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SOCIAL CLASS AND PSYCHIATRIC DIAGNOSIS: DIFFERENTIAL FINDINGS IN A LOWER-CLASS SAMPLE¹

by

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Over-all rates of mental illness have been found to be greatest among the lower classes.^{1,2,3} In a related study Kasl and French⁴ found that within a given type of occupation, the lower the status, the greater the propensity to visit a medical clinic.

Within specific diagnostic areas, Hollingshead and Redlich² are probably known best for their finding of increased percentages of schizophrenics and total psychotics among the lower classes. Further data with regard to functional psychoses and social class are summarised in Table 1. In general, these studies bear out Hollingshead and Redlich.² Schizophrenia tends to be most prevalent among the lower classes, Classes IV and V. The affective psychoses tend to show higher rates in the middle or upper classes, equivalent to Classes II and III. Functional psychotics as a group tend to predominate in Social Classes IV and V, perhaps due to a greater prevalence of schizophrenic than affective disorder. Several studies show little difference in their samples, and perhaps this can be explained on the basis of Kohn's suggestion⁵ that schizophrenia is related to social class only in cities of 100,000 or more.

The literature shows no clear trend about neurotics (Table 2): three studies indicate that neurotics predominate among the lower classes (IV and V), two studies that neurotics predominate in the middle or upper classes, and one study that there is no difference among classes.

Other diagnoses have received somewhat less attention in the literature. A number of studies, however, were found that did bear on the general diagnostic areas in the current American Psychiatric Association Diagnostic Manual II⁶. All four studies find that the highest rates of organic brain syndrome (psychiatric difficulty is due to a central nervous system lesion—Table 3) are found among the lower classes, that is Classes IV and V. Class V tends to show more organic brain syndrome than Class IV.

Of 6 studies, only the early data of Hollingshead and Redlich² disagree that personality disorders (Table 4) appear largely in Classes IV and V. There is a slight predominance of Class IV over Class V.

Psychosomatic or psychophysiological disorders (Table 5) were found to be common in the lower classes in six studies, but no differential prevalence was found in four other studies. Christenfeld's⁷ was one of three studies that found no difference, but suggested that psychophysiological disease might appear when a lower class person had a strong and unfulfilled desire to move to the middle or upper class.

Only one study each used the diagnostic areas of 'transient situational disturbance' or 'no diagnosis'. Katchadourian and Churchill⁸ found transient situational disturbance to be highest in Class I, while McDermott *et al.*⁹ found 'no psychiatric diagnosis' to be highest in the middle class, Class III.

A great deal has been written on mental retardation and social class (Table 6).

Sarason and Gladwin¹⁰ summarised the literature to 1958, which showed that the intelligence quotient declined with indices of lower-class status. The literature since then has been in essential agreement (Table 6).

Thus, one would expect the incidence of mental retardation to rise in inverse proportion to class. The literature leads to the following predictions: 1. Greater lower class prevalence in personality disorders, functional psychoses, organic brain syndromes, mental retardation and psychophysiological disorders; 2. Affective psychotics and the transient situational disturbance or no diagnosis categories in the middle-class; and 3. No clear prediction is possible about neuroses or behaviour disorders of childhood and adolescence.

Many of the studies cited did not use Hollingshead's¹¹ *Two Factor Index to Social Position*. This resulted in inability to distinguish between Classes II and III and between Classes IV and V. The present study, using a predominately lower-class sample, differentiates between Classes IV and V by Hollingsheads Index.¹¹

Procedure

Patients who completed contact with the Psychiatry Department of Cleveland Metropolitan General Hospital during 1972 were studied. Cleveland Metropolitan General is a county hospital that serves also as one of the two primary teaching hospitals of Case Western Reserve University School of Medicine. Three primary subdivisions within the department are a daytime out-patient service, an evening mental health clinic, and an in-patient consultation service with other specialites in the hospital. The Evening Mental Health Clinic has been described by Schlachter, Miller and Lenkoski.¹² The consultation service takes referrals entirely from other specialites of the general hospital, while the Daytime Out-patient Clinic does this predominantly as well. An occasional self-referred patient is also seen in the Out-patient Clinic.

