A Study of the Relationship Between Social Class and the Treatment of Mental Illness at the Winnipeg Psychiatric Institute

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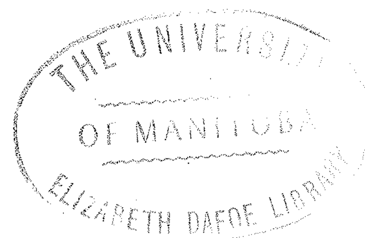

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CHAPTER I

SYNTHESIS OF THE LITERATURE

Purpose for Study:

Mental illness is a major problem in our society today. During 1971 there was a total of 110,725 patients admitted in the 274 reporting mental health institutions in Canada. This figure includes 36,624 patients admitted in 47 public mental health hospitals; 3,428 patients in 48 institutions for the mentally retarded; 1,686 patients in 9 federal psychiatric units; 43,363 patients in 91 public psychiatric units; 14,537 patients in 14 psychiatric hospitals; 677 patients in four aged and senile homes; 8,755 in 17 hospitals for addicts; 1,304 in 42 treatment centres for emotionally disturbed children and 351 in two epilepsy hospitals. These figures do not include facilities such as clinics, out-patient departments, half-way houses, and day and night centres. The 1971 figure represents a 6% increase over that of 1970. Due to increased need, the number of public psychiatric units reporting augmented from 47 to 91 since 1961 and the number of public health hospitals from 45 to 46.[1]

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1. Dominion Bureau of Statistics. "Mental Health Statistics, Institutional Admissions and Separations." Vol. 1, 1971, pp. 83-204.

Twenty-one of the 274 reporting institutions are situated in Manitoba. Here, there was a total of 6,785 patients admitted during 1971. Of these, 1,506 were admitted in two public hospitals; 266 in two institutions for the mentally retarded; 241 in the federal psychiatric unit; 2,814 in five public psychiatric units; 1,045 in two psychiatric hospitals; 759 in three hospitals for addicts and 154 in six treatment centres for emotionally disturbed children.[2]

Any indication that diagnosis and treatment of mental disorders are influenced by a person's social class rather than being based solely on the nature of his illness raises strong opposition in a democratic, egalitarian society.

On the basis of previous research on these topics,[3] it has become a matter of concern that persons requiring treatment for psychiatric disorders receive differential treatment on the basis of their social class. The issue of differential treatment given to people of various social classes is of sufficient importance to merit examination of the available evidence.

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2. Dominion Bureau of Statistics. "Mental Health Statistics, Patients in Institutions." Vol. 2, 1971, pp. 83-208.

3. Norman O. Brill and Hugo A. Storrow. "Social Class and Psychiatric Treatment," Archives of General Psychiatry, Vol. 3, No. 10 (Oct., 1960), pp. 340-344.

Alan L. Grey, "Social Class and the Psychiatric Patient: A Study in Composite Character," Contemporary Psychoanalysis, (1966). pp. 87-121.

August B. Hollingshead and Frederick O. Redlich. Social Class and Mental Illness: A Community Study. New York: John Wiley and Sons, Inc., 1958.

Jerome K. Myers and Bertram H. Roberts. Social Class, Family Dynamics and Mental Illness. New York: John Wiley and Sons, 1968.

Hypothesis:

The study we are proposing for our Master's thesis in Social Work is based on the hypothesis that a patient's social class will influence the kind of treatment he will receive for psychiatric disorders at the Winnipeg Psychiatric Institute.

Other studies indicate that lower classes are more likely to get shock and organic therapy, whereas the middle and upper classes are more likely to get psychotherapy. Therefore, treatment given for psychiatric disorders tends to reflect an individual's social class and not only the type of illness.

Lines of Reasoning:

Several lines of reasoning suggest this correlation. First, principles of psychotherapy may be class-linked, that is, they are directed to the verbal, more educated social classes who share the same goals and values as the psychotherapist.[4] Second, middle and upper classes, due to their education and values know what they want and they are willing to wait for the results of psychotherapy. On the other hand, the lower class tends to be present-oriented and demands

4. Eugene Gallager, Myron R. Sharaf and Daniel Levinson, "The Influence of Patient and Therapist in Determining the Use of Psychotherapy in a Hospital Setting." Psychiatry, Vol. 28, No. 4 (Nov., 1965), pp. 297-310.

immediate gratification. Thus they find it difficult to see the value of long term treatment.[5] Third, due to the lack of motivation on the part of the lower class people to continue treatment once the immediate crisis situation is under control, they tend to become minimally involved in psychotherapy or discontinue it after the initial interview. As a result, this form of treatment is sometimes considered a waste of time by the therapist and is often not recommended for them.[6] Fourth, practical issues of the poor are often impediments to effective psychiatric care, for example, transportation costs, loss of wages, and so forth. This would not be as much of a problem for the other classes involved.[7] Fifth, limited psychotherapeutic treatment facilities and personnel must be considered -- psychotherapy is therefore often emphasized for those who it is felt will benefit most from it, that is, the upper and middle classes.[8]

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5. James T. McMahon, "The Working Class Psychiatric Patient; A Clinical View." Mental Health of the Poor, ed. Riessman, Cohen, and Pearl. New York: The Free Press, 1964, pp. 284-302.

6. Betty Overall and H. Aronsom, "Expectation of Psychotherapy in Patients of Lower Socioeconomic Class," American Journal of Orthopsychiatry, Vol. 33, No. 3 (April, 1963), pp. 421-430.

7. McMahon, Op. cit., p. 285.

8. Gallagher, Op. cit., p. 299.

Assumptions:

Our hypothesis rests on the following assumptions:

First, our society is composed of different social classes representing different values and life styles.

Second, the patients using the Winnipeg Psychiatric Institute will be representative of the various social classes in our society.

Third, there will be different kinds of treatment given to patients entering the Psychiatric Institute for psychiatric services.[9]

Fourth, the various social classes will use the Institute for different reasons -- that is, the upper and middle classes may consider it part of treatment whereas the lower class may consider it total treatment.[10]

Fifth, the values of the therapist in relation to his social class will influence his diagnosis of the patient and treatment recommended.[11]

Sixth, any psychiatric problem treated at the Psychiatric Institute may be viewed as mental illness.

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9. Manitoba Department of Health and Social Development. Annual Report 1970. p. 25.

10. Betty Overall and H. Aronson, Op. Cit.
Louis Schneiderand Sverre Lysgaard. "The Deferred Gratification Pattern: A Preliminary Study." American Sociological Review, Vol. 18 (1953), pp. 143-149.

11. Solomon Hirsch, Doris Hirsch and Aubrey Shane, "Psychiatric Care for Lower Class Out-Patients," Psychiatric Association Journal, Vol. 10, No. 4, (August 1965), pp. 290-297.
Neugeboren, Bernard. Psychiatric Clinics: A Typology of Service Patterns.

Literature Synthesis:

On the basis of our review of the literature, it would appear that differential treatment exists for individuals in various social classes in our society. In the area of mental illness, which is the concern of this research, various studies indicate that differential treatment for psychiatric disorders also exists on the basis of social class.

