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**Social Class and the Psychiatric Patient:  
A Study in Composite Character**

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ALAN GREY, Ph.D.

## Social Class and the Psychiatric Patient: A Study in Composite Character

### The Problem and Its Background

AN UNPLEASANT TRUTH confronting the mental health professions is that psychotherapeutic care of the poor is markedly inadequate. In a major study of this problem, which found significantly higher incidence and prevalence of psychoses at the lowest socioeconomic level in New Haven, it is tersely put that the lowest socioeconomic stratum “needs help most—social and psychiatric—and gets it least.”<sup>13</sup> The difficulty lies not merely in the inability of the underprivileged to pay for treatment or obtain it free of cost. Even more disturbing is the apparent ineffectiveness of such treatment once it has been secured. According to the findings of another large scale research, “Within the universe of patient-therapist relationships, the chances of a successful outcome . . . seem to vary considerably among the several socioeconomic segments of the patient population in a range from about 7 in 10 of the top segment to 3 in 10 of the bottom one.”<sup>84</sup> A successful outcome was defined here in terms of social functioning as rated independently by two psychiatrists.<sup>34</sup>

What is the source of the trouble? The answer most often given by experts involved in working with the lower class patient population is, “the middle class character of the mental health movement and the associated inappropriate nature of the services offered to low income people.”<sup>32</sup> New departures in treatment designed to suit the needs of the poor, are the solutions they propose. Another wide-



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

spread view whose blunt expression sometimes finds its way into print holds that, since the poor seem incapable of benefiting from psychotherapy, we systematically confine this mode of treatment to the higher social levels.<sup>15</sup>

A number of questions are intertwined in the various ongoing controversies. *Are lower class patients actually given less extensive psychiatric care, even when all financial barriers are removed? If so, is it due primarily to their lesser importance in the eyes of middle class therapists? Or is there evidence of other factors, such as a tendency among lower class patients to be less responsive to customary treatment procedures because of different personality orientation? If such a distinction exists between lower class and middle class patients, does it center essentially around discrepant value systems, or do other significant aspects of personality vary predictably from one status level to another?*

These issues are of sufficient importance, socially and theoretically, to merit careful examination of the available evidence. Hollingshead and Redlich, for example, offer striking indications of class differences based on their New Haven patient census, but at the same time acknowledge a pressing need for further data to determine which of their various observations will hold for equivalent patient status groups in other parts of the United States. Systematic clinical evidence must "... appear in other samples and in other areas of behavior before the existence of classes as functional status groups can be said to be demonstrated."<sup>13</sup>

One aspect of this paper is the presentation of a study of relationships between social class and personality characterizing patients in a midwestern mental hospital. These results will be compared with published reports about other patient groups and also about nonpatient populations. The comparison with "normal" samples is an additional test of class-character generalizations suggested by psychoanalytic theory, which by and large held that the abnormal is continuous with the normal. Thus, meaningful relationships between class and character occurring in patients should also be detectable in the general population. Seen in this context of related studies, our data will help to assess whether the status concept is of theoretical and practical use to the psychoanalyst.

The pertinence of the sociological dimension to psychoanalysis frequently has been asserted in principle but has been only sketchily applied in clinical practice. It is evident that a continuing gap re-

mains between the two fields and another intention of this paper is to more solidly bridge this gap through an intensive examination of the concept of social class.

### Social Class

The concept of social class is one with distasteful connotations to egalitarian-minded Americans, and one whose sociological meaning is often poorly understood. The introduction of the social class concept does not imply a mechanistic formula by which all persons within a given sociological grouping are seen as invariably similar, regardless of unique events in their lives, individual qualities of family relationship, biological heredity and so forth. It investigates only probability statements, to the extent warranted by the evidence, that people of a given group are *more likely* to exhibit certain characteristics. In fact, by adding further factors for the clinician's consideration, it may help him better to understand the complexity and variety of conditions which have contributed to the development of the individual who is his patient.

Experts adopt somewhat varying classificatory systems, depending partly on the nature of the group studied and partly on their purposes. Warner's approach<sup>39, 40</sup> will be summarized here because it was the method employed for this study, and because the schemes of Hollingshead, Srole, and others essentially derive from it.

The Warner group devised a scale which assigns a numerical score to each of the following seven prestige-related characteristics: occupation, source of income (inherited, earned, etc.), house type, dwelling area, education, amount of income, ethnic origin. From these is derived an Index of Social Characteristics (I.S.C.), whose numerical score places the rated subject in an appropriate category.

In our own study sample, half of the patients were identified as middle class and the other half as lower class. Each major class in turn is subdivided into an upper and lower subgroup. The initials used for convenience in designating each status category in this study (and in the sociological literature), and representative associated occupations are as follows:

MC—Middle Class

UMC—Upper Middle Class: lawyer, factory manager

LMC—Lower Middle Class: salesman, office worker



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

### LC—Lower Class

ULC—Upper Lower Class: barber, semi-skilled worker

LLC—Lower Lower Class: laborer, tenant farmer

This scale takes on significance for the clinician only if the various levels can be shown to exhibit their own characteristic behavior patterns. Indeed, for the general population, social class level has proved to predict the groupings from among which people tend to choose their friends<sup>39</sup> and also much about their “attitudes, values and behavior. Social class is correlated with such diverse phenomena as use of leisure time, educational opportunities, voting behavior, fertility, community power, crime rates, marriage patterns and political participation. . . .” Stated in another way, social class is an important determinant of one’s very life chances<sup>26</sup> according to data available for the general population. If each social class constitutes a more or less distinct subculture, then MC psychotherapists might understandably fall into errors of ethnocentrism with LC patients, such as those documented from the social psychiatric literature by Riessman<sup>32</sup> as follows:

The institutional features of psychotherapy (the setting of the “office,” the futuristic orientation, the stress on self-actualization and insight) are undoubtedly more congenial to middle-class life styles; thus middle-class patients are preferred by most treatment agents, are seen as more treatable; psychotherapy is more frequently recommended as the treatment of choice, and diagnoses are more hopeful (with symptomatology held constant) . . . . In essence these (LC) clients are alienated from treatment.

The therapist is further limited in his work with lower class patients because of certain psychological tendencies that have been found to correlate with LC status which are unfavorable to intensive psychotherapy. Among these psychological tendencies typical of the LC patient are limitations in introspective capacity, a tendency to externalize emotional circumstances,<sup>10, 16</sup> an inclination to expect magical cures.<sup>3</sup> Even where psychiatric treatment is equally available to them, as in a health insurance program, they seek it less and drop out sooner.<sup>2, 34</sup>

Against such a background of evidence what does one do about the “untreatable” LC patient? Does one abandon the attempt at psychotherapy, even in free or low cost settings, on the grounds of husbanding resources?<sup>15</sup> Or does one dismiss the class concept as of doubtful utility and “treat each patient as an individual”? This sec-

ond position may appear ethically unimpeachable but runs the risk of blindness to what Erikson has called “the larger events of the world.”<sup>5</sup> By refusal to face a major problem calling for new approaches and answers, the net effect of this second position may still be to abandon LC patients as untreatable, one by one, as individuals. This is the dilemma if LC patients are, in fact, not only less treated but significantly less treatable in traditional terms.

### Theory of Class-Character Relationship

The connection between social class influences and personality patterning has particularly significant implications for certain aspects of psychoanalytic theory. Positive findings would encourage the emphasis on environmental factors that has characterized the American psychoanalytic scene for several decades. But more precisely, it would lend support to the principle that adequate understanding of the environment requires a larger interpersonal frame of reference than the family romance. As Horney put it in 1937:

“ . . . emotional problems have been created by the specific life conditions existing in that culture. That they do not represent problems common to ‘human nature’ seems to be warranted by the fact that the motivating forces and conflicts in other cultures are different from ours.”<sup>14</sup>

That is, class-personality study is an opportunity to test the theoretical orientation first emphasized in psychoanalysis by the “cultural” or neo-Freudian schools. If important relationships are found between one’s status subculture and personality orientation, then neo-Freudian theories are not merely supported but afforded a new research method for further clarification and development.

