

195  
2  
5

# ANNOTATIONS

## SOCIAL CLASS, MENTAL ILLNESS, AND AMERICAN PSYCHIATRY<sup>1</sup>

### AN EXPOSITORY REVIEW<sup>2</sup>

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THIS book may well have a marked effect upon the future practice of psychiatry. It reports the results of a major investigation by a sociologist-psychiatrist team of the relationships between social class and the appearance and treatment of mental illness. Fragmentary findings had been made available before (twenty-five articles have appeared over the last five years), but a great deal of important material is presented here for the first time and the authors have expanded their forthright interpretations of the study's implications for the treatment of the mentally ill.

The excitement of a pioneering study arises from the freshness of its point of view and the provocativeness of its findings. It poses new questions and places old ones in a new light. This quality of exciting discovery is present in the important and sometimes startling findings of this study. We can give some indication of the significance of the book by quoting

<sup>1</sup> Hollingshead, August B. and Redlich, Frederick C.: *SOCIAL CLASS AND MENTAL ILLNESS*. New York, John Wiley & Sons, 1958, 442 pp., \$7.50.

<sup>2</sup> A number of persons commented on earlier versions of this paper. In particular, the exposition has benefitted from the detailed comments of Ernest M. Gruenberg, M.D., Matthew Huxley, and Frank Riessman. Only the authors, of course, bear responsibility for the final formulations presented in this paper.

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the three major hypotheses which are the central concerns of the investigation:

(I) The prevalence of treated mental illness is related significantly to an individual's position in the class structure. (II) The types of diagnosed psychiatric disorders are connected significantly to the class structure. (III) The kind of psychiatric treatment administered by psychiatrists is associated with the patient's position in the class structure.

A major problem of such ground-breaking investigations is that the core discovery overwhelms both authors and readers alike by the brute fact of its existence. In the first wave of response there is often a neglect of fundamental questions concerning the approach, the methodology, and the interpretations placed upon the data. The chapter summaries tend to enter without qualifications into the folklore of the discipline.

The potential importance of this book for theory, research, and practice in the mental illness field is too great to permit such neglect.

## I. EXPOSITION OF FINDINGS

A. *The Social Class Structure.* The basic data on social class composition is derived from interviews with respondents in a 5 per cent sample of all households in the metropolitan area of New Haven, Connecticut, which had a total population of about 236,940 persons. The New Haven population is divided into five social classes arranged in a hierarchal order. The family's class position is determined by the score of the head of the family on a weighted "Index of Social Position" that is derived from three separate scales measuring the social rank of his (a) area of residence; (b) occupation; and (c) education. The weights used in the formula for computing the summary index and the cutting points used to distinguish between classes were decided on specifically for this study and are not extrapolation from theory or other research. Roughly, occupation receives almost as much weight as the other two scores combined.

Class I, or the *upper class*, constitutes about 3 per cent of the population. It is composed of both "old" and "new" fam-

ilies who live in the most exclusive residential areas; the family head is a college graduate who is either an executive of a large firm or a professional. Class II, the *upper middle class*, is 8.4 per cent of the population and is made up occupationally of the managerial and professional groups. In Class III, the *lower middle class*, who make up 20.4 per cent of the population, about half are in salaried white collar work and the remainder either own small businesses, are semi-professionals, foremen, or skilled workers.

Class IV, the *working class*, is the largest group and accounts for half the households (49.8 per cent). Half of the group is semi-skilled workers, a third is skilled, and about a tenth is white collar employees. The overall educational level is much lower than in the class above it.

The *lower class*, Class V, which is 18.4 per cent of the population of New Haven, is made up of unskilled and semi-skilled workers of low education.

A rich and detailed description is provided of the historical background of the social class structure and of certain cultural characteristics of each of the classes such as their religious, family, ethnic, and leisure time patterns.

B. *The Prevalence of Persons in Psychiatric Treatment*. A "Psychiatric Census" was carried out in which an attempt was made to enumerate all persons from the New Haven metropolitan area who were "in treatment with a psychiatrist or under the care of a psychiatric clinic or mental hospital between May 31 and December 1, 1950."

The procedure here was remarkably thorough: systematic inquiries were made of revelant facilities and practitioners in New England and New York City and to special facilities further afield. The investigators' persistence brought response from every hospital and clinic contact and from 70 per cent of the private practitioners. In all, they believe that they may have missed only about 2 per cent of the community's residents who were receiving treatment. A total of 1,891 cases was enumerated on whom there was sufficient data for analysis. The data thus only permit discussion of *treated* mental illness, not of the total amount of mental illness in the community. To study the latter, a different type of research design with

a psychiatric interview or some similar device of a cross-section of the community would be necessary. Thus, in the Hollingshead-Redlich study, there would have had to have been a

(Table A.) Class status and the distribution of patients and nonpatients in the population.

CLASS	POPULATION, %	
	Patients	Nonpatients
I	1.0	3.0
II	7.0	8.4
III	13.7	20.4
IV	40.1	49.8
V	38.2	18.4
	<i>n</i> = 1891	236,940
	$\chi^2 = 509.81, 4\ df, p < .001$	

SOURCE: Hollingshead, A. B., & Redlich, E. C.: *Social Class and Mental Illness*, Table 8, p. 199.

illness. As can be seen in Table A, classes I through IV are somewhat underrepresented in the patient population, while Class V, to which 38 per cent of the patient group are assigned by their scores on the Index of Social Position, is greatly over-represented with twice as many patients as might be expected on the basis of their number in the community. Significant differences are also found in a comparison of treated prevalence rates per 100,000 population (computed so as to adjust for age and sex differences among the classes) which are distributed as follows:

(Table B.) Class status and rate of (treated) psychosis per 100,000 population (age and sex adjusted).

