Medical Index," the
"Army Neuro-Psychiatric Screening Adjunct," and the "Minnesota Multiphasic Personality Inventory" to guide interviews which lasted an average of 45 minutes. Subject responses were then transferred to a two-part summary form for evaluation by psychiatrists who did not always agree on the diagnostic category into which the respondent was classified. The result was that two new diagnostic groups were created and included in the research analysis. The subjects in these compromise categories made up 21.7% of the total of 1660 respondents. Symptom ratings by the same psychiatrist judges also had little internal consistency (Langner and Michael, 1963). Other researchers have avoided similar problems by confining their attention to one specific disorder which can be bounded by a particular set of symptoms. This has been the solution utilized in studies by Lidz, et al. (1965, 1968); Cohen, et al. (1954); Donnelly (1960); Horner (1964); and others.

From our consideration of definitional attempts we have concluded that the concept of mental illness is at a level of abstraction that renders satisfactory definition at the research level difficult if not impossible. We have, therefore, chosen to narrow our conceptualization and focus on the role of mental patient. On one hand this perspective may exclude some persons suffering mental disorders and may even include some whom circumstance rather than illness may continue within the patient role. On the other it enables us to define our research population with a definiteness based on both professional diagnoses and community norms. Our subjects are mental
patients. Their states of mental illness, or health, will not be
definitionally evaluated by this investigation.

Family

Previous studies have investigated family connected variables
in relationship to mental illness. Many of these have been limited
by ad hoc perspectives on their families from adult subjects. While
there is, perhaps, no time of life in which the effects of the family
may be examined without some risk of contamination from other sour­
ces, there is one period during which we may assume that contamina­
tion is minimal. That period is the time of childhood.

Cross-sectional investigations utilizing adult recollections
to uncover family conditions which existed during childhood present
certain problems of both ethics and validity. Because they depend
upon interview techniques with patients and their families, such
studies risk detriment to the well-being of patients and are of
suspicious validity since findings based upon memories and impres­
sions may be affected toward dubious accuracy not only by the pas­
sage of time but also by emotion and/or symptom biased perceptions,
as well as by systematic influences like socially held values, fam­
ily size and present characteristics of the patient.

This study seeks to avoid certain of these problems by utili­
zing longitudinal data from the hospital records of child mental
patients. The base line data, used in this study to predict mental
illness status, consists of information gathered by professionals,
psychiatrists and certified social workers, acting in their official capacities as employees of a state mental institution. The use of official records represents an unusual and challenging research opportunity since investigations using "hard" data which have focused on child mental patients have rarely been reported. More often studies like My Language Is Me (Parker, 1971), Dibs In Search of Self (Axline, 1964), Children Who Hate (Redl, 1951) and others utilize case history techniques to probe psychological antecedents and therapeutic successes with one or a few child patients. These investigations may have scientific value to the extent they clarify theory through illustration, thus suggesting hypotheses for more rigorous testing. On the other hand, generalizations from case studies may not always be valid since the case study technique is limited by a tendency to subjective researcher interpretations.

In a sense, however, this study is also a case study, since it utilizes data on an entire population of children in a single state mental facility. It is a case study relating family structure to mental patient status in one regional hospital. It seeks, however, to avoid the subjective analyses of many case studies through its use of data collected in advance of predicted outcomes. Our analysis will also allow an objective statistical examination of multiple independent variables as they combine and interact to affect behavior. However, because this study focuses on a single mental hospital, it cannot generalize with known validity about mentally disturbed children and their families in all societies. It can
generate hypotheses regarding the universe of child mental patients in all mental hospitals on the basis of unusually precise and valid exploratory research data.

Perhaps the limitation which has been most pervasive to research on the family has been a general neglect of theoretical base. In a review of sociological literature on the family published in major journals during the seven year period from 1962 through 1968, Klein, et al., reported that only ninety-one of six hundred articles surveyed could be considered theoretically based research. Three hundred and twenty-one other articles were classified as empirical reports without theoretical framework (Klein, et al., 1969).

Yet the area of the family is certainly not lacking in theoretical literature. Works by Hill and Hansen (1960), Christiansen (1964), Nye and Berardo (1966), Eshleman (1969) and others have reviewed and clarified a number of conceptual approaches to the sociology of marriage and the family. Specific theoretical perspectives have been enunciated by Parsons and Bales (1953), Zelditch (1955), Goode (1964), Reiss (1965), Stryker (1964) and others. On the surface at least, the state of the disciplinary area appears to be thriving. Yet Klein and associates were able to find traces of theoretical-conceptual frameworks in only two hundred and forty-seven of the six hundred research, theoretical, and "discussion" articles on marriage and the family which they surveyed. Of these the situational-interactional framework was most popular closely followed by the structural-functional approach. Even so, the first
of these two perspectives was the source either of discussion or research in only thirty articles over the seven year span sampled. The structural-functional perspective was utilized a total of twenty-seven times (Klein, et al., 1969).

Although Nye and Berardo identified and reviewed eleven separate theoretical perspectives in their book of essays on conceptual frameworks (1966), a glance at Figure I presents convincing evidence that only three sociological approaches have predominated during the past decade.

**Figure I**

Theoretical-Conceptual Frameworks Utilized In Sociological Articles on Marriage and the Family, 1962 through 1968

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<th>Framework</th>
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<td>Situational-Interactional</td>
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<td>27.3</td>
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<tr>
<td>Structural-Functional</td>
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<tr>
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<tr>
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<td>2.0</td>
</tr>
<tr>
<td>Historical</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>Economic</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Unclassified (Psychological, general sociological, social psychological, etc.)</td>
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(Klein, et al., 1969)

Certain of the basic assumptions of the dominant theoretical viewpoints have been implicitly but powerfully influential within sociology during this period. For example: many texts have accepted
as a "given" the structural-functionalist view that the defining characteristic of the family remains the responsibility for the reproduction and early socialization of children together with the provision for stable sexual and emotional relationships for adults (Leslie, 1967; Murdock, 1949; Coser, 1964).

Other traditional responsibilities, once also accepted as universal and prerequisite to societal survival, were the economic and educational functions of the family. These two functions are recognized as having diminished and even to have disappeared as industrialization and urbanization have weakened geographically based family bonds of extended kinship which created group solidarity through economic interdependence. Today, parental employment outside the home and public responsibility for the education of children are taken for granted in industrial societies and, we are told, the conjugal two parent family pattern is replacing extended kinship structures globally (Goode, 1970).

In 1965 the remaining accepted and defining universals of the conjugal family were challenged by Reiss, who maintained that the responsibilities for the primary socialization of the young and for the maintenance of emotional stability for adult family members were ethnocentrically created conceptualizations which were not characteristic of all families in all societies. Reiss argued that the nurturant socialization of the newborn is the only function of the family that is universal to all societies (Reiss, 1965).
The Reiss view of the family is an important divergence from the mainstream of sociological thought. The "companionship" family of the structural-functional perspective assumes a two parent paradigm with pathological connotations attached to variations from this model. The Reiss perspective forces the researcher to consider that it may not be variations from the two parent pattern which are intrinsically pathological but rather a lagging cultural perspective which forces disadvantageous and sometimes pathological interaction patterns upon normal but single-headed organisms in a society in which two heads are the norm.

Not only structural-functional theory, but also situational-interactional theory, has had considerable influence on research on the family. The latter is probably the more flexible of the two theoretical perspectives since it views the family as a "unity" of interacting personalities in a constant state of dynamic process (Eshleman, 1969, p. 34). Like the structural-functional viewpoint this perspective ordinarily accepts a two parent paradigm of family structure. When this paradigm is coupled with the statement by Burgess that "The family lives as long as interaction of its members exists and dies when this interaction ceases," (cited by Eshleman, 1969, p. 34) the pathological connotations connected with the single parent family pattern once again become pervasively influential to research; for in single parent families interaction with a second parent as significant other (Sullivan, 1953), sex role model (Mussen and Distler, 1959), or emotional outlet (Glasser and Glasser, 1965) is intermittent or non-existent.

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Slater has stated that "... the only time in a child's existence when two parents are 'necessary' is when it is conceived," (Slater, 1962, p. 297). From Slater's perspective the single parent family may be seen as a healthy mutation of the two parent family, better suited to the mobility and occupational diffusion of complex technological societies than the traditional family pattern from which it evolved.

It may be that the family, whether headed by a single or several parents, must be considered as a many-faceted social fact and that its relationship to the life outcomes for its children cannot be explained by reference (whether explicit or implicit) to only one theoretical perspective. The family influences its children as a system, interacting with other sub-systems within the total society; and as a group in a continuing interaction process with its members responding and adapting to one another. It shapes their futures as a small group, possessing attendant weaknesses and strengths, and as a systemic institution charged with responsibilities of socialization and allocation and valued with particularistic esteem or suspicion within its cultural setting. If we are to investigate its effects, we must attempt insofar as we are able to base our hypotheses on a totality of relevant considerations.

We are forced to be very explicit on this matter. We cannot accept an implicit assumption that the single parent family pattern is intrinsically pathological, for to do so would add an attitudinal bias to our methodology. Perhaps, as Slater indicates, the single
parent family is a lusty new species of the order, "family." This study attempts to clarify the issue by examining some characteristics and theoretical problems of parents within the one and two parent structural patterns.

The model of the two parent family which is most often used was developed by Parsons and Bales and tested by Zelditch (Parsons and Bales, 1955; Zelditch, 1955). It is a functional model, based upon a division of "tasks" between the parents, assigning major responsibility for expressive leadership to the maternal parent. The mother is the primary force for integration of the family unit, the principle source of nurturant attention and affection for its members.

The paternal parent is the instrumental leader of the two parent family. His primary responsibility is to provide for the material security of the group. Since his is the instrumental leadership, the father role is one of vital linkage between the family and the larger social system. Research generally supports the assertions that: (1) family status is derived from the father's social position; (2) the social attitudes of the paternal parent are reflected in the social perspectives of the children; and (3) the final source of discipline and authority within the family is the paternal parent in consequence of his instrumental power.

Several theoretical discussions have considered the problems involved when this traditional differentiation is combined in one role within the family headed by a single adult. The first of these, written by Glasser and Navarre in 1965, sees the single parent family
as a product of narrowing kinship patterns brought about by modern spatial mobility. They consider that the single parent family contains certain inherent characteristics which will tend to affect adversely its functions of allocation and socialization.

Glasser and Navarre suggest that the single parent will tend to feel excessively burdened by dual responsibility for often conflicting expressive and instrumental parental roles. This sense of overburdenment tends to become more acute since at the same time the single parent ordinarily suffers from deprivation of positive sources of adult support and sexual-emotional release which are available to married parental partners as part of traditional conjugal relationships. Under the circumstances, according to Glasser and Navarre, the lone parent may neglect or, at the very least, de-emphasize responsibility to either (or both) the expressive or the instrumental aspects of the parental role. This tendency toward neglect of some aspect of parental responsibilities affects in turn the socialization function of the family, creating voids and discontinuities which influence adversely the social perceptions of the children.

Because ninety per cent of all single parents are women, Glasser and Navarre suggest that children of one parent families may develop personality defects related to their affiliation with a single female-sexed parent. Since the preparation and opportunity structure of the occupational system is differentially lower for women, the children of a single female parent may suffer from physical and social deprivation connected with the economic situation of their family. Since
many acceptable avenues of communication with the larger society are often unavailable to the single female, her children may also suffer from a kind of family-based provincialism which is less prevalent among children of two parent families. Finally, Glasser and Navarre aver, the children of single parents may (as a result of deprivation of hetero-sexual role models) (1) develop a structurally distorted perception of the social world; (2) suffer unusual feelings of isolation and anxiety; (3) exhibit emotional problems in school and with peers; and (4) experience unusual difficulty in achieving independent adulthood (Glasser and Navarre, 1965).

In her 1970 article, Burgess discusses the single parent family as both a social and a sociological problem. Burgess emphasizes the isolating effects of contemporary social attitudes toward single parent families and maintains that many of the problems of single parents and their children stem from (1) social neglect of the emotional and financial dilemmas which plague single parents and (2) social labeling which often categorizes these families as "disorganized," "unstable," or "broken" (Burgess, 1970).

Consideration of the Glasser and Navarre and of the Burgess articles might lead to total acceptance of the dismal assumption that the one parent family is intrinsically pathological. Empirical research on this pattern of family structure, however, presents findings which are often ambiguous and sometimes contradict such a conclusion.
The Research Literature: Family and Mental Illness

Our interest in this discussion is concentrated upon characteristics of the single parent family as a causal variable related to a specific outcome, that of the child mental patient role. Yet much of the research on the single parent family has focused on a single aspect of the phenomenon, treating this familial pattern as the dependent and unhappy result of various social and social psychological factors. If we are to understand the influence exerted upon its children by the structure of the one parent family, we must therefore search in diverse areas of the available literature for data which can be interpreted inferentially as being relevant to our purposes; for these data are discovered not only in studies primarily concerned with mental illness, but also within other areas like social problems, deviant behavior, marital relationships, and employed women.

Early studies of schizophrenic patients disagree on the importance of family structure as an influence on the illness. In 1958 Wahl presented findings on a group of 392 schizophrenics. He showed that 48% of the males and 37% of the female subjects had lost a parent by death or separation before attaining the age of fifteen years. In his report Wahl quotes several studies which presented comparable figures for normals. In these the incidence of parental deprivation was consistently below 20% (Wahl, 1954).

Because Hollingshead and Redlich were examining social class rather than family structure in relation to mental illness, they did
not interpret certain findings of their 1958 investigation which are relevant to this review. Examination of their text, however, reveals that in Class V, the lowest of the social classes studied, 41% of the children under seventeen years in age came from "broken" homes. This class contributed eight times as many schizophrenic subjects as did Classes I and II combined. Actually, these two classes may be considered to encompass three categories or strata: a "core" upper-class category in which only 3.4% of the children lived in "broken" homes; a "new family" category in which 18% of the children lived in affluent but structurally "broken" homes and an upper middle-class group in which only 5% of the children had lost a parent by death or separation. Mention is made of extended kin arrangements which create additional adult-child relationships within the "core" and the middle-class groups (Hollingshead and Redlich, 1958).

Unfortunately, we have no way of knowing the contribution of subjects to the Hollingshead study which was made by these "broken" homes. The investigators established a relationship between marital disorganization and mental illness but did not control for family structure during childhood. The researchers were satisfied that social class accounted for the mental disturbances of their subjects. The weight of family structure within classes can only be inferred.

More recently, Stanley studied 176 young mental patients between the ages of seven and seventeen. These children were treated for emotional disorders in a children's unit of a state mental hospital during a six year period from July 1, 1961 to June 30, 1967.
Stanley reported that 60.2% of his subjects were from mother dominated families. Over 50% had experienced 180 days or more without the presence of a paternal parent. "Some" had experienced a succession of "fathers" (Stanley, 1970).

Hunt and Smith have related AFDC support of single parent female headed families to repetitive instances of illegitimacy and "inferior social, educational and physical development" in children. They cite research which reports almost double the percentage of community cross-sectional psychiatric problems in children of welfare families. The highest incidence of psychiatric impairment was suffered by Black children from both welfare and non-welfare families. For Blacks as a group, the onset of psychiatric problems was reported to be a problem of adolescence; but for Black children from welfare families, mental and emotional disturbances often became manifest during the early elementary years of education when the children were from six to nine years in age (Hunt and Smith, 1969).

The hypothesis that the single parent family structure is contributory to mental illness receives inferential support from the series of case studies of families of schizophrenics reported by Lidz and associates over a period of years. Lidz has called schizophrenia a "deficiency disease;" the deficiency indicated being in the area of socialization (Lidz, et al., 1965, p. 363). The entire orientation of these researchers to their long-term intensive study of the intrafamilial environments in which schizophrenic patients develop is based upon a conviction that a pathological family
environment is an important factor in the etiology of schizophrenia. In their 1965 report Lidz and his associates concluded that in every case at least one parent, usually the mother, had used the child as a sort of substitute for a spouse with whom they had a distorted and unsatisfactory relationship. According to the researchers, this substitution leads to potential homosexuality, feelings of rejection and incestuous tendencies with concomitant intensification and prolongation of a need for parental protection (Lidz, et al., 1965).

Lidz' studies convinced him that the family of the schizophrenic patient is of vital importance, not only as part of the etiological background of illness, but also as a therapeutic problem. Lidz enunciated his conclusion in a 1968 lecture in which he indicated that (1) therapy must provide socializing experiences which have been missed by the patient because of his familial background; and (2) include family therapy as an essential ingredient to patient recovery. In Lidz' opinion "Even after prolonged hospital stay, it is usually unwise for the patient to return to his family" (Lidz, 1968).

Kohn and Clausen were engaged in an ecologically oriented study of the etiology of mental illness when they were forced to revise some of their basic assumptions and hypotheses. They had assumed that there would be a relationship between neighborhood characteristics and/or father's occupation and the incidence of mental illness. Their assumption was not supported by their findings. What they did find was that their schizophrenic subjects differed from their matched controls in certain significant respects -- especially with
reference to their social participation in childhood and adolescence and to the structuring of parental authority relationships within their families (Kohn and Clausen, 1955). Clausen reached the conclusion that the designation of a person as being mentally ill is related not only to psychological states but also, and importantly, to cultural stereotypes and to social and psychological characteristics which may have little to do with illness as such. Like Lidz, Clausen concludes that much of mental illness is based upon "faulty socialization," which creates unsuccessful social performances that, in turn, lead to the label of "mentally ill" (Clausen, 1968, p. 44).