Notions about the influence of culture on personality were explored in anthropology, sociology and orthodox psychoanalysis, of course, before they emerged clearly in neo-Freudian thought. By 1941 when Erich Fromm published *Escape from Freedom*,<sup>7</sup> a rich “culture and personality” literature had already been established, but interestingly enough, its attention had been focused primarily on general populations and very seldom referred specifically to the mentally ill.<sup>4</sup> The Appendix to Fromm’s 1941 book was among the first to offer a general formulation of class-character relationships sufficiently sophisticated to interest psychotherapists. Although it was considerably more detailed than *The Neurotic Personality of Our Time* in spelling out connections between social conditions and personality



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

structure in the Western world, the focus of this work was on certain psychopathological manifestations of German society as a whole, and its concepts were therefore not specifically applicable to the task of the psychotherapist. Current research concerned with the psychotherapy of the poor might be regarded as the first efforts to articulate longstanding sociological convictions of the neo-Freudians in a sufficiently concrete form to make them susceptible to systematic operational validation. Ironically, professionals formally associated with neo-Freudian institutes have made few research efforts in this area to test their tenets.

While the theoretical Appendix to *Escape from Freedom* does not concern itself with psychotherapy specifically, it does deal with the broader problems of communication and influence in terms pertinent to a social class orientation in the treatment situation. Fromm observes, for example, that “people with a different kind of character structure would hardly understand what a person setting forth such aims of another social group was talking about even if they understood his language.”<sup>7</sup> He introduces the concept of “social character,” for which his briefest definition is “. . . that part of their character structure that is common to most members of the group . . . . Different societies or classes within a society each have a specific social character.”<sup>7</sup>

While the idea that a characteristic personality type may arise in any given milieu did not originate with Fromm, his portrait in depth of the German petit bourgeois did in fact, apply the concept to a particular class in a contemporary Western culture, rather than to the exotic circumstances heretofore explored by pioneers like Benedict, Mead or Kardiner. The “type” he described was within the experience of the clinician, giving a greater immediacy to the link between sociologist and psychotherapist. Implicitly, even goals were defined for psychoanalysis within a cultural context. “Positive freedom” was recommended as “the spontaneous activity of the total, integrated personality,” allowing one to go beyond the cultural imperatives of his milieu without, at the same time, isolating himself from it (pp. 258 ff.).

Utilizing Fromm’s position, three hypotheses were derived relevant to the interconnections between social class, social character, and psychotherapy. These enter into the frame of reference for our own investigation, and also for comparison with other relevant researches. The hypotheses are as follows:

- I. MC mental health personnel regard and treat MC patients more favorably than they do LC patients.
- II. The *observed* behavior (i.e., a facet of “social character”) of MC patients is more consonant with expectations of MC hospital staff than is LC patient behavior.
- III. There are significant differences between MC and LC patients in their *recalled* experiences as children and as adults. (For these other aspects of social character, inquiry is focused primarily on family life.)

### Method of Study

The research program was conducted in 1949, before the current burgeoning of interest in psychotherapy with the poor. A detailed report of results is available on microfilm only.<sup>9</sup> The sample of forty male patients, divided equally between MC and LC, was observed and intensively interviewed at a Veterans Administration psychiatric hospital near a large urban area in the middle west. The sample size is small in terms of the magnitude of the total population to which it belongs, but fairly large by comparison with subsequent research of a similarly intensive nature. In the case study aspect of Hollingshead and Redlich’s New Haven project, for example, there was a total of twenty-five males.<sup>26</sup> Because samples in this field have been small and because the patient universe in the United States is large, it becomes important to cross-check consistency of results in different geographic areas.

Subjects in our sample were selected from the “Convalescent Section” of the hospital, actually a group of wards for legally competent patients, including recent admissions, who were not expected to require long-term institutionalization. Patients were free to terminate their hospital stay at any time and encouraged to leave for intervals up to several days while still officially registered at the installation. This policy attracted a somewhat larger proportion of MC veterans than were usually found in free institutions. The criteria for admission to these wards imposed a functional rather than diagnostic emphasis. This yardstick eliminated those most severely disturbed who would be incapable of informative interviews and in whose cases the question of constitutional factors arose more urgently.

The study sample was composed, then, of legally competent psychiatric patients, all of whom had been in military service during World War II. They all were at least third generation gentile Americans with no conspicuous ethnic features in their upbringing. The





term "ethnic" here is used to designate distinctly recognizable foreign cultural characteristics such as the regular use of a foreign language in the home, residing in a foreign nationality neighborhood, or attending a recognizably foreign church. All subjects were reared by their own families, including a natural or legal father and mother. Since ethnic backgrounds and broken homes<sup>33</sup> are more frequent in the lower class, and since the influence of these factors might be attributed spuriously to the status difference itself, the control of such variables provides an unusually rigorous test of social class influence. In determining class level, Warner's Index of Social Characteristics was used to estimate the status of the patient's *father* during that patient's first twelve years of life, spent in what sociologists have termed his "family of orientation" or childhood family. Orientation status is more pertinent to this study than is current status, since the childhood milieu is an important focus of interest for us.

Patients were selected for the sample on the simple basis of "first come, first taken," provided that they fulfilled the sociological criteria described above. This procedure proved very satisfactory, for several later comparisons of the study sample with total Convalescent Section population indicated no "significant" differences between them. Our criteria for "significance" were statistical (i.e., with a minimal confidence limit of .05), and all findings to be reported were "significant" in this statistical sense unless otherwise noted.

The average subject was about thirty years old, psychoneurotic (72%), either single or parted from his wife (67%), and Protestant (63%). Once chosen for the study, he was interviewed by either of two clinical psychologists, for three or four sessions totaling from eight to twelve hours. Afterward, supplementary data were gathered from his responses to written questionnaires, from hospital records, and from interviews with hospital staff members who had worked with him.

#### HYPOTHESIS I: How Hospital Staff Regards and Treats Patients of the Two Social Classes

Moving from method to content, the first issue for investigation concerns the professional staff of the hospital and how well their responses to patients can be predicted simply from information about the patients' social status. The problem advisedly is stated, at this

point, as one of prediction alone. That is, the first step simply is to establish *whether there are differences between the two class groups* in the clinical evaluations and amount of treatment accorded them. The exploration of underlying causes is best done step by step and is undertaken, insofar as our data allow, in subsequent sections of this study. Without specific evidence it is unwarranted to assume that any observed differences are due to prejudice.

*Do empirical results show differences?* They show that more than half (65%) of the MC patients in our sample were selected for psychotherapy by Convalescent Section psychiatrists, while this service was proffered to only one quarter of the LC group. Moreover, once in treatment, the middle class patient was seen more frequently. Here the contrast is even more striking. For instance, the majority (56%) of the *treated* LC group had fewer than five private contacts with their psychiatrists, while *all* of the treated MC's were seen more often! An interesting sidelight to the general picture is that the psychiatrist in charge of assigning cases gave himself not a single patient from the lowest status group (LLC).