(1) Social Class

In dealing with the concept of social class we have found various definitions and methods of measurement as well as several inherent difficulties.[12]

Allan Gray defines social class as "aggregates of individuals often without specific inherent differentiating

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12. Bernard Barber. Social Stratification: A Comperative Analysis of Structure and Process. New York: Harcourt, Brace & World, Inc., 1957.
John F. Cuber and William F. Kinkel. Social Stratification. New York: Appleton-Century Crofts, Inc., 1954.
Harold M. Hodges, Jr., Social Stratification: Class in America. Cambridge, Massachusetts: Shenkman Publishing Co., Inc., 1954.
Joseph A. Kahl. The American Class Structure. New York: Holt, Rinehart & Winston, 1966.
Mills, C. Wright. "The Middle Class in Middle-Sized Cities" in Class, Status, and Power, ed. Reinhard Bendix and Seymour M. Lipset. 2nd ed. New York: The Free Press, 1966, pp. 275-281.
Melvin M. Tumin. Social Stratification: The forms and functions of inequality. Englewood Cliffs, New Jersey: Prentice-Hall, 1967.
August B. Hollingshead and Frederick C. Redlich. Social Class and Mental Illness. New York: John Wiley and Sons, 1958.

characteristics, who enter into and maintain relations with one another on a basis of equality, in contrast to other members of the community from whom they are distinguished by socially recognized standards of inferiority and superiority. Members of a given class characteristically develop a similar mode of life and similar attitudes of behavior and with varying degrees of explicitness, and a sense of belonging together."[13]

S. Ossawski states that any group which is regarded as one of the basic components of the social structure may be called a "class" of the social structure. He gives three basic assumptions involved in the term "class" --

a. Classes constitute a system of the most comprehensive groups in the social structure.

b. The class division concerns social statuses connected with a system of privileges and discriminations not determined by biological criteria.

c. The membership of individuals in a social class is relatively permanent.[14]

Basically, the many methods of measurement can be divided into single and multiple item indexes.

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13. Allan Gray, ed., Class and Personality in Society. New York: Atherton Press, 1969, p. 2.
14. Stanislaw Ossawski. "Different Conceptions of Social Class," in Class, Status and Power, ed. Bendix Reinhard and Seymour M. Lipset, Op. cit., p. 91

In considering single item indexes, it has been found that they have both advantages and disadvantages -- that is, they are easier to standardize and are reliable but often lack validity.[15] The most commonly used single index is occupation.[16] Elba Edward states that each occupational grouping represents a larger population group with a somewhat distinct standard of life, economically and to a considerable extent, intellectually and socially. "Each of them is thus a really distinct and highly significant social-economic group.[17] However, there is the problem of how to classify occupations.

Hodges criticizes the use of occupation as a one-factor index stating that it is insufficient since there is no exact one to one relationship; he indicates it is necessary to use two indexes at least to insure some validity.[18]

The main advantage of using a multiple-item indice is that several indicators in combination would tend to increase the validity of any index. For example, Hollingshead and Redlich used three indicators of social class: (1) residential address, (2) occupational position of family head,

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15. Barber, Op. cit., p. 173.
16. Joseph A. Kahl and James A. Davis, "A Comparison of Indexes of Socio-Economic Status," American Sociological Review, Vol. 20, (1955), p. 317-325.
17. Barber, Op. cit., p. 173.
18. Harold Hodges, Op. cit., p. 96.

and (3) education of head of the home. These indicators were based on the following assumptions: (1) social stratification exists in the community, (2) status positions are determined mainly by a few commonly accepted cultural characteristics, and (3) items symbolic of status may be scaled and combined by the use of statistical procedures so that a researcher can quickly, reliably, and meaningfully stratify the population.[19]

Hollingshead and Redlich's index of social position has been used in various other studies, for example, studies completed by Myers and Bean,[20] Myers and Roberts,[21] Myers and Shaffer,[22] and Robinson, Redlich and Myers.[23] Ellis, Lane and Olesen have devised what they call an improved index of social class based on Hollingshead and Redlich's index. Using occupation as their major variable they substitute

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19. August Hollingshead and F. Redlich, Op. Cit., p. 66.
20. Myers, Jerome K. and Lea L. Bean. A Decade Later: A Follow-Up on Social Class and Mental Illness. New York: John Wiley and Sons, 1968.
21. Jerome K. Myers and Bertram B. Roberts. Social Class, Family Diagnosis and Mental Illness. New York: John Wiley and Sons, 1959.
22. Jerome K. Myers and Leslie Shaffer, "Social Stratification and Psychiatric Practice: A Study of an Out-Patient Clinic, "American Sociological Review, Vol. XIX, (1954), pp. 307-310.
23. H. A. Robinson, Frederick C. Redlich and Jerome K. Myers, "Social Structure and Psychiatric Treatment," Am. J. of Orthopsychiatry, Vol. XXIV, April, 1954, pp. 307-316.

class identification for education.[24]

Another indicator of social status is B. Blishen's single item, multiple-factor table whereby he ranks occupations according to income and education.[25] Since this scale has been devised for Canadian society and has been used in various studies,[26] we felt it would be suitable to our present research.

(2) Differential Treatment by Class

Various studies indicate that differential treatment is given according to class in many areas, for example, medicine and education. These studies indicate that the lower class people receive inferior treatment as compared to those in higher social classes. This seems to support our hypothesis that differential treatment would be similarly given in the area of mental illness.

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24. Robert A. Ellis, W. C. Lane, and U. Oleson. "The Index of Class Position: An Improved Intercommunity Measure of Stratification," American Sociological Review, Vol. XXVIII, No. 2, (April, 1963), pp. 271-277.
25. Bernard R. Blishen. "A Socio-economic Index for Occupations in Canada" in Canadian Society: Sociological Perspectives. B. Blishen, F. Jones, K. Naegele, J. Porter (Eds.). Toronto: MacMillan of Canada, 1971.
26. John Porter, "Social Class and Education," Social Purpose for Canada, ed. Michael Oliver. Toronto: University of Toronto Press, 1961, pp. 114-127.

It has been observed in the medical profession that there is a relationship between illness, social factors, and type of treatment given to people in different social classes.[27]

In the area of education, it has been verified that not only is differential treatment given to students by teachers according to class,[28] but that, in general, social class largely affect an individual's life chances.

(3) Mental Illness

Our review of the literature indicates that there is no consensus in regards to definitions and categorization of mental illness. Thomas Scheff states that "problems of definition arise, in part, because all behaviors occur within specific group contexts, and the frames of reference of the evaluators are not always comparable. Also, since the evaluators may be located at different foci of interaction with the person, the behavior they see may differ

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27. Raymond S. Duff and August B. Hollingshead. Sickness and Society. New York: Harper and Row Publishers, 1968.
G. Orwell. Shooting an Elephant. New York: Harcourt, Brace and World, Inc., 1950.
David Sudnow. Passing On. Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1967.
28. R. N. Bush. The Teacher Pupil Relationship. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1954.
Robert E. Herriott and Nancy Hoyt St. John. Social Class and The Urban School. New York: John Wiley and Sons, Inc., '66.
Robert J. Havighurst, Paul H. Bowman, Gordon P. Liddle, Charles V. Matthews, James V. Pierce. Growing Up in River City. New York: John Wiley and Sons, 1962.
August B. Hollingshead. Elmtown's Youth. New York: John Wiley and Sons, 1949.

significantly."[29]

Robert B. Edgerton refers to mental illness as "a term or label applied to a person thought to be conducting himself in an inappropriate, abnormal or unreasonable behavior for persons in that culture who occupy a similar class position."[30]

James Coleman refers to mental illness as being abnormal behaviour: a "pathological deviation from the norm or usual: behavior that is detrimental to the individual and/or the group.[31] August Hollingshead and F. Redlich define mental illness socially; that is, whatever a psychiatrist treats or is expected to treat must be viewed as mental illness.[32]

Socio-cultural as well as psychological factors are involved, depending on who is judging the behavior. In diagnosing mental illness, T. Schmidt and Charles Fonda found agreement with respect to diagnosis of a disorder occurred only in about 50 percent of the cases.[33] Therefore,

29. Thomas Scheff, ed., Mental Illness and Social Process. New York: Harper & Row, 1967, p. 25.
30. Robert B. Edgerton. "On the recognition of Mental Illness", in Changing Perspectives in Mental Illness, ed., Stanley C. Plog and Robert B. Edgerton. Chicago: Holt, Rinehart and Winston, Inc., 1969, p. 50.
31. James C. Coleman, Abnormal Psychology and Modern Life, 3rd ed. Glenveiw, Illinois: Scott, Foresman and Co., 1964, p. 656.
32. August B. Hollingshead and Frederick Redlich, Op. cit.,p.11.
33. Herman O. Schmidt and Charles P. Fonda, "The Reliability of Psychiatric Diagnosis," Journal of Abnormal and Social Psychology, Vol. 52, (Oct., 1956), p. 266.

a major problem in defining and catagorizing mental illness is that there is no uniform diagnostic system. As a result diagnostic label and type of treatment will vary depending on who is treating the illness.