After the final contact with each patient, the evaluator or therapist fills out a form, including a final diagnosis based on categories established in the American Psychiatric Association Diagnostic and Statistical Manual II.⁶ At the time of initial contact the patient's education and most recent occupaton are determined. These are combined through Hollinghead's Two Factor Index,¹¹ to yield an estimate of social class. The final diagnosis is the one used in the current study, as is the social class determined by Hollinghead's Two Factor Index.¹¹

A number of investigators have concluded that diagnostic agreement between evaluators is inadequate for specific entities within broad categories, but is fairly accurate when confined to broad categories such as neurosis.^{13, 14, 15, 16, 17, 18, 19, 20.} Diagnoses in this report were therefore placed in the 11 broad categories described in APA Diagnostic and Statistical Manual II⁶: Mental retardation, Organic brain syndrome—psychotic, Organic brain syndrome—non-psychotic, functional psychosis, neurosis, personality disorder, psychophysiological reaction, special symptom, childhood and adolescent behaviour disorder, no manifest psychiatric disorder and non-specific conditions, and transient situational disturbances.

In order to maintain the possibility of comparing pairs of diagnoses should the over-all data show significance, a one-way analysis of variance was done by diagnosis, using the social class as the 'score'. The sample population was not normally distributed across the social classes, but it was felt that, a social class population from which a sample was drawn would not show significant deviations from the normal distribution. Hollinghead's Index¹¹ produces a score from 11 (highest of Class I) to 77 (lowest of Class V), from which Classes I-V are determined.

RESULTS

A total of 2,974 diagnoses were recorded, an average of two per subject. About half of the subjects were in Social Class V (N=1,496), a third in Social Class IV (N=1,030), one-tenth in Social Class III (N=328), and about four per cent in Social Class II (N=117). Social Class I had three subjects, which was about one-tenth of one per cent of the total sample.

Personality disorder (N=892) was the most frequent final psychiatric diagnosis, followed closely by neurosis (N=821). Each represented more than one-fourth of all diagnosed subjects. Transient situational disturbance (N=407) and no manifest psychiatric disorder (N=286) or non-specific condition were the next two most common diagnoses the frequency representing over one-eighth and slightly under one-ninth. The only other large group was functional psychosis (N=102) with about one-fifteenth of the total population. The other six main psychiatric categories were diagnosed in fewer than 100 subjects, each or less than four per cent of the sample.

Due to the continuous nature of the underlying distribution (weighted sum of education and occupation values), the social classes were treated as an interval scale. That is, distances between adjacent classes were assumed to be relatively equal, since 80 per cent of the subjects in each diagnostic group fell into Social Classes IV and V; assuming an interval scale could only distort the data from Classes I-III or 20 per cent of the data. A social class mean therefore computed for each diagnostic group.

Means for all diagnostic groups fell between Social Class IV and Social Class V. The order of increasing mean (Table 7) was as follows: no manifest psychiatric disorder and non-specific condition (highest), transient situational disturbance, neurosis, personality disorder, special symptom, functional psychosis, psychophysiological disorder, mental retardation, organic brain syndrome-psychotic, organic brain syndrome-non-psychotic, and behaviour disorder of child and adolescence (lowest).

A one-way analysis of variance of social class scores by psychiatric diagnosis was performed. The F-ratio for the main effect of diagnoses was 10.74 (d.f.=10/2963) which is very significantly greater than 0, ($p < .01$). This analysis is presented in Table 8.

Since the F-ratio among the diagnoses is significant, a Newman-Keuls Test on the differences between all pairs of means was performed.²¹ This Newman-Keuls Test showed results as follows: Mental retardation, organic brain syndrome—psychotic, organic brain syndrome—non-psychotic and behaviour disorder of childhood and adolescence were all significantly ($p < .05$) more lower-class (higher score) than the other seven diagnoses. A minor additional finding was that no manifest psychiatric disorder and non-specific conditions showed a significantly ($p < .05$) higher social class than did psychophysiological disorder.

DISCUSSION

The current study supports previous studies showing that organic brain syndromes are diagnosed most frequently among patients in the lower classes. Within the lower classes, organic brain syndrome is a diagnosis applied to those in the lowest social class, Class V.

Similarly, as is often seen in the earlier literature, mental retardation is more likely to be diagnosed among patients in the lower class. Mental retardation has an even higher probability of being diagnosed among Class V patients.

The small sample of behaviour disorders of childhood and adolescence should perhaps be taken as only suggestive at this time, even though the sample indicates only six per cent in Class IV and none in the higher social classes. This diagnosis has not been studied as much in the social-class literature as other diagnoses.