LC patients and MC patients were further distinguished not only in the amount of treatment given but also in evaluations of response to treatment. Such appraisals were elicited from a variety of professional personnel. *Psychologists*, when asked to evaluate degree of improvement in patients they treated, found positive movement in three-quarters of their MC's, while less than one-quarter of their LC's were reported to be progressing. *Social workers* were effective in maintaining continuous contact with patients, and often with their families, from time of admission to time of departure. When these social workers were asked to judge change in their cases, they found *all* of the UMC's to have made much improvement, compared with one-third of the LC's. *Vocational advisors* were asked to estimate, for each of their sample patients, the severity of practical occupational difficulties. The inquiry was directed toward judgments about social circumstances, such as effective demand for the patient's skills, rather than toward his vocation-related emotional difficulties. The advisors found practical vocational problems in more than three-quarters of the LLC group (80%), but in only a quarter of MC patients. Whether or not these vocational evaluations were biased by the advisors' notions concerning the nature of a "satisfactory" job, the higher frequency of negative evaluations *did not* lead to more intensive work with the group identified as more needful. In fact,



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

only 40 per cent of the LLC's completed their advisement programs, while among the MC patients who sought this aid, *all* followed through to the end.

Thus, statistically significant differences could be observed between MC and LC patients in the evaluation and treatment accorded them. Strikingly, such differences *consistently are in the same direction*, with MC patients always emerging in the more favorable position.

Adding to the consistency of the picture are the findings of other recent studies which range over a variety of populations and places.<sup>2, 10, 13, 34</sup> Our own research provides a particularly stringent test of class differences, since it was conducted in a hospital setting where certain factors were controlled (i.e., equalized for the two groups) which might enhance differences if limited to persons living at home. Such problems as paying for treatment were eliminated, as were those of inaccessibility or ignorance of treatment facilities. Thus, although opportunities for equal treatment were optimal in these respects, significant differences appeared.

Another suggestive inference deriving from our own study data is: not only psychiatrists, but all professional groups in the hospital respond less favorably to LC than to MC groups. This fact has direct bearing on proposals which have been made to improve psychotherapeutic care of the underprivileged through a greater use of the non-medical professions.<sup>13</sup> Because the services of nonmedical professionals are less costly than of medical professionals, such a policy would undoubtedly mitigate financial problems attendant on the treatment of LC populations. But would these psychologists and social workers, classified though they are among the social science specialists, bring a more effective sociological sophistication to the treatment situation? There is nothing in our data to indicate that they do. But unless one is prepared to attribute LC treatment difficulties to biological inferiority, it seems likely that interpersonal processes related to given social levels are instrumental factors in the observed differences between the groups. Whether it is a matter of interclass prejudice, or whether harder life circumstances, associated characterological differences and similar variables play a part is not clear from the data so far presented. These data do indicate, however, that at present, the "social science" members of the traditional clinical team, are encountering difficulties with LC patients which are similar in nature to those faced by psychiatrists.

The differentiation between patient groups is further reflected in the very length of their hospital stay. *None* of those at the lowest social level (LLC) remained more than one hundred days, whereas the *majority* (59%) of the higher status men (ULC, LMC, UMC) continued on for a longer period. This finding is superficially contrary to reports in most of the relevant literature that LC patients remain in the hospital longer, but closer inspection resolves the seeming contradiction. Whereas the "difficult" patient is typically incarcerated for longer intervals in the traditional mental hospital either for psychiatric or disciplinary reasons, the reverse was the policy in our Convalescent Section. In the "Section," repeated or serious infractions of rules led to disciplinary discharge and the patient was free, in any case, to walk out whenever he chose. A common denominator for the longer stay in the traditional hospital and a shorter one in the Convalescent Section was, then, an unfavorable view by the staff of the patient. How can we say that the earlier LC departure was due to greater friction with the staff, rather than more rapid improvement? The evidence is provided by the official hospital records, themselves, and is based on the data for all Convalescent Section patients during the time of study, as well as for our study sample. It was found for the total resident population of 146 men, as well as for the intensive sample of 40, that LC patients had a significantly shorter stay than MC. The records specify, moreover, that one third (32%) of all LC patients were discharged for disciplinary infractions or had their departures classified as "AWOL," a frequency three times as high as in the equivalent MC group (11%).

Briefly then, LC patients are less often given psychotherapy and, when given, it involves fewer contacts and results in less improvement as judged by hospital staff. As members of the general patient community, LC men are seen as less acceptable by hospital administration, an evaluation they reciprocate by removing themselves more rapidly from it when permitted to do so. All of these data support Hypothesis I, that "MC mental health personnel regard and treat MC patients more favorably than they do LC patients."

#### HYPOTHESIS II: Social Class and Patient Behavior

Closer examination of class-related differences in patient behavior may illuminate the nature of the trouble between LC patients and staff. The investigation can begin with the already noted fact that LC patients committed more major infractions of hospital rules and



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

more “AWOLS.” Serious infractions of rules usually involved such matters as bringing liquor onto hospital premises, returning from leave in a disruptively intoxicated state, repeated overstay of leave without notification, and neglect or defiance of regulations for the maintenance of cleanliness and order on the wards. This LC lack of discipline was also reflected in less flamboyant acts, related in spirit and coalescing into a fairly consistent picture.

These lesser infractions might be illustrated by looking at a time-honored behavior clue used in psychotherapy—promptness and reliability in attendance. In itself, tardiness or absence becomes important only when it seriously reduces the time available for treatment. Some of the significance of irregularity, too, lies in its correlation with other manifestations of resistance not so easily accounted for in statistical testing. Even when he does appear for meetings, the irregular patient is often less communicative and generally less motivated toward a therapeutic objective. These ramifications are reinforced by the high value placed on promptness in middle class American culture. Even if the patient’s own social background does not accord a similar high value to time regularity, he gives an impression to the middle class clinician of lack of concern about the therapeutic enterprise.

*Were the MC patients more reliable about appointments?* Records kept by hospital vocational advisors indicated that half of those MC’s who consulted them were “very regular” in attendance, and that this was true for *none* of the LC’s. The records of the psychologist-therapists similarly show that none of their MC patients missed as many as a fifth of scheduled meetings, but that almost half (46%) of the LC sampling exceeded this amount. Not only in his repudiation of hospital rules, then, but also in his responses to treatment services when they are proffered, the LC patient shows a well-defined pattern of noncompliance with the expectations of hospital authorities and their psychotherapeutic methods.

Previously published studies have shown that LC patients avail themselves less of psychiatric *outpatient* treatment even when cost is not a barrier.<sup>2</sup> This has sometimes been attributed to the general lack of information or greater fear of hospitals in the lower class. Our results underscore that even after the LC patient is hospitalized, after there has been hospital exposure to “mental health education”

meetings, with maximum physical accessibility to the professional office and explicit reminders by the nursing staff, he continues to be reluctant. These observations coincide sufficiently with other reports to warrant the conclusion that we are witnessing a general estrangement between professionals and their LC patients, rather than the shortcomings of a particular institution. Moreover, some of the reasons for this apparent lack of success with LC patients, seem to lie deeper than those involving accessibility of information, hospitalization fears, and the like.