The opinion that mental illness is importantly the socially defined product of deficient or faulty socialization has been echoed from another perspective by Goffman and Becker who discuss deficiencies in terms of "command of performance," and suggest that the person who is defined as mentally ill may never have mastered the social "rituals" which create successful interaction experiences and a stable definition of self (Goffman, 1959; Becker, 1962).

The family is usually the major and the first agent of socialization. Particular two parent family types appear with regularity in research on familial backgrounds of mentally disturbed subjects. Typically, the mother is the dominant parent. A subordinated paternal parent usually is a shadowy or somewhat cold figure to the disturbed subject. Overanxious patients tend to have a dominant maternal parent who is overprotective. Aggressive schizophrenic patients often have a dominant maternal parent who is rejecting and
demanding (Lidz, 1965). Maternal dominance is the attribute which is a common tendency in these two parent families -- and the single parent family is by definition dominated by its adult head who is often female.

A few studies have examined father absence in relationship to mental and emotional problems of boys. Research dealing with wives and sons of Norwegian sailors has presented evidence that these children of absent fathers were characterized by greater immaturity dependence, inept peer relationships and compensatory or aggressive behavior than were boys from father-present families (Lynn and Sawrey, 1959; Sawrey, 1959).

Wylie and Delgado studied twenty father-absent boys at Youth Guidance Center in New England. They found the same tendency to aggressive behavior among their subjects as that which had characterized the Norwegian children. A majority of their subjects combined learning problems with their aggressive tendencies (Wylie and Delgado, 1959).

In another study of father-absent adolescent boys, Kopf concluded that the most important family variable associated with school adjustment involved maternal attitudes and behavior more than the fact of father absence (Kopf, 1970).

Earlier, Pederson reported that emotionally disturbed and normal sons from military families showed differential effects of father absence. This differential appeared to be related to personality disturbances of maternal parents. Pederson postulated "an
interaction between father absence, maternal pathology and the child's degree of disturbance" (Pederson, 1966).

Harris reached a somewhat similar conclusion in a report which analyzed factors contributing to learning difficulties of school-aged boys. Harris attributed problems in concentration and academic skills to "a chronic feeling of anxious insecurity" related to the ineptitude or rejection of their mothers as homemakers (Harris, 1966).

On the other hand, employed mothers who like single parents might be expected to evidence functional similarities to the mothers of the Harris study because of their "double and conflicting roles" seem to have little or no abnormal influence upon their young children's attitudes. This was the conclusion reached by Nye, et al., in research investigating hypothesized differences in nervous symptoms, antisocial and withdrawing behavior between children of employed and non-employed maternal parents (Nye, et al., 1963).

Siegel, et al. (1963), examined matched groups of pre-school children of working and non-working mothers but found no significant differences in either dependency or aggressive behaviors between the two groups (Siegel, et al., 1963). They suggested, however, a sex differential in the impact of maternal employment. Similarly, Burchinal also reported that he found no significant differences in the personalities and school adjustment characteristics of white children from two parent families whose mothers were employed and the characteristics of their peer counterparts whose mothers were not working outside their homes (Burchinal, 1964).
In a study of child adjustment and mothers' attitudes, Hoffman concluded that children whose employed mothers held positive attitudes toward working were significantly less successful in peer group relationships than were the children of non-working maternal parents. Children whose mothers worked but held negative attitudes toward employment manifested low frustration levels and aggressive tendencies. The sons of employed mothers were significantly more dependent upon their teachers than were those whose mothers were not employed (Hoffman, 1961).

One major sociological work on divorce is that of Goode. In it he conceded that there is "no doubt that broken homes are related to juvenile delinquency, even within the same economic stratum" (Goode, 1956, 1965, p. 308). Despite this concession, however, Goode concluded that most divorced mothers felt that there were positive effects for their children in the change to a tranquil single parent home from one of pre-divorce conflict.

Nye furnished support for Goode's position with findings that adolescents from broken homes were better adjusted in 13 of 21 measures than were children from unhappy but intact families (Nye, 1957). Neither Goode nor Nye, however, made comparisons of children from broken homes with children from home environments which could be rated as "normal" in marital satisfaction.

The trauma experienced by children when parents divorce was investigated by Landis in the mid-fifties. Landis utilized 295 college students as respondents to an eight page questionnaire. He
found that remembered traumatic effects were greater for children who had perceived their families as happy than for those children to whom their parents' divorce came as a relief from unhappy family situations. Children who remembered pre-divorce conflict between their parents experienced less personal trauma but felt more "used" by their parents during and after the family breakup. Approximately one third of Landis' subjects, including some too young at the time of divorce to recall the event, had felt "different" from other children and had used face-saving strategies to bolster their lack of self-confidence in peer interaction (Landis, 1960).

Studies on the effects of parental loss by death have presented conflicting conclusions regarding the relative impact of the loss of one or the other parent. Wahl found four times the incidence of parental loss by death among his mentally ill subjects than that prevalent among the general population. Since death of the paternal parent was a far more common occurrence among his subjects than was death of a mother, Wahl suggested that the factor of father bereavement might explain the greater frequency of schizophrenic psychosis found among males (Wahl, 1954).

Still earlier, Blum and Rosenweig also found the incidence of parental death to be higher among their 147 mentally ill subjects than was normal for the general population. Their findings led them to believe that the death of the same sex parent is most traumatic to a child's mental and emotional well-being (Blum and Rosenweig, 1944). Barry, however, found no substantial differences by
sex in the impact of parental death upon his young psychotic sub-
jects (Barry, 1939).

Jenkins classified 1500 subjects according to six problematic be-
havioral categories; an overanxious group, an undomesticated group,
a socialized delinquent group, a withdrawn group, a brain-damaged
group, and a mentally retarded group. Three of these, he found,
were characterized by a predominant attribute of family background.
Children who were classified as "overanxious" because of fearfulness,
shyness, etc. tended to be youngest children of over-protective
mothers. Those children who were classified as "undomesticated,"
or unsocialized aggressive because of their manifestations of hos-
tility, temper, firesetting, etc. tended to come from homes charac-
terized by overtly critical and rejecting mothers. Lack of consis-
tency was an attribute typical of both parents of these unsocialized
youngsters.

"Socialized delinquents," like the undomesticated subjects,
tended to come from large families. These aggressive children were
so classified as a result of behavioral acts which involved theft,
truancy and running away. Their family background typically in-
cluded a cold and neglecting mother and a rigid and punitive father
or stepfather. Children from broken homes tended to predominate in
both aggressive categories. In general boys outnumbered girls by
a ratio of two or more to one in each of the three behavioral groups.
Almost half of the girls were classified as "overanxious" (Jenkins,
1967).
Bronfenbrenner has stated that, "In general, father absence contributes to low motivation for achievement, inability to defer immediate for later gratification, low self-esteem, susceptibility to group influence, and juvenile delinquency. All of these effects are much more marked for boys than for girls." (Bronfenbrenner, 1967, p. 525.)

A number of investigators agree that broken homes are more productive of juvenile delinquents than are intact ones. Not all of these agree with Brofenbrenner that the effects are more marked for boys than for girls, however. A summary of eight studies made between 1899 and 1949 presents evidence that girls are influenced toward delinquency by a broken familial background more consistently than are boys from similar homes. In these eight studies the proportion of male delinquents from broken families ranged from 14% to 54%; 38% to 68% of the delinquent girls in the studies were from broken families. In this recapitulation of fifty years of research on delinquency, the median percentage of male delinquents from single parent families was 34.5%. The median for female delinquents was 52% or 17.5% greater (Shulman, 1961).

A percentage differential similar to that of the above half-century summary of delinquency attributes was found in a study of school dropout in 1964. 64% of the girls and 48% of the boys who left high school before graduating were from broken homes. Only 12% of the girls and 28% of the boys who graduated were from disrupted family backgrounds (Schreiber, 1969).
A comparison of studies on school dropouts in Alabama during 1964 and in Los Angeles in 1965 shows almost identical relationships between dropout and family background. 42% of the Alabama dropouts and 43% of those in Los Angeles were not living in homes shared by both their natural parents (Schreiber, 1969).

One characteristic, prevalent among nearly 61% of the 500 delinquent boys who were the subjects of the Gluecks' study of family environment and delinquency was a family background in which there was a severed marital relationship (Glueck and Glueck, 1962).

More recently, Chilton and Markle also conclude that more juvenile delinquents come from broken families than do children who are not delinquent. They found: (1) that delinquents from one parent families more often commit serious offenses; and (2) that children from one parent families are more often recidivistically delinquent than are children from families with traditional structures (Chilton and Markle, 1972).

Other researchers have challenged the basic assumptions and methods of studies like the ones reviewed above on the grounds that sampling procedures utilizing subjects who have been in some way officially designated "delinquent" are biased toward inclusion of boys from lower class and single parent homes. These researchers argue that delinquent acts may be prevalent among girls and among children of middle class and traditionally patterned families also, but that these offenders are unlikely to become listed in the records of police and community agencies. This argument has led to...
a number of investigations based upon self-reports of delinquent acts by middle class boys and girls. These affirm the contention that there are large areas of society in which delinquency is protected from official community action (Wise, 1967; Nye, et al., 1958).

A large body of research literature relates deviant behavior to factors other than family variables. An early approach relates deviance, criminality, mental illness, etc. to biological pre-dispositions of typology and/or heredity. The most famous of the somatotypologies was developed by Sheldon in the late forties. He identified three "ideal" body types, based respectively on physical tendencies toward obesity, muscularity, and fragile slimness. From his study of 200 delinquent boys, Sheldon decided that mesomorphy, which is characterized by muscularity and nervous energy, is most conducive to delinquent behaviors of the three constitutional types and suggested that only through selective breeding could the problem of delinquency be solved (Sheldon, 1949).

Sheldon and Eleanor Glueck undertook to test the Sheldon typology in a mammoth and methodologically impressive investigation involving 500 delinquent boys together with an equivalent number of non-delinquents. They concluded that the mesomorphic body type represents at most a potential which is only activated in combination with other factors of environment, situation and personal meaning (Glueck and Glueck, 1956).

A number of investigations of genetic factors in relationship to personality maladjustment have utilized twins as subjects and controls. Typical of these is a study by Kallmann which concludes
that the "chance of developing schizophrenia in comparable environments increases in proportion to the degree of blood relationship to a schizophrenic case." Kallmann maintains that schizophrenia must be a genetic predisposition "probably recessive and autosomal" (Kallmann, 1961, p. 97).

Still another body of research relates deviance to social class. The Hollingshead and Redlich study is a model of this category, since it relates rates of incidence, types of mental illness, and treatment procedures and durations to the social strata of various categories of patients (Hollingshead and Redlich, 1958).

A decade after the Hollingshead and Redlich research, a "follow-up" investigation was undertaken, using essentially the original population. This research reported that social class was still a decisive factor in the prognosis of mental illness, affecting not only treatment but also the readmission rate and post-hospitalization social adjustment of mental patients. The higher his social status, the less likely a subject from the original Hollingshead and Redlich research was to be hospitalized after the passing of ten years (Myers, Bean and Pepper, 1965).

Langner and Michael's report based on the Midtown Manhattan Study also concentrates on socio-economic status as the major source of stress. They assume socio-economic status mediates and interacts with all other "componant variables," i.e., health and family, creating a pattern of cummulative strain (Langner and Michael, 1963).

Ecological studies, relating mental illness to factors of
spatial distribution, would appear to be closely related to those which concentrate on social class since residences are likely to be segregated according to class distinctions. Using an ecological approach, Faris and Dunham found progressive decreases in mental illness from city center outward in both Chicago and Providence. This pattern was true only for schizophrenic disturbances; cases of manic depressive psychosis were scattered throughout the cities in random fashion (Faris and Dunham, 1939, 1960).

Other studies by McKenzie (1921), Mowrer (1942) and Dunham himself (1947) supported the Faris and Dunham conclusions. Others by Jaco (1960) and by Kennedy (1964) have contradicted the circular patterning. These studies have found mental illness to be spatially patterned but not in the radial manner proposed as a universal rule by Faris and Dunham.

Ecological studies have tended to concentrate attention on urban areas, guided by an implicit assumption that mental illness is irrevocably linked to the gesellschaften life style of city dwellers. Research has suggested that this assumption may not be correct. A few investigators have found evidence that the apparent differential between incidence of mental disturbance in cities and rural areas may be a reflection of hospital first admission rates in cities. In other words, there may be a treatment differential rather than one of rate between the country and the city (Owen, 1941; Presidential Commission on Income Maintenance Programs, 1969).

Finally, let us consider a group of investigations which deal
with marginality and mental illness. Under this classification we will subsume studies of occupational mobility like that of Ellis (1952); of ethnic mobility represented by the work of Stoneququist (1937; 1961), Kerckhoff and McCormick (1955) and McBee (1935); and of ethnic discrimination and segregation. The latter category has been the subject for a number of analyses and studies, notably by Kardiner and Oussay (1951) and by Grier and Cobbs (1968). All of these have found positive relationships between marginality and mental illness. We would emphasize that marginality, not ethnicity, appears to be the key factor. In pluralistic societies where pressures toward acculturation are low or in societies in which immigrant groups are able to preserve an "ethnic density," rates of hospitalized mental illness have been shown to be very low. In at least several studies these rates have been shown to be lower than that of the general population (Murphy, 1959; Mintz and Schwartz, 1964). However, whether this reflects a differential in treatment customs like that hypothesized between rural and urban areas remains an untested possibility.

Although we have discussed a number of the most prevalent approaches to research on the mentally ill, it may be argued that we have never really strayed from the area of the family. Our synthesis of theoretical perspectives will be based upon the assumption that the influence of the family is pervasive in every situation of a child's existence. From this point of view each of the research approaches discussed in this section are family based. A child
inherits body type and genetic predispositions from his biological parents. His social status is ascribed to him during his childhood years from that accorded to the head of his family. His area of residence is dependent upon the same circumstance. And, finally, in a sense every child becomes a migrant when he first ventures from his family primary group into a world of school and peers and secondary relationships. For some children this immigration may constitute a more traumatic "cultural shock" than for others. It is our intention in the section which follows to explore the impact the single parent familial pattern may have in intensifying, not only the child's trauma, but also the societal reactions to it which might lead to a relatively permanent allocation of the youngster to the role of mental patient.

Our review of the literature has led to a theoretical problem which is both social and social psychological. We have uncovered an apparent paradox. On one hand a respectable body of research has found no differences in the mental states of children from single and two parent and on the other hand we have discovered research which strongly suggests that a single or dominant parent familial background contributes to the susceptibility of children to delinquency and/or mental illness. We must create an explanation if we are to reconcile these apparent paradoxical observations found within the literature. It is to this reconciliation that we next turn our attention.

The discussion which follows offers several explanations, an
important one of which centers on the family as a small group which is a sub-system of society. From this theoretical perspective the dyadic child-parent relationship is viewed as conducive to manifestations of performance error (residual deviance) on the part of children, not only within their family units but also in their early contacts with peers and schools. These performance errors by children are likely to be exacerbated by the suspicion and status ambivalence which may be accorded to children of one parent families, a family structure believed to be a deviant pattern by a large portion of present day society. Thus, deviant behavior like extreme timidity, aggression, and fantasizing, which might be denied, and therefore transitory, if exhibited by children from two parented backgrounds may be labeled by many as "abnormal" and "bizarre" when it is perceived in one parented children. This labeling, based upon expectations of unusual products from unusual family patterns, tends not only to affirm initial deviance but also to distinguish and therefore reinforce the perpetrator. This sets up circular interactions between self-fulfilling prophecy and behavior which effectively bias socialization processes toward self-acceptance of deviancy by the children and toward their differential allocation and retention in social roles as mental patients.
The One Parent Family as a Small Group

Coser indicates that a stable group should be large enough to furnish an outlet for the free expression of both positive and emotional tension. In order to do this, its size should be flexible to the extent that the loss of one of its numbers can be tolerated but not ignored (Coser, 1964). In a day when bonds of extended kinship have weakened and all but disappeared, the single parent family ordinarily does not meet Coser's criterion.

Considered as a dyadic group, every family headed by a single adult shares a structural instability, a potential for sudden dissolution by loss of a single member. Because the dyad has an irreplaceable membership structure, it tends to create uniquely close and dependent relationships of intense but insecure interaction and, at the same time, to guard jealously against non-member infiltration and renegade disaffiliation. Yet in the one parent family each child's security is anchored rigidly in a single adult-child dyad.

This ordinarily is not true of the traditional two parent family since it is structured to allow both dyadic and triadic intergenerational permutations of interaction. This multiplicity of interaction possibilities promotes stability and mediates tension for both children and parents through a give and take of changing coalitions, (Bossard and Ball, 1960). In the two parent family these permutations ordinarily are also wholesome sources of socialization and reassurance, although they can become dysfunctional as in instances

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when one parent usurps adult domination and/or uses them for neurotic personal goals. Ideally, however, these subsystems, or permutations, evolve through time, allowing the child to identify with an expanding social world supported by the security provided by the combined solicitude of two biological or sociological parents.