It is difficult to generalize from the difference between 'no manifest psychiatric disorder' and 'psychophysiological disorder', since only these two diagnoses are involved. Past literature has suggested a low social class for psychophysiological disorders and a higher one for no manifest psychiatric disorders, so this finding may be taken as moderately supportive of the earlier literature.

Most surprising was the absence of findings with regard to psychoses, neuroses, personality disorder and, perhaps, transient situational disturbance. The last-named diagnosis has not received much attention in the literature and is not commonly used other than within the A.P.A. Diagnostic categories.

What reasons can be suggested for the absence of social class differences with regard to psychosis, neurosis and personality disorder? First, one may suggest that the nature of the current sample, over 80 per cent of it in Classes IV and V, accounts for some of the differences. Perhaps differences would appear with greater numbers of middle and upper-class patients, as suggested in studies showing middle or upper-class prevalence for some diagnoses.^{2,9,22,8,3} Secondly, in contrast to some earlier studies the present data were not compared with the population without psychiatric diagnosis, but merely with other diagnoses. Hollingshead and Redlich², for example, show increased prevalence of psychosis with increasingly lower social class, when one contrasts the rate with the total population in that class. If, however, one contrasts the rate of psychoses with other diagnoses, many of these differences are less striking or absent. Thirdly, in a further difference from many of the previously cited studies the current study uses only A.P.A. DSM II⁶ diagnoses. No others were allowed. This may have resulted in a slight constriction in some areas where an evaluator might preferred a diagnosis not in DSM II⁶ such as 'paranoid' or 'obsessive compulsive trend'. Numerous other studies have indeed allowed this, but it does render comparison difficult. In addition, other types of diagnoses such as 'transient situational disturbance' and 'personality disorders of childhood and adolescence' may be over represented simply because their availability as possible categories. Fourthly, the present group of diagnosticians may have become somewhat more familiar with lower-class types of personality, because of the high representation of Classes IV and V. This may have resulted in a tendency away from earlier predilections towards personality disorder and psychosis and an increased differentiation of functional diagnoses within the lower classes. The diagnosticians in Hollingshead's and Redlich's² study may have been psychoanalysts who had not seen great numbers of lower-class mental patients. Fifthly, a high proportion of patients were referrals from other services in a general hospital. This might have tended to eliminate people who would ordinarily attend facility such as the mental health centre of a clinic unattached to a general health centre. Finally, evaluators were allowed to use as many diagnoses as they desired and averaged two per patient.

What further work can the present study suggest? Mental retardation has in general not been compared with psychopathological diagnoses. The present study along with a few earlier ones suggests that when this is done, the lowest social class (Class V) tends to display mental retardation at the highest rate. Class V also tends to elicit the diagnosis of organic brain syndrome to a greater extent than Class IV and the higher social classes. Both of these terms have a somewhat

derogative flavour. Mental health clinicians unfamiliar with the psychopathological reactions of Class V may tend to give them diagnoses other than those they might assign to other classes. On the other hand, organic brain syndrome and mental retardation may result from the same aetiological factors, factors tending to exert more influence on the lower socio-economic groups.

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TABLE 1
Literature on Social Class of Functional Psychotics

Author	Social Class
Ahmad, 1971 ³	Lower Class
Dunham, 1964 ²³ Schizophrenics	Class V
Hollingshead and Redlich, 1958 ²	Class IV and V, Schizophrenics and total functional psychotics; Class IV—affective psychoses
Katchadourian and Churchill, 1969 ³	Schizophrenics, lower-class manics, upper-class
Maltzberg, 1956 ²⁴	Class IV (Affective psychoses trend toward Class III)
McDermott, Harrison, Schrager, Lindie, and Killins, 1967 ²⁵	No difference, but more thought disturbance in Class V and children
Siegel, Kahn, Pollock and Fink, 1962 ²⁶	No difference

TABLE 2
Literature on Social Class of Neurotics

Authors	Social Class
Ahmad, 1971 ³	Upper Class
Katchadourian and Churchill, 1969 ³	Upper Class - Middle Class
Hollingshead and Redlich, 1958 ²	Class IV
McDermott, Harrison <i>et al.</i> , 1970 ²⁷	Class IV
Siegel, Kahn, Pollock and Fink, 1962 ²⁶	No difference
Yamamoto and Goin, 1966 ²⁸	Class V