CLASS	ADJUSTED RATE PER 100,000
I-II	523
III	528
IV	665
V	1,668
Total Population	808

SOURCE: Text Table p. 210.

psychiatric study of all of the individuals included in the 5 per cent sample of New Haven to enable statements to be made about "true" incidence and prevalence.

The major finding—one of the study's core discoveries—is of a systematic relationship between social class and the treated prevalence of mental

In a more detailed analysis, Hollingshead and Redlich divide the patient group into specific diagnostic categories. A first glance reveals that the differences among the classes in treated prevalence rates are much greater for psychoses

DIAGNOSTIC CATEGORY OF NEUROSIS	CLASS			
	I-II	III	IV	V
Antisocial and Immaturity Reactions	21	32	23	37
Phobic-Anxiety Reactions	16	18	30	16
Character Neuroses	36	23	13	16
Depressive Reactions	12	12	10	8
Psychosomatic Reactions	7	9	13	11
Obsessive-Compulsive Reactions	7	5	5	0
Hysterical Reactions	1	1	6	12
	<i>n</i> = 98	119	182	65
$\chi^2 = 53.62, df 18, p < .001$				

SOURCE: Table 13, p. 226.

(Table C.) Percentage of patients in each diagnostic category of [treated] neurosis—by class (age and sex adjusted).

than for neuroses. The proportions of patients diagnosed as psychotic increase as one moves from Class I-II through Class V and conversely the proportions diagnosed as neurotic decrease (this reversal of the first relationship is automatic inasmuch as the two general categories make up the whole of the patient group). However, since this is a tempting finding to cite, it is important to point out that the authors discount its general importance and attribute it as possibly arising from the "differential use of psychiatric facilities by the population."

There are interesting differences among the social classes in regard to the specific neurotic disturbance which is modal among those who are in treatment: In Classes I and II the modal disturbance is character neuroses; in III and V, anti-social and immaturity reactions; while phobic-anxiety reactions are frequent in Class IV. Each of the above accounts for about one-third of the neurotic patients in each class as can be seen in Table C.

With regard to specific types of psychoses, much less variation in their percentage importance is found than is the case with the neuroses, as Table D reveals. In particular, for some of the major categories, differences are essentially non-existent—schizophrenia is the predominant psychotic disorder in all classes and the proportions of all psychotics who are schizo-

DIAGNOSTIC CATEGORY OF PSYCHOSIS	CLASS			
	I-II	III	IV	V
Affective Psychoses	21	14	14	7
Psychoses resulting from Alcoholism and Drug Addiction	8	10	4	8
Organic Psychoses	5	8	9	16
Schizophrenic Psychoses	55	57	61	58
Senile Psychoses	11	11	12	11
<i>n</i> = 53		142	584	672
$\chi^2 = 48.23, df\ 12, p < .001$				

SOURCE: Table 14, p. 228.

(Table D.) Percentage of patients in each diagnostic category of [treated] psychosis—by class (age and sex adjusted).

phrenic run from a low of 55 per cent in Class I to 61 per cent in Class IV. This finding is striking since earlier studies have reported a much higher rate of schizophrenia in Class IV and V neighborhoods than in other neighborhoods. Little variation exists among the classes in diagnoses of senile psychoses (11 or 12 per cent in each). Class V is disproportionately low in the affective psychoses with 7 per cent, and the other classes give figures of 14 or 21 per cent. Organic psychoses are highest in Class V (16 per cent) and lowest in Class I (5 per cent),

(Table E.) Class status and the rate of different types of [treated] psychoses per 100,000 of population (age and sex adjusted).

TYPE OF DISORDER	CLASS			
	I-II	III	IV	V
Affective Psychoses*	40	41	68	105
Psychoses Due to Alcoholism and Drug Addiction†	15	29	32	116
Organic Psychoses‡	9	24	46	254
Schizophrenic Psychoses§	111	168	300	895
Senile Psychoses	21	32	60	175
<i>n</i> = 53		142	585	672

\*  $\chi^2 = 17.49, 3\ df, p < .001.$

†  $\chi^2 = 77.14, 3\ df, p < .001.$

‡  $\chi^2 = 231.87, 3\ df, p < .001.$

§  $\chi^2 = 452.68, 3\ df, p < .001.$

||  $\chi^2 = 88.36, 3\ df, p < .001.$

SOURCE: Table 15, p. 232.

and Class IV with 4 per cent has half the rate of the other classes for psychoses resulting from alcoholism and drug addiction.

The treated prevalence rates for all of the separate neuroses (except hysterical reactions) show statistically significant differences among the classes. However, there is no ordering from a higher to a lower class that is consistent from one diagnostic category to another. The pattern of each neurosis with class must be examined and interpreted separately, as the authors do. Table E on the rates of persons in psychiatric treatment for different types of psychoses by class is the clearest demonstration in the book of an ordered inverse relationship of the type of disorder under treatment and social class. Although the curves for each disorder (affective, organic, schizophrenic, etc.) vary, in *every* case there is an increase in the rates as one moves from Class I-II to Class III, to Class IV, to Class V.

*C. The Incidence of Mental Illness.* One of the most important tools of epidemiological research and analysis is the distinction between *incidence*, i.e., the occurrence of new cases during some specified time, and *prevalence*, i.e., the total number of active cases in the population during some specified time. Although incidence is one of the components in a total prevalence picture, there is no systematic relation between the two since cases may be active currently that first appeared at any point in the past. In other words, as is generally known, prevalence rates do not directly reflect incidence rates since the former are dependent on rates of recovery and mortality from illness as well as on the occurring of illness.