In consequence of the unique pattern of the single parent family, its children may be denied the customary physical and emotional security accorded children by the structure of the traditional family. Because it is basically a dyad, the single parent structure is characterized by two disparate attributes: (1) the optimal conditions for the internalization of parental values, since nurturance and discipline necessarily issue from a single source (Slater, 1962) and (2) the optimal conditions for development of anxious insecurity, rigidity and repressed hostility (Coser, 1964). Lacking security, the children of single parent families may never develop the "basic trust" which Erik Erikson has called the "first component of a healthy personality," (Erikson, 1955, p. 55) and which Bettelheim has described as "the ground rock of all later trust in others and in oneself . . ." (Bettelheim, 1968, p. 215).

As a further consequence of the dyadic pattern of the one parent family, adult authority is represented to the child in the figure of his single parent who, because of the inter-generational structure of the dyad, is inevitably leader to the child as follower. So the single parent is possessed of totalitarian power but at the same time is deprived of emotional outlet and support available in the traditional conjugal coalition. The product of this combination of power
and deprivation may be inconsistent treatment of the child thus creating malevolent attitudes (Sullivan, 1953).

Even if the dyadic child-parent relationship escapes this tendency to malevolence development, the child's achievement of personal autonomy may still be impeded in a number of ways. If the single parent is over-protective, the child may suffer deprivation of successive experiential challenges which normally develop an expanding capacity to cope with the social and physical environment. Thus the child is unsure of his abilities and may respond to outside contact with school and peers with fearfulness culminating in heightened susceptibility to psychosomatic illness and other neurotic manifestations (Malamud, 1944).

If the single parent is demanding, the child, driven by the unstable attributes of his dyadic security source, may in order to maintain his family role respond with the sort of inauthenticity of behavior which has been described by Lidz as an ingredient of certain types of schizophrenia (Lidz, et al., 1968).

By definition the single parent structure cannot furnish double adult sex role models within the group. Thus the opposite sexed child of the single parent family may internalize inappropriate attitudes and behaviors for his ascribed sexual status, resulting in conflict with social norms and susceptibility to resultant trauma (McCord, et al., 1964).

Finally, the child's achievement of personal autonomy may be impeded by his perception of his single parent as undemocratic and
rejecting. The resentment caused by this perception will tend to remain unresolved because of the child's intense need to maintain a stable family relationship. Since it is suppressed, this resentment may be extended over time to other persons resulting in aggressive tendencies toward peers and/or ambivalent attitudes toward adult authority which may remain unsuspected and therefore unresolved until tension causes covert hostility to become overt aggression or unconventional behavior (Burgess, et al., 1963).

The One Parent Family as a Sub-System of Society

The family is not only a small group, it is also a social system with functions which create overlapping boundaries with other sub-systems in the larger society.

These points of overlap do not at first consciously concern the growing child. They affect him nonetheless. For the social status which is accorded his family is also his by virtue of his biological membership. The status of his family may restrict or enlarge his opportunities. It will surely affect his self-identity through the treatment he will be accorded as he begins to interact with members of other societal sub-systems.

Our review of the literature has uncovered a paradox which is worthy of recapitulation at this point. Methodologically sound studies by Nye, et al., and others have uncovered no significant differences in personality between one and two parented children whose behavior falls with a range that is considered "normal."
Yet investigations of "abnormal" groups find a disproportionate number of children from homes headed by a single adult. Are "normal" children from single parent families more susceptible to abnormalities? Or are they more susceptible to a societal definition as "abnormal" and to subsequent allocation and retention in deviant role engulfment via a series of self-fulfilling prophecies based upon the structure of their families?

The allocation functions of the family and the school have been the basis for encyclopedic theoretical and methodological endeavors within sociology. Many of these efforts concern themselves with the social statuses and occupational roles which are the adult outcomes of allocating forces inherent to families and to schools. Others describe the processes by which these manipulate not only children's future accessibility to various positions in the opportunity structure but also their self-definitions as to their worthiness to assume the various roles attending these positions. In other words, the allocation functions of the family and the school have been presented as acting both to assign or restrict opportunity and to ensure acceptance of those roles which function to maintain the systemic equilibrium of the total society (Parsons, 1959; Coser, 1951; Turner, 1969).

It may be that there is a logical but seldom verbalized extension to sociology's acceptance of allocation as a function of socialization. Perhaps there is a reverse side to the allocation coin; for, if most children are assigned and molded to accept "normal"
roles necessary to the maintenance of society, it may follow that some children are allocated and socialized to accept deviant roles with latent, but equally, indispensible functions.

The View of Deviance as a Consequence

During the past several decades the view of deviance as a social role has begun to gain acceptance through the efforts of Lemert, Becker, Goffman, Scheff and others of the "Labeling Perspective." Their approach has evolved from the Symbolic Interactionism emphasis on social process but is not antithetical to Functional Theory.

Because "labeling theorists" tend to view deviance as a consequence rather than a quality, they insist upon a duality of emphases: (1) the interaction processes through which a society assigns deviance as an ascribed status and (2) the interaction processes through which a person becomes deviant as an achieved status. These dual emphases contribute a directional broadening, although not an entirely new concern, to deviance theory. The often quoted words of Becker state it most succinctly:

"... deviant behavior is behavior that people so label."

and

"We need a model which takes into account the fact that patterns of [deviant] behavior develop in orderly sequence."

(Becker, 1963, pp. 9 and 23.)

Many of the basic elements of labeling theory originate in the ideas of George Herbert Mead and his conceptualization of the development through interaction of a social self. Mead's explication of
social interaction as a reflexive process in which ego and other(s) act and respond to one another, his concept of the generalized other and his interpretation of the self as a social object with whom ego may experience interaction are all important elements in labeling theory. So, also, are Mead's concepts of career and commitment (Mead, 1934).

Edwin M. Lemert is usually credited with the founding of the labeling perspective. In 1951 he published a book entitled Social Pathology: A Systematic Approach to the Theory of Sociopathic Behavior. In it he presented a theory of deviance as a "process of deviance and societal reaction . . ." The Theory has seven postulates:

"1. There are modalities in human behavior and clusters of deviations from those modalities which can be identified and described for situations specified in time and space.

2. Behavioral deviations are a function of culture conflict which is expressed through social organization.

3. There are societal reactions to deviations ranging from strong approval through indifference to strong disapproval.

4. Sociopathic behavior is deviation which is effectively disapproved.

5. The deviant person is one whose role, status, function, and self-definition are importantly shaped by how much deviation he engages in, by the degree of its social visibility, by the particular exposure he has to the societal reaction, and by the nature and strength of the societal reaction.

6. There are patterns of restriction and freedom in the social participation of deviants which are related directly to their status, role, and self-definitions.
The biological strictures upon social participation of deviants are directly significant in comparatively few cases.

7. Deviants are individuated with respect to their vulnerability to the societal reaction because: (a) the person is a dynamic agent, (b) there is a structuring to each personality which acts as a set of limits within which the societal reaction operates."

(Lemert, 1951, pp. 22-23.)

In the same volume Lemert also contributes his concepts of primary and secondary deviation (Lemert, 1951, pp. 75-77). Primary deviation refers to deviant behavior which exists within a context of role which is socially acceptable. In Lemert's self-italicized words: "When a person begins to employ his deviant behavior or a role based upon it as a means of defense, attack, or adjustment to the overt and covert problems created by the consequent societal reaction to him his deviation is secondary." He continues:

"... a point is reached where ingrouping and outgrouping between the society and the deviant is manifest. At this point a stigmatizing of the deviant occurs in the form of name calling, labeling, or stereotyping.

"The sequence of interaction leading to secondary deviation is roughly as follows:

(1) primary deviation; (2) social penalties; (3) further primary deviation; (4) stronger penalties and rejections; (5) further deviation, perhaps with hostilities and resentment beginning to focus upon those doing the penalizing; (6) crisis reached in the tolerance quotient, expressed in formal action by the community stigmatizing of the deviant; (7) strengthening of the deviant conduct as a reaction to the stigmatizing and penalties; (8) ultimate acceptance of deviant social status and efforts at adjustment on the basis of the associated role." (Lemert, 1951, p. 77.)

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The viewpoint expressed by Lemert contributed enormously to the healthy infancy of labeling theory while at the same time it seriously, if not mortally, wounded perspectives which (1) were basically static cause and effect explanations and (2) treated deviance as involving the concepts of status and role. To those who followed Lemert, the causes of primary acts of deviance were relatively unimportant: the processes which led from the primary act to the secondary deviance outcome were far more significant, since their action-reaction patterning between society and individual implied a cumulative alternation as independent and dependent variable.

If Lemert can be credited with having founded labeling theory, Howard Becker almost certainly should be credited with elaborating and "popularizing" his approach. During the 50's Becker wrote a number of essays on deviance which were published in 1963 in a collection called *Outsiders: Studies in the Sociology of Deviance*. The book is small, simply written and easily read. Its impact has been megatonic. In it Becker "labeled" the perspective by his recurring use of the term, labeling, and by the definition: "The deviant is one to whom that label has successfully been applied: deviant behavior is behavior that people so label." (1963, p. 9.)

Becker introduced the idea of the deviant career as a step by step sequence of chance events ("contingencies") which at any point may pass an individual on toward or away from an outcome of what Becker terms "deviant commitment." (1963, pp. 24-39.) Having introduced the concept of "career," Becker amplified it by delineating
first the careers and then the consequences of several groups of deviants; marijuana users and jazz musicians, then shifted to the other element in the deviance equation to follow the natural history, or "career," through which rules are made and enforced.

Scheff has developed a labeling oriented theory of mental illness as "residually deviant behavior." He suggests that society labels as "mentally ill" those persons who violate norms which are so taken for granted that violation of them is beyond normal expectation. Society has developed a vocabulary for categorizing deviant behaviors like "crime, perversion, drunkenness and bad manners." Others, like refusing to face a conversational partner or looking into his forehead rather than his eyes, we may find strangely bizarre. It is these behaviors that are placed in a residual category which we label "mental illness" (Scheff, 1963).

Scheff maintains that residual deviance arises from diverse sources and that, while it is widespread, it is largely unnoticed or denied and transitory. He hypothesizes "that the most important single factor (but not the only factor) in the stabilization of residual deviance is the societal reaction. Residual deviance," according to Scheff, "may be stabilized if it is defined to be evidence of mental illness, and/or the deviant is placed in a deviant status and begins to play the role of the mentally ill." (Scheff, 1963, p. 54.)

We have shown earlier in this discussion how residual deviance could be socialized in the context of interaction with a single
parent. While rejecting, overprotective, and inconsistent parents are to be found within the structure of two parent families, tendencies to these characteristics are surely increased by the heavy burdens of responsibility borne by single parents. At the same time parental impact on children must also be greater under the conditions of parental domination which are inevitably part of the familial pattern.

Even before children leave their family communities to migrate to the larger one of peers and teachers, they have been assigned the status of their family. Ordinarily, their status is based upon that of their father; a circumstance which may, but normally does not, contribute to marginality in their new surroundings since father's occupation is usually the primary determinant of their place in the hierarchy of social stratification and this is a relatively impersonal attribute.

For the children of single parents, this is not true. Their families are marginal families in present day society by virtue of their structure and that marginality creates an ambivalent status for them. Goode has written of "status ambivalence" as a force creating pressures toward remarriage for the single parent (Goode, 1965). Status ambivalence may also bias social views of the residual (primary) deviant acts of children from single parent families, affirming and reinforcing them; in short allocating and retaining children in processual careers leading to deviant social roles as mental patients.
Similar to lower class juvenile delinquents, these children may be less protected from official labeling than are children with clearly defined family statuses. At the same time they may be more liable to certain errors of social performance because of the intense dyadic isolation of their early socialization.

From this perspective, a typical "career" of the single parented child mental patient might develop in the following processual stages: Intensely dyadic early socialization may result in errors of social performance (residual deviance), both with peers and teachers and within the child's family. These errors are affirmed rather than denied because of the ambivalent social status of the family and its members. Affirmation adds to status ambivalence and reinforces the original residual deviance, generalizing and socializing the child to ever-widening life situations and evaluations of deviance which become officially certified by society and accepted by the child with his entry into a hospitalized mental patient role. Hospital admission is accompanied by staff evaluations which also are influenced by knowledge of the structure of the patient's family. Even recovery, i.e., release from treatment and the custodial safety of the hospital, is affected by staff members who may be reluctant to release a child to a family whose structure they evaluate as pathological and therefore detrimental to the child's emotional well-being.
General Hypothesis and Research Objectives

Viewed from the perspective of small group and labeling theory, children of one parent families may exhibit tendencies toward residual deviance caused by faulty social performances learned within the context of their intimate but insecure relationships with their dyadic single parents. Because society views family structures which do not conform to the two parent ideal with ambivalent suspicion, this residual deviance will not be rendered transitory by denial, but rather will be affirmed and reinforced by a series of evaluative contingencies which culminate, but do not end, with the allocation of the children to the roles of hospitalized mental patients. The duration of this allocation will be dependent upon staff evaluations which also will be influenced by the single parent pattern of the children's families, thus acting to retain children within their mental patient roles for periods of time which will be longer for children of single parents than for those of traditional familial backgrounds.

Based upon this synthesis of small group and labeling theory, the following general hypothesis constitutes the elaborated thesis tested in this investigation:

Child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families, when controlling for diagnosed illness, social class and other social and psychological factors generally considered relevant to forecasting length of hospitalization.
This, then, is the general hypothesis which guided the research phase of this study and which was tested with data collected on child mental patients in a state mental hospital in the midwestern United States.

Certain other variables such as social class and age may add to the exposure of children to the evaluative decisions and socialization experiences which affirm or deny the allocation of single parented children to mental patient roles. These, together with other selected variables like diagnosis, genetic background of mental illness, and others which have been demonstrated or asserted by previous investigators to contribute to the incidence and duration of mental illness, will be used as control variables in this study.

In addition it may be that some variables like social class, mother's age, and genetic background interact with the structure of children's families in affecting the allocation and retention of children in mental patient roles. These will be the focus of exploratory analysis which seeks to answer the following questions:

**Question 1:** Does knowledge of family structure, i.e., single or two parent familial background add importantly to considerations like diagnosis, genetic predispositions, socio-economic status, urban-rural environment, race, sex and developmental stage of maturity in predicting lengths of time child mental patients will be hospitalized?

**Question 2:** What are the relative influences of social and psychological variables like diagnosis, genetic predispositions, socio-economic status, urban-rural environment, race, sex and developmental stage of maturity on the lengths of hospitalization of child mental patients from one parent vs. those from two parent families?
Question 3: What have been the effects of child patient oriented programs on lengths of stay of child mental patients? Are these effects differentiated by the family structure of the patients? By sex? By age? By race?

Question 4: Is there a tendency for differential diagnoses to accrue to child mental patients from one parent families? From families with two parents?
CHAPTER II

METHODS

The Guides to Research Procedures

From the theoretical perspectives discussed in the previous chapter, the following general hypotheses were developed:

$H_{R_1}$: Child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families.

$H_{R_1a}$: Child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families, controlling for the effects of diagnosis, family members in mentally ill roles, socio-economic status, urban-rural environment, race, sex, birth order and developmental stage of maturity.

Three derived hypotheses also guide the procedures and considerations of this investigation:

$H_{R_2}$: The relative influences of diagnosis, history of family roles of mental illness, socio-economic status, urban-rural environment, race, sex, birth order and developmental stage of maturity on length of hospitalization will be greater for child mental patients from single parent families than for those from two parent families.

$H_{R_3}$: Diagnoses which are dependent upon organic symptoms of illness (with central nervous system damage and seizures) will tend to be equally distributed between single and two parented child mental patients.

$H_{R_4}$: Diagnoses which are dependent upon subjective evaluations of illnesses (psychosis, neurosis, adjustment reaction of childhood, without central nervous system damage and/or seizures) will tend to accrue to children of single parent families in greater proportions than to children of two parent families.
Related analyses examine the influences of hospital program, type of admittance, intelligence level, sibling numbers and mother's age and education in order to ascertain the contributions of these to the prediction of length of hospitalization.

The Population and the Research Setting

The subjects were patients in a state hospital which serves both adults and children from a thirteen county area in southwestern lower Michigan. Like the three other residential mental hospitals in the state, it provides comprehensive programs for children who are under treatment for emotional and mental disorders. These programs include:

(1) psychiatric evaluation and screening;
(2) non-residential day care services for area children,
(3) night care services for children who are in advanced treatment and attending public schools,
(4) residential treatment, including on-site educational facilities, for children from the thirteen county service area,
(5) after-care services for children who do not live near a center designed for this purpose.

The children who are the subjects of this investigation were admitted as residential patients during the period between July 1, 1961 and June 30, 1967. All of the youngsters in the study were between the ages of seven and seventeen at the time of their admittance. The data utilized in the present investigation are based on official records of these children through December 16, 1972.

The history of the development of programs for children at the
hospital has been recounted by Stanley.* He cites an early report of "The Trustees for the Michigan Asylums" dated 1861 which enumerated four patients aged under twenty years among the one hundred and forty-one admitted to the hospital during its first two years of existence. At that time, and for almost a hundred years to follow, only a small percentage of the patients were children. Youngsters who were resident patients lived on adult wards without educational and treatment facilities keyed to the special problems of their youthful years.