Having seen the limitations of circumstantial explanations, we must now consider those hypotheses having graver implications. The most widely known of these hypotheses is that the difficulty lies in class prejudice on the part of the professional worker. As one exponent of this position has put it:

We wish to reiterate that the value differences between high status psychiatrists and lower status patients are a serious obstacle in psychotherapy, even if psychiatrists were to consider their cultural and social horizons and learn to understand the class IV and V [lower class] patient. The mere suggestion of such a bias may offend psychiatrists who, like most professional practitioners, do not like to think in terms of social differences. Nevertheless, a number of different social and cultural factors operate on the psychiatrist, the patient, his family to produce the relationship reported here.<sup>13</sup>

The psychotherapist’s responsibility for becoming aware of his prejudices and for minimizing their interference with his work can only be affirmed. Undoubtedly, those publications which have called attention to class bias have performed an indispensable service. There is now the danger, however, that in having conveyed the impression that professional ethnocentrism is the central issue, it may be used as a rationale to fully explain the higher rate of LC failures in therapy. An implied solution might be to reform the values of the psychotherapist or, perhaps, to match each patient with a psychotherapist of the same early family status. But such inferences would neglect a number of considerations which may be crucial. It may be, for instance, that a lower class upbringing emphasizes ways of learning and communicating that diverge from those typical in the middle class. Such variations in orientation might call for modifications in the psychotherapist’s manner of educating and communicating. A hypothesis of this nature is consistent with the assertion that “the failure of psychotherapy with low income groups is in large measure





ALAN GREY, PH.D.

due to the insistence on a particular mode of treatment, namely the psychodynamic, insight, reconstructive, approach.”<sup>32</sup> There is even the possibility that a sound solution calls for environmental modifications in the circumstances of the poor beyond the scope of treatment as now conceived.

As a safeguard against unwarranted assumptions, certain questions merit serious consideration: *Do LC patients display a pattern of antagonism and discipline only in response to the values of the therapist and other middle class people? Or do they have a generally different orientation toward authority, of whatever class, than do MC patients? If so, is this LC authority orientation integral to an even more extensive patterning of LC personality, to a LC social character distinguishably different from the MC orientation? If such class-character differences are observable, how compatible are current psychotherapeutic techniques with identifiable potentialities of the LC social character for learning and change?* Even tentative answers to these questions may help in a fuller assessment of causes and remedies.

Beginning with reactions to authority, case histories may be examined to assess whether LC patients typically break the rules more often than MC's, as they were observed to do in the hospital. LC autobiographical recollections are more indicative of this tendency than are MC reports. For instance, drinking, gambling, and nonmarital sex activities began earlier and, with certain qualifications, continue to be a more regular part of their lives, as are physical battles with peers. More LC patients had been arrested for breaking the law in various ways (45% LC and 15% MC). It is difficult to find a precise analogue in extra-hospital behavior to being AWOL, but significantly more of our LC patients had run away from their parents' homes as children (80% LC and 27% MC) and had played hookey from school (85% LC and 60% MC). The LC pattern of “acting out against society, their family, and themselves”<sup>20</sup> has also been noted in other studies of psychiatric patients.

For certain of these behavior patterns we need not confine ourselves to patient populations but can compare the lower class way of life with the middle class in the general or “normal” population. Turning to the context of “total institution” other than the mental hospital, i.e., the armed forces, we have the finding of Stouffer and his associates<sup>29</sup> that World War II soldiers who had not completed

high school (a crude index of LC status) wound up in the guard-house for AWOL offenses significantly more often than those soldiers with more education. Similar knowledge about higher crime rates among the less educated in the civilian community has been available to sociologists for some time.<sup>23</sup>

Such information demonstrates that “acting out” against authority is not a response aimed at the middle class therapist and his class-limited experience and values. The traditionally lower class milieu of the Army and of urban tenement neighborhoods evoke similar responses from LC men. It is an LC style of reaction in many social contexts, even in nonpatient LC populations. Evidence from the general sociological literature as well as our own, then, supports the second hypothesis, that there are observable behavioral differences on a class basis.

Particularly significant, this hypothesis suggests that the psychotherapist is not necessarily the active instigator of his LC patient's antagonism and flight, but rather, such behavior reflects the inadequate state of present knowledge about coping with readily aroused LC patient defenses. The implication here is that the development of remedies for the treatment impasse requires the consideration of more than differences in values. The therapist is to a large extent impeded by inertia—not an exclusively middle class vice—the reluctance of any highly trained person to relinquish familiar skills and the feeling of expertise in favor of uncertain experimentation. A further impediment to therapeutic effectiveness is a lack of sophistication in psychosocial concepts. This partly reflects an oversight in training in all of the mental health professions—a neglect to teach relevant information already known about the larger social context in which both patient and therapist live. And part of what is not taught simply is not known. Cross-cultural adaptation of psychotherapy is currently at one of the boundaries of knowledge in this field. Awareness of the deficiencies may help to dispel the inertia.

An unfortunate hazard in relating to someone from another subculture who speaks one's own language is that one may misinterpret his life circumstances, his style of communication or his social role, without even realizing it. The therapist may be particularly puzzled by the seeming paradox of impulsivity and acting out of feelings as inferred from the history of an LC patient and the picture of restraint and deference which is presented in the consulting room. To



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

reduce confusion with LC patients, it may be useful to draw a sharp distinction between “impulsivity” and autonomy, or freedom from conventionality. As expressed by Fenichel: “. . . there is a tendency to equate ‘socially low’ and ‘instinctually uninhibited,’ and ‘socially high’ and ‘sublimated,’ ‘inhibited.’”<sup>6</sup> “Psychodynamic” thinking may even reinforce such confusion if it loosely equates “direct expression of instincts,” of sexuality and aggression, with spontaneous behavior, lack of inhibition.

Considering LC men in the light of our sociological information, it is clear that even their “swift action without forethought,” as impulsivity has been defined<sup>12</sup> may be decreed culturally for given circumstances. Thus, the prescribed and inculcated masculine role in the lower class may call for defiant behavior as the appropriate style for coping with lost or hurt feelings. In the LC milieu, aggressive acts may be the way to avert particular dangers associated with crying, pleading, talking things over, or even letting oneself or anyone else know of such inclinations. Insofar as being “natural” implies direct expression or communication of inner feeling, the LC man’s “impulsive” act of defiance is hardly that. Is it not a concealment, a failure in self-expression, an abdication of personal autonomy to social convention? Such defensive patterns can be so strongly reinforced by experience, and alternative skills of direct verbal communication may be so atrophied, as to create a barrier unbreachable by communication techniques adequate in a different subculture.

Case literature is replete with examples of apparent misunderstandings by clinicians who regard the lower class as “less conforming” when in fact it may be that the patient rather than conforming to the therapist’s customs, follows *his own* LC norms rather rigidly. This image of LC man as nonconformist is held even by social class experts in the mental health field.<sup>20</sup> Which is the case for our lower class sample? Can it be said that they are, as a group, more spontaneous or more rigid in their personal relationships than MC patients? The question brings us to our third and last hypothesis, which investigates intrafamilial experiences.

### HYPOTHESIS III: Class Differences in Recalled Intrafamilial Experiences

The patients in our sample grew up during those years before World War II which were clouded over by economic depression. Almost half of the LC group (40%) recalled their families as hav-

ing received public assistance during that time but, as might be expected, there was only one such respondent in the MC group. Food donations, hand-me-down clothing, and all the other unpleasant accompaniments of poverty were considerably more frequent in the childhood experiences of LC patients.

Compounding the difficulties of small income, LC patients were members of significantly larger families. Whereas 40 per cent of the LC group reported six or more children, only 15 per cent of the MC group came from families of this size. Though a larger family requires a greater investment of parental time and effort, LC mothers often had less time to give. More of these mothers worked, even before our patients had reached school age (20% LC and 5% MC); by the time our subjects were in grade school it was true of 35% LC mothers and 5% MC. This disparity continued during high school years (25% LC and 0% MC). The decline in number of LC working mothers reflects the fact that their adolescent children had begun to get jobs and were helping the family finances (80% LC and 44% MC). The LC adolescents contributed more money, with about 40% giving more than a fifth of their earnings on a more regular basis and over a longer period of time, as against *no* equally large contributions from MC respondents.