All the figures reported above, and those in previous articles based on the study are for the prevalence of being in treatment. The most important new material in the volume is the presentation of incidence data for the psychiatric sample. It was derived by separating-out patients who entered or re-entered treatment during the interval of observation from those who had been in treatment at the beginning of the interval. It should be emphasized again that both incidence and prevalence rates refer to individuals *in treatment* rather to individuals with a mental disorder whether or not they are

in treatment. Consequently, the appropriate definition of incidence data for this investigation might be the numbers or rate of those first coming into treatment and prevalence might

(Table F.) Class status and rate of incidence of [treated] neurosis and psychosis per 100,000 population (age and sex adjusted).

CLASS	RATE
I-II	97
III	114
IV	89
V	139
Total	104

$\chi^2 = 8.41, 3\ df, p < .05$

SOURCE: Text Table p. 212.

cally significant but the differentials are markedly reduced in comparison with the prevalence rates. Class IV now has the lowest rate. The authors summarize by stating: "Classes I and II contribute almost exactly the number of new cases (incidence) as could be expected on the basis of their proportion of the community's population. Class IV had a lower number than could be expected proportionately, whereas Class V had an excess of 36 per cent," (p. 215). In further analyses, Hollingshead and Redlich demonstrate that there is *no* significant statistical difference among the classes in the rate at which persons come under treatment for neuroses and show that the sharpest break in this rate for psychoses as a whole and for schizophrenia (both cases where the overall differences among classes are statistically significant) occurs between Classes IV and V with very little difference appearing among the rates for Classes I through IV (pp. 235-6). (We shall return at a later point to these important findings regarding incidence.)

The data on incidence and prevalence reveal that Classes IV and V comprise two-thirds of the community (68.2 per cent) and provide more than three-fourths (78.3 per cent) of the mental patients. Thus, due to the size of these two classes, the high psychotic incidence rates in Class V, and the long duration of illnesses in both classes, *psychiatry—whether or not it*

be stated as the numbers or rate of those in treatment during the study period.

The rates of coming into treatment for all kinds of mental illness are reported in Table F.

The table shows that the overall differences remain statisti-



is aware of it—is largely concerned with Class IV and V patients. Of course, private practitioners have few Class IV and V patients, but our calculations of the Hollingshead-Redlich data show that these two sources of treatment work with only 21 per cent of all New Haven mental patients.

D. *Paths to Treatment.* In an excellent discussion of the paths to psychiatric treatment, the authors make explicit their fundamental orientation that mental illness is a socio-cultural phenomenon as well as a psychological one. Thus, they state “. . . abnormal acts can be evaluated only in terms of their cultural and psychosocial contexts,” and “Whether abnormal behavior is judged to be disturbed, delinquent, or merely idiosyncratic depends upon who sees it and how he appraises what he sees.”

The sources of referral for treatment, i.e., the agencies or persons who decide that the behavior is that “type” of abnormality for which psychiatric treatment is appropriate, vary systematically by social class. Among neurotics, 55 to 60 per cent of those in Classes I through IV are likely to have been referred by physicians (almost entirely by private practitioners in the first three classes, and about half the time in Class IV by clinic physicians). The proportion of neurotic cases coming from medical referrals drops to 40 per cent in Class V; an equivalent proportion is referred by social agencies; with an additional 14 per cent directed to treatment by the police and courts (p. 186).

The differences are even more striking among psychotics where one-third of the patients in Class I were self-referrals and another 40 per cent came through family and friends. More than three-fifths of the Class III and IV patients were referred by physicians. For Class IV psychotics the police and courts are important, accounting for 19 per cent of the cases, and in Class V these two sources account for 52 per cent while social agencies contribute 20 per cent. The findings for schizophrenia are similar to those for psychosis in general (pp. 187-189).

The brief case reports that are presented to illustrate the different treatment consequences that follow on the same behavior when exhibited by persons of different classes should

be required reading in all psychiatric residency programs. The authors note that "there is a definite tendency to induce disturbed persons in Classes I and II to see a psychiatrist in more gentle and 'insightful' ways than is the practice in Class IV and especially in Class V, where direct, authoritative, compulsory, and at times, coercively brutal methods are used."

And, their bitter, concluding epigram to this section is uncomfortably appropriate to their findings: "The goddess of justice may be blind, but she smells differences, and particularly class differences."

*E. Patterns of Treatment.* At the end of their chapter on the Treatment Process, Hollingshead and Redlich state that "the data presented lead to the conclusion that treatment for mental illness depends not only on medical and psychological considerations, but also on powerful social variables to which psychiatrists have so far given little attention," and that "We have found real differences in *where, how, and how long* persons in the several classes have been cared for by psychiatrists."

These conclusions are based on a large number of detailed analyses of relations among diagnosis, treatment agency, treatment, and social class. We shall cite only a few of the more decisive findings.

First, the patient group as a whole divides into three relatively equal parts according to the principal type of therapy received; psychotherapies, organic therapies, or custodial care. Eighty-four per cent of the psychotic group is in treatment in a state mental hospital; 64 per cent of the neurotics are in the hands of private practitioners and another 23 per cent are being treated in clinics.<sup>5</sup>

Despite the stress placed on diagnosis in psychiatric theory and practice, there is no overall relationship for neurotic patients between type of treatment and the specific diagnostic label attached to the patient. However, treatment is related directly to both social class and the agency in which the patient is treated. Even where treatment is received from the same facility, which is the most stringent test since it eliminates the selective bias that is present in the differential access to and

<sup>5</sup> Calculating the data in terms of the psychiatric agency involved, reveals some important practices: 30 per cent of the patients treated by private practitioners and by public clinics are suffering from various types of psychotic disorders.

choice of facilities by the different classes, there is a marked relationship between social class and type of treatment. For example, over 85 per cent of the Class IV and V neurotics in treatment with private practitioner receive "directive psychotherapy," while 45 per cent of Class I and II private patients receive "psychoanalysis or analytic psychotherapy." Consistent with this is the inverse relationship between social class and the likelihood of receiving the traditional "50 minute hour." (Ninety-four per cent in Classes I and II, 45 per cent in Class V, Tables 28, and 29, pp. 268-70).