After World War II, the child population of hospitalized patients began to increase. With the increase came over the years an expansion of residential psychiatric and educational services expressly designed for children. The educational program, which is geared to the children's individual capacities, needs, and post-hospitalization potentials, has furnished a model for other residential mental facilities for children in the state.

The program began in 1953 when half day classes for boys first were conducted by volunteers in a "classroom" created from an eight by twenty-four foot hallway. From this beginning the program has grown, reaching essentially its present organizational structure in 1967.

*The foregoing description of services, as well as much of the content of the rest of this section, has been used with the permission of Roland G. Stanley, Ph.D., director of education services at the hospital. Some material was gathered in conversation with Dr. Stanley. A large portion is summarized from his doctoral dissertation (Stanley, 1970).
At the time of this report children's services at the hospital includes four separate educational programs. One appears very like a conventional school. It is an academically oriented unit for children from seven to seventeen. A second, furnished with soft carpeting, muted stimuli decor and non-distractive study carrels, is designed primarily for very young hyperkinetic patients. Both of the foregoing are "total" programs; that is, the children live on attractive wards, separated from quarters oriented to the needs of adult patients and suitably decorated with regard to children's size and interests.

Two other educational programs, Pre-vocational Habit Training for Boys and Pre-vocational Habit Training for Girls, are planned to teach non-academically oriented adolescents skills and work attitudes for minimal employment. These children live on mixed wards with adult patients.

We have recounted briefly the characteristics of the Children's Services programs because these were established during the period from 1961 to 1967, during which time some of our subjects were admitted as patients. Some of the subjects, therefore, were hospitalized and released without having had contact with the programs. Since this is a factor which may have affected length of hospitalization, we have included program participation in our exploratory analysis.
The Children

The records of a number of children are not included in the analysis of this study. Several children died during their hospitalization. Their records have been removed from the data utilized for this investigation.

Examination of other records revealed that some patients had been hospitalized for periods of less than three months. Inquiry confirmed that these children had been released or withdrawn from the hospital within a short time after admission without "real" inclusion in the patient population. Usually, these children were withdrawn "against medical advice" or because of "diagnostic orders" otherwise placing them. Cases in these categories will be considered in another report planned to investigate family background variables in relationship to type of discharge.

Children whose familial backgrounds included parental substitutes like grandparents, siblings, foster homes, and other assigned sources of socialization have not been included among the subjects for this investigation when it was impossible to ascertain from their records whether these parental surrogates were equivalent to the single or two parent family model in structure.

Finally, children admitted during the period covered but who had not been released as of December 15, 1972, are not included among the subjects in this report. Some of these patients are now part of the adult population of the hospital. Others remain under treatment in Children's Services.
Despite these omissions, individual examination of each case record disclosed 116 patients who could be categorized positively as children with two parent backgrounds. These children were living with two parents at the time of their admission to the hospital and, additionally, had never been separated from either parent for a period in excess of 180 days during the years preceding hospitalization.

An additional 105 children were designated as having single parent backgrounds. These subjects were either living with one parent at the time they entered the hospital or had experienced separation from a parent for a period in excess of 180 days at some time previous to admission as a residential mental patient.

One parented subjects have been considered analytically as a single group and as three sub-groups according to the following criteria:

1. One Parented - General: Encompasses all 105 single parented subjects.

2. One Parented - at hospitalization: Encompasses 9 subjects who were living with only one parent at admission but who had not experienced 180 days or more as a member of a single parented family.

3. One Parented - 180 days: Encompasses 53 subjects whose backgrounds included 180 or more days experienced within a one parent family structure but who were living with two parents at the time they were admitted to the hospital.

4. One Parented - Specific: Encompasses 43 subjects who were living with only one parent when they were hospitalized and who had experienced this single parent family structure for periods of 180 days or more.
Data Collection

Longitudinal information noted from official case histories constitute the data for this study. These histories were initially recorded and compiled by a psychiatric social worker. They include contributions from medical, educational, and psychological services at the hospital.

Collection of the data from these records was directed, and in one instance of extreme confidentiality was executed, by Roland G. Stanley, Ph.D., director of the education programs for the hospital. The data are unusually noteworthy for their accuracy and comprehensive content. Two research assistants, each given twenty hours of training by Dr. Stanley, corrected admission lists against daily registers for the period and transcribed the datum on each subject. Each record was checked separately by Dr. Stanley before and after keypunching and rechecked for this investigation.

Procedures

In regard to this particular hospital we have the researcher's dream, a total regional population. Any differences we may find, any prediction equation we may develop, will be important. It should be recognized, however, that our results will be population specific and not generalizable with known validity to a universe containing other populations of child mental patients in other mental hospitals. In addition any procedure we may utilize which employs a statistical
test of significance must be based upon the rather dubious assumption that (1) this period represents a sample in time which includes all child mental patients, past and future, who have been or will be treated in this particular facility or (2) the patients at this hospital constitute a typical subset of a universe of child mental patients in similar hospitals designed to furnish equivalent services.

Our general hypothesis presents some alternatives of analysis. It will be recalled that we have hypothesized that child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families. Since our data is unusually complete, we can analyze our findings as either population or sample data. Each method contributes to the amount of information available to us. Each furnishes empirical generalizations from which to generate future hypotheses.

First, we have considered \( H_{R_1} \) as referring to one specific universe of child mental patients in order to test the general hypothesis \( H_{R_1} : L_1 > L_2 \) (where \( L_1 \) = length of hospitalization for patients who are the children of single parents and \( L_2 \) = length of hospitalization for children of two parent families). Because we are considering \( H_{R_1} \) as it refers to a specific population, we do not require a significance test to affirm or reject our hypothesis. If \( \bar{L}_1 > \bar{L}_2 \), we have supporting evidence for \( H_{R_1} \).

Our second population-specific procedure was designed to illicit further information on lengths of time children from one and two parented families were hospitalized. We set up criterion
categories based on length of stay. Criterion I, considered to indicate "No Difference" between the two groups is based upon a differential of less than three months between the two groups. Criterion II, considered to indicate "Moderate Difference" between the two groups is based upon a differential of over three but less than six months between the two groups. Criterion III, considered to indicate "Large Differences" in length of hospitalization between patients of single parent families and those with two parents, is based upon a differential of six months or more in length of stay between the two groups.

We are enabled to narrow and specify these differences in hospitalization periods between our two structural categories because of the parametric characteristics of our data. Thus, if $0 < \bar{L}_1 - \bar{L}_2 < 3$, we can aver confidently that family structure made little or no difference in length of hospitalization among our subjects. If $3 < \bar{L}_1 - \bar{L}_2 < 6$, moderate differences in length of stay may be indicated between the two groups; and, if $\bar{L}_1 - \bar{L}_2 \geq 6$, we can assert that large differences in length of hospitalization exist between the one and two parented children who make up our research population.

In an extension of this procedure, we could apply statistical techniques appropriate to the assumption that $L_1$ and $L_2$ refer to the lengths of hospitalization for child mental patients from one and two parent families who constitute a sample typical of other hospital populations in time and space, computing a test statistic of the
null hypothesis, \( H_{01} : L_1 = L_2 \) to ascertain if the mean lengths of stay of one and two parented children differ at the .05 level of significance.

We could then expand this mode of analysis by doing a series of significance tests, each testing the significance of differences between control categories.

We could also utilize analysis of co-variance techniques, calculating adjusted L's and means based upon pooled scores within the categories of diagnosis, race, and other control variables upon which we wished to elaborate (Snedecor and Cochran, 1971).

\[
(L_{1} : X_1, X_2, X_3, \ldots X_n = \text{Adj. } L_{1})
\]

\[
(L_{2} : X_1, X_2, X_3, \ldots X_n = \text{Adj. } L_{2})
\]

Since we are interested in determining the predictive efficiency of family structure both alone and in combination with other theoretical variables, we have elected to use multiple regression and correlation techniques as our approach to analysis. This approach can indicate to us what the relative weights of the various independent variables contribute to the prediction of length of hospitalization. It can indicate to us what proportion of a totality of factors we have taken into consideration in analyzing our data, and enable us to conjecture not only on possible factors missed in this study but also to estimate the weight these would contribute to hospitalization. Thus our analysis is oriented to provide interpretations within the boundaries of the present report and assessments upon which to base ongoing investigation.
Statistical Procedures

The use of nominal data in regression equations was facilitated by the creation of dummy variables.

Watts (1963) has questioned whether the designation, "Dummy Variable," "denotes a property of the variables or a deficiency to the analyst . . . ." Whatever the suggested meaning of the title, the technique has proved invaluable in translating variable measurements to dichotomous "scores" which may be used as elements in regression equations.

One may think of this process of dichotomization as classifying obtained measurements by dividing those for each variable into two groups for comparison. Those which qualify for group membership through similarity are coded for computer use as "1"; those which are dissimilar beyond a category standard set by the researcher, are categorized as "0".

In this instance most of the variables were categorical in nature. Non-categorical data, like socio-economic status and patients' ages, lent themselves readily to dichotomization.*

* Duncan (1961) found that 48.9% of the U. S. civilian labor force could be classified by scores below 20 on his socio-economic index. Dichotomized at the same point (20), the subjects of this study were slightly lower in socio-economic status, since 53% had family backgrounds which would be classified as below 20 on the Duncan scale.

Age dichotomy was borrowed from another area of deviant behavior, juvenile delinquency. It has been shown that about 66% of the juveniles arrested are over the age of 13 years (Cavan, 1969). Pre-pubescent children are likely to be turned over to their parents. The breaking-point for this study was selected as 13 years.
Multiple regression is based upon a linear regression equation, \( Y - \alpha = \beta_1X_1 + \beta_2X_2 + \ldots + \beta_nX_n \). This equation represents the path of the means of the dependent variable, \( Y \), for all combinations of the multiple independent "X" variables, assuming that the dependent variable is distributed normally in multi-dimensional space around fixed values of the "X" variables, intersecting with each "X" value as the others are held constant. This planar extension of the idea of the regression line is used to predict population parameters from sample data with the least squares equation, \( Y = a + b_1x_1 + b_2x_2 + \ldots + b_nx_n \) in which "a", the regression constant, and "b", the reflection of the planar slope, are calculated to minimize the squared difference between the predicted and the actual dependent behavior. \( (Y - Y)^2 \). (Blalock, 1960).

The correlation coefficient, "r", between two variables, A and B, is a standardized symmetrical expression of linear association, including all the influences that create the relationship. \( R^2 \) represents the total variation in the dependent variable which is explained by the other; or, in the case of multiple regression, the total variation in the dependent variable which is explained by the combined influences of the independent variables.

The regression weight, "b", is a function both of the strength and the form of the relationship, estimating the slope of the best fitting line by minimizing the sum of the squares of deviations of actual Y values from the predicted regression line. Both "b",
and "r", are related to covariation and to deviation. Only "b", however, is dependent on measurement unit sizes. Changes in unit sizes will change the slope of the regression line or plane but not the correlation, "r", between the variables (Blalock, 1960).

Partial correlation coefficients and regression (b) weights are obtained for multiple variables by isolating and adjusting for the influences of the rest from each. Partial regression "b"s, for samples are standardized to correct for scale differences between variables. These indicate how much change is affected in the dependent variable by a change in one of the independent variables, controlling for other influences (Blalock, 1960).

Both partial correlation coefficients and beta weights are related to covariation; partials to standardized covariance and beta weights to covariation minimizing the squared deviations of the dependent variable from the regression slope. In other words, they are related as standardization is related to raw scores.

In order to test our general hypothesis we first ascertained the zero order correlation between family structure and length of hospitalization, testing the significance of this correlation coefficient with a two-tailed test statistic. Significance level for this test, as for all tests conducted in the analysis, is at the .05 level.

Next we developed a "restricted" model based upon the predictors most often affirmed by theory and research as influential in determining length of inpatient treatment of mental patients, and
a "full" model which consisted of the variables which made up the "restricted" equation plus the added factor of family structure.

(Restricted $R^2$: sex, socio-economic status, rural-urban environmental background, race, hospital diagnosis, developmental stage of maturity and members of family in mentally ill roles.)

(Full $R^2$: restricted model + family structure.)

For each of these models we computed a multiple $R^2$, or coefficient of determination. These were compared, using the Melicher method for testing the significance of the variance in the dependent variable which has been explained by the combined independent variables in each regression model (Melicher, 1965).

\[
F = \frac{R^2(n - k - 1)}{(1 - R^2)(k)}
\]

and

\[
F = \frac{(R^2_A - R^2_B)(n - k_1 - k_2 - 1)}{(1 - R^2_A)(k_1)}
\]

or

\[
(H_{R^2}: R^2_2 - R^2_1)
\]

Computer techniques have, in the process, given us the individual contributions of each variable, allowing us to examine the influence of each with other influences held constant.

Other multiple regression equations have been designed as bases for additional correlational analyses, amplifying our information through creation of statistical subsamples and through the inclusion and/or combining of certain variables relevant to the prediction of length of hospitalization in association with family structure.
Summary

The foregoing chapter has recounted the considerations and analytic procedures utilized in the investigation. Specifically, Chapter II has presented the hypotheses to be tested, the details of research setting and data collection, the operational specifications defining subject categories, and described the analytical procedures upon which the findings presented in Chapter III are based.
CHAPTER III

FINDINGS

Introduction

The thesis of this study is that children from one parent families will be hospitalized for longer periods of time than will children allocated to roles as residential mental patients who are from two parent familial backgrounds. This hypothesized difference in duration of hospitalization is seen as related to the socialization and allocation functions of the family acting on its children both as a small group and as an institution within society. The findings concerning this and related theoretical propositions will be presented in this chapter.

Before presenting the results of this investigation, however, it seems appropriate to describe the attributes which characterize and differentiate the subject groups.

The Children

Individually, the children who are patients in the hospital seem very much like school children within the "normal" population. In visits to the various Children's Services schools covering a span of three years, we found the children outgoing, talkative, apparently happy, and affectionate. Perhaps unusually affectionate.
These are subjective impressions. Objective consideration of the subjects, as a group, reveals certain differences from the general population, however. The section which follows will discuss demographic characteristics. The aggressive behaviors, attempted suicides, fantasies, and other performance errors which brought the children to the hospital as mental patients will not be considered since these data are not available on all of the subjects.

The characteristics of the subjects will be presented according to the following categorizations:

All Subjects: Includes 221 one and two parented mental patients.

Two Parented: Includes 116 subjects who had never lived within a single parent family for a period exceeding 180 days and who were living with two parents at the time of admission to the hospital.

One Parent - General: Includes all 105 single parented subjects.

One Parented - at Admission: Includes 9 subjects who were living with only one parent at admission but who had not experienced 180 days or more as a member of a single parented family.

One Parented - 180 days: Includes 53 subjects whose backgrounds included 180 or more days experienced within a one parent family structure but who were living with two parents at the time they were admitted to the hospital.

One Parented - Specific: Includes 43 subjects who were living with only one parent when they were hospitalized and who had experienced this single parent family structure for periods of 180 days or more.
Differential Characteristics

Within the general population males outnumber females at this age level. U. S. census statistics (1970) show 103.7 boys for every 100 girls between the ages of 5 and 17. Among subjects, males constitute a proportion (61%) greater than that of the general population (51%). This predominance of boys is particularly notable among the subjects who are from single parent backgrounds (64% to 67%).

Table 3:1

Distribution of Subjects According to Sex
Comparison to General Population (1970 Census)
and Among Subject Groups

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Sex Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>26,733M</td>
<td>25,753M</td>
<td>103.7</td>
</tr>
<tr>
<td>All Subjects</td>
<td>134 (61%)</td>
<td>87 (39%)</td>
<td>156.4</td>
</tr>
<tr>
<td>Two Parents</td>
<td>66 (57%)</td>
<td>50 (43%)</td>
<td>132.6</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>68 (65%)</td>
<td>37 (35%)</td>
<td>185.7</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>6 (67%)</td>
<td>3 (33%)</td>
<td>203.0</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>34 (64%)</td>
<td>19 (36%)</td>
<td>177.8</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>28 (65%)</td>
<td>15 (35%)</td>
<td>185.7</td>
</tr>
</tbody>
</table>

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Examination of Table 3:2 discloses that over half the young mental patients had passed their thirteenth birthdays before being admitted to the hospital. Although boys outnumber girls within the patient population, the predominance of adolescents is largely caused by the overwhelming proportion of adolescent females. Among the girls, 82% were over 13 at the time they were admitted. On the other hand, boys tend to be pre-adolescent at admittance. Eighty-three per cent of the patients who were between 7 and 13 at admittance are boys. This represents 57% of all boys admitted.

Table 3:2

Distribution of Subjects According to Developmental Age - Stage and Sex

<table>
<thead>
<tr>
<th></th>
<th>Pre-Adolescent (Under Thirteen Years)</th>
<th>Adolescence (Over Thirteen Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>All Subjects</td>
<td>76 (34%)</td>
<td>16 (7%)</td>
</tr>
<tr>
<td>Two Parents</td>
<td>39 (34%)</td>
<td>9 (8%)</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>37 (35%)</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>One Parent - at Ad-</td>
<td>4 (44%)</td>
<td>-</td>
</tr>
<tr>
<td>mission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>17 (32%)</td>
<td>6 (11%)</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>16 (37%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

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According to the 1970 census there were approximately 204,266 young people between the ages of 14 and 24 within the United States. Of these, 12 1/2% were non-White or about equal to the ratio of Blacks to Whites of all ages. Within the patient population examined in Table 3:3, Blacks in the One Parent - Specific subgroup constitute a proportion approximating that of the United States. In the rest of the patient population, however, Whites are more in the majority than within the general population.