One example of a classification system is James Coleman's, which he considers five broad categories -- psychoneurotic, psychosomatic, psychotic, character disorders, and drug and alcohol addiction. These are explained as follows:

(1) Psychoneurotic -- pathological development trends within the personality of the individual which lead to misevaluations of environmental problems, to severe conflicts, and to inefficient personal and social adjustments.

Examples: anxiety, asthenic, conversion, dissociative, phobic, obsessive compulsive, and neurotic depressive reactions.

(2) Psychosomatic -- physical symptoms resulting from the continued emotional mobilization during stress; often involves actual tissue damage.

(3) Psychotic -- patient manifests a severe personality decompensation with a marked distortion and loss of contact with reality.

Examples: schizophrenic, paranoid, affective psychosis, manic depressive, involutional psychosis.

(4) Character disorders -- involve patterns of overt maladjustive behaviour ("acting out") rather than mental or

emotional symptoms, and the individual may even have little or no sense of distress.

Examples: special symptom reactions such as stuttering, juvenile delinquency, crime, deviant sexual behavior, and psychopathic reactions.

(5) Drug and alcohol addiction.[34]

In contrast, A. Hollingshead and F. Redlich consider two broad categories, psychosis and neurosis. They do not attempt to define their two main categories but describe the sub-categories as follows:

(1) Neurosis

a. Anti-social and immaturity reactions -- characterized by unapproved and intolerable behavior with minimal or no overt sense of distress to the patient, manifested by life-long patterns of acting-out behavior.

b. Character neurosis -- patients exhibit mixed symptoms of varying degrees and some behavior disturbances; do not fit into other specific reaction types.

c. Phobic and anxiety neurosis -- anxiety tends to be focused on specific situation, eg. fear of darkness.

d. Depressive neurosis -- patient is burdened with emotional reactions to some social situation in which feelings of guilt, shame and anxiety are internalized in a specific way.

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34. James C. Coleman, _Op_. _Cit_., Chapter 14.

e. Obsessive compulsive neurosis -- compulsive ritualistic behavior and obsessive ideation.

f. Psychosomatic neurosis -- psycho-genic reactions with somatization symptoms, eg. psychogenic gastro-intestinal reaction, psychogenic cardiovascular reactions, psychogenic genitourinary reaction, psychogenic respiratory reaction, psychogenic skin reaction.

g. Hysterical reactions -- individual changes anxiety into sensory or motor reaction and derives secondary gain from symptoms.

(2) Psychosis

a. Affective psychosis -- includes manic and depressive behavior or combinations.

b. Drug and alcohol addiction -- includes all chronic drug and alcohol addicts.

c. Organic psychosis -- miscellaneous group of disorders with organic etiology, eg. psychoses due to infectious disease, such as syphilis.

d. Schizophrenic psychoses -- fundamental disturbances of ideation, emotion and volition; includes six reactions: latent, simple, hebephrenic, catatonic, paranoid and unclassified types plus two paranoid disorders, paranoia and paranoid state.

e. Senile psychoses -- arise in later years of life and are caused mostly by circulatory and metabolic disorders

of the brain.[35]

(4) Types of Treatment

Since our study is concerned with variations in types of treatment, we have reviewed literature dealing with some of the possible treatment methods. J. Coleman states that the aims of any treatment are for the physical, psychological, and sociological well-being of the patient.[36] Similarly in this area there is no uniform classification of treatment methods.

Coleman divides therapy into two broad categories, medical and psychotherapy.[37]

a. Medical therapy -- shock (insulin, electro), psychosurgery, i.e. brain surgery (e.g. lobotomy), and chemotherapy (tranquilizers, energizers).

b. Psychotherapy (talking therapy) -- which begins on the assumption that "the patient should gain insight into his own emotional processes."[38]

In contrast, Hollingshead and Redlich utilize four categories -- no treatment, organic, psychotherapy, environmental hospital therapy.

a. No treatment -- includes general diagnostic, forensic diagnostic, compensation diagnostic, and hospitalization with no treatment.

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35. August Hollingshead and F. Redlich, Op. cit., pp 222-227.
36. James Coleman, Op. cit., p. 555.
37. James Coleman, Op. cit., Chapter 14.
38. Henry Weihofen, "Psychiatry for the Poor" in Canada's Mental Health, Vol. 16, No. 3, 4 (May-Augs. 1968), p. 14-15.

b. Organic -- includes physical therapy, hydrotherapy, electroshock, insulin shock, and other shock therapy, drugs, sedation, operation, and other.

c. Psychotherapy -- (re-education of patient as he works through personality problems with therapist, or accepts and follows therapist's notions), includes psychoanalysis, analytic psychotherapy, eclectic psychotherapy, relationship psychotherapy (supportive, suggestive, and directive), hypnosis, hypno-analysis, and narco-analysis.

d. Environmental hospital therapy -- includes occupational, educational, individual and other therapy.[39]

Another different classification system involving three categories -- psychotherapy, organic treatment, and no treatment -- has been devised by Robinson, Redlich and Myers.

a. Psychotherapy is defined as including all behavioral methods, largely verbal in nature by which attempts are made to help patients suffering from behavioural disturbances. Types of treatment here include range from orthodox Freudian methods of psychoanalysis to nondirective group therapy.

b. Organic Treatment refers to physical chemical treatment methods principally directed to an organ or organ system and includes, then, all types of physical therapy and

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39. Hollinshead and Redlich, _Op. cit._, p. 386.

drug treatments as well as lobotomies, topectomies and the various shock treatments. It does not include medical or surgical treatment for organic illness unrelated to behaviour disorders.

c. No treatment refers exclusively to institutional cases in custodial care who are not receiving organic treatment or psychotherapy.[40]

(5) Relationship Studies (class, mental illness and treatment)

Particularly relevant to our research are various studies supporting our hypothesis that a patient's social class will influence the kind of treatment he will receive for mental illness. In general these studies indicate that treatment depends not only on medical and psychological considerations but also on social variables.[41] Some of the possible explanations for differential treatment may be explained by the presence of an enormous social and emotional gulf, and resultant communication barrier,[42] between the lower class patient and the therapist who generally belongs to a higher social class.[43]

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40. H. A. Robinson, Frederick C. Redlich and Jerome K. Myers, Op, cit., p. 308.
41. Hollingshead and Redlich, Op. cit., p. 386.
42. Jerome K. Myers and Leslie Shaffer, Op. cit.
43. Eugene Gallagher, Myron R. Sharaf and Daniel Levinson, Op. cit. Eugene Gallagher and Daniel J. Levinson, Patienthood in the Mental Hospital. Boston: Houghton Mifflin Co., 1964. Leonard Schneiderman, "Social Class, Diagnosis and Treatment," American J. Of Orthopsychiatry, Vol. XXXV, No. 1, (Jan., 1965), pp. 99-105.