A similar relationship between the "depth" and duration of the therapy and social class is also found in clinics, and there is additional evidence in a separate study of one clinic that the "patient's class status determines the professional level of the therapist who treats him." Public hospitals appear to be more democratic in their assignment of treatment to neurotic patients, inasmuch as there is no overall relationship between social class and treatment in these institutions.

The findings with regard to class bias in the type of treatment given to psychotic patients and to schizophrenics are less clear and less consistent than for the neurotic group. On the other hand, the relations of class to the duration and history of treatment are very significant and very revealing. For example, as one moves down the class ladder, the likelihood for schizophrenics of having been in continuous treatment increases, while moving in the other direction there is an increased likelihood of periods of remission and re-entry into treatment. In other words, once he enters treatment the Class V schizophrenic is likely to be kept under psychiatric care (Table 38, p. 295). Further, for psychotics there is a direct increase from Class I to Class V in the time duration of their present course of treatment; while for a neurotic this relationship is reversed. In other words, while the lower class neurotic is dismissed from treatment much more quickly than patients from higher classes, the lower class psychotic is rarely perceived as "ready" to leave treatment.

In comparing patients of Classes III-V who have been admitted to the hospital for the first time with patients of the same classes who have been hospitalized previously, a striking

finding emerges: The new patient is more likely to receive custodial care than the longer time patient! The implication is that patients of these classes are not given custodial care because of the failure of other methods but are somewhat routinely assigned to this very limited care. In Class V, for example, 64 per cent of the patients who are receiving custodial care had not had any previous treatment.

No discussion of treatment is complete that omits mention of expenditures and fees. The chapter dealing with this material contains more detailed comparative information than is available in any other source. One of the most salient findings is that the mean cost per day in private hospitals is higher for Class IV patients than for patients in the higher classes (\$31.11 to \$23.76 for a Class I person). This result which is contrary to expectation results from the discriminatory discounts granted higher status persons. Further, the higher status persons receive the most expensive therapies which leads the authors to state: "To use a metaphor, private hospitals are designed for the 'carriage trade' but they are supported by the 'shock box.'" A similar relationship is found in clinics where treatment expenditures per patient are strongly related to class status, with the result that "Class II patients receive the most therapy and Class V patients the least." This finding is particularly disturbing since the clinics have presumably been developed to serve the psychiatric needs of lower status persons.

*F. Recommendations.* In a thoughtful and interpretive summary of the implications of their findings for the problem of the mentally ill in our society, Hollingshead and Redlich point to the gap between the extent of the need and the resources currently available to meet it. While they give proper emphasis to the financial problem (what America needs is a "good five-dollar psychotherapist"), they also point to the difficulties that result from the differences in cultural values and role expectations between psychiatrists and patients from the lower social classes. They note that psychiatrists tend to come from the upper and middle classes and have outlooks which lead many of them to dislike Class IV and V patients and to disapprove of the behavior patterns of Class V individuals.

More than money will be needed. Among the possible partial solutions to the problems that they suggest are proposals that psychiatrists themselves be trained to recognize and deal squarely with the differences between themselves and patients from other classes; that new forms and modes of therapy be developed to reach the "difficult" patients (whose difficulty seems to reflect the difference between his and his therapist's class positions more than his psychological disturbance); and, that new non-medical therapists, whose education would be less expensive than psychiatrists', be trained to treat the emotional disorders which do not have medical problems associated with them.

## II. DISCUSSION OF FINDINGS

This detailed and complex study touches on a large number of important issues concerning the social context of mental illness and its treatment. It represents a distinct step forward in a number of ways.

Three features of the study are especially notable: (a) The presentation of incidence figures as well as prevalence data is strongly to be commended. (b) The method of estimating the social class of patients and the community, despite the limitations indicated below, is an improvement over those employed in previous studies which tended to assume that all who lived in a particular area or paid a similar rent were in the same class. (c) Social class is linked to many more facets of mental illness than just the rate and kind of mental illnesses; in particular, the link of class to the treatment process is innovative.

In our discussion we have restricted ourselves to and organized our comments around three topics that are critical for the study: the concepts of social class and mental illness; the validation of the basic hypotheses; and, the implications of the study for psychiatric treatment.

*A. Concepts of Social Class and Mental Illness.* Among sociologists, there is a variety of approaches to the problem of social stratification. Hollingshead and Redlich view the different classes as differently primarily in their "styles of life" and use their combined scores on education, occupation, and

residence as rough indices of these five different sub-cultures rather than as variables that are important in their own right.

In a study that directs explicit attention to the problems of getting "to" treatment and getting something "out of" treatment, the use of a combined index is unfortunate since it precludes analyses that might help to clarify what is involved in these processes. For example, it would have been of particular interest to be able to examine the relationships of education to the prevalence and treatment data in order to determine if an increase in education is associated with an increase in the propensity to view one's problems in psychological terms and therefore to benefit from psychological modes of treatment. Such a possibility is suggested by results in recent surveys of attitudes toward mental illness.<sup>6</sup> Enough evidence also exists to indicate that educational differences among individuals of the same occupational level are associated with differences in other characteristics, such as attitudes on public issues, so as to make the possibility of such cross-breaks especially desirable.<sup>7</sup>

In the Hollingshead system, some wage-earners are Class IV, others III or V, while white-collar workers are either III or IV. The class groupings thus become overlaps of various kinds, reducing their homogeneity, confusing comparisons and making generalizations difficult. An anomaly is that 18 per cent of New Haven was assigned to Class V in a time of prosperity. This figure seems high even with New Haven's migrant labor situation and may be due to a conceptualization of Class V which leads to a broad category characterized by widely varying behavior; for example, regular but unskilled workmen are lumped together with irregular but semi-skilled workmen.