Table 3:3

Distribution of Subjects According to Race
Comparison to General Population (1970 Census) and Among Subject Groups

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>178,580M</td>
<td>25,686M</td>
</tr>
<tr>
<td>All Subjects</td>
<td>206 (93%)</td>
<td>15 (7%)</td>
</tr>
<tr>
<td>Two Parents</td>
<td>109 (94%)</td>
<td>7 (6%)</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>97 (92%)</td>
<td>8 (8%)</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>9 (100%)</td>
<td>- -</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>50 (94%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>38 (88%)</td>
<td>5 (12%)</td>
</tr>
</tbody>
</table>
Although only five of the thirteen counties served by the hospital contain cities of over 10,000 to 25,000 persons, urban children constitute an overwhelming majority of the mental patients in the hospital. Table 3:4 shows that proportions of urban children are highest for two parented subjects.

Table 3:4

Distribution of Subjects According to Urban-Rural Background
Comparison to General Population (1970 Census)
and Among Subject Groups

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>149,325M (73.5%)</td>
<td>53,887M (26.5%)</td>
</tr>
<tr>
<td>All Subjects</td>
<td>200 (90.5%)</td>
<td>21 (9.5%)</td>
</tr>
<tr>
<td>Two Parents</td>
<td>109 (94%)</td>
<td>7 (6%)</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>91 (87%)</td>
<td>14 (13%)</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>9 (100%)</td>
<td>- -</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>46 (87%)</td>
<td>7 (13%)</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>36 (84%)</td>
<td>7 (16%)</td>
</tr>
</tbody>
</table>

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Fifty-three per cent of our subjects have socio-economic status scores of below 20 on the Duncan scale. This is a proportion that closely approximates the ratio observed by Duncan (1961) and validated in subsequent censuses (U. S. Census - 1970). Among One Parent - Specific, and One Parent - at Admission groups, however, the socio-economic ratio is weighted toward lower scores.

Table 3:5

Distribution of Subjects Grouped According to Duncan's Two-Part Division of the General Population

<table>
<thead>
<tr>
<th></th>
<th>Scores Under 20</th>
<th>Scores Over 20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Population</strong></td>
<td>(Duncan Estimate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(49%)</td>
<td>(51%)</td>
</tr>
<tr>
<td>All Subjects</td>
<td>118 (53%)</td>
<td>103 (47%)</td>
</tr>
<tr>
<td>Two Parents</td>
<td>59 (51%)</td>
<td>57 (49%)</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>59 (56%)</td>
<td>46 (44%)</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>6 (67%)</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>27 (51%)</td>
<td>26 (49%)</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>26 (60.5%)</td>
<td>17 (39.5%)</td>
</tr>
</tbody>
</table>
The child mental patients who are our subjects are shown to come from families averaging four children per family (Table 3:6). Less than half the subjects come from families with three or fewer children. Two parented subjects have family backgrounds averaging 3.9 children. Those subjects with a single parent come from families averaging 4.1 children.
<table>
<thead>
<tr>
<th></th>
<th>Means</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
<th>Five</th>
<th>Six</th>
<th>Seven</th>
<th>Eight</th>
<th>Nine</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Subjects</td>
<td>4.0</td>
<td>23 (10%)</td>
<td>39 (18%)</td>
<td>30 (14%)</td>
<td>56 (25%)</td>
<td>23 (10%)</td>
<td>18 (8%)</td>
<td>21 (9.5%)</td>
<td>6 (3%)</td>
<td>1 (.5%)</td>
</tr>
<tr>
<td>Two Parents</td>
<td>3.9</td>
<td>14 (12%)</td>
<td>20 (17%)</td>
<td>16 (14%)</td>
<td>29 (25%)</td>
<td>13 (11%)</td>
<td>10 (9%)</td>
<td>7 (6%)</td>
<td>4 (3%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>4.1</td>
<td>9 (8.5%)</td>
<td>19 (18%)</td>
<td>14 (13%)</td>
<td>27 (26%)</td>
<td>10 (9.5%)</td>
<td>8 (8%)</td>
<td>14 (13%)</td>
<td>2 (2%)</td>
<td>--</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>4.1</td>
<td>--</td>
<td>--</td>
<td>1 (11%)</td>
<td>6 (67%)</td>
<td>2 (22%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>4.0</td>
<td>4 (8%)</td>
<td>10 (19%)</td>
<td>9 (17%)</td>
<td>12 (23%)</td>
<td>5 (9%)</td>
<td>5 (9%)</td>
<td>6 (11%)</td>
<td>1 (2%)</td>
<td>--</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>4.1</td>
<td>5 (12%)</td>
<td>9 (21%)</td>
<td>4 (9%)</td>
<td>9 (21%)</td>
<td>3 (7%)</td>
<td>3 (7%)</td>
<td>8 (19%)</td>
<td>1 (2%)</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ten</td>
<td>Eleven</td>
<td>Twelve</td>
<td>Thirteen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Subjects</td>
<td>2 (1%)</td>
<td>1 (5%)</td>
<td>--</td>
<td>--</td>
<td>1 (5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two Parents</td>
<td>--</td>
<td>1 (1%)</td>
<td>--</td>
<td>--</td>
<td>1 (1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Parent - General</td>
<td>2 (2%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>1 (2%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>1 (2%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3:7 shows the distribution of subjects according to their birth ranks. Very few of the patients are only children. Almost one-third are oldest children. Among one-parent groups this proportion is higher than is true of the two parented subjects. On the other hand, youngest children tend to come from two parent familial backgrounds.

Table 3:7

<table>
<thead>
<tr>
<th>Distribution of Subjects According to Birth Order</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>All Subjects</td>
</tr>
<tr>
<td>Two Parents</td>
</tr>
<tr>
<td>One Parent - General</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
</tr>
<tr>
<td>One Parent - Specific</td>
</tr>
</tbody>
</table>
American women bear their last child at the average age of 26. This estimate has been supported by every U. S. census since 1940. Census data since that date has shown consistently that the ages of 20 through 24 are the peak childbearing years (U. S. Census, 1970). The maternal parents of our subjects appear on the whole to be very similar in age to maternal parents of normal children from 7 through 17 within the general population; however, single mothers are, as a group, shown to be more youthful than mothers of two parented subjects in the findings shown in Table 3:8.

Table 3:8

<table>
<thead>
<tr>
<th>Distribution of Subjects According to Mothers' Age</th>
<th>Twenties</th>
<th>Thirties</th>
<th>Forties</th>
<th>Fifties</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Subjects</td>
<td>18 (8%)</td>
<td>118 (54%)</td>
<td>69 (31%)</td>
<td>16 (7%)</td>
</tr>
<tr>
<td>Two Parents</td>
<td>7 (6%)</td>
<td>53 (46%)</td>
<td>46 (40%)</td>
<td>10 (9%)</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>11 (10%)</td>
<td>65 (62%)</td>
<td>23 (22%)</td>
<td>6 (6%)</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>-</td>
<td>7 (78%)</td>
<td>2 (22%)</td>
<td>-</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>4 (8%)</td>
<td>33 (62%)</td>
<td>13 (24%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>7 (16%)</td>
<td>25 (58%)</td>
<td>8 (19%)</td>
<td>3 (7%)</td>
</tr>
</tbody>
</table>
Table 3:9 presents means, modes, and medians of mothers' ages by subject group. Among all mothers, the modal age is 37 at the time of children's hospitalizations. Within the single parent group the range is from 23 to 56 years. The 23 year olds had borne their children at the ages of 12 and 16 respectively. The 57 year old was 41 when her child was born. Within the two parent group, maternal ages ranged from a minimum of 26 to a maximum of 57 years at the time their children were hospitalized. These mothers were from 16 to 44 years old when they bore the children who later became mental patients.

Table 3:9

<table>
<thead>
<tr>
<th>Measures of Central Tendency</th>
<th>- Mothers' Ages -</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Subjects</td>
<td>38.3 37.0 37.0 57.0 23.0</td>
</tr>
<tr>
<td>Two Parents</td>
<td>38.6 39.0 37.0 57.0 26.0</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>37.0 37.0 37.0 56.0 23.0</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>37.4 36.0 33.0 47.0 31.0</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>37.3 37.0 33.0 56.0 23.0</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>36.6 37.0 37.0-40 52.0 23.0</td>
</tr>
</tbody>
</table>
Examination of the educational levels attained by the maternal parents of our subjects reveals large differences between the subject groups. Mothers who are single parents generally have less education than do those who are married. Table 3:10 shows that less than half of the single mothers have attended school beyond the 10th grade.

Table 3:10

Distribution of Maternal Parents According to Years of Formal Education Completed

<table>
<thead>
<tr>
<th></th>
<th>Ten Years or Less</th>
<th>High School 11th and 12th</th>
<th>College or Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Subjects</td>
<td>85 (38%)</td>
<td>95 (43%)</td>
<td>41 (19%)</td>
</tr>
<tr>
<td>Two Parents</td>
<td>32 (28%)</td>
<td>55 (47%)</td>
<td>29 (25%)</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>53 (51%)</td>
<td>40 (38%)</td>
<td>12 (11%)</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>1 (11%)</td>
<td>6 (67%)</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>27 (51%)</td>
<td>21 (40%)</td>
<td>5 (9%)</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>25 (58%)</td>
<td>13 (30%)</td>
<td>5 (12%)</td>
</tr>
</tbody>
</table>
Despite the educational differential between parent groups, Table 3:11 presents findings revealing that single parented subjects, as a whole, achieve essentially equivalent I. Q. scores on hospital administered tests with patients from two parent backgrounds. I. Q. levels vary more among single parent subgroups with greatest differences in I. Q. indicated between the group of subjects who have experienced one parent families for periods of over 180 days and the group whose parents had separated within six months of hospitalization.

Table 3:11

<table>
<thead>
<tr>
<th>Measures of Central Tendency</th>
<th>Patients' I.Q.'s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Means</td>
</tr>
<tr>
<td>All Subjects</td>
<td>91.3</td>
</tr>
<tr>
<td>Two Parents</td>
<td>91.1</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>91.4</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>102.3</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>91.8</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>88.8</td>
</tr>
</tbody>
</table>
Summary of Descriptive Characteristics

Certain patterns of similarity and difference are discernible among the groups of child mental patients. Boys predominate in all the groups but particularly among pre-adolescent patients. Over 90% of the patients are White children from urban areas. Mean I. Q. of the patients is approximately 9 points below the national norm.

The socio-economic ratio of two parented subjects is closely equivalent to the Duncan proportional division of the general population. Socio-economic levels of one parented subjects show wide variations from the Duncan division. By subgroup this varies from Duncan's 49/51 ratio for patients who had experienced one parent families for over 180 days on a temporary basis to a ratio of 67/33 for patients whose parents had separated at or about the time of hospitalization.

One parented subjects, as a whole, tend to be oldest or middle children in families which are slightly larger than are those of patients from two parent backgrounds. Often these families are headed by single adults who have ten years or less of formal education.
Family Structure as a Predictor of
Length of Hospitalization

The general hypothesis of this study proposes that:

Child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families, controlling for the effects of diagnosis, family members in mentally ill roles, socio-economic status, urban-rural environment, race, sex, birth order and developmental stage of maturity.

Findings comparing measures of central tendency on lengths of stay are presented in Table 3:12. This table shows that average hospitalization periods vary widely by subject group.

Table 3:12

<table>
<thead>
<tr>
<th></th>
<th>Means</th>
<th>Mode</th>
<th>Median</th>
<th>Standard Deviation</th>
<th>Group Size (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Subjects</td>
<td>30.7</td>
<td>11.0</td>
<td>26.0</td>
<td>20.93</td>
<td>221</td>
</tr>
<tr>
<td>Two Parents</td>
<td>27.1</td>
<td>20.0</td>
<td>22.5</td>
<td>19.76</td>
<td>116</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>34.7</td>
<td>40.0</td>
<td>33.0</td>
<td>21.55</td>
<td>105</td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>16.8</td>
<td>11.0</td>
<td>13.0</td>
<td>10.16</td>
<td>9</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>33.2</td>
<td>40.0</td>
<td>33.0</td>
<td>20.26</td>
<td>53</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>40.3</td>
<td>37.0</td>
<td>36.0</td>
<td>22.77</td>
<td>43</td>
</tr>
</tbody>
</table>

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The general hypothesis of this investigation is supported by the finding that child mental patients from one parent families remain in residential hospital treatment for over 7 1/2 months longer than young patients whose familial backgrounds are structured on the two parent model. This period is 1.6 months greater than the 6 month criterion designated as constituting a "large difference" between groups. (See procedures for analysis, Chapter II.)

"Large" differences are also found in lengths of hospitalization between subgroups of the One Parent family category. These differences appear not only in comparison with the Two Parent group but also among subgroups.

Only 9 children compose the One Parent at Admission subgroup. These patients were raised in a continuously two parented family until at or about the time they were admitted to the hospital. The "large" difference from Two Parent subjects is, for this group, opposite from the direction hypothesized. In Table 3:13, subjects in the One Parent at Admission subgroup are shown to remain in residential treatment an average of 10.3 months less than Two Parented subjects.

A second One Parent subgroup is composed of 53 patients whose familial backgrounds include the absence of one parent for periods of 180 days or more. At the time these children entered residential treatment, their families were headed by two parents.
Findings on the hospitalization lengths of these subjects support the general hypothesis. As indicated in Table 3:13, the average length of stay of the subgroup designated as One Parent - 180 Days is 6.1 months longer than the mean stay of two parented subjects, a "large" difference.

Comparison of average periods of hospitalization shows the One Parent - Specific subgroup to differ most greatly from the two parented subjects. These children were living with one parent at the time they were admitted to the hospital and had been members of single parent families for at least 180 days during the year prior to hospitalization. The difference between mean lengths of hospital treatment of One Parent Specific and Two Parented subjects is more than double the 6 month criterion period. Table 3:13 presents findings indicating a 13.2 months differential between the two groups.
<table>
<thead>
<tr>
<th>Subject Group</th>
<th>$\bar{L}_1 - \bar{L}_2^*$</th>
<th>Comparison in Reference to $H_{R1}$</th>
</tr>
</thead>
</table>
| $L_1 = \text{One Parent General}$  
$L_2 = \text{Two Parent}$                      | 7.6 months               | 7.6 6 = "Large" Diff.*  
$H_{R1}$ Supported                               |
| $L_1 = \text{One Parent at Admittance}$  
$L_2 = \text{Two Parent}$                       | neg. 10.3 months         | -10.3 +6="Large" Neg. Diff.*  
$H_{R1}$ Not Supported                           |
| $L_1 = \text{One Parent - 180 Days}$            
$L_2 = \text{Two Parent}$                       | 6.1 months               | 6.1 6 = "Large" Diff.*  
$H_{R1}$ Supported                                |
| $L_1 = \text{One Parent - Specific}$            
$L_2 = \text{Two Parent}$                       | 13.2 months              | 13.2 6 = "Large" Diff.*  
$H_{R1}$ Supported                                |

*Indicates that the associated chi square was significant at the .05 level.
Table 3:14 shows that "large" differences exist among One Parent subgroups. The number of subjects who compose the One Parent at Admission group is, of course, very small. The hospitalization periods of these 9 patients are shortest of all subjects. They also deviate less from their mean than any other group of subjects, a circumstance which bestows a certain face validity on the findings.

The One Parent - 180 Days subgroup is hospitalized an average of 16.4 months longer than the children who are designated as One Parent - at Admission. Patients who are members of the One Parent - Specific category average 23.5 months longer in the hospital than the One Parent - at Admission group. Each of these are large population differences. Each is significant if the totality of subjects is considered as a sample of "typical" child mental patients.

Table 3:14

<table>
<thead>
<tr>
<th>One Parent Subgroups</th>
<th>16.4 months</th>
<th>23.5 months</th>
<th>7.1 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1 = One Parent 180 Days</td>
<td>(6 = Large Diff.)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L2 = One Parent at Admission</td>
<td></td>
<td>(6 = Large Diff.)*</td>
<td></td>
</tr>
<tr>
<td>L1 = One Parent - Specific</td>
<td></td>
<td></td>
<td>(6 = Large Diff.)*</td>
</tr>
<tr>
<td>L2 = One Parent at Admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L1 = One Parent - Specific</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L2 = One Parent - 180 Days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Indicates that the associated chi square was significant at the .05 level.
The hypothesis that child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families has been supported on a general level by the findings in the preceding section.

The search now becomes one for an answer to the question, "Why?" Is it truly the effects of family structure which lengthens or shortens children's tenure in mental patient roles or does the concept of family structure conceal attributes which are the real determinants of the subjects' periods of treatment? The testing of $H_{R1a}$ attempts to solve this theoretical problem in an elaboration of $H_{R1}$ as follows:

$H_{R1a}$: Child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families, controlling for the effects of diagnosis, family members in mentally ill roles, socio-economic status, urban-rural environment, race, sex, birth order and developmental stage of maturity.