After reviewing various studies relating social class to type of psychiatric treatment received S. Hirsch, Doris Hirsch and Shane concluded that the reason for differential treatment lay both with the therapists and lower class patients themselves. Due to different value orientations psychiatrists may tend to reject lower class patients by failing to refer them for intensive psychotherapy, while on the other hand lower class patients, when referred, often reject the recommended treatment.[44] Also, psychiatrists generally select for psychotherapy patients who they feel will benefit most from the treatment. Because lower class individuals tend to be present-oriented, they may find it difficult to see the value of long-term treatment and as a result often are not motivated to become involved in verbal therapy.[45]

One proposed alternative solution to the problem of differential treatment has been to involve non-professionals as bridgemen between professional and lower class individuals.[46]

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44. Solomon Hirsch, Doris Hirsch and A. Shane. Op. cit.
45. James T. McMahon, Op. cit.
Betty Overall and H. Aronson, Op. cit.
Frank Riessman, Jerome Cohen and Arthur Pearl, eds., Mental Health of the Poor. New York: The Free Press, 1964.
G. J. Sarwer-Foner, "Psychotherapy in Relation to the Changing Canadian Scene," Canadian Psychiatric Association Journal, Vol. X, No. 2, (April, 1965)
William Snyder. The Psychotherapy Relationship, New York: The MacMillan Co., 1961.
46. Robert Reiff and Frank Riessman. The Indigenous Non-Professional: a Strategy of Change in Community Action and Community Mental Health Programs, Report No. 3, National Institute of Labour Education, Mental Health Program, Nov. '64.

F. Sobey claims that the utilization of the poor, the untrained, the neighborhood non-professional can reduce the social distance between the middle class professional and the poor person with a vastly different style of life.[47]

In summary our review of the literature would indicate that the various social classes receive differential treatment in various areas, of which mental illness is no exception. In an attempt to operationalize our hypothesis we have also looked at the various methodological procedures for measuring social class and type of treatment received for psychiatric disorders. This will be discussed in Chapter three which deals with our Research Design.

47. Francine Sobey. The Non-Professional Revolution in Mental Health. New York: Columbia University Press, 1970.

CHAPTER II

SETTING

For our study we required a psychiatric setting in which the patients are representative of all social classes. In addition, we needed a facility in which different modes of treatment would be used in treating patients with various psychiatric disorders.

In considering possibilities available, and the requirements necessary for our study, it became apparent that the Winnipeg Psychiatric Institute would be the most suitable setting in which to conduct our research.

The Winnipeg Psychiatric Institute is a 56-bed acute treatment hospital with a large out-patient department. It serves mainly the population of greater Winnipeg. Being a centrally located Provincial Institution we felt it would be the most representative of all social classes and various psychiatric disorders.

History:

The provincial institutions for the care of the mentally disordered include (a) the Selkirk Hospital for Mental Diseases, which was opened in 1886, (b) the Brandon Hospital for Mental Diseases, opened in 1891, (c) the Psychopathic Hospital (now the Winnipeg Psychiatric Institute) on the grounds of the Winnipeg General Hospital,

opened in 1919. There is also the Manitoba School for Mentally Defective Persons at Portage la Prairie, opened in 1933. In 1966 these four provincial institutions had a total population of almost 3,900, making a rate of 428 per 100,000 population compared to the Canadian average of 372. In addition, there are psychiatric units in various general hospitals, all located in Winnipeg -- Winnipeg General Hospital, St. Boniface General Hospital, Misericordia Hospital, Grace Hospital, and Victoria General Hospital. These units take in about one-half of the total number of patients admitted to psychiatric beds in the province of Manitoba.[48]

When established, the Psychopathic Hospital was the first psychiatric hospital in Canada to be closely associated with a general hospital and medical school. The original objectives of the institution were as follows: (1) to minimize the stigma attached to mental illness, (2) to treat "early recoverable" cases and so prevent prolonged institutionalization and chronicity, (3) to relieve mental hospitals of overcrowding, and (4) to be a centre of psychiatric teaching and research.[49]

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48. D. G. McKerracher, Trends in Psychiatric Care (Ottawa: Queen's Printers, 1966), pp. 92-95.
49. H. C. Hendrie and M. B. Varsamis, "Historical Note: The Winnipeg Psychopathic Hospital 1919-1969, An experiment in Community Psychiatry," in Canadian Psychiatric Association Journal, Vol. 16, 1971, pp. 185-186.

It was felt that this type of facility was successful in improving the delivery of psychiatric services in the province. In 1919, only 31.6% of the patients were transferred to other institutions and at the same time the total admissions to Selkirk Mental Hospital decreased by approximately 50%. In 1920, 41% of the patients admitted to the Winnipeg Psychopathic Hospital were transferred; in 1962, 22%, and in 1969, 21.1%.[50]

The demand for its' services was high. Originally, bed occupancy rate was 99% and the admission rate remained the same until the early 1940's. Following World War II it increased in the 1950's, and more rapidly in the 1960's. In 1920 there were 372 admissions; in 1929, 266; in 1939, 334; in 1949, 545; in 1959, 608; in 1969, 1,080; and in 1970, 1.085.[51] In 1970, average daily population was 53.46 patients. Considering that the institute has 56 beds, there was, in effect, full bed occupancy for the entire year.

In 1968, 31.5% of the in-patient population consisted of schizophrenics; in 1969, this percentage increased to 31.66%. The affective psychosis population of 1968 accounted for 12.37% of the total number of in-patients while in 1969 this figure increased to 17.6%. The general rise of admissions can be partially attributed to the increased acceptance

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50. Manitoba Department of Health and Social Development Annual Report, 1969, p. 144.
51. Ibid, 1970, p. 143.

of alcoholism as an illness by the medical community. In 1968 the total proportion of patients being treated for alcoholism was 11.98%. This figure increased to 14.4% in 1969. In addition, the admission of the aged suffering from senile and arterio sclerotic dementia and of adolescents who are abusing drugs was an increasing problem in the 1960's which has continued to the present.[52]

Although initially the percentage or readmissions was low, it has been steadily increasing and reached an all-time high in 1969. In 1929, 19.8% of the patients were readmitted; in 1959, 39.5%; in 1969, 51%. The 1969 Annual Report of the Institute acknowledges several reasons for this occurance: (1) the natural course of many psychiatric illnesses is chronic or recurrent, (2) with improved service to the patient, more families and ex-patients are willing to seek help from the same place, and (3) anti-psychotic drugs control the symptoms of schizophrenia, but they have to be taken for long periods of time, probably for life. When discontinued, overt psychotic symptoms reappear, necessitating readmission to the hospital.[53]

Out-patients:

An out-patient department was set up at the Psychiatric Institute with the aim of preventing institutionalization

52. _Ibid._, 1969, p. 142.
53. _Ibid._, 1969.

whenever possible. It was hoped that by treating people in the community the number of admissions and readmissions could be reduced.

The total number of out-patient visits in 1958 was 2,000; in 1964, 6,800; in 1968, 10,326; in 1969, 12,322; in 1970, 13,617.[54] These numbers do not include patients and their families seen by psychology, social services, or nursing.

Most out-patients now attending the Out-Patient Department consist of ex-inpatients who require long-term care. With the advent of anti-psychotic drugs much of the load has been transferred from the in-patient services to the Out-Patient Department.

A sizable proportion of out-patients are schizophrenics on maintenance phenothiazines. There was a total of 100 patients attending the Out-Patient Department for maintenance bi-weekly injections of fluophenazine enanthate in 1970. Thirty-six out-patients were on prophylactic lithuim carbonate therapy that year. In addition, a behavior therapy program was started in 1970 for selected patients on a trial basis.[55]

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54. _Ibid._, 1970, p. 144.
    Ibid., 1970, p. 25.
55. _Ibid._, 1970, p. 25.