Occupation scores correlate .88 with the original criterion on which the weighted index was based, and correlate less highly than this with residence and education (.50 and .72 respectively, p. 394). From this, it would appear that little would have been lost if occupation alone were used as the index

<sup>6</sup> See relevant findings in the forthcoming National Opinion Research Center study directed by Shirley Star; *PEOPLE'S ATTITUDES CONCERNING MENTAL HEALTH*. New York: Elmo Roper, 1950; and Elaine and John Cumming, *CLOSED RANKS*. Cambridge: Harvard University Press, 1957.

<sup>7</sup> Stouffer, Samuel: *COMMUNISM, CONFORMITY AND CIVIL LIBERTIES*. New York: Doubleday, 1955. Riessman, Frank: "Workers' Attitudes Toward Participation and Leadership," unpublished doctoral dissertation, Columbia University, 1955.

of social class. On the other hand, much might have been gained by this procedure since, in addition to permitting potentially revealing analyses, it would have reduced the heterogeneity of the social class groups allowing for more precise interpretations of the results. (If the data for occupation, education, and area of residence have been separately recorded by the researchers, it would be a comparatively simple procedure to see what variations by education exist within levels of occupations as classified, for example, by the Bureau of the Census. Such additional "runs" of the data would extend their usefulness, especially by permitting comparisons with other investigations.)

The importance of the study's findings, and our confidence in them, rests in large part on the fundamental assumption that the two basic variables of social class and mental illness have been measured independently of each other—if not, then the found relationships must be viewed skeptically as possibly spurious. This seems an easy enough assumption to accept. However, the findings in a recent study<sup>8</sup> raise serious doubts as to its validity. In this exceptionally well-controlled study, Haase is able to demonstrate that the same set of presenting symptoms is diagnosed as more severe when the patient is perceived by subtle cues to be a working class person than when he is seen as in the middle class. In the Hollingshead-Redlich study, despite the safeguards, this bias might be reflected in such findings as the relatively higher rates of psychoses as compared to neuroses when one moves down the class hierarchy, and would directly affect the relative sizes of the populations coming into treatment as well as the prevalence rates of persons in treatment for the different classes. One such study, of course, is insufficient grounds for rejecting the findings presented here. The issue, however, is of such crucial importance that the final acceptance of the findings must rest on further investigations of the relationship of class to the diagnostic process itself.

<sup>8</sup> Haase, William: "Rorschach Diagnosis, Socio-Economic Class, and Examiner Bias," unpublished Ph.D. dissertation, New York University, 1956. For a general discussion of diagnostic tests and social class, see Riessman, Frank and Miller, S. M.: Social Class and Projective Tests. *Journal of Projective Tests*. December, 1958, 22, pp. 432-439.

B. *The Validation of Hypotheses.* Compared to most investigations of complicated areas in social science, this book is a model of clarity with regard to the presentation of its guiding hypotheses and the procedures by which these hypotheses were tested empirically. The assumptions behind each decision in the development of the research design are stated explicitly and the basic instruments are described with sufficient detail so as to permit other researchers to replicate the study with exactitude.

This report is organized around three hypotheses that were formulated explicitly and tested directly. (Findings on two other hypotheses dealing with social mobility and the relation of class to developmental factors in psychiatric disorders will be reported in the forthcoming companion volume by J. K. Myers and B. H. Roberts, *SOCIAL CLASS, FAMILY DYNAMICS, AND MENTAL ILLNESS.*) Briefly, the hypotheses, which we have quoted earlier, state that the social class structure is related to the treated prevalence of mental illness, the specific types of diagnosed psychiatric disorders, and the types of treatment administered by psychiatrists to patients. The authors conclude that their findings confirm these hypotheses, and we have reported the relevant findings in our expository section above. At this point, we shall re-examine their interpretations of some of the critical tables.

One of the major faults in the authors' approach to their findings is found in the first direct comparison that they present between the proportions of patients and the proportions of persons in the community in each of the five social classes (see Table A). Only *one* class, Class V, has disproportionately more patients than its frequency in the population, and *all* the other classes have less patients than would be expected. (If the data in this table are re-computed with the omission of Class V, the Chi Square test—the statistic used to evaluate all of the major findings—remains statistically significant but is markedly reduced in size, and the disproportionate contribution of Class IV is only 4 per cent more than expected, and of Class III, 3 per cent less than expected.)

While at various points they note that the major difference is between Classes IV and V, they include in their summary of



this table the statement that "The lower the class, the greater proportion of patients in the population." The same interpretive tendency is found in their discussion of class differences in adjusted rates of mental illness (p. 210) where they ignore the fact that the Class III rate is actually *lower* than the rate in Class I-II. Again, in commenting on the class differences in incidence rates, they state (p. 212) "In a word, class status is linked to the incidence of treated mental illness." (The rates are shown in Table F.) A re-computation of these data, omitting Class V, reveals Class III and *not* Class IV as having a higher than expected number of patients.

Basing their remarks on the data we have just reviewed, Hollingshead and Redlich conclude their chapter by stating "... enable us to conclude that Hypothesis I is true. Stated in different terms, a distinct inverse relationship does exist between social class and mental illness. The linkage . . . follows a characteristic pattern; Class V, almost invariably, contributes many more patients than its proportion of the population warrants. Among the higher classes there is a more proportionate relationship. . ." (p. 217).