As indicated in Table 3:15, the zero-order correlation between family structure and length of hospitalization is .18. This indicates at most only a negligible relationship between the two variables. Zero order correlations of other variables, i.e., damage to the central nervous system, seizures and age/stage of development with length of hospitalization equal or slightly exceed the coefficient relating length of hospitalization with family structure.
Table 3:15

Correlation Matrix Indicating Zero Order Correlations Between Major Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Length of Stay</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Family Structure</td>
<td>.18</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Sex</td>
<td>.09</td>
<td>.08</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Race</td>
<td>.05</td>
<td>-.03</td>
<td>.00</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Urban/Rural Envir.</td>
<td>-.02</td>
<td>.11</td>
<td>-.03</td>
<td>-.09</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Mental Deficiency</td>
<td>.04</td>
<td>.05</td>
<td>.11</td>
<td>-.17</td>
<td>.05</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Chronic Brain Syndrome</td>
<td>.13</td>
<td>-.04</td>
<td>.05</td>
<td>.06</td>
<td>-.06</td>
<td>-.16</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Psychotic</td>
<td>.10</td>
<td>.05</td>
<td>-.11</td>
<td>.04</td>
<td>-.10</td>
<td>-.13</td>
<td>-.15</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>9. Neurotic</td>
<td>.03</td>
<td>.01</td>
<td>.04</td>
<td>.04</td>
<td>.27</td>
<td>-.05</td>
<td>-.06</td>
<td>-.05</td>
<td>1.00</td>
</tr>
<tr>
<td>10. Adj. Reaction</td>
<td>-.02</td>
<td>.05</td>
<td>-.02</td>
<td>-.08</td>
<td>.01</td>
<td>-.19</td>
<td>-.21</td>
<td>-.19</td>
<td>-.07</td>
</tr>
<tr>
<td>11. Other</td>
<td>-.12</td>
<td>.02</td>
<td>-.03</td>
<td>.10</td>
<td>.00</td>
<td>-.29</td>
<td>-.32</td>
<td>-.28</td>
<td>-.10</td>
</tr>
<tr>
<td>12. Central Nervous System Damage</td>
<td>.21</td>
<td>.01</td>
<td>.06</td>
<td>.00</td>
<td>-.06</td>
<td>.04</td>
<td>.54</td>
<td>-.01</td>
<td>-.07</td>
</tr>
<tr>
<td>13. Seizures</td>
<td>.18</td>
<td>.03</td>
<td>.01</td>
<td>-.10</td>
<td>.02</td>
<td>.11</td>
<td>.17</td>
<td>-.02</td>
<td>-.04</td>
</tr>
<tr>
<td>14. Socio-Econ. Status</td>
<td>.05</td>
<td>.05</td>
<td>-.07</td>
<td>-.11</td>
<td>.10</td>
<td>.08</td>
<td>-.09</td>
<td>.09</td>
<td>-.01</td>
</tr>
<tr>
<td>15. Family - Mentally Ill Roles</td>
<td>-.03</td>
<td>.11</td>
<td>.00</td>
<td>.01</td>
<td>.13</td>
<td>-.03</td>
<td>-.07</td>
<td>.04</td>
<td>.09</td>
</tr>
<tr>
<td>16. Birth Order - Oldest</td>
<td>-.12</td>
<td>.06</td>
<td>-.02</td>
<td>.00</td>
<td>.02</td>
<td>.02</td>
<td>-.09</td>
<td>-.07</td>
<td>.10</td>
</tr>
<tr>
<td>17. Birth Order - Youngest</td>
<td>-.11</td>
<td>.15</td>
<td>-.08</td>
<td>-.06</td>
<td>-.09</td>
<td>-.10</td>
<td>.03</td>
<td>.01</td>
<td>.06</td>
</tr>
<tr>
<td>18. Birth Order - Only Child</td>
<td>-.05</td>
<td>-.02</td>
<td>-.13</td>
<td>.02</td>
<td>-.09</td>
<td>-.07</td>
<td>-.04</td>
<td>.08</td>
<td>.08</td>
</tr>
<tr>
<td>19. Age at Admittance</td>
<td>.19</td>
<td>-.12</td>
<td>.26</td>
<td>-.04</td>
<td>.09</td>
<td>.08</td>
<td>.24</td>
<td>-.23</td>
<td>.05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variables</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Adj. Reaction</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Other</td>
<td>-.39</td>
<td>1.00</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Central Nervous System Damage</td>
<td>-.18</td>
<td>-.06</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Seizures</td>
<td>-.13</td>
<td>-.09</td>
<td>.41</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Socio-Econ. Status</td>
<td>.01</td>
<td>-.07</td>
<td>-.02</td>
<td>.06</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Family - Mentally Ill Roles</td>
<td>-.08</td>
<td>.07</td>
<td>.19</td>
<td>.13</td>
<td>-.06</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Birth Order - Oldest</td>
<td>-.08</td>
<td>.15</td>
<td>.05</td>
<td>.02</td>
<td>-.10</td>
<td>-.01</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Birth Order - Youngest</td>
<td>.03</td>
<td>-.01</td>
<td>-.06</td>
<td>.01</td>
<td>.12</td>
<td>-.08</td>
<td>-.09</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Birth Order - Only Child</td>
<td>-.01</td>
<td>.02</td>
<td>-.00</td>
<td>.01</td>
<td>-.05</td>
<td>-.12</td>
<td>.38</td>
<td>.48</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>19. Age at Admittance</td>
<td>.17</td>
<td>.05</td>
<td>.19</td>
<td>.13</td>
<td>.01</td>
<td>-.06</td>
<td>-.10</td>
<td>-.12</td>
<td>-.05</td>
<td>1.00</td>
</tr>
</tbody>
</table>
For this particular population of subjects any relationship between family structure and hospitalization length may be considered substantively significant. Statistical testing, however, does not support the validity of the relationship at the .05 level ($F = 211.7$ with 219 and 1 degrees of freedom) as sample data (Blalock, 1960).

Low zero order correlations characterize the gross relationships between most of the major variables listed in Table 3:15. This might seem to contradict previous theory and research positing strong linkages between variables. Since these are gross relationships, however, the net contributions of the major independent variables to the length of residential treatment may be suppressed by intrusion one upon another (Rosenberg, 1968).

The following restricted regression equation was designed to examine the effects on length of hospitalization of the control variables in combination:

Equation 3:1 $Y = a + X_1 + X_2 \ldots X_{17}$.

where $Y =$ length of hospitalization
$a =$ obtained constant or point of intercept
$X_1 =$ sex
$X_2 =$ race
$X_3 =$ urban/rural environment
$X_4 =$ diagnosis of mental deficiency
$X_5 =$ diagnosis of chronic brain syndrome
$X_6 =$ diagnosis of psychosis
$X_7 =$ diagnosis of neurosis
$X_8 =$ diagnosis of adjustment reaction of childhood (or adolescence)
$X_9 =$ other diagnoses
$X_{10} =$ birth rank, youngest child
$X_{11} =$ birth rank, oldest child
$X_{12} =$ birth rank, only child
$X_{13} =$ central nervous system damage
This restricted model yielded an $R^2$ of .15. Using the techniques outlined by Melicher (1965), the significance of the variance in length of hospitalization explained by the combining of the test factors was tested according to the following formula and found to be significant at the .05 level:

$$F = \frac{R^2(n-k-1)}{(1-R^2)(k)}$$

which becomes

$$F = \frac{.15 (221-17-1)}{(1-.15)(17)}$$

$F = 2.11$ with 201 and 17 d.f.

The foregoing $F$ level supports the assumption that the combined control variables explain the observed variation in lengths of hospitalization not only for the subjects as a universe of 221 child mental patients (a given) but also for the subjects as a sample of some larger universe of child mental patients of which they may be typical.

It remains to be seen what increment of explanatory power the factor of family structure adds to the cumulative influences of the controls.

Equation 3:2 $Y = a - X_1 + X_2 \ldots + X_{17} + X_{18}$,

where $X_{18}$ = family structure.

Since any increment must be a significant explanation on both a population and a sample basis, analytical focus now is upon the net added contribution of the family structure model over that of
controls alone. Because the One Parent Model has been given a Dummy Variable score of one and the Two Parent Model one of zero, any contribution linked to a positive partial correlation will support Hypothesis la.

The proportion of additional explanation of variation in duration of hospitalization can be calculated by the following formula:

$$\text{Partial } R^2 = \frac{R^2_{\text{Equa. 2}} - R^2_{\text{Equa. 1}}}{1 - R^2_{\text{Equa. 1}}}$$  
(Melicher, 1963.)

The partial $R^2$ for equation 1, the restricted model, and equation 2, the family structure model, shows an increment of positive explanatory effect equaling .01. An F was calculated to test the significance of the net added contribution of the family structure equation:

$$F = \frac{(R^2_{\text{Equa. 2}} - R^2_{\text{Equa. 1}})(n-k_1-k_2-1)}{1-R^2_{\text{Equa. 2}}(k_1)}$$  
(Melicher, 1965.)

where $k_1 =$ number of variables added to the restricted model in order to form the family structure model

$k_2 =$ number of variables in the restricted model

Substituting from equation 1 (restricted) and equation 2 (added family structure) this formula becomes:

$$F = \frac{(.16 - .15)(221 - 1 - 17 - 1)}{(1 - .16)(1)} = \frac{(.01)(202)}{.84} = 2.40$$

which for 202 and 1 degree of freedom is not significant statistically.

For the subjects as a population the global concept, family structure, is significant because it can be said that knowledge of family structure adds some, if only very little, explanation to the variations observed in length of hospitalization. Considered
as a sample of some larger population, the hypothesis that child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families, controlling for the effects of diagnosis, history of family members in mentally ill roles, socio-economic status, urban-rural environment, race, sex, birth order and developmental stage of maturity must be rejected.

A second full model was also designed. It utilized the One Parent subgroups rather than the One Parent - General category of family structure in order to examine the possibility that the first model used a concept so global that it encompassed different and therefore suppressing family forms.

The zero order correlations of these subgroups; One Parent at Admission, One Parent - 180 Days, and One Parent - Specific with Length of Hospitalization are presented in Table 3:16:

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Correlation Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Parent at Admission</td>
<td>-.14*</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>.07*</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>.23*</td>
</tr>
</tbody>
</table>

*Sig. P < .05
As with family structure, the gross relationships between length of hospitalization and the various subgroups of one parent family patterns are only slight. Calculation of a partial $R^2$ yields a proportional measure of additional explanatory power of .08 over the restricted control model. Although the positive increment is not large; for this particular population the general hypothesis is supported by the findings. Apparently type of family structure acts to influence the length of time children remain hospitalized as mental patients.

As sample data the hypotheses are not supported by the findings, however. An $F$, calculated to test the net added contributions of family subgroups, yields a score of 4.17 which with 203 degrees of freedom is not significant statistically at the .05 level.

In a sense both the foregoing family structure models have been restricted equations since interaction terms have not been added to either. Interaction terms are the multiplicative effects which result over and above the separate influences of two independent (or main effect) variables as they combine (Kerlinger, 1964). If a subject has a positive score on two of the main effect variables, an interaction term is created by adding a new dummy variable on which he also is given a positive classification.

In this instance interaction terms were created for each category of one parent structure; general, at admission, 180 days, and specific in combination with each of the control variables. Two further regression equations were then designed:
Full Model Regression 1:
\[ Y = a + X_1 + X_2 \ldots X_{18} + X_{18}X_1 + X_{18}X_2 + \ldots X_{18}X_{17} \]
where \( X_{18} \) = one parent-general:

and

Full Model Regression 2:
\[ Y = a + X_1 + X_2 + \ldots X_{18} + X_{19} + X_{20} + X_{18}X_1 + X_{18}X_2 + \ldots X_{18}X_{17} + X_{20}X_1 + X_{20}X_2 + \ldots X_{20}X_{17} \]
where \( X_{18} \) = one parent – at admission
\( X_{19} \) = one parent – 180 days
\( X_{20} \) = one parent – specific

The emerging statistical evidence of the effects of the one parent family structure as an influence on length of hospitalization of child mental patients is presented in Table 3:17. The partial \( R^2 \), indicating the proportional increment obtained by the addition of interaction effects, and the significance levels testing those effects are supportive of the proposition that one parented child mental patients will remain in the hospital for longer periods of time than two parented child mental patients, controlling for the effects of diagnosis, history of family members in mentally ill roles, socio-economic status, environment, race, sex, birth order and age.

It may be noteworthy that subcategories of the one parent family lend greater support to hypotheses I and Ia within this hospital population than does the global concept of the one parent family. Considered as sample data, however, the subgroup evidence is not
statistically significant over the general category. It is possible that a search for a prediction equation should consider the one parent subgroup as a subgroup of the two parent family rather than of the one parent structure. This possibility will be considered in the chapter of discussion and conclusion which follows.

The question may be raised as to the permissibility of utilizing interaction effects between controls and family structure but not examining interactions among the controls themselves. This would be an interesting, if exhausting, task were the task at hand that of developing a model of, as nearly as possible, a totality of explanation for lengths of hospitalization. The task rather is to test an hypothesized difference between one and two parented child mental patients. The hypothesized difference is given a measure of affirmation by the fact that the interaction equation F's are significant at the .05 level. Membership in a one parent family appears to have a significant multiplicative impact on the control factors which is not characteristic of the two parent family as an independent variable.

The interaction analysis is not complete. It has not utilized possible interaction effects among the controls themselves. The brief examination made in this investigation should be considered, therefore, as a directional indication for possible consideration in planning future research not as support for $H_{1a}$ as sample data in the conclusions of the study.

The basic model for comparing the influences of the control variables on the time periods one and two parented patients remain in
Table 3:17

Zero Order and Multiple Regression Correlations
Indicating Development of Statistical Evidence
of Family Structure as a Predictor of
Length of Hospitalization of Child Mental Patients

<table>
<thead>
<tr>
<th>Subject Groups</th>
<th>R</th>
<th>R²</th>
<th>1-R²</th>
<th>Partial R² (Proportional Increment added by Family Structure to Control Factors)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Zero Order Correlations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Parent - General</td>
<td>.18</td>
<td>.03</td>
<td>.97</td>
<td></td>
</tr>
<tr>
<td>One Parent - at Admission</td>
<td>-.14</td>
<td>.02</td>
<td>.98</td>
<td></td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>.07</td>
<td>.004</td>
<td>.996</td>
<td></td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>.23</td>
<td>.05</td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td><strong>Multiple Correlations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controls Only - (family structure not included)</td>
<td>.38</td>
<td>.15</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td>Controls plus One Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. = General</td>
<td>.41</td>
<td>.16</td>
<td>.84</td>
<td>.01</td>
</tr>
<tr>
<td>2. = Subgroups</td>
<td>.45</td>
<td>.20</td>
<td>.80</td>
<td>.08</td>
</tr>
<tr>
<td>3. = General with Interaction</td>
<td>.63</td>
<td>.40* **</td>
<td>.60</td>
<td>.42</td>
</tr>
<tr>
<td>4. = Subgroups with Interaction</td>
<td>.69</td>
<td>.48* **</td>
<td>.52</td>
<td>.63</td>
</tr>
</tbody>
</table>

*Significant increment over Controls Only, .05 level.
**Significant increment over equivalent One Parent Model without interaction effects.
the hospital remains that posited in Chapter II and utilized in testing general hypotheses $H_{R1}$ and $H_{R1a}$. Hypothesis 2 proposes that:

The relative influences of diagnosis, history of family members in mentally ill roles, socio-economic status, urban-rural environment, sex, race, birth order and developmental stage of maturity on length of hospitalization will be greater for child mental patients from single parent families than for those from two parent families.

Zero order correlations of the controls with periods of hospitalization are compared by one and two parent subject groups in Table 3:18. These correlations support $H_{R2}$ on a gross level as it applies to this particular population of mental patients.
**Table 3:18**

Zero Order Correlations Between Control Variables and Length of Hospitalization Compared by One and Two Parent Family Structure

<table>
<thead>
<tr>
<th>Variable</th>
<th>Two Parents</th>
<th>One Parent - General</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 116</td>
<td>N = 105</td>
</tr>
<tr>
<td>Sex (Male)</td>
<td>.12</td>
<td>.04</td>
</tr>
<tr>
<td>Race (White)</td>
<td>.03</td>
<td>.08</td>
</tr>
<tr>
<td>Environment (Rural)</td>
<td>-.09</td>
<td>.00*</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Deficiency</td>
<td>-.05</td>
<td>-.02</td>
</tr>
<tr>
<td>Chronic Brain Syndrome</td>
<td>.12</td>
<td>.17</td>
</tr>
<tr>
<td>Psychosis</td>
<td>.06</td>
<td>.11</td>
</tr>
<tr>
<td>Neurosis</td>
<td>.00</td>
<td>.05</td>
</tr>
<tr>
<td>Adjustment Reaction</td>
<td>.06</td>
<td>-.10*</td>
</tr>
<tr>
<td>Other</td>
<td>-.13</td>
<td>-.11</td>
</tr>
<tr>
<td>Central Nervous System Damage</td>
<td>.13</td>
<td>.21</td>
</tr>
<tr>
<td>Seizures</td>
<td>-.01</td>
<td>.17*</td>
</tr>
<tr>
<td>Birth Rank:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oldest</td>
<td>.20*</td>
<td>-.11*</td>
</tr>
<tr>
<td>Youngest</td>
<td>.19</td>
<td>.04*</td>
</tr>
<tr>
<td>Only Child</td>
<td>-.10</td>
<td>.02*</td>
</tr>
<tr>
<td>Family in Mentally Ill Roles</td>
<td>-.01</td>
<td>-.10*</td>
</tr>
<tr>
<td>Age (Pre-adolescent)</td>
<td>.13</td>
<td>.20</td>
</tr>
<tr>
<td>Socio-Economic Status (Below 20)</td>
<td>-.03</td>
<td>.00</td>
</tr>
</tbody>
</table>

*Significant Differences between correlations on same variable at .05 level.*
The comparisons in Table 3:18 may be interpreted by considering zero-order correlation as a measurement of the magnitude of gross influence of an independent variable upon the dependent one. This influence may be direct or mitigated through another independent variable, hence the use of the term "gross." Thus, hospitalization is lengthened by 12% of one standard deviation if a two parented subject is a boy; by 4% of one standard deviation if the boy has only one parent.