TABLE 3
Literature on Organic Brain Syndrome and Social Class

Authors	Social Class
Frumkin, 1954 ²⁹	Lower Class (Increase with increasing lowness of class)
Hollingshead and Redlich, 1958 ²	Lower Class especially IV
Maltzberg, 1956 ²⁴	Class V ('dependent')
McDermott, Harrison <i>et al.</i> , 1970 ²⁷ ...	Class IV

TABLE 4
Literature on Personality Disorder and Social Class

Authors	Social Class
Dunham, 1964 ²³	Class V
Hollingshead and Redlich, 1958 ²	Classes III and IV
Katchadourian and Churchill, 1969 ⁸	Classes IV and V
Mazer, 1972 ³⁰	Lower Class (From behaviour, not diagnosed)
McDermott and Harrison, 1970 ²⁷	Class IV
Yamamoto and Goin, 1966 ²⁸	Class IV

TABLE 5
Literature on Psychophysiological Psychiatric Diagnosis and Social Class

Authors	Social Class
Christenfeld, 1966 ⁷	No difference (but more lower class if frustrated desire to become upper-class members)
Cobb, Kasl, Chen and Christenfeld, 1965 ³¹	Lower Class
Friedman and Hellerstein, 1968 ³²	Lower Class
Hollingshead and Redlich, 1958 ²	Class IV
Kasl and French, 1962 ⁴	Lower status within class
Katchadourian and Churchill, 1969 ⁸	No difference
Mc Dermott, Harrison <i>et al.</i> , 1970 ²⁷	Lower Class (IV - V)
Merskey, 1965 ³³	Lower Class
Rennie and Srole, 1956 ²²	Classes I and V
Syme, Borhoni and Buechley, 1966 ³⁴	No difference

TABLE 6
Literature on Mental Retardation and Social Class

Authors	Social Class
Birtchnell, 1971 ³⁵	Class IV
Fozard and Nuttall, 1971 ³⁶	Lower Class as lower I.Q.
Mazer, 1972 ³⁰	No relation to school under achievement
McDermott, Harrison, <i>et al.</i> , 1970 ²⁷	Class V
McDermott, Harrison, <i>et al.</i> , 1965 ⁹	Class IV - better at school than Class V, but Class IV disturbed in other ways
McDermott, Harrison, <i>et al.</i> , 1967 ³¹	Classes I and V
Sarason and Gladwin, 1958 ¹⁰	Lower I.Q. with lower class
Stein and Sausser 1969 ³⁸	Lower Class

TABLE 7
Frequency of Social Class by Psychiatric Diagnosis

DIAGNOSIS	Social Class					Total	Mean
	1	2	3	4	5		
1. No manifest psychiatric disorder and non-specific conditions		11	44	135	96	286	4.1049
2. Transient situational disturbances		19	52	150	186	407	4.2359
3. Neurosis	2	49	85	274	411	821	4.2581
4. Personality disorder		29	100	324	429	892	4.2924
5. Special Symptoms				21	9	30	4.3000
6. Functional psychosis		5	21	64	102	192	4.3698
7. Psychophysiological disorder		4	6	26	60	96	4.4791
8. Mental retardation	1		2	12	49	64	4.6875
9. Psychotic organic brain syndrome			5	14	71	90	4.7333
0. Non-psychotic organic brain syndrome			3	9	66	78	4.8077
1. Behaviour disorder of childhood and adolescence				1	17	18	4.9444
Total	3	117	328	1030	1496	2974	4.3151

TABLE 8
Analyses of Variance of Social Class by Diagnosis

Source of Variance	Sum of Squares	df	Mean Square	F Ratio	p less than
Diagnosis	71	10	7.1	10.74	0.01
Error	1960	2973	0.661		
Total	2091				

ABSTRACT

Social class and the American Psychiatric Association Diagnostic and Statistical Manual II Diagnosis were examined for all patients contacting the Department of Psychiatry over a year at a large county hospital. This sample was primarily lower class – 50 per cent Class V and 33 per cent in Class IV. All diagnoses showed average class between IV and V. Organic brain syndrome, both psychotic and non-psychotic, and mental retardation had lower average social class than other diagnoses. A small sample of the diagnosis behaviour disorder of childhood and adolescence was also lower than other diagnoses. Class V patients with mental malfunction may present differently than patients from other social classes. The absence of differences on neurosis and functional psychosis may have been due to the predominance of lower class patients, diagnosticians more familiar with lower class patients, or the allowable choice of diagnoses.

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