What we are attempting to point out by this close review of their data is that the authors' tendency to report that there is a consistent and ordered inverse relationship between social class and mental illness is simply not an accurate interpretation of their findings. It would have been, as a matter of fact, more consistent with their "styles of life" view of social classes to have stressed what we believe is the major finding, namely the consistent differences between Class V and the other classes, with the differences that exist among the latter not clearly and consistently patterned in a hierarchal fashion.

Our attention was first called to this problem by the comments and remarks of other professionals and students who were summarizing the book's findings in seminars and staff meetings by statements like "The lower the class the higher the rates of mental illness." The general tendency in discussions of class differences to group together Classes I-II versus Classes IV and V is another contributor to the misinterpretation of their findings. The book is so notable for its clarity in other respects that it is unfortunate that the interpretive sum-

maries lend themselves so easily to confusion and distortion. (It might also be mentioned that synoptic statements of the order—"The lower the class the higher the rates of mental illness"—ignore the nature of the Hollingshead-Redlich data which are of treated illnesses not total illnesses. The relation between treated and total illnesses in different social classes is not known and the total rates cannot be assumed to be a standard coefficient of the treated rates.)

In interpreting the relationships between class and specific types of neurosis and psychosis (Hypothesis II) there is a tendency to use an overall significant statistic to report differences for specific disorders when the latter are less systematic and depend on rather small numbers of cases. For example, their two basic tables (Tables C and D) demonstrate that overall, there are statistically significant associations of the five classes with the seven specific neuroses and with the five specific psychoses. They then refer to an "extreme concentration" of hysterical patients in Class V. Examination reveals there are only eight Class V patients in this category and the reduction of the cell by two or three cases would erase its percentage difference from Class IV. Again, they state, "The higher the class, the larger the proportion of patients who are affective psychotics," yet a reduction of three cases among those in Classes I-II would completely eliminate the differences from Class I through Class IV, leaving only Class V as different from the others.

So far, except for one illustration, we have been concerned in our discussion with the reports and interpretations of prevalence data which permit specific tests of the authors' explicit hypotheses and form the major substantive findings around which the book is organized. We have already remarked on the important distinction between prevalence and incidence and will turn now to the findings on the incidence of specific disorders.

Hollingshead and Redlich separately compute rates for each of the "components" of prevalence: new cases arising during their six months interval of observation (incidence), cases that re-entered treatment during that period (re-entry), and those that had been in treatment at the beginning of the period (con-

tinuous). They then proceed to test for significant differences among the classes for each of these rates, separately for neuroses and psychoses. (See data presented in Table G. We consider them to be the most important findings in the book on social class and mental illness.)

They find significant differences among the classes for each of the component rates *except* for the incidence of neurosis. In other words, there is no systematic relationship between social class and the rates of coming into treatment for neurosis.

It appeared to us that the statistical significance of the other relationships of class and incidence rates (both new and old cases) might depend almost entirely on Class V. We re-computed incidence and re-entry rates for neuroses and psychoses, omitting Class V from the calculations. The test showed *no* significant differences among Classes I through IV. (Chi Square for the incidence and re-entry of neuroses are

(Table G.) Incidence, re-entry, continuous, and prevalence rates per 100,000 for [treated] neuroses and psychoses—by class (sex and age adjusted).

NEUROSES				
Class	Incidence	Re-entry	Continuous	Prevalence
I-II	69	44	251	349
III	78	30	137	250
IV	52	17	82	114
V	66	35	65	97
$\chi^2 =$	4.40	8.64	69.01	56.05
$df$	3	3	3	3
$p$	> .05	< .05	< .001	< .001

  

PSYCHOSES				
Class	Incidence	Re-entry	Continuous	Prevalence
I-II	28	44	117	188
III	36	38	217	291
IV	37	42	439	518
V	73	88	1344	1505
$\chi^2 =$	12.37	15.73	748.47	741.09
$df$	3	3	3	3
$p$	< .01	< .01	< .001	< .001

SOURCE: Table 16, p. 235.

1.96 and 3.36; for psychoses, the figures are .28 and .08. None of these is significant at the .05 criterion value.)

To summarize these findings: there are *no* significant differences among social classes I–V in the incidence of new cases of neuroses. There are *no* significant differences among classes I through IV in the incidence of new *or* old cases of neuroses *or* psychoses. Class V has significantly different and higher rates of new and old cases of psychosis (and the inclusion of Class V in the computations suggests that Class IV has a *lower* rate of re-entry of neurotics than the other classes).

The contrast between the significant differences in prevalence and the findings we have just reported of non-significant differences in incidence is extremely important. By concentrating on the prevalence data, an important finding for sociologists and psychiatrists—that Class IV has the lowest overall mental illness rate—is ignored, and some traditional views about the incidence of mental illness are left untouched. There is an implication at many points throughout the book that the prevalence findings may be interpreted as class differences in the likelihood of developing various mental illnesses (the descriptions of class sub-cultures in Chapters 3 and 4, and the discussions of social class and the life cycle in Chapter 12 are presumably given an important place in the book because treated prevalence data are to some extent thought of in these terms). It is also likely that the findings will be discussed in both the lay and professional literature to some extent as if the prevalence findings did bear on questions of etiology.

Perhaps a recent statement on this by Dr. Redlich himself may serve to minimize such a tendency. “The New Haven study has not really brought out anything which is of etiological significance in explaining differences in prevalence, and prevalence in itself is not a very good measure from an epidemiological viewpoint. . . We found, as far as the accumulation of schizophrenics in the lower classes is concerned, that although not entirely, it is mostly due to the fact that the lower socioeconomic groups get different treatment and have different opportunities for rehabilitation.”<sup>9</sup> It is unfortunate that this

<sup>9</sup> SYMPOSIUM ON PREVENTIVE AND SOCIAL PSYCHIATRY, April 15–17, 1957. Walter Reed Army Institute of Research, Washington, USGPO, 1958. (p. 199).

position was not stated as clearly in the book under review. In addition to these restrictions on the interpretation of the prevalence findings, and the fact that the data deal only with *treated* prevalence, our re-examination of the incidence data also supports the conclusion that the etiological significance of social classes for mental illness is yet to be demonstrated.