In-patients:

Treatment of in-patients is eclectic and includes pharmacoth therapy, electro-convulsive therapy, psychotherapy, and milieu therapy. Although an electic approach is used, one psychiatric treatment method that the Institute feels has stood the test of time is convulsive therapy. This type of treatment was pharmacological in the 1930's and has been electrical since the 1940's. More patients were treated in this way during 1969 than 1959, but the total number of treatments per patient decreased from 6.1 to 3.1.[56]

The in-patient department is said to have a balanced program of activities for patients--for example, occupational therapy, recreation, geriatric program, young adult program, and alcohol education program.

The Institute consists of four main departments, representing four different disciplines--psychiatry, psychology, social work, and nursing. These four departments co-operate in providing an interdisciplinary team approach to treatment.

Psychiatric Department:

The psychiatric department is composed of psychiatrists, residents, and medical students, with an emphasis on

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56. Ibid., 1969, p. 144.

teaching and research. The psychiatrists are primarily responsible for diagnosis and determining the focus of treatment. Where treatment involves intensive psychotherapy, medication, and/or organic therapy, psychiatry carries out the therapy. They also act in a consultative role to the other disciplines as well as to other agencies in the province.

Psychology Department:

The psychology department is staffed by three psychologists whose activities can be divided into four major areas--psychological testing, psychotherapy, teaching, and research. The main focus of the department has been on psychological testing as an aid to diagnosis. Psychologists are also involved in specialized individual therapy on a more limited basis.

Social Service Department:

The Social Service Department consists of six social workers who are actively involved during all phases of the patient's treatment. Their focus is on contacting each patient and their next of kin of all new admissions to obtain a detailed social history to aid in the diagnosis and treatment plan of the patient. Contact with the relatives is to be maintained throughout the period of hospitalization. Similar services are offered to re-admissions.

The department is also responsible for contacting and screening out-patients. They provide brief services involving information, referral to other social agencies, and short-term supportive therapy. In a few cases, they provide more intensive casework, make home visits and supervise foster home patients.

Nursing Staff:

The nursing staff and allied services are administered by the Winnipeg General Hospital. The nurses are responsible for ward care as well as being involved in various hospital therapy groups, such as the geriatric program, alcoholic program, recreation program, and activity programs for the closed wards.

The nurses have been the prime movers in initiating, organizing, and maintaining contact with the Public Health Nurses for after-care of selected ex-inpatients. They have also been involved in the Out-Patient Department, especially in the follow-up of the group of schizophrenics who attend bi-monthly for maintenance fluophrenazine enanthate injections.

In order to broaden our understanding of the hospital's functioning, we spoke to various representatives of the different departments mentioned above. We also spent some time on the wards talking to a few inpatients. (Refer to appendix I).

As previously mentioned, the hospital staff work together on a team approach in treating patients. An inter-disciplinary conference is held twice a week on both wards for the purpose of diagnosis, planning of treatment, and discussion of cases. In addition, these meetings provide an educational opportunity for the residents and interns. At this time all cases are reviewed briefly and special attention is given to the patients who have not been improving with prescribed treatment.

Psychiatrists:

From our interviews with the psychiatrists, it seems that there is a tendency to rely on physical treatment rather than verbal. This was attributed by the psychiatrists to the fact that the Institute seems to get the severest cases, more psychopaths, and those who require some form of physical treatment, while the psychiatric wards in the general hospitals tend to treat more neurotic and the less severe cases. However, there is some variation as each psychiatrist is free to practice according to his particular philosophy. When the diagnosis is relatively clear, there will be little variation between psychiatrists as to treatment. However, in the many cases where the diagnosis is less certain there may be considerable variation as to treatment prescribed. All psychiatrists do at least some follow-up treatment while others see patients strictly on an out-patient basis. Due

to lack of time the visits tend to become a quick check-up for reassessment and medication. When possible the psychiatrists also use supportive therapy techniques. Due to the tremendous number of out-patients, the limited psychiatric staff find it impossible to carry out intensive long-term psychotherapy in the majority of cases. However, the psychiatric department is involved in intensive group therapy. One example is the Young Adult program which is operated on both an in-patient and out-patient basis.

The psychiatrists make use of the psychology department mainly for assistance in diagnosis of difficult cases. In addition they also refer patients requiring specialized treatment. The social service department is viewed as a resource which can provide relevant information on the patient's home situation. This information is used as an aid in diagnosis and formulating treatment and discharge plans.

Psychology:

The psychologists view their role at the Institute as being two-fold: (1) as an ancillary discipline to the psychiatrists, and (2) as an independent practice. Although a large proportion of their time is spent in psychological testing for the purpose of diagnosis and assessment for both the Psychiatric Institute and other agencies in the community, they have also developed specialized therapeutic techniques

such as behavior modification, hypnosis and relaxation therapy. The department is also involved in teaching medical and dental students and psychiatric residents and in addition carries out various research projects.

Social Services:

The social work staff see their role as that of a liaison between the psychiatrists, patients, and families. Their main focus is on working with patients and their relatives during their stay in the hospital and after discharge. Ideally, every new patient and his family are contacted by a social worker in order to obtain a history of psycho-social data to aid in diagnosis, treatment, and discharge plans. The department's rationale is that each patient should be followed up for a period of 2-3 months and then referred to another social agency if necessary. However, due to limited staff and time, follow-up tends to be mainly on an emergency basis.

Nursing:

The nursing staff is composed of both Registered Nurses and Registered Psychiatric Nurses who perform the same functions. Their main role is in seeing that the basic needs of the patient are met and in looking after the "well" part of the patient to keep it from getting worse. They are also very involved in the group activities within the hospital--for example, alcoholic program, geriatric program, young

adult program, and various recreation activities. On the ward, each patient is assigned to a particular nurse who is responsible for providing the psychiatrist with daily progress notes.

In-Patients:

At the psychiatrists' request, and because they comprise part of the organization of the hospital, we interviewed a small group of in-patients selected at random one evening at the Institute.

In general, the in-patients with whom we spoke had no major complaints about the hospital and treatment they were receiving. However, they did express a general feeling of apathy, and boredom seemed to be a common problem. The organized activities available did not seem to be of interest to several of them, and they expressed a desire for more meaningful activities. Some of the patients also felt that their contacts with the psychiatrists were too brief and that there was little opportunity for intensive individual therapeutic sessions. Ward contact between the patient and social worker seemed to be very minimal, and some patients were unaware that social services were available to them.

In conclusion, it should be noted that the above information obtained from the interviews was not gathered from a random sample in a scientific way, but rather in unstructured, informal discussions with available staff and patients.

However, we feel that this information is helpful in broadening one's understanding of the hospital's functioning and in describing the setting for our research.

CHAPTER III

RESEARCH DESIGN

Sample:

Our study is based on a survey of all initial admissions at the Psychiatric Institute during 1970, and the treatment received by these patients. That is, anyone admitted initially at the Psychiatric Institute for a psychiatric and/or emotional problem during the 1970 calender year, is included in our population as a psychiatric patient.

The total number of admissions (including re-admissions) for 1970 was 1,085. Since we were considering only first admissions, our sample consisted of 504 cases.

We obtained all necessary information for our three major variables from the patients' files. These variables include indicators of social class, psychiatric diagnosis, and treatment recommended.

Operational Definitions:

We are defining social class as an aggregate of individuals who occupy a broadly similar position in society, based on the indicators of income, occupation and education. In measuring social class we have chosen to use Bernard Blishen's 1967 Revised Occupational Class Scale (see Appendix II) mainly because it was devised for Canadian society.