### The Parent as Helper

Returning to the earlier years, care of the children typically fell to an older sibling in the mother’s absence from the LC household. Even in this all-male sample, more than half the LC subjects (56%) had to supervise younger sibs at times, while more than three-quarters of the MC sample were never given such an assignment. These differences between the class groups are associated with differences in the availability of many kinds of parental attention. MC parents, for instance, were considerably more involved in their sons’ educational efforts from the very outset, both in such community organizations as PTA and in more intimate, direct contacts with the children. A third of UMC patients got daily assistance with school work, as against one or two patients receiving such help at all the other status levels. A third of all MC patients were taken to school regularly through the early grades, as compared with one LC patient, although the former tended to live somewhat nearer to the school. Half the MC parents were recalled as having advised their children about such educational problems as choice of courses and so forth,



but only a tenth of LC parents were depicted as having done this. At the lowest status level, LLC, most of the patients (80%) recalled their parents as frankly indifferent about the marks they received, while practically all (95%) of the MC subjects saw their mothers and fathers as concerned about their school performance. A similar picture emerges concerning religious education, with more actual attendance at church and Sunday School in the middle class.

In short, parents of the LC patient expected him to contribute more to the family, but were able to give him less. The data presented thus far may be seen as merely reflecting typically greater MC emphasis on church and school. This would be to gloss over the evident fact that in our urban American culture, compulsory education involves a good deal of every child's time, regardless of class, and is an important factor in defining his identity and future relations with the larger community.<sup>38</sup> Education being a major avenue of social mobility, these data also indicate how MC and LC tend to perpetuate themselves. In our sample, 55% of the children of LC parents failed to finish high school; *all* of the MC respondents had at least a high school education and most of them (65%) had some college training.

In any case, it is pertinent to examine other aspects of the relationship between parents and children. Despite more limited time, LC mothers were almost always familiar with at least some of their children's friends during the grade school years—in fact, with slightly greater frequency than was true of MC parents (90% LC and 85% MC). This reflects a tendency particularly characteristic of the ULC segment of LC parents, to maintain extended family ties and to cluster in the same general neighborhoods as their own parents, siblings, cousins, etc. Familiarity with one's children's friends, in these cases, was often simply coincidental with family contacts. The LC parent's acquaintance with his children's friends was of a more casual nature, usually involving less active supervision and participation than was typical of the MC group. Thus, most of the LC patients (70%) were seldom taken out for social visits or entertainment by their parents during childhood, while almost all of the MC group (95%) recalled such activities as an integral part of family life. Thus, also, by the time they had reached high school and were physically more mobile, only 50% of the LC patients reported their parents as acquainted with their male friends, while such familiarity was still true of 80% of the MC parents, thereby indicating the long-

er "childhood" of the MC patient. The evidence, then, continues to reveal a more extensive contact between parent and child in the MC group than in the LC, not only in educational activities but in other areas as well.

### Parental Discipline

Certain differences again are apparent between the status groups in terms of modes of discipline. First, while it appeared that parents, alone, exercised the prerogative of punishment in our MC families, at least a quarter of the LC patients reported that it was also administered by older siblings and parent surrogates. This is an understandable consequence of larger families and maternal absence, but one underscoring the less intimate parent-child tie in the LC group. There were important differences, too, in the kinds of punishment used, physical force being far more characteristic of the lower level. In the socially lowest of the subgroups (LLC), for instance, almost all subjects (88%) reported that force was regularly employed by fathers to coerce not only the children, but even the children's mothers, as against only one such case in all the higher subgroups. Considering the LC group as a whole, most of them (70%) said they had received severe beatings as youngsters, in contrast to only a quarter of the MC sample. Moreover, the LC patients had been punished in this fashion to a later age, often well into the teens.

Much of this class difference in the extent of physical punishment can be attributed to differing paternal attitudes toward force. While slightly more than half the mothers in both strata were reported as using physical discipline in early childhood, LC fathers were given to beatings more than their wives, administered them with greater severity and to a later stage in their son's development. MC fathers, on the other hand, relied on beatings less than their own wives and far less than LC fathers. (40% of MC fathers used physical sanctions as compared with 60% of MC mothers, 75% of LC fathers, 55% of LC mothers.) An MC patient might still feel hurt or resentful at the time of reporting a long-past paternal beating. To him it was out of keeping with what their relationship should have been. But an LC patient was more likely to laugh, impressed with the power of the blows and accepting authority as essentially harsh.

This is not to imply that MC patients were less exposed to discipline by their fathers. Indeed, once attention is turned to non-





ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

physical modes of control, a greater variety and extent of supervision is reported by MC patients than by LC. MC fathers relied on verbal devices like praise and blame, and lectures about right conduct, as well as on the giving and withholding of affection and privileges. Emphasis was placed on grasping the reasons, on anticipating the reactions of others, whereas in the LC home, the concept of obedience was associated with staying out of trouble. Thus it might be expected that MC patients would become more self-regulatory and more inclined toward self-criticism in conflicts with authority. This greater inclination of MC patients to develop a self-critical orientation was reflected in responses when asked whether they were inclined to regard their current unhappiness as due to their own sins of the past. Although the MC patients were a better educated group, more sophisticated and less given to naïve superstition, a majority of them (65%) avowed such feelings, while only a third (35%) of the LC subjects acknowledged such guilt reactions. MC home life had encouraged and rewarded this kind of internalization and usually had succeeded in instilling it. It is likely that in LC families, fathers unwittingly encouraged their sons' defiant and provocative behavior by virtue of their relative inaccessibility to other forms of interaction.

A cross-check of other researches reveals similar findings. Miller and Swanson<sup>24</sup> report LC patients as locating the source of their problems in external forces. Kohn<sup>19</sup> describes LC child-rearing practices as focused on conformity to imposed rules "in contrast to the self-direction focus of the middle-class."

As the image of "the LC patient" becomes more distinctly defined, his unsuitability for prevailing methods of psychotherapy becomes more apparent. Current treatment typically requires the patient to see his own behavior as inappropriate and to use this awareness as a starting point for self-reorganization. The whole disciplinary history of the MC patient in his family of orientation has better prepared him for such an approach.

The indicated differences are only smaller facets of generally unlike authority patterns in the two groups, to be traced by further comparisons of attitudes toward parents, particularly fathers. However, one *similarity* between these middle and lower class men is worth noting first: both groups show definite inclinations to feel closer to their mothers. Both MC and LC patients reported "Mother"

as the parent with whom they got along better as children (78% MC and 70% LC), and also as the one toward whom they felt closer as adults at the time of the study (80% MC and 93% LC).

#### Attitudes toward Parents

Behind these broadly parallel popularity ratings of "Mother" lurk important distinctions between the class groups in terms of their images of parental roles. In essence, the LC patient sees "Mother" and "Father" in far more sharply contrasting lights than does his MC fellow-patient. These parental images have evolved as a result of the more rigidly defined patterns of role differentiation which prevail in the lower class home—a condition reaching back into an historically older tradition of our Western culture. One is struck by how much "... the intangible realm of values and attitudes is reminiscent of the past, for the blue collar world is insulated from contemporary currents of thought."<sup>20</sup>

While the LC father observes a traditional distance during his son's early years, in the group we studied and in a number of studies to be discussed below, his behavior does not tend to fit the folklore about the gradual coming together of father and son as the boy gets older, at least not in this psychiatric sample. Typically, he neither guides his son, nor does he play with him to the same extent as the MC parent. Later, he seldom is a source of financial help, often expecting such assistance, himself, from his unmarried son. He is less important in the community and less to be counted on at home than an MC father. This more negative LC experience was reflected during interviews when, asked for random memories of their parents, most of the LC group had unpleasant recollections of fathers (70% about fathers and 20% about mothers), while the MC patients divided quite equally in this respect (45% about fathers and 40% about mothers). Two thirds (63%) of LC patients also recalled Dad as the authority behind their most unpleasant chores, while only a third of MC patients responded in this way.