When the spurious issue of etiology is brushed aside, the book's major findings stand out quite clearly and they are of extreme importance. Essentially, these refer to the differential psychiatric treatment given to patients of different classes with the apparent result of an accumulation of cases in the lower classes. Besides the differences between the distributions of incidence and prevalence rates that we have discussed there are other findings that bear on this. The differences among classes on the paths to treatment, the types of treatment received, and the costs of treatment are important contributions to the understanding of the social aspects of medicine.

It should be noted that in many respects the study is an important followup of the Committee on Costs of Medical Care more than two decades ago.<sup>10</sup> By carefully studying how many and what kinds of persons are in psychiatric treatment, the nature and place of treatment, how much medical time is spent with them and the costs of treatment, a baseline is provided for discussion of the most effective social utilization of psychiatric manpower and resources. Coupled with other data, the present study provides an opportunity to define the "psychiatrically indigent" category—undoubtedly a much more inclusive category than that of the "medically indigent."

The authors' conclusions regarding class bias in treatment do not depend on the other findings and do not suffer from the weaknesses of method and interpretation that we have discussed above. They are to be commended for their courage in facing this important issue squarely and for their no less coura-

<sup>10</sup> See the report by Lee, Roger I. and Jones, Lewis Webster: *THE FUNDAMENTALS OF GOOD MEDICAL CARE*. Chicago: University of Chicago Press, 1933. They quote Dr. Olin West that "... the outstanding problem before the medical profession today is that involved in the delivery of adequate, scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life." "Adequate medical care" is defined in both quantitative and qualitative terms: "... a sufficient quantity of good medical care to supply the needs of the people according to the standards of good current practice." (p. 3).

geous attempt to meet the problem by a forthright presentation of a number of proposals that are decidedly controversial in American psychiatric practice.

*C. Implications of the Study.* In view of the preceding discussion, we shall not take space to discuss the important theoretical issues about the relationship of social factors to the etiology of mental illness.<sup>11</sup> Rather, we shall restrict our remarks in this section to the study's implications for psychiatric practice.

It has been well known before this that the needs of the population for psychiatric treatment were not being met adequately. What this investigation demonstrates beyond this, is that the distribution of available resources is socially discriminatory. We believe that a serious moral question is also involved in this discovery, since the psychiatric profession legitimates its claim to high status and to social and economic rewards on the grounds that it functions in a "universalistic" nondiscriminatory way. Actually, it operates in such a way as to restrict its "best" treatments to persons in the upper social classes.

We agree that the need requires the development of new modes of treatment, better understanding by psychiatrists of social class patterns and their reactions to them, and new types of non-medical therapists. We wish, however, to point to some of the assumptions involved in these recommendations and raise some questions that deserve further consideration. First, the authors appear to assume that psychoanalysis or some form of analytic psychotherapy is always ideally preferable to a directive or organic mode of treatment, and that therefore Class IV and V patients are being short-changed. At one level this is a value question since the different therapies are associated with different therapeutic goals, and the issues of what goals to select and who is to decide upon them lie in the realm of value. At another level, this is an empirical issue of whether other forms of treatment might not actually be more effective, rather

<sup>11</sup> Nor shall we discuss a problem that we have alluded to several times—how representative the census of patients is of all of the mentally ill people in New Haven, especially in regard to the social class distribution of the total. Since individuals of different classes come to clinic and other treatment through different routes, it may not be assumed that the census sampled to the same degree the actual amount of all mental disorders in the different social classes.

than simply less costly and less demanding for certain groups of patients. Definitive empirical evidence does not yet exist to provide an answer to this question.

There also seems to be the assumption that it is the psychiatrist who relatively completely controls the type of treatment given. It may be that patients search out psychiatrists who will give them their preferred type of treatment and reject non-preferred treatments, both from private practitioners and within the clinics and hospitals. The selective process and pressures emanating from the patient cannot be ignored in a full account of the biased pattern of psychiatric treatment.

This leads to a related point. There is a tendency to discuss the problem of therapy with working class and lower class persons in a way that implies that the therapist wishes to give the patient "more" than the patient wishes. For example, some practitioners assert that the therapist wants to help the patient come to his own decisions, but the patient only wants to be told what to do; the therapist wants to establish a long term relationship with the patient, but the patient wants a quick remedy; the therapist wants deep and lasting changes, but the patient is satisfied with superficial and transient results. The alternatives may be multiplied beyond this, but what is important is that they seem to imply a rejection of the therapist and the therapeutic process by the patient. We should like to suggest that quite the opposite may be happening. Rather than asking for "less" than he is offered, the working class and lower class patient may actually be asking for "more" in the sense that he wants a fuller, more extensive, and more permanent relationship than is possible either within the traditional definition of the therapeutic relationship or in terms of what the therapist wishes to enter into. In other words, it may be the therapist who drives the patient from treatment because he cannot handle the demands placed upon him, rather than the patient who drops treatment because its demands are too much for him.<sup>12</sup> (With the knowledge we have of working class and

<sup>12</sup> Some evidence exists that many patients of other classes may have similar sets of expectations and present similar problems to psychiatrists. In a by-product of the study under review, it has been found that Class III and V patients exhibit strong resemblances in their expectations of therapy. Our hypothesis would be that it is the low-educated members of Class III who especially exhibit "non-psychiatric"

(Continued on page 197)

ethnic cultures it is difficult to subscribe without qualification to assertions that patients from these groups do not like to talk or have special difficulties entering into relationships. The basic questions are: What kind of relationships, with whom, and under what conditions? In raising these questions we are suggesting that some prevailing interpretations of working class and lower class life may have to be re-evaluated.)