This scale provides a device for placing an individual somewhere in the class system on the basis of his occupation. The data Blishen used to construct this scale was taken from the Dicennial Census of 1961 which classifies occupations according to income and years of schooling.

Blishen's revised scale is similar to the scale devised by Otis Dudley Duncan in which he assigned scores to the United States Census occupational titles to assess the status of occupations. In his revised 1967 scale, Blishen expressed the income and education variables as a percentage rather than as a function of the mean. Both the original and revised scales produce similar results and illustrate stability in the structure over time, despite variations in procedure, thus demonstrating its reliability. According to Duncan, the three indicators of income, education, and occupation seem to be related in the following way: "A man qualifies himself for occupational life by obtaining an education; as a consequence of pursuing his occupation, he obtains income. Occupation therefore is the intervening activity linking income to education."[57]

57. Otis Dudley Duncan, "A Socio-Economic Index for all Occupations" and "Properties and Characteristics of the Socio-Economic Index," pp. 109-138, pp. 139-161 respectively, Albert J. Reiss (Ed.) Occupations in Social Status. New York: Free Press of Glencoe Inc., 1961 in Bernard Blishen "A Socio-Economic Index for Occupations in Canada", op. cit., p. 498.

In establishing cutting points for determining class intervals, Blishen tried several different methods and found little variation in results. We chose his method of using the ten digits of the index values--for example, level I includes all those with an index score of 70.00 or more, level II, those between 60.00 and 69.99 (see appendix III).

For the purposes of our study, we used Blishen's six levels and also found it necessary to include both a welfare group (where no occupation was known) and a group for whom we could find no indicator of occupation, income or education. Following Warner's class divisions, these eight groups were labelled as follows: upper upper, lower upper, upper middle, lower middle, upper lower, lower lower, and again we added two categories, welfare and unknown.[58] Because of the size of our population, we found it more meaningful to combine these eight classes into four major groupings: levels 1 and 2 (upper upper and lower upper) comprising the upper class, levels 3, 4, and 5 (upper middle, lower middle, and upper lower) comprising the middle class, and levels 6 and welfare (lower lower and welfare) comprising the lower class and a group of unknowns.

58. W. Llord Warner and Paul S. Lunt. _The Social Life of a Modern Community, Yankee City Series_. New Haven: Yale University Press, 1941, p. 287.

Diagnosis:

Our second major variable is that of psychiatric diagnosis which we are defining as the determination of the particular nature of the individual's illness including a description of possible causes and symptoms. For our study we have used the hospital's diagnostic categories which are based on the International Classification for Mental Diseases (adapted to Canadian society). The Institute has developed six broad categories of psychiatric diagnosis: (1) schizophrenia, (2) affective psychoses, which includes manic depressive disorders, involutional depressive disorders, psychotic depressive disorders, endogenous depressive disorders, recurring depressive disorders, senile depressive disorders, psychotic depressive reactions, acute manic disorders, agitated depressive disorders, retarded depressive disorders, schizophrenic affective depressions, (3) neurosis and personality disorders, which includes reactive depression, immature personality, sociopathic personality, inadequate personality, alcoholism, drug addiction, sexual deviations. In addition, we have included the following in this category: aggressive personality, obsessive compulsive disorder, situational reaction and depression, neurotic depression, behavior disorders, psychoneurotic disorders, anxiety reaction, and hysterical personality. (4) organic states which includes epileptics

and senile dementia. We have included chronic brain syndrome, acute polyneuritis, toxic psychosis, korsekoff psychosis, and arterio sclerotic dementia. (5) retardation, and (6) acute psychotic episode.

For the purpose of our study, we combined all psychotic illnesses into one major category of psychoses--schizophrenic and paranoid states, affective psychoses and acute psychotic episodes. In addition, we combined those disorders where a physical or organic component is predominate (organic states and retardation). It was also necessary to include a group of patients who were undiagnosed. We thus have 4 major groups: (1) psychoses, (2) neurosis, (3) organic conditions, and (4) undiagnosed.

Our third major variable is treatment received for the particular illness, in the hospital and/or as a part of follow-up. Forms of treatment have been divided into the following categories: (1) type of drugs, (2) electroshock therapy, (3) psychotherapy, (4) social work contact, (5) psychological referral, and (6) hospital therapy, including occupational therapy and group therapy.

Drug therapy has been divided according to the scheme used by the hospital. The main drug categories are neuroleptics (anti-psychotic), tranquilizers (sedatives), antidepressants, and stimulants. In addition, we included a category of drugs not found in the above classification and

those that were unknown. The most commonly used neuroleptic drugs, in our population, are chlorpromazine, largactil, nozinan, melleril, neuleptil, stelazine, and haldol. The main tranquilizers found were chlorolol, valium, and librium. In the anti-depressant group we found mainly tofranil, elavil, aventyl, and noveril. The most common stimulant was benzedrine. The unknown category includes among other drugs those used for organic conditions. In those cases where more than one category of drugs was administered, we chose the dominant drug (i.e. the one given in the highest dosage as compared to the average dosage), or the drug category in which the majority of the drugs given to a particular patient belonged.

Electroshock treatment, a form of convulsive therapy, is used mainly to alleviate depression and schizophrenic reactions. In addition to recording whether or not electroshock was given, we also accounted for the number of treatments and the length of stay in the hospital before treatments were begun.

Psychotherapy involves the "re-education of the patient as he works through personality problems with the therapist, or accepts and follows the therapist's notions."[59] Psychotherapy traditionally involves frequent intensive sessions between patient and therapist. However, since we

59. Hollingshead and Redlich, op, cit. p. 269.

had no accurate means of measuring length or intensity of individual therapeutic contacts, we found it necessary to consider any recorded verbal contacts, while at the hospital and during follow-up, as psychotherapy.

Any social work involvement with the patient and/or family recorded on the patient's file (other than the original intake sheet) was considered a social work contact. Generally this involved an extensive social history obtained from the patient's relative, as well as follow-up contact.

Since therapy done by the psychology department is not recorded in the patient's main file, we considered only referrals for psychological assessment. For this reason, we cannot account for specific types of therapy administered by this department.

Hospital therapy was considered also only when recorded on the file. However, we realize that a number of patients could have been involved in various programs without it being recorded.

After obtaining the necessary information from the files on our three major variables, we related each type of treatment to the patient's diagnosis and social class.

CHAPTER IV

DATA ANALYSIS

Sample:

The actual figures describing the characteristics of our 504 cases are recorded on tables 21-25 in Appendix 3. For the purpose of our analysis we have converted these figures into percentages.

TABLE 1

PERCENTAGE OF PATIENTS BY SOCIAL CLASS

Social Class	Percentage of Total Population
Upper	12
Middle	40
Lower	35
Unknown	13
Total Percentage	100%

As indicated in the above table, the middle and lower classes comprise the major percentage of our population (75%), while the upper class represents only 12%. The 13% of our population that falls in the unknown category, will not be considered in the following analysis, since we could not obtain sufficient information to identify the social class.

TABLE 2

PERCENTAGE OF PATIENTS IN EACH AGE GROUP
BY SOCIAL CLASS

Age Group	Social Class			Percentage of Total Population
	Upper	Middle	Lower	
Under 15	5%	3%	2%	3%
15-24	31	30	31	31
25-34	20	16	21	19
35-44	16	18	11	14
45-54	8	12	11	10
55-64	7	5	5	5
65-74	5	11	7	9
75+	8	8	11	9
Total %	100%	100%	100%	100%

The most highly represented age group falls in the 15-24 year category (31%) with 53% of the total population under 35 years of age. In addition, the aged group (over 65 years) comprises 18% of the total population.