Interview responses consistently revealed the MC son's measurably greater respect for his father, as compared with the LC patient. For instance, MC's usually found Dad's advice more sensible than Mother's in practical matters, but not so the LC's (60% MC and 17% LC). Or again, almost to a man, the LC's saw their fathers' social activities as less desirable than those of their mothers (90% LC and 50% MC). These reactions are inaccurate as reflections of the patients'





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ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

own social activities, but consequently all the more striking in that they strongly point to rejection of the LC father and furthermore suggest how few sons in this patient population had worked out a satisfactory identification with their own roles as men. The LC father is an alien figure, feared in his physical strength but seldom valued as a source of guidance, particularly after his sons are grown.

#### Attitudes toward Authority

Though these LC reactions suggest a ready explanation for generalized LC resentment of authority, the low status patient's attitudes are more complex than might be expected from this evidence alone, and from his defiant behavior in the hospital and the community. Despite low ratings of specific aspects of his own father's behavior, our working class interviewee displayed great need for conventionalized authority images. LC patients would reveal dissatisfactions with parents when questions were set in a context of clearly defined external events, much more readily than if subjective feelings or broad generalizations were sought. They did not volunteer criticisms of parents nearly so readily as did MC subjects. But authority needs were shown in more than mere verbal restraint or awkwardness. The same LC men who ignored paternal advice significantly more often than MC subjects (on a set of specific issues) expressed the highest regard for paternal advice in general (75% LC and 14% MC). Or when asked if their parents had "understood" them as children, the predominant LC reaction was that both mother and father had been very sympathetic (84% LC versus 17% MC). Again, more LC's than MC's in our sample actually had run away from home as children, but when asked in another context whether they had *wanted* to run away, fewer LC's remembered the desire, including those who actually had eloped (50% LC and 75% MC).

Further manifestations of authority needs in the LC can be traced. In their classic research on *The Authoritarian Personality*, Adorno and his colleagues state that their sample of "working class men" scored higher in authoritarian thinking on a standardized psychometric questionnaire, than did any other group except prison inmates.

"For that matter," they wrote, "the extremely high scoring San Quentin inmates come in very large part from the working class, and there is good reason to suppose their general outlook depends on their background as well as upon the circumstance of their being in prison."<sup>1</sup>

How to reconcile this LC attraction to conventionalized authority figures with the simultaneous manifestations of resistance to them, in the home, the community, the hospital?

The information at our disposal suggests the following picture: During childhood, LC training emphasizes response to externally imposed regulation, "... the blue-collar parents have retained a pre-Freudian innocence about human behavior. ... If they puzzle over the rebelliousness or obedience of their children, they seek the explanation in discipline and wonder if they have been 'too easy' ..."<sup>20</sup> Compared with MC training, the LC family demonstrates a relative neglect of those parental techniques likely to induce internalized, self-regulatory restraints. The parent, notably the father, is less closely involved in his sons life than is the case in the MC home, whether it be to share pleasures, provide direction, or set consistent disciplinary limits. The LC boy does not find or expect much empathic response from parental or other authorities. Encountering difficulties with people or circumstances, he is likely to interpret them as his own problem behavior has been understood by his parents, as due to the recalcitrance of hostile forces. This externalizing orientation is likely to be reinforced by experience with agents of the larger community, like teachers and police, who are more impatient with him, more likely to antagonize, than if he were a nice middle class boy.

Experiences outside the home also tend to expose the LC father's limitations in both commanding respect from even minor figures of authority in the community, as well as his lack of power to act in the boy's behalf. Father becomes progressively less attractive and is depicted in his son's interviews as neither effectively helpful nor responsive. In fact, *most* authorities are assumed to be unresponsive. The powerful ones, such as community figures, and the father as experienced in early childhood, are found to be basically harsh or indifferent. Additionally, the father later emerges as often ineffectual—a situation which is especially distressing to the boy whose implicit frame of reference "solves" difficulties by reliance on external agencies. Seen in the context of the treatment situation, this pattern of conflicts lends itself to a characteristic transference reaction in which the LC patient longs for a strong protector but is impelled to fight against the need in himself by repudiating the therapist, in order to defend against the pain of anticipated disappointment.

Miller has pointed out the "... lack of a consistently present male figure with whom to identify and from whom to learn essential com-



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

ponents of a male role.” He adds that since “. . . women serve as a primary object of identification during preadolescent years, the almost obsessive lower class concern with ‘masculinity’ probably resembles a type of compulsive ‘reaction-formation.’”<sup>25</sup> Our own psychotherapeutic activities with the LC patient do indicate a tendency to build up a self-protective veneer of toughness to reinforce his uncertain masculine identification, to deny his need for male authority figures who, according to his own past experience, are likely to prove untrustworthy. As Fenichel succinctly says about certain “acting-out” patients, “Their impulsive acts may then signify a striving for a goal which they simultaneously try to avoid because they are afraid of it.”<sup>26</sup>

Such a formulation not only accounts for the observed LC wariness toward psychotherapy relationships, but suggests possible remedies. For instance, a well-conceived authoritarian treatment style might engage members of this social stratum more successfully than the classic rule that “. . . the analyst divorces himself as completely as possible from direct control of the patient’s life.”<sup>21</sup> This time-honored principle of detachment may be recognized as implicitly geared to the internalizing personality orientation of the middle class. While “the rule” is often violated in practice, the proposal that it be abandoned in principle with a certain social group may be sufficiently disturbing to some readers, to call their attention to the kinds of value conflicts that can involve the therapist working with LC populations. At any rate, the intervention tactic is suggested here, not as the writer’s value preference, but simply in connection with his prediction that it would reduce the number of blue collar drop-outs at clinics. The prediction apparently is confirmed by such evidence as the following:

*Frank Riessman.* Analysis of findings from Charles Kadushin’s unpublished study of the attitudes toward psychotherapy of 1400 applicants for treatment at hospitals and clinics in New York City, 1962. It was found that lower socio-economic individuals who locate their problems environmentally prefer that psychotherapy be highly directive. This was far less true for the lower socio-economic group who viewed the cause of their difficulties in somatic terms.<sup>30</sup>

This quotation does not constitute a recommendation for the routine use of authoritarian techniques with the poor. In all clinical work, the particular patient must be appraised individually and procedures adjusted accordingly. The point is that insofar as the LC

patient fits this composite portrait, the psychoanalytically trained therapist may function more effectively if he is free enough to reconsider approaches heretofore discouraged by dictums of his professional ideology.

### Orientations to Intimacy

Obstacles to psychotherapy with LC patients arise not only from reluctance of the therapist to take a strong directive position. Both therapist and LC patient may find themselves baffled by certain divergent value orientations in each other which never emerge into explicit language. The MC therapist, for example, sets great store by empathic capacity, the ability to share intimate feeling, as both a private and a professional virtue. Despite whatever limitations he may have in this quality, his MC patient usually accords it a similarly high place; in fact, greater empathic experience may be his major treatment goal. The widely observed American need for “love”<sup>28</sup> is peculiarly true of the MC American. To the LC male patient, the phenomenon—as an aware experience mediated by words—is usually unimportant and difficult to understand. The impediments posed to introspective “insight” treatment by this externalizing tendency are formidable.