### III. RESEARCH PERSPECTIVES IN SOCIAL PSYCHIATRY

Perhaps nothing emerges more clearly from the book viewed as a whole than the need for continued systematic research on the relationships of social factors to mental illness and psychiatric practice. Our critical comments on the Hollingshead-Redlich study have included suggestions as to how future studies of a similar nature might be improved. We should like at this point to note briefly some additional areas and questions for research that have been suggested by both the achievements and shortcomings of this work.

A. *The Etiology and Epidemiology of Mental Disorders.* The etiological significance of social variables such as social class for various mental disorders remains an open question. Clearly, studies of "true" incidence will be needed before we are able to suggest answers to this question. In design these studies will have to be comparative and longitudinal and they will have to permit the isolation and control of different and changing forms of psychiatric practice. Field investigations of "true" prevalence such as the "Midtown" and "Stirling County" studies, reports from which are now in preparation, will provide a beginning for understanding the relationships between such data and those for treated prevalence as reported by Hollingshead and Redlich. It is to be hoped that future investigations, in addition to including alternative indices of social class, will also be concerned with the effects of other social factors such as, for example, community and family structure, and ethnicity.<sup>13</sup>

attitudes. Redlich, F. C., Hollingshead, A. B., and Bellis, E.: Social Class Differences in Attitudes Towards Psychiatry. *American Journal of Orthopsychiatry*, January, 1955, 25, pp. 60-70.

<sup>13</sup> For an illustration of the relation of one aspect of community structure, namely, multiple- vs. single-family dwelling units, to cerebral arteriosclerosis and senile psychosis, see, New York State Department of Mental Hygiene, FOURTH ANNUAL  
(Continued on page 198)



More attention will have to be paid to the general problems of psychiatric diagnosis and classification. The nomenclature of the clinic is not particularly useful for field studies, but conceptual links must be forged among the different typologies and indices that are being developed. In all of this work it will be of particular importance not to neglect the fact that the process of psychodiagnosis is inherently a social process and full understanding requires the perspectives of sociological theory and analysis. In addition to data on types of disorders, the extension of a public health approach to the control of mental illness will require information on the severity and the extent of disability associated with mental illness so that large-scale social programs in the prevention, termination, or reduction of such disabilities may be undertaken.<sup>14</sup>

*B. Patterns of Psychiatric Treatment.* The findings presented by Hollingshead and Redlich on the different paths to treatment followed by patients from different classes are very important, and this is an area in which we need to know much more. The history of the illness before the point of referral, the factors that enter into seeking help at a particular stage, the relation of time and type of referral to outcome, and the relationships of all of these to social class require exploration in further studies.

What variables and processes are involved in the initial phase of treatment that seems to be such an important determinant of later outcomes? How much choice is available to the patient and how does he exercise his choice? How does the process of class discrimination in assignment and treatment operate in clinics and other treatment facilities? How are the goals of treatment set and how are these goals related to the different values of patients and therapists and to their images of and attitudes toward each other?

The list of important research questions may be expanded

REPORT OF THE NEW YORK STATE HEALTH COMMISSION, 1954, pp. 31-33; on the impact of ethnic variations in family structure, see, Barabee, Paul and von Mering, Otto: Ethnic Variations in Mental Stress in Families with Psychotic Children. *Social Problems*, October, 1953, 1, pp. 48-53; and Singer, J. L. and Opler, M. K.: Contrasting Patterns of Fantasy and Motility in Irish and Italian Schizophrenics. *Journal of Abnormal and Social Psychology*, July, 1956, 53, pp. 42-47.

<sup>14</sup> Gruenberg, Ernest M.: Application of Control Methods to Mental Illness. *American Journal of Public Health*, August, 1957, 47, pp. 944-952.

easily. We wish to end with a special plea for evaluative studies of the effects of various forms of psychiatric treatment. There is a desperate shortage of systematic evidence in this area, and without such evidence our decisions regarding proper treatment tend to be determined by current fashions in psychiatry or by implicit social values and assumptions.

Although we have been critical of some of the methods and interpretations we should like to stress our respect and admiration for this fascinating and exciting study. It is a book of considerable significance that focuses our attention on a range of important problems which had barely been discussed before. We regard it as a study of psychiatric practice rather than as one of epidemiology, and consider it a great contribution to the study of treatment. If it is not the definitive study that hopefully may be made in the next decade or two, that study will, in part, be possible because of the pioneering work of Hollingshead and Redlich.

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## BRITISH CHILDREN UNDER FIVE

**S**INCE 1946 the children born in Great Britain during the first week of March of that year have been the subjects for observations on a number of aspects of child growth and development. By biennial home interviews with the mothers, examination of hospital records, and measurement of the child, information has been assembled relating to the children's growth, illnesses, training, family's use of community services, home conditions, and similar topics. The observations when the children were two and four years of age have been summarized in the report, *CHILDREN UNDER FIVE*.<sup>1</sup>

The major classification of the child population in the presentation of the data is that of social group, based on the father's occupation at the beginning of the survey in 1946. Seven groups are defined: professional and salaried, black coated (white collar), skilled, semi-skilled, unskilled, agricultural, and

<sup>1</sup> Douglas, J. W. B., and Blomfield, J. M.: *CHILDREN UNDER FIVE*. London, George Allen and Unwin Ltd., 1958, 177 pp. 21s.