TABLE 3

PERCENTAGE OF PATIENTS IN VARIOUS ETHNIC GROUPS BY SOCIAL CLASS

Ethnic Group	Social Class			Percentage of Total Population
	Upper	Middle	Lower	
British Isles	36%	30%	22%	26%
French	7	9	10	10
Other Western European	13	13	10	11
Northern European	2	5	2	3
Southern European	0	1	1	1
Eastern European	13	12	19	14
Asiatic	0	2	0	1
Native Indian, Eskimo & Metis	0	5	10	8
Other and Not Stated	30	23	25	26
Total %	100%	100%	100%	100%

47% of our total population are descendants of western European countries with the largest group from the British Isles (26%). The other western European category includes Belgium, Netherlands, Germany, Austria, Luxemburg, and Switzerland. The northern, southern, and eastern countries represent 18% of the total population. The northern European category includes Iceland, Denmark, Norway, Sweden, and Finland. The southern European category includes Italy, Spain, Portugal

Malta, and Greece, and the eastern European category includes Russia, Ukraine, Albania, Czechoslovakia, Hungary, Poland, Yugoslavia, Romania, Bulgaria, Estonia, Latvia, and Lithuania. The other and not stated category is comprised primarily of those patients whose ethnic origin is unknown (24%) and includes American and Jewish people who make up the other 2%.

TABLE 4

TYPE OF ADMISSION ACCORDING TO SOCIAL CLASS EXPRESSED IN PERCENTAGES

Type of Admission	Social Class			Percentage of Total Population
	Upper	Middle	Lower	
Voluntary	43%	42%	30%	37%
Compulsory	34	39	42	40
Unknown	23	19	28	23
Total %	100%	100%	100%	100%

The above table indicates that more upper and middle class patients were admitted voluntarily, rather than on a compulsory basis, whereas the opposite is true for lower class patients. A large percentage of all classes were admitted from the Emergency Department at the Winnipeg General Hospital and since we could not determine the nature of their admissions, they have been placed in the unknown category.

TABLE 5

PERCENTAGE OF PATIENTS IN EACH DIAGNOSTIC CATEGORY BY CLASS

Diagnostic Category	Social Class			Percentage of Total Population
	Upper	Middle	Lower	
Psychoses	49%	43%	35%	40%
Neuroses	39	40	44	41
Organic Conditions	10	15	19	16
Undiagnosed	2	2	2	3
Total %	100%	100%	100%	100%

As can be seen from the above table, there is almost an equal percentage of psychotic and neurotic disorders in our population. While a larger percentage of upper class patients are psychotic rather than neurotic the opposite is found amongst the lower class patients. There is little difference between these two diagnostic categories within the middle class group. Since the undiagnosed category represents only 3% of the total population, this group of patients will be omitted from our following analysis.

Treatment:

Treatment as related to diagnostic category and social class is analyzed in the following tables. The actual figures are recorded on tables 26-40 in Appendix 3.

TABLE 6

LENGTH OF STAY IN HOSPITAL BY DIAGNOSTIC CATEGORY
AND SOCIAL CLASS EXPRESSED IN PERCENTAGES

	Diagnosis									
	Psychosis			Neurosis			Organic Conditions			
	Social Class									
Length of Stay in Hospital	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	Percentage of Total Population
0-1 Week	24%	19%	18%	34%	41%	39%	0	13%	17%	29%
2-3 Weeks	33	43	52	29	44	41	50	33	20	39
4-5 Weeks	40	23	21	29	12	16	33	17	38	20
6-7 Weeks	0	10	3	8	3	3	17	20	15	8
8 or More Weeks	3	5	6	0	0	1	0	17	10	4
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Of those diagnosed as being psychotic, 57% of the upper class was hospitalized for three weeks or less whereas 70% of the lower class was hospitalized for the same length of time. A larger percentage of the upper class than either middle or lower class patients remained in the hospital four to five weeks. However, a larger proportion of middle class patients remained in longer than six weeks in this diagnostic category. A similar trend appears with those patients admitted for organic conditions.

63% of the upper class patients diagnosed as neurotic remained in the hospital three weeks or less as compared to 85% of the middle class and 80% of the lower class. A larger proportion of the upper class remained hospitalized for more than four weeks (37% as compared to 15% and 19%, respectively for middle and lower classes).

TABLE 7

PERCENTAGE OF PATIENTS RECEIVING VARIOUS DRUG THERAPIES
BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS

Type of Drug	Psychoses: Upper	Psychoses: Middle	Psychoses: Lower	Neuroses: Upper	Neuroses: Middle	Neuroses: Lower	Organic: Upper	Organic: Middle	Organic: Lower	Percentage of Total Population
	Social Class									
Neuroleptics	81%	79%	76%	50%	33%	26%	100%	43%	47%	52%
Tranquilizers (Sedatives)	3	9	3	25	29	28	0	37	12	18
Anti-Depressants	13	8	5	12	15	11	0	3	9	9
Stimulants	3	0	0	0	0	0	0	0	0	0
Other and Unknown	0	3	8	0	10	20	0	17	24	12
No Drugs	0	1	8	13	13	15	0	0	8	9
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Column headings grouped under "Diagnoses".)

All upper class patients diagnosed as psychotic received this type of therapy. Neuroleptics were the most frequently used drugs for all classes diagnosed as psychotic. A higher percentage of upper class patients received anti-depressant drugs as compared to the other two classes.

In the neurotic category there was little variation of drugs by class other than the significantly higher percentage of upper class patients receiving neuroleptics (50%) as compared to the middle and lower class patients (33% and 26%, respectively).

All upper class patients diagnosed as having an organic condition received drug therapy in the form of neuroleptics, whereas approximately one-half of both the middle and lower class patients received this type of drug. In contrast, 8% of the lower class patients received no drug therapy for this condition.

TABLE 8

PERCENTAGE OF PATIENTS RECEIVING ELECTROSHOCK TREATMENTS
BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS

	Diagnoses									
	Psychoses			Neuroses			Organic			
	Social Class									
Number of Treatments	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	Percentage of Total Population
1-3 Times	10%	8%	11%	4%	0%	3%	17%	0%	0%	5%
4-6 Times	17	17	13	8	0	1	0	7	0	6
7 and Over	10	6	8	0	1	0	0	0	0	3
No Treatments	63	69	68	88	99	96	83	93	100	86
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

14% of our entire population received electroshock treatments on first admission. For all diagnostic categories, a higher percentage of upper class patients received electroshock treatments than either of the other two classes.

TABLE 9

LENGTH OF TIME IN HOSPITAL BEFORE ELECTROSHOCK TREATMENTS BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS EXPRESSED IN PERCENTAGES

	Diagnoses									
	Psychoses			Neuroses			Organic			
	Social Class									
Length Before Electroshock	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	Percentage of Total Population
1-3 Days	36%	0%	15%	33%	0%	0%	0%	0%	0%	13%
4-6 Days	9	22	30	0	100	33	0	50	0	23
7-9 Days	27	22	15	0	0	0	0	0	0	16
10-12 Days	10	12	15	0	0	67	0	0	0	16
12+	18	44	25	67	0	0	100	50	0	32
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Due to the fact that only 13% (10 patients) of the 73 patients receiving electroshock (see table 28, Appendix 4) were diagnosed as neurotic or having organic conditions, we are considering for our analysis only those who were diagnosed as psychotic. Of these, a larger percentage of the upper and lower classes (45% in each class) received electroshock within the first week after admission, than did the middle class (22%). The larger percentage of middle class (44%) patients, as compared to upper (18%) and lower classes (25%) waited more than twelve days before receiving treatments.