The experience of interviewing our sample presented many qualitative indications of this nonintrospective orientation in the lower class. A most conspicuous indicator—assuming the interviewee to be a willing informant—lies in the absence of certain kinds of statements, in a poverty of sensitive psychological reactions to significant people. “Sensitivity” here denotes not accuracy or perceptiveness, but awareness and concern about subjective experiences. For instance, when LC patients were asked to reminisce about their parental homes, even with specific questioning, a substantial proportion of them could recall no differences between their parents in attitudes toward relatives and friends (30% LC and 5% MC), did not remember whether their father or mother had any favorites among the children (55% LC and 25% MC), forgot whether the children ever had been compared with each other (65% LC and 25% MC), and also affirmed that they were unconcerned about such matters (40% LC and 11% MC). But rather than multiply such illustrations, one can see more directly the ramifications of this tendency by assessing their effect on the task of the psychotherapist. A tally of reports by treating psychologists who worked with members of our study sample



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

indicates that while *all* MC patients spontaneously spoke of problems involving family ties and dependency feelings, only about half (56%) of the LC group did so. Considering its conspicuousness in the clinical setting, one is hardly surprised to encounter references to it in a number of publications.<sup>10, 31</sup>

The LC tendency to perceive events, even human relationships, primarily in terms of the external and the tangible is well described by Komarovsky in an account of her interviews with nonpatient “blue collar” wives:

For me perhaps the most surprising aspect of the blue-collar world had to do not with manners and morals, but with the cognitive style of the people. . . . The word “surprise” was usually taken to mean an unexpected present. The word “help” meant money or services, not help in the psychological sense. “When you feel that way [low for no apparent reason] can your mother help you?” The woman might pause for a moment, being puzzled by the non sequitur, and say, “No, she doesn’t have any cash to spare.”<sup>20</sup>

LC lack of verbal contact with subjective feelings was quite consistent, ranging over a wide sampling of personal relationships. Whether it was early family history or current friendship, whether it involved male friends or wives or sweethearts, the same absence of reference to emotion, to intimacy, was evident. When asked to talk about any dissatisfactions with their closest buddy, most LC patients (61%) could find nothing wrong with him, but most MC’s (80%) did identify dislikes. This was not simply because MC’s felt more negatively about their friends. In fact, significantly more MC men made explicit references to the intimacy and duration of their relationships (60% MC and 25% LC). In the socially highest subgroups (UMC), most men also spoke of consulting their friends for personal advice ( 56% UMC and 19% of all others). Class predispositions toward seeking help from male authorities, including fathers and therapists, are pointedly suggested by these data.

Class differences also are reflected from the very outset of heterosexual activity for our sample. Significantly more LC patients recalled their early dating history as enjoyable (80% LC and 50% MC), and more frequently had sexual relationships with girls who were their social peers (45% LC and 20% MC). Do lower class men more readily establish close and spontaneous relationships with women, or does their greater ease with them derive from different, perhaps less demanding, goals? A significantly higher divorce rate in

the lower class, generally, argues against the idea of happier LC relationships with women, but still leaves the matter obscure.

To clarify the quality of their heterosexual relationships, patients were interviewed about many matters, including what they sought in marriage. MC’s were considerably more inclined to express a desire for emotional intimacy and support (79% MC and 42% LC), for a woman who would offer affection and understanding (75% MC and 50% LC). All MC’s felt they should and would speak of almost anything with this wife, but about a quarter of the LC’s (28%) had important reservations about discussing even their own mutual sexual relations. If LC men are rather reserved, the MC’s reveal an indiscriminating belief in the discussion of “everything.” This MC overstress on intimacy serves as a reminder that the higher status patients are not without their own problems, although our focus on LC characteristics may distract inadvertently from that obvious fact.

MC concern about wifely companionship was revealed also in the definite ideas most of them (90% MC) had formulated about how much education their mates should have, while this was stated as a matter of little or no importance to many LC subjects (45%). It was not that MC patients wanted maximally educated spouses but rather that, in their more egalitarian conception of relations between the sexes, they consciously sought women whose educational backgrounds would not be too far from their own level in either direction. In fact, a quarter of the MC’s spontaneously observed that “too much” education might lead a wife to regard herself as the man’s superior. Worries of this sort did not trouble any LC’s whose conscious views were predicated unquestioningly on the traditional formula of male superiority. This difference between classes in sex roles is depicted another way in a recent study of LC marriage in a nonpatient population:

For working-class couples there is no issue over who does what around the house. Not only the men, but even the women accept the traditional division of masculine and feminine tasks, and the women do not expect assistance from their husbands in every day circumstances. Moreover, whereas educated women have misgivings about being “just a housewife”, not a trace of this attitude appears in the blue-collar class.<sup>20</sup>

The contrast between LC conventionalization of male-female relationships, and MC personalization of them, is depicted nowhere more clearly than in sexual matters. This may appear surprising in the light of LC “impulsive” tendencies, but again it urges a distinc-



ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

tion between impulsivity, which may be culturally stereotyped, and spontaneity. LC conventionality in sexual matters is quite consistent, in fact, with an overall view of LC male behavior as a stylized masculinity, a defensive separateness from women arising from uncertainty about one's role identification and mastery. As to the evidence itself, significantly more MC patients practiced variations in sexual intercourse beyond the conventional act. More MC patients held the view that "anything goes" which is acceptable to both partners and not injurious physically. It was clear, too, that the MC's spoke more freely with their sex partners about their mutual sex experience and consequently were more aware of the partners' reactions and preferences.

Once again, data about the nonpatient population coincides with our own. In this case, it is the extensive work of the Kinsey group.<sup>17</sup>

Another report on sexual attitudes also becomes relevant here: Else Frenkel-Brunswik observes about the authoritarian-minded that their values in sexual matters "... tend to be *conventionally determined* as opposed to the more *individualized* values of low scoring subjects"<sup>1</sup> and again, that "A lack of individuation and of real object relationship can be found in the field of sex as it was previously found in the attitude toward the parents."<sup>1</sup> (Italics are by Frenkel-Brunswik.)

The authoritarian character syndrome is a pattern of responding in human relationships, marked by a hierarchical rather than egalitarian inclination close adherence to conventionally determined acts and beliefs, avoidance of intimacy, externalization of blame, and "acting out" behavior. Because of the coincidence of tendencies in our LC patient sample with this construct, it becomes meaningful to speak of a *lower class authoritarian character orientation* which is significantly more frequent in that stratum than among middle class patients.

While there is no implication that this pattern is identical with the authoritarianism of another class, culture, or time, or that it describes all lower class patients, the evidence of several studies suggests that it has practical diagnostic utility. It can help to predict behavior and provide clues to treatment approaches, as will be amplified in the following pages. Moreover, it is in accordance with the psychoanalytic principle which holds that the abnormal is continuous with the normal, and with actual data of other cited tendencies in the general, nonpatient population. In short, the presented evi-

dence supports our third hypothesis, that there are significant differences between MC and LC male patient groups in terms of recalled interpersonal experiences as children and as adults in the specific areas of inquiry.

The following summary of all results will facilitate the further consideration of implications.

#### Summary of Findings

- I. Middle class personnel of a psychiatric hospital were found to regard and treat middle class (male) patients more favorably than lower class (male) patients. They judged the outcome of treatment to be more favorable for middle class patients.
- II. The observed hospital behavior of middle class (male) patients differed significantly in certain respects from that of their lower class counterparts. Specifically, the higher status group observed hospital procedures more carefully and engaged significantly less in acting out behavior.
- III. There were significant differences between the two social class levels in their reports of certain childhood experience and current relationships.
  - A. As adults, lower class patients are significantly more inclined than their middle class fellows to regard and respond to others in a conventionally determined fashion. They manifest less desire for intimacy, more "acting out" behavior in the community, and other tendencies which might be summarized as a "lower class authoritarian orientation."
  - B. A connection was suggested between this lower class character pattern and certain factors in the lower class "composite case history." Factors which are significantly more prominent in the LC childhood history are: less parental help and attention, a more authoritarian disciplinary climate, and a less favorable basis for positive identification with the father. Resulting uncertainty about one's masculine role may be particularly relevant in the development of authoritarian tendencies.