Using this perspective, the values in Table 3:18 may be interpreted to indicate trends within the population.

Boys are shown to be hospitalized for longer periods than girls, a trend which has greater impact on the hospitalization of two parented boys than on those with one parent. White children in general are hospitalized longer than Black, particularly if they are from single parented families. Urban children from two parent families appear to be affected toward greater periods of hospitalization by their city backgrounds; however, it should be noted that proportions of Blacks and also of rural subjects within both subject groups are very small thereby jeopardizing any conclusions as to the significance of these relationships beyond this particular hospital population.

On 12 of the 17 control variables the correlations may be interpreted as related to longer periods of hospitalization for one parented child mental patients. Five variables have a gross impact to lengthen the hospitalization time of two parented
patients. These five are masculinity, diagnosis of adjustment reaction, a history of other family members likewise allocated to roles of mental illness, and birth rank as oldest or youngest child.

If the correlations are viewed as a sample rather than population data, seven control variables differ significantly in gross impact on lengths of hospitalization for the two subject groups. Thus $R^2$ is supported at the .05 level of confidence by findings on the following variables: environment, adjustment reaction diagnosis, seizures, birth rank, and family roles of mental illness.

In order to compare net effects of the various controls, stepwise regression equations were calculated. These add variables step by step in descending order of explanatory power.

Table 3:19 presents the ordering of the controls for one and two parent subjects, indicating the increment to explanation of hospitalization length and the total explanatory power ($R^2$) associated with each addition.
### Table 3:19

**Stepwise Ordering of Control Variables**  
According to Ranked Impact on Length of Hospitalization  
for One and Two Parent Groups

<table>
<thead>
<tr>
<th>Step</th>
<th>Two Parents</th>
<th>One Parent</th>
</tr>
</thead>
</table>
| 1.   | Central Nervous System Damage  
\( R^2 = .042 \) Partial \( R^2 = .042 \) | Central Nervous System Damage  
\( R^2 = .044 \) Partial \( R^2 = .044 \) |
| 2.   | Birth Rank = Oldest  
\( R^2 = .062 \) Partial \( R^2 = .020 \) | Age  
\( R^2 = .076 \) Partial \( R^2 = .032 \) |
| 3.   | Birth Rank = Youngest  
\( R^2 = .076 \) Partial \( R^2 = .014 \) | Diagnosis: Psychosis  
\( R^2 = .101 \) Partial \( R^2 = .024 \) |
| 4.   | Seizures  
\( R^2 = .089 \) Partial \( R^2 = .013 \) | Family in Mentally Ill Roles  
\( R^2 = .119 \) Partial \( R^2 = .020 \) |
| 5.   | Diagnosis: Mental Deficiency  
\( R^2 = .104 \) Partial \( R^2 = .015 \) | Seizures  
\( R^2 = .130 \) Partial \( R^2 = .011 \) |
| 6.   | Environment: Rural/Urban  
\( R^2 = .115 \) Partial \( R^2 = .011 \) | Birth Rank: Oldest  
\( R^2 = .139 \) Partial \( R^2 = .009 \) |
| 7.   | Sex:  
\( R^2 = .125 \) Partial \( R^2 = .009 \) | Diagnosis: Neurosis  
\( R^2 = .146 \) Partial \( R^2 = .007 \) |
| 8.   | Diagnosis: Other  
\( R^2 = .132 \) Partial \( R^2 = .007 \) | Diagnosis: Chronic Brain Syndrome  
\( R^2 = .153 \) Partial \( R^2 = .007 \) |
| 9.   | Race  
\( R^2 = .136 \) Partial \( R^2 = .004 \) | Birth Rank: Youngest  
\( R^2 = .157 \) Partial \( R^2 = .004 \) |
| 10.  | Age  
\( R^2 = .139 \) Partial \( R^2 = .002 \) | Birth Rank: Only Child  
\( R^2 = .165 \) Partial \( R^2 = .008 \) |
| 11.  | Diagnosis: Chronic Brain Syndrome  
\( R^2 = .143 \) Partial \( R^2 = .004 \) | Diagnosis: Adjustment Reaction  
\( R^2 = .170 \) Partial \( R^2 = .005 \) |
| 12.  | Socio-Economic Status  
\( R^2 = .145 \) Partial \( R^2 = .002 \) | Diagnosis: Other  
\( R^2 = .171 \) Partial \( R^2 = .001 \) |
| 13.  | Diagnosis: Neurosis  
\( R^2 = .146 \) Partial \( R^2 = .001 \) | Diagnosis: Mental Deficiency  
\( R^2 = .173 \) Partial \( R^2 = .002 \) |
<table>
<thead>
<tr>
<th>Step</th>
<th>Two Parents</th>
<th>One Parent</th>
</tr>
</thead>
</table>
| 14.  | Diagnosis: Psychosis  
      R² = .147 Partial R² = .0017  
      | Race  
      R² = .174 Partial R² = .001 |
| 15.  | Diagnosis: Adjustment Reaction  
      R² = .152 Partial R² = .000*  
      | Sex  
      R² = .1743 Partial R² = .001 |
| 16.  | Birth Rank: Only Child  
      R² = .153 Partial R² = .000*  
      | Environment  
      R² = .1745 Partial R² = .000* |
| 17.  | Family in Mentally Ill Roles  
      R² = .153 Partial R² = .000*  
      | Socio-Economic Status  
      R² = .1745 Partial R² = .000* |

*Increment very slight (less than .001).

As Table 3:19 shows, the only variable whose impact is shared in importance by both one and two parented subjects is that of central nervous system damage. The ordering of the other control variables leads to the conclusion that the periods of hospitalization of the two subject groups is the result for the most part of the differing interaction of the same set of factors. For two parented patients the five controls most predictive of length of hospitalization are central nervous system damage, birth rank of oldest child, birth rank of youngest child, seizures, and mental deficiency. Three of these are negative relationships whose impact is toward lessening the amount of time spent in the hospital. Only central nervous system damage and mental deficiency act to add to the period two parented children spend in residential treatment. Of the various categories of illness included in the controls only central nervous system damage and mental deficiency are susceptible to completely
non-subjective, i.e., non-human diagnosis with electro-encephlo-
graphic techniques.

Four of the five most predictive controls act to increase the
periods of hospitalization of one parented children. These four
factors are central nervous system damage, age (pre-adolescence),
diagnosed psychosis and seizures. Only history of family members
in roles of mental illness is related to shortened periods of treat-
ment. Psychosis notably is diagnosed primarily on the basis of per-
formance error rather than by objective measures.

Although there is no question that the impact of individual con-
trol factors differ between subject groups, the cumulative power of
explanation added by the controls is not significant statistically.
With total $R^2$'s of .39 (two parent regression equation) and .42
(one parent regression equation) $R^2$ is supported by the findings
as population but not as sample data.

Damage to the central nervous system and seizures are control
factors with important impact upon the length of time both one and
two parented child mental patients remain in the hospital. $R^3$ is
not concerned with periods of hospitalization, however. Rather it
proposes the following:

Diagnoses which are dependent upon organic symptoms of
"illness" (damage to the central nervous system and/or
seizures) will tend to be equally distributed between
single and two parented child mental patients.
Table 3:20

Frequency of Organic Involvement and Non-Involvement
One and Two Parented Subjects

<table>
<thead>
<tr>
<th>Central Nervous System Damage and/or Seizures</th>
<th>One Parent</th>
<th>Two Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms Present</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>Symptoms Absent</td>
<td>83</td>
<td>93</td>
</tr>
<tr>
<td>%</td>
<td>79%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Table 3:20 indicates that the proportions of children within the one and two parented groups who exhibit symptoms of central nervous system damage and seizures are very close but not precisely equal. Although a slightly larger proportion of one than of two parented child mental patients suffer from organically symptomatic ills, $H_{R3}$ has not been rejected on the basis of two factors.

1. The hypothesis directs that it be tested for tendency to equivalence rather than for exact equivalency.

2. Differences between one and two parent subject groups were not significant statistically when the findings were tested as sample data with a chi-square test statistic.

Hypothesis 4 relates to forms of mental illness that must be diagnosed through subjective interaction between physician and patient. It proposes:

Diagnoses which are dependent upon subjective evaluations of illness (psychosis, neurosis, adjustment reaction of childhood, without central nervous system and/or seizures) will tend to accrue to children of single parent families in greater proportions than to children of two parent families.

Table 3:21 presents the findings relating to the above hypothesis.

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Table 3:21

Incidence of Diagnoses Based Upon Symptomatic Performance Error
One and Two Parented Subjects

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>One Parent No. (%)</th>
<th>Two Parents No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis, Neurosis,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment Reaction</td>
<td>40 38%</td>
<td>36 31%</td>
</tr>
<tr>
<td>Other</td>
<td>65 62%</td>
<td>80 69%</td>
</tr>
</tbody>
</table>

The table shows a tendency toward incidence of evaluatively diagnosed illness among one parent subjects that is 7% higher among one parented subjects than among those with two parents. This indicates a population tendency that supports the hypothesized proportionate differential between subject groups. A calculated chi square, however, does not permit rejection of the null hypothesis at the .05 level when the findings are analyzed as sample data.

Four exploratory questions were posed in Chapter I of this report. The first of these was stated as follows:

Question 1: Does knowledge of family structure, i.e., single or two parent familial background add importantly to considerations like diagnosis, genetic predispositions, socio-economic status, urban-rural environment, race, sex and developmental stage of maturity in predicting lengths of time child mental patients will be hospitalized?

This question is answered by support of $H_{R_1}$ as population but not as sample data. Within this particular population of children who are patients in a specific state mental hospital, knowledge of the structure of familial background enables prediction of length
of hospitalization in a direct relationship with the amount of knowledge we have of the structure. Apparently, children whose admission to treatment coincides with the trauma of separation from a parent will remain hospitalized for the shortest period of time.* More certainly, children from two parent families will be released from treatment after a shorter period than one parented children in general. As for these patients from single parent familial backgrounds, children whose parents have separated and then re-established their two parent familial relationship will be released after significantly shorter stays than children whose families can be said to be truly and permanently headed by a single adult.

The second question focused on traditional explanations of "mental illness."

**Question 2:** What are the relative influences of social and psychological variables like diagnosis, genetic predispositions, socio-economic status, urban-rural environment, race, sex and developmental stage of maturity on the lengths of hospitalization of child mental patients from one parent vs. those from two parent families?

Damage to the central nervous system was a decisive variable for both one and two parented subjects. This was the only factor that shared equal importance for both groups, however. Despite the differences in individual impact of the various control factors, the cumulative explanatory power of the combined factors did not vary

*Discussed at length in Chapter IV of this report.*
significantly between the two principle subject groups. Significant variation in cumulative impact was found among one parent subgroups, however. Table 3:22 repeats the restricted model $R^2$'s for two parent and one parent - general groups and adds those of the one parent - 180 days and of the one parent - specific categories.

Each regression model contributing the $R^2$'s of Table 3:22 was computer calculated utilizing a stepwise regression program. This features a step by step development of the complete equation with each independent variable being forced into the regression equation in a separate stage according to its contribution to the $R^2$. Thus, the first variable selected made the greatest contribution to the $R^2$ and each following selection made successively less (Anema, 1971).

In every equation either family structure or central nervous system damage was selected as either first or second stepwise entry, accounting for approximately half of the total $R^2$. In regression models utilizing the one parent - general structure the independent variable of first selection was central nervous system damage. In those utilizing one parent - subgroups, the category, one parent - specific was the initial inclusion. Age, pre-adolescence, was consistently selected for the third addition to the subgroup regression models.
Table 3:22

Coefficients of Determination (R²'s) Indicating Relative Cumulative Explanatory Power of Control Variables on Hospitalization Periods of Two Parent, One Parent - General, One Parent - 180 Days, and One Parent - Specific Subgroups

<table>
<thead>
<tr>
<th>Family Structure of Subject Group</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Subjects</td>
<td>.145</td>
</tr>
<tr>
<td>Two Parent</td>
<td>.153</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>.175</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>.230</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>.355</td>
</tr>
</tbody>
</table>

Question 3 was concerned with the effects of special educational and treatment "children's services" programs described in Chapter II. It inquired as follows:

Question 3: What have been the effects of child patient oriented programs on lengths of stay of child mental patients? Are these effects differentiated by the family structure of the patients? By sex? By age?

In order to answer this question, zero order correlations between length of hospitalization and family structure, age, sex, and socio-economic status were computed. These coefficients, together with mean lengths of stay for the various categories are compared in Table 3:23. The subgroup, "at admission," and "race" have not been included in the comparison since sample sizes were very small. (Only 9 subjects could be categorized as one parented at admission. "Race" included only 15 Black children.)
Table 3:23

Impact of Children's Services Programs on Length of Hospitalization Compared According to Family Structure, Sex, Age, and Socio-Economic Status

<table>
<thead>
<tr>
<th>Subject Category</th>
<th>Means</th>
<th>Mode</th>
<th>Median</th>
<th>Standard Deviation</th>
<th>Zero Order Correlation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Structure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Subjects</td>
<td>30.7</td>
<td>11.0</td>
<td>26.0</td>
<td>20.93</td>
<td>.072</td>
<td>221</td>
</tr>
<tr>
<td>Two Parents</td>
<td>27.1</td>
<td>20.0</td>
<td>22.5</td>
<td>19.76</td>
<td>.033</td>
<td>116</td>
</tr>
<tr>
<td>One Parent - General</td>
<td>34.7</td>
<td>40.0</td>
<td>33.0</td>
<td>21.55</td>
<td>.145</td>
<td>105</td>
</tr>
<tr>
<td>One Parent - 180 Days</td>
<td>33.2</td>
<td>40.0</td>
<td>33.0</td>
<td>20.26</td>
<td>.063</td>
<td>53</td>
</tr>
<tr>
<td>One Parent - Specific</td>
<td>40.3</td>
<td>37.0</td>
<td>36.0</td>
<td>22.77</td>
<td>.241</td>
<td>43</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent</td>
<td>27.8</td>
<td>11.0</td>
<td>24.0</td>
<td>20.51</td>
<td>.183</td>
<td>147</td>
</tr>
<tr>
<td>Pre-adolescent</td>
<td>36.3</td>
<td>16.0</td>
<td>34.0</td>
<td>20.74</td>
<td>-.089</td>
<td>74</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>32.3</td>
<td>11.0</td>
<td>28.0</td>
<td>22.00</td>
<td>.058</td>
<td>134</td>
</tr>
<tr>
<td>Female</td>
<td>28.3</td>
<td>23.0</td>
<td>24.0</td>
<td>14.03</td>
<td>.110</td>
<td>87</td>
</tr>
<tr>
<td><strong>Socio-Economic Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 20 (Duncan Scale)</td>
<td>30.6</td>
<td>11.0</td>
<td>28.0</td>
<td>19.17</td>
<td>.060</td>
<td>118</td>
</tr>
<tr>
<td>Above 20 (Duncan Scale)</td>
<td>30.8</td>
<td>20.0</td>
<td>24.0</td>
<td>22.88</td>
<td>.081</td>
<td>103</td>
</tr>
</tbody>
</table>

Table 3:23 shows that the impact of children's services programs has been to lengthen slightly the lengths of stay for all categories presented except that of pre-adolescents. This is a surprising result of the exploratory analysis at first glance.

Further comparison of the zero order correlations within the categories of age, sex and socio-economic status implies that children's services educational programs have the greatest impact on subjects whose social performances in the larger society may require the most resocialization toward the avoidance of performance error. The impact of children's services may be to lessen the rate of rehospitali-
zation rather than to shorten it. Exploration of this possibility, however, is beyond the limitations of this study.

A fourth question has been explored in the analyses testing \( H_{R_3} \) and \( H_{R_4} \). It referred to differential diagnoses as follows:

**Question 4:** Is there a tendency for differential diagnoses to accrue to child mental patients from one parent families? From families with two parents?

The findings, presented in Table 3:20 and Table 3:21, indicate that such tendencies in fact do exist. Diagnoses which are the result of educated evaluations on the part of trained personnel are slightly more likely to accrue to children of one parent families than to those with two parents within this hospital population.