#### Implications for Psychoanalysis

When objectively tested, the class-character frame of reference provides a meaningful portrait of a group of psychiatric patients.





ALAN GREY, PH.D.

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

The portrait has stability from one research sample to another and continuity with the nonpatient population. It suggests that there is sufficient regularity about social processes so that, from knowledge of an individual's cultural origins, predictions can be made about his "social character." This is not to propose a new dictum that "sociality is destiny"; on the contrary, the point is that patient behavior has a multiplicity of determinants, among which the sociological are relevant to clinical practice.

The documented difficulties of mental health professionals in dealing with patients from class groups outside their own suggests, too, that even an educated man does not necessarily know a culture simply because he lives in it. Understanding a society, particularly one as complex and heterogeneous as ours, requires confirmation by systematic research. Optimal clinical use of results of such research requires revisions in the education of the psychotherapist.

What would such revisions entail? Nothing less than the integration of sociological knowledge into the routines of our diagnostic procedures and into our understanding of interpersonal processes. More than a decade ago, Sullivan suggested that

"The general science of psychiatry seems to me to cover much the same field as that which is studied by social psychology," and he further noted that "... this calls for the use of the kind of conceptual framework we now call *field theory* ... [or] ... the pattern of processes which characterize the interactions of personalities in particular recurrent situations or fields which 'include' the observer."<sup>37</sup>

Information about the patient's status as an integral part of diagnostic assessment moves toward implementation of this field theory approach to the sociologically aware psychotherapist; it provides a frame of reference about the cultural fields in which the patient has developed, those in which he currently operates, and their relationship to the therapist's own circumstances and outlook. It advises about possible transference reactions, potential areas of misunderstanding when patient and therapist are of different social origins, potential coincidence of distortions when they are at the same level, and so forth.

The social status-and-character approach is thus a diagnostic and predictive tool. Concerned with the individual's part in social processes, this orientation is actually more consonant with contemporary psychoanalytic theory than are the familiar Kraepelinian diagnostic categories which tend to catalogue "disease symptoms" in a semi-

vacuum almost devoid of interaction processes. Thus, while the proposal of a diagnostic concept like "LC authoritarian character orientation" at first may appear to fall outside the context of psychoanalysis, the impression is due more to its novelty than to any intrinsic theoretical difficulty. The wedding of social-epidemiological techniques with intensive clinical study provides an integrative means for bridging the gap between what Sullivan has called "social psychology," and our regular clinical procedures. Inherent in any categorization is the danger that it can be used rigidly to force the patient into a descriptive mold that does not conform with his actual lineaments. To avoid this hazard with the LC patient requires not a neglect of available social character portraits but rather, as in any diagnosis, their sensitive use as a set of clues, along with other relevant data.

Applied in this manner, the class-character construct will contribute usefully to whatever diagnostic procedures one employs and will thereby have implications for the choice of therapeutic techniques. In considering the generalizations about the LC male, for example, it will be seen that he typically differs from the MC patient in more than values. His "authoritarianism" is not as accessible to the usual psychoanalytic methods. His "cognitive style" (i.e., mode of learning and perceiving) and his manner of communication are not well suited to the typical psychoanalytic emphasis on introspection, verbalization, and minimal external direction.

What does this imply for psychoanalysis as a treatment method? The answer calls for several predictions, including a guess about how analysts will choose to define their methods and spheres of operation in the future. Maintained in its present form, psychoanalysis can persist as the intensive psychotherapy of the middle classes and of those from other classes who meet its characterological specifications. Conceived very broadly, to include all procedures designed to reintegrate dissociated aspects of the psyche, the problem of extending the scope of psychotherapy to benefit LC patients should be one which permits of a solution. Such work could lead to important expansions in conceptions and techniques, comparable to the "character analysis" revolution of several decades ago.

The nature of those new techniques can only be surmised from a survey of methods already proposed for work with the LC. One recent publication<sup>29</sup> advocates approaches which rely less on introspection and encourage "motoric activities" suitable to the LC per-



ALAN GREY, PH.D.

sonality style. Also favored are procedures that make problems immediate and concrete and therefore presumably more involving for the LC patient. Role-playing<sup>31</sup> is recommended, as are family therapy, group therapy, and “multiple intervention” in the case work tradition. “Pills and needles” are suggested by these same authors as supplementary devices to satisfy LC needs for magic and authority. As a guiding principle, one paper asserts:

“It has been found that with blue-collar workers and lower socio-economic groups it is more practical to set direct and immediate treatment goals . . . rather than gear treatment toward long-range personality reorganization.”<sup>10</sup>

The recommendations in the foregoing paragraph reflect not our own views but those most conspicuous in the literature, a literature so recent that none of these suggestions has been tested adequately as yet. On the one hand, the suggested strategies are relatively sophisticated, implicitly or otherwise going beyond a preoccupation with LC values and recognizing the at least equally significant cognitive style characteristics of LC personality patterning. But some of the procedures are so inconsistent with the principle of reintegration of the dissociated, that they cannot be regarded meaningfully as psychoanalytic treatment. If they should prove the most effective kinds of approaches, then psychoanalysts may work with the “LC authoritarian,” but they will not be practicing psychoanalysis. Insofar as some of these approaches run the danger of reinforcing authoritarian attitudes, they raise interesting questions about psychotherapeutic goals. For instance, should that method be used which provides the quickest relief, regardless of whether it may pose long-run hazards to effective functioning of the patient in a democracy? Should such an approach be paid for out of public funds?

Do the limited treatment goals urged for LC patients imply that this group is more severely damaged or only that it seeks less? Unhappily, there is a lack of measuring devices for clearcut determination of severity of illness. Epidemiological studies reveal a higher per capita rate of LC patients in hospitals but this greater prevalence may be indicative of an accumulation due to neglect rather than a higher incidence of breakdown. Another factor complicating evaluation of degree of illness among the poor is a kind of partisan loyalty frequently observed among the experts. For example:

“Considering the lack of opportunities and difficult life conditions of the worker, a lower class psychodiagnostic record which is identical with that

SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

of a middle class person might be presumed to indicate greater health and better prognosis.”<sup>29</sup>

The MC humanistic tradition of loyalty to the underdog and reservations about the bourgeoisie shines through this statement like a beacon. Meritorious in themselves, such sentiments may breed impatience with facts and ultimately lead to unrealistic policies. Thus recent social commentary is richly garnished with references to “white collar alienation” while, ironically, class-character research indicates that unawareness of feeling and avoidance of intimacy are significantly more extensive in lower class groups. Moreover, the pragmatic yardstick of treatment results suggests greater difficulty in achieving characterological change in LC patients, a limitation accepted even by experts developing improved methods.

Disregard of these facts may not prove a service to the LC patient in the long run, because it may lead unwittingly to over-estimation of what treatment alone can accomplish for them. A more tempered enthusiasm might propose that, *in addition to treatment*, other strategies be considered in work with the lower class. If more difficult life situations can be expected to generate more severe emotional disturbance, then “closely linked with economic under-privilege is psychological under-privilege”<sup>18</sup> and careful consideration should be given to preventive measures. Programs should be designed to identify and modify social conditions which actively intensify the stresses of lower class life. This calls for a new kind of mental health expert, equipped to assess the psychological impact of the larger socio-political processes on the individual. The degree to which these factors influence emotional health should not be minimized. As a more immediate goal, serious attention should be given to the development and use of preventive psychotherapeutic techniques during pre-school and early school years with children who live in areas showing high mental illness rates. These children need to be reached before barriers to certain aspects of human relationship have become so fixed as to interfere profoundly with availability to emotional contact in daily life or in psychological treatment.

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SOCIAL CLASS AND THE PSYCHIATRIC PATIENT

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