The categories which were considered as evaluatively diagnosed were psychosis, neurosis and adjustment reaction of childhood or adolescence. Each of these may be said to be manifested by extremity of error in social performance. Diagnoses dependent upon physically measureable symptoms like central nervous system damage and seizures (epilepsy) tended to be equally distributed between one and two parent patients.

The findings analyzed in this chapter both support and negate the differential between one and two parented child mental patients which was proposed in Chapter I. The theoretical proposals appear to have validity for this population of subjects. Considered as sample data, the findings do not permit generalization to other groups of child mental patients. This apparent paradox will be one subject of focused discussion in the summation, conclusions, and implications considered in Chapter IV which follows.
CHAPTER IV

SUMMARY, CONCLUSIONS AND IMPLICATIONS

Summary

Theoretical Background

The purpose of this investigation has been an examination of a proposed relationship between family structure and the retention of children in deviant roles as residential mental patients. Specifically, this study has proposed that child mental patients from one parent families will be hospitalized for longer periods of time than will those from two parent families.

Although trends toward increased numbers of single parent families and increased societal emphasis on mental health and mental illness have paralleled one another in time, the possibility of a structured relationship between the two phenomena has seldom been documented. More often, sociological attention has focused on other social issues like juvenile delinquency, school dropout, pre-marital pregnancy and alienation. Frequently, these studies furnish inferential information pointing to the single parent family as one likely causal factor to juvenile deviance.

Most studies, which have considered the families of persons diagnosed as "mentally ill," have been concerned primarily with etiological processes within an aberrant two parent setting. While
the theoretical development of this investigation has considered the causes of commitment to the role of mental patient, its focus has been upon tendencies toward performance error which may be normal products of early socialization in a family headed by a single adult. More specifically, this study has been concerned with the one parent family as its structure may contribute not only to error in social performance but also to a social affirmation of error which tends to allocate and retain one parented children in deviant roles, i.e., roles of mental patients. In other words, the major interest of this study has been in the possibility of differential treatment which may bias the careers of children as mental patients in a manner similar to the processes which have been reported as discriminating between juvenile offenders on the basis of their family backgrounds (Circourel and Kitsuse, 1968).

Viewed as a dyadically structured small group, the one parent family contains structural potentials for tense and unconventional early socialization which may result in errors of social performance as its children migrate beyond their families to a world of teachers and peers. These errors may tend to be affirmed and reinforced because of the ambivalent social status accorded by society to the one parent family. Thus may begin a series of evaluative contingencies which culminate, but do not end, with the allocation of the children to roles as hospitalized mental patients. For, especially in the hospital, evaluative contingencies are operative; in diagnosis, in prognosis and, finally, in staff decisions to release patients from
hospital care. At every step knowledge of the single parent pattern of the children's families may be influential in lengthening differentially the periods of time child patients from one parent families will remain in the mental hospital.

Procedures and Findings

In order to explore the validity of this theoretical perspective, this study utilized data from the official case histories of 221 children who had been residential patients in a state mental hospital in Michigan. Of these, 105 were from families headed by a single parent. All were under 18 years of age at the time of their admittance.

The unusual attributes of the data affected the analytical procedures used in this investigation. Since the data were collected comprehensively on all eligible subjects within a single hospital, the data could be considered legitimately as applicable only to one particular population of child mental patients. Support or rejection of hypotheses was based upon this limitation. An "as if" element was added to the analyses, however. As an exploratory exercise, each procedure in the analysis of findings has first treated the data as they apply within the parameters of the specified population and then has examined the findings "as if" they were representative of typical patient groups meeting the sampling assumptions necessary for significance testing and generalization.
This research has sought clarification of four basic questions:

1. Does knowledge of family structure, i.e., single or two parent familial background add importantly to considerations like diagnosis, genetic predispositions, socio-economic status, urban-rural environment, race, sex and developmental stage of maturity in predicting lengths of time child mental patients will be hospitalized?

2. What are the relative influences of social and psychological variables like diagnosis, genetic predispositions, socio-economic status, urban-rural environment, race, sex and developmental stage of maturity on the lengths of hospitalization of child mental patients from one parent vs. those from two parent families?

3. What have been the effects of child patient oriented programs on lengths of stay of child mental patients? Are these effects differentiated by the family structure of the patients? By sex? By age? By race?

4. Is there a tendency for differential diagnoses to accrue to child mental patients from one parent families? From families with two parents?

Based upon the theoretical development of this investigation, hypothetical propositions could be asserted provisionally regarding three of the above questions. Question three was given exploratory attention only.

It was hypothesized and confirmed that:

Child mental patients from families headed by a single adult will be hospitalized for longer periods of time than will patients from two parent families.

One parented subjects as a group were found to be retained in a residential treatment for a period averaging 7.6 months longer than were two parented child patients. This constitutes a "large difference"
considered as population data. Analyzed "as if" it were a finding based on sample data, the null hypothesis of no statistical difference between groups could be rejected at the .05 level.

The elaboration of Hypothesis I constituted the general thesis of this investigation. \( H_{R1a} \) proposed as follows:

Child mental patients from single parent families will be hospitalized for longer periods of time than will those from two parent families, controlling for the effects of diagnosis, family members in mentally ill roles, socio-economic status, urban-rural environment, race, sex, birth order and developmental stage of maturity.

The number of controls posed an analytical problem which was solved by the use of multiple regression models. Using these techniques, the elaborated hypothesis was supported on a population basis. The null hypothesis could not, however, be rejected at the .05 level when the findings were considered "as if" they were based on sampling procedures. Serendipitous findings, however, based on exploration of interaction terms created from family structure in combination with the various controls, gave inferential evidence that prediction models containing a statistically more manageable number of controls might legitimately hypothesize elaborated differences in length of hospitalization between samples of one and two parented child mental patients.

In the present instance, however, complete interaction models would have involved terms greater in number than the total N. Cogent comparisons therefore could not be attempted.
Hypothesis II was addressed to the comparative influences on child mental patients from one and two parent families of the various controls. It predicted as follows:

The relative influences of diagnosis, history of family roles of mental illness, socio-economic status, urban-rural environment, race, sex, birth order and developmental stage of maturity will be greater for child mental patients from single parent families than for those from two parent families.

The hypothesis was confirmed within the limits of the subject population. Among these particular child mental patients, the aggregate impact of the various controls had greater explanatory power in connection with length of hospitalization for children from one parent family structures. An "as if" treatment of the findings as sample data, however, did not support $H_{R_2}$ to the degree necessary for generalization to child mental patients at other times or in other hospitals.

Among individual control variables, only central nervous system damage shared equal and first importance for both one and two parent regression models. Birth rank was more powerful in impact on two parented children. Rank as the oldest among siblings was related to the lengthening of hospitalization for this group. Its impact, less important, on one parented children was toward shortened periods of treatment.* Socio-economic status was a variable of lesser impact for both groups, as shown by its zero order correlation

*See Table 3:18.
with length of stay,* and by its position of low priority as a selec-
tion in the stepwise regression programs.

Hypotheses III and IV consider the possibility of differential diagnoses for one and two parented child mental patients. Hypothesis III is based upon the technologically measureable attributes of damage to the central nervous system and of seizures (epilepsy). Based upon the theoretical perspectives of this study, it was hypothesized that:

Diagnoses which are dependent upon organic symptoms of "illness" (with central nervous system damage and/or seizures) will tend to be equally distributed between one and two parented child mental patients.

Hypothesis III was supported as population data with a difference of only 1% between the proportional findings for the one and two parent groups. It was also supported by statistical test when treated "as if" the findings were based upon sample data.

Although the symptomatic manifestations of damage to the central nervous system and of seizures are amenable to objectively based diagnosis, a number of other abnormal mental conditions are of necessity diagnosed on the basis of highly trained but nonetheless human evaluations of command of performance (Goffman, 1959). Hypothesis IV proposes that the element of human evaluation will introduce a difference between one and two parented mental patients as follows:

Diagnoses which are dependent upon subjective evaluations of illness (psychosis, neurosis, adjustment reaction of childhood — without central nervous

*See Table 3:18.
system and/or seizures) will tend to accrue to children of single parent families in greater proportions than to children of two parent families.

Hypothesis IV was supported by the finding that a 7% greater proportion of one than of two parented subjects were undergoing treatment for evaluatively diagnosed "ills." The difference in proportional incidence was not great enough, however, to reject the null hypothesis when this was tested "as if" the subjects were sampled for a larger universe of one and two parented mental patients.

No hypothesis was proposed in regard to the impact of Children's Services at the hospital. Rather, as has been stated in Chapter II, the development of special programs oriented to the needs of child patients has been recognized and examined as a factor which might tend to bias the findings of this study.

The general impact of the children's services programs has been toward a slight lengthening of periods of hospitalization. There was a differential impact, however, which was greater for patients from one parent families than for those from families whose structure contained two parents. The period of hospitalization of two parented patients explained by participation in the children's services programs averaged only 18 days. The impact of participation in children's services programs on length of hospitalization of one parented patients amounted to an average of 3 months.
The differential between subjects on the basis of socio-economic status was found to be negligible, amounting to an average of less than a week (6 days). Girls have been affected more greatly than have boys, if relationships between participation in Children's Services and length of hospitalization are compared; however, in terms of actual days of retention in the hospital the differential is only one extra day.

The greatest differential observed between participant and non-participant groups was linked with age. For pre-adolescent patients the gross impact of Children's Services has been to lessen the period of hospitalization an average of 18 days. For adolescent subjects the effect of children's services programs has had an opposite, and greater, impact, accounting for about 15 weeks of the average length of time this group remained in residential treatment.*

Discussion

In the analysis of the data, reported in Chapter III, several unexpected patterns were mentioned briefly as having emerged in the findings. These will be discussed in this section.

The first of these unexpected patterns evolved with the separation of the one parent - general subject group into the following subcategories:

*Average impact in time is based upon the zero order correlations of Table 3:23.
1. One Parented - at admission: This group included 9 subjects who were living with only one parent at the time of hospital admission but who had not experienced 180 days or more as a member of a single parented family.

2. One Parented - 180 days: This group included 53 subjects whose background included 180 or more days of membership in a family structured on the one parent model but whose familial pattern contained two parents at the time of their admittance to the hospital.

3. One Parented - specific: This group included 43 subjects who not only were living with only one parent at the time they were hospitalized but also had experienced membership within a single parent family structure for a period of at least 180 days.

These subgroups might be considered as categorized according to the degree to which they approximate an "ideal" model of the one parent family background. Thus, group one, the one parented - at admission, is made up of subjects whose family structure is least like the ideal and group three of subjects whose families approximate the hypothetical one parent family model as closely as feasible within the size limitations of the available population.

On the basis of the theoretical development in Chapter I, a lengthening pattern of hospitalization periods was expected from group to group. This expectation was fulfilled by the finding that significant differences existed between the average hospitalization periods of the subject groups and that these differences were toward longer terms of in-patient treatment as the families of the subjects approached closer to the ideal (see Tables 3:12 and 3:13).

What was not expected was that group one, the one parent - at admission subcategory of the one parent family, would not only have
the shortest average length of stay of the one parented groups but would also have a mean period of hospitalization significantly shorter than that of the two parented subjects.

The group is small but the finding was troubling, particularly in view of the fact that the standard deviation is the smallest of all the subject groups. A number of possible alternatives can be advanced either individually or in combination as an explanation for the finding.

1. The one parented - at admission subgroup is atypical. It is made up of 9 subjects whose lengths of hospitalization are clustered several standard deviations below a "true" mean.

2. The one parented - at admission subgroup should have been considered as a two family subgroup since these patients presumably had experienced socialization within two parented families and had had little opportunity for labeling interactions before entering the hospital.

3. Entry of the one parented - at admission subgroup to the hospital was occasioned by temporary performance errors related to the immediacy of the children's loss of a parent.

4. Discharge of the one parented - at admission subgroup from the hospital was related to needs of a traumatically affected single parent whose emotional stress prevailed over staff evaluations.

5. Discharge of the one parented - at admission subgroup was hastened by the reunification of their families as two parent units.

Verification of any of these explanations has proved to be impossible. Recoding of these 9 cases as two parent subjects results in a net increment of positive explanatory power (partial $R^2$) of .06 obtained by the addition of family structure to the restricted control
equation. This increment is significant at the .05 level ($F = 12.63$ with 1 and 202 d.F) when tested "as if" it were a sample finding, a result which lends support to alternatives 3 and 4 above.

Casually obtained knowledge confirms that one patient was returned to reunited parents. Such information is not part of the official case histories of the patients, however. Re-examination of their files revealed that three subjects in the group were released with direct discharges and four were discharged on a convalescent basis. For two patients no information as to type of release could be uncovered. Conversations with hospital staff led to formulation of the proposition that early discharge, at least in the cases involving discharge to convalescent status, might be related to the emotional demands of a distraught single parent.

A study of "The Trauma of Children When Parents Divorce" furnished the background for the proposal concerning temporary loss of command of performance. Landis (1960) sampled 183 children of divorced parents and found that all of them reported feelings of insecurity and unhappiness. The effect was greatest, however, for those children who had been shocked by the dissolution of what they had considered a "happy" family. Were the one parent - admission child mental patients so traumatized? Within the boundaries of the present investigation there can only be conjecture. The provocative questions raised by the one parented - at admission subgroup can be resolved only within the context of a more extensive research design utilizing a larger population.
A second unexpected pattern which emerged in the analysis was that the general impact of the children's services programs has been to lengthen the periods of time that child patients remain in the hospital. Yet the admission that this finding was not expected is also a recognition that our surprise is itself an example of the culturally learned predisposition to evaluation which may serve to label and retain our single parented subjects in their deviant roles. We "expected" child oriented programs to shorten lengths of stay. In view of the theoretical perspective of this study we should have surmised that more opportunities for interaction with concerned staff members would lengthen periods of hospitalization and that the impact of this concern would be greater for children from one parent families. Responsible authority would want to be very certain of a child's mental and emotional stability if his release meant he must return to a family environment perceived as pathological to the healthy development of his personality. The theoretical motives are admirable and the impact of Children's Services may very well be to facilitate permanent recovery in terms of adequate command of performance in the larger social environment. The finding remains that evaluative concern is labeling which acts to retain the children in their deviant roles.
Conclusions and Implications

This study has advanced a provisional explanation of a differential which was found between the lengths of hospitalization of one and two parented child mental patients. It has proposed a tendency to performance error arising in an intensely dyadic early socialization of children within single parented families and receiving affirmation, reinforcement and continuing affirmation from a social environment which suspiciously views the single parent family as a deviant institutional structure.

On the basis of this theoretical explanation the study has sought to ascertain whether children from one parent families are retained in deviant roles as mental patients for longer periods of time than children who possess two parent familial backgrounds. This report can confirm with confidence only that this was the case among 221 child mental patients in one state mental hospital in the midwest.

While it is true that the conclusions of this investigation cannot be generalized to other child mental patients across space and time, it is also true that this research has hypothesized on the basis of its theoretical perspectives, has tested those hypotheses and has confirmed them within one specific subject population. Because it has dealt with a particular population, this report can affirm conditional confirmation of its hypotheses with a confidence dependent upon certainty rather than probability.
This study is a case study. Its purpose has been the development and preliminary exploration of the validity of a theoretical perspective. It has completed this task with results that imply first that further testing of its hypotheses on a more general, and generalizable, level would be a valuable undertaking.

The findings of this investigation do not imply that the structure of the single parent family is intrinsically pathological. To do so would negate the social contributions of people like Martin Luther King, Abraham Lincoln, and Eleanor Roosevelt or the relatively unheralded but nonetheless valuable lives of the many anonymous persons whose childhoods have been spent in the context of the one parent family structure. The findings do imply a potential for early errors in social performance on the part of single parented children, however. This implied potential constitutes a derived hypothesis which could be tested by objective research.

The findings also imply that early performance errors will allocate and retain children in deviant roles according to the degree with which their families are perceived as deviating from the norm by the people (peers, teachers, police, caseworkers, neighbors, etc.) with whom the children interact. From this general implication another set of testable hypotheses can be deduced.

Other implications of the findings are particularly relevant to the aims of agencies of education, law enforcement, and mental health. If validated by more extensive research, the relevance of family structure to allocation and retention in deviant careers might give
Impetus for policy decisions which would lower the age of formal education to the nursery years. It also implies that the training of professionals who deal with children should include the explicit recognition of cultural biases of perception and evaluation and the relationship of these to the life careers of children.

The theoretical perspective which has been tested in this investigation has concentrated on the structure of the single parent family; however, it has implied relevance for other family structures which, because of subcultural differences in custom, are viewed generally with ambivalence and suspicion and therefore often the objects of deviant labeling. Thus, this study has implications for the children of minority and ethnic groups whose performance errors and memberships in "deviant" family structures render them susceptible to societal labels and subsequent permanent allocation to various deviant roles.

Closing Statement

Clearly, this research is an initial effort to clarify the impact of family structure upon the life outcomes of children. Additional investigations are called for to broaden and verify our knowledge of the one parent family. For the numbers of these families have grown to such proportions within our society as to make attention to their social needs in terms of research, counselling, adult education and child care facilities imperative.
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