TABLE 10

NUMBER OF PSYCHOTHERAPEUTIC SESSIONS BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS EXPRESSED IN PERCENTAGES

	Diagnosis									
	Psychotic			Neurotic			Organic			
	Social Class									
Number of Psychotherapy Sessions	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	Total Population
1-3 Times	33%	35%	32%	46%	46%	44%	17%	23%	44%	39%
4-6 Times	33	31	29	25	30	25	83	33	12	26
7-9 Times	8	12	13	4	5	4	0	17	3	7
10-12 Times	13	3	5	4	1	1	0	3	0	3
13 and Over	0	0	2	4	3	3	0	7	6	2
No Sessions	13	19	19	17	15	23	0	17	35	23
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

77% of our entire population received psychotherapy. Of those patients diagnosed as psychotic, a higher percentage of the upper class received psychotherapy as compared to the middle and lower classes. The same is true of those diagnosed as having organic conditions. Of those diagnosed as neurotic, approximately the same percentage of upper and middle class patients received psychotherapy (83% and 85% respectively), whereas the percentage of lower class patients receiving psychotherapy was significantly lower (77%).

TABLE 11

PERCENTAGE OF PATIENTS RECEIVING STUDENT HISTORY BY SOCIAL CLASS

Social Class				
Student History	Upper	Middle	Lower	Percentage of Total Population
Yes	31%	40%	33%	35%
No	69	60	67	65
Total %	100%	100%	100%	100%

Although middle class patients received a slightly higher percentage of student histories, there was no significant difference between classes.

TABLE 12

PERCENTAGE OF PATIENTS RECEIVING SOCIAL WORK CONTACT BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS

	Diagnosis									
	Psychosis			Neurosis			Organic Conditions			
	Social Class									
Social Work Contact	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	Percentage of Total Population
Yes	57%	58%	58%	66%	48%	42%	83%	47%	38%	48%
No	43	42	42	34	52	58	17	53	62	52
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

For those patients diagnosed as psychotic there was no significant difference by class as to whether or not there was social work involvement. However, for neurotic and organic conditions, the upper class received considerably more social work contact, with the lower class receiving the least of any of the three groups.

TABLE 13

PERCENTAGE OF PATIENTS REFERRED FOR PSYCHOLOGICAL ASSESSMENT BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS

	Diagnosis									
	Psychosis			Neurosis			Organic Conditions			
	Social Class									
Psychological Referral	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	Total Population
Yes	20%	12%	19%	30%	22%	24%	0%	13%	6%	18%
No	80	88	81	70	78	76	100	87	94	82
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Out of the 18% of the total population referred for psychological assessments, we could find very little significant difference between social classes (see Table 33, Appendix 4).

TABLE 14

PERCENTAGE OF RESPONDENTS TAKING PART IN HOSPITAL THERAPIES BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS

Hospital Therapy	Diagnosis									Percentage of Total Population
	Class									
	Psychosis			Neurosis			Organic			
	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	
Occupational Therapy										
Yes	0%	0%	4%	13%	2%	1%	0%	0%	0%	2%
No	100	100	96	87	98	99	100	100	100	98
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Alcoholic Program										
Yes	0	2	0	13	15	13	0	0	0	6
No	100	98	100	87	85	87	100	100	100	94
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Young Adult Program										
Yes	6	5	8	8	11	9	0	0	3	7
No	94	95	92	92	89	91	100	100	97	93
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Only 2% of the entire population received occupational therapy; 6% attended the hospital alcohol program, and 7% attended the Young Adult program. Because of the small number of patients involved, we could find little significant difference by social class (see Table 34, Appendix 4).

TABLE 15

DISPOSITION OF PATIENT BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS EXPRESSED IN PERCENTAGE

Disposition	Diagnosis / Class: Psychosis			Neurosis			Organic			Percentage of Total Population
	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	
Home	75%	69%	53%	79%	81%	69%	17%	27%	24%	61%
Nursing Homes	4	2	1	0	3	0	33	27	41	6
Mental Hospitals	7	20	38	13	1	3	50	37	21	16
General Hospitals	7	0	1	0	0	1	0	3	0	1
Prison, Police Hold or Detention	0	0	3	0	4	9	0	0	0	3
Death	0	1	0	0	0	0	0	0	6	1
Against Medical Advice	7	5	3	4	5	9	0	0	0	7
Other Institutions	0	3	1	4	6	9	0	6	8	5
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

As indicated on the above table, a higher percentage of upper class patients diagnosed as psychotic were discharged home, to nursing homes, and to general hospitals, as compared to the percentage of middle and lower class patients. A significantly lower percentage of the patients of the upper class were sent to mental institutions, prison, or detention, and other institutions as compared to the other two groups. Other institutions include Nassau House, River House, Matheson House, Salvation Army Half-Way House, Manitoba School for Retardates, St. John's Cathedral Boy's School, Canadian National Institute for the Blind. Also, a higher percentage of the upper class patients within this diagnostic category left the Institute against medical advice as compared to the percentage of middle and lower class patients.

Within the neurotic category a higher percentage of upper and middle class patients returned home as compared to the percentage of lower class patients. Of those lower class patients not discharged home, a higher percentage were sent to general hospitals, prison, detention, and other institutions as compared to those of the upper and middle classes.

In the organic group, a larger percentage of patients from all social classes are discharged to nursing homes as compared to patients diagnosed as psychotic and neurotic.

TABLE 16

PERCENTAGE OF RESPONDENTS FOR WHICH FOLLOW-UP WAS RECOMMENDED BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS

Recommended Follow-up	Diagnosis / Class: Psychosis			Neurosis			Organic			Percentage of Total Population
	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	
Yes	77%	56%	45%	58%	58%	60%	0%	10%	18%	48%
No	23	44	55	42	42	40	100	90	82	52
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Follow-up as recommended for 48% of the total population. A significantly higher percentage of upper class patients diagnosed as psychotic were recommended for follow-up as compared to middle and lower classes. There was no significant difference by class for those patients diagnosed as neurotic. Follow-up was not recommended for the majority of patients (72%) diagnosed as having organic conditions.

TABLE 17

TYPE OF FOLLOW-UP BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS EXPRESSED IN PERCENTAGES

Type of Follow-up	Diagnosis									Percentage of Total Population
	Class									
	Psychosis			Neurosis			Organic			
	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	
Medical	7%	7%	2%	0%	4%	1%	0%	3%	6%	4%
Psycho-Therapy	7	5	3	17	8	12	0	0	0	6
Medical & Psychotherapy	53	40	31	29	29	35	0	3	9	28
Medical, Psychotherapy & Electroshock	0	0	2	0	0	0	0	0	0	1
No Follow-up	33	48	62	54	59	52	100	94	85	62
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Of those for whom follow-up was recommended (48%), 38% actually received follow-up. A significantly higher percentage of upper class patients diagnosed as psychotic received some type of follow-up as compared to the middle and lower classes. More specifically, some form of psychotherapy was chosen as a treatment method for a significantly higher percentage of upper class patients (60%) as compared to middle (45%) and lower class (36%) patients. There was little difference between classes for those diagnosed as neurotic in the use of psychotherapy as a follow-up treatment method.

A higher percentage of upper class patients than middle or lower class patients received strictly medical follow-up; however, the lower class was the only group receiving electroshock on an out-patient basis. For those diagnosed as neurotic there was little difference between classes, however a larger percentage of middle than upper or lower classes received strictly medical follow-up. No class received electroshock on an out-patient basis.

TABLE 18

FOLLOW-UP CONTACTS BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS EXPRESSED IN PERCENTAGES

No. of Follow-up Contacts	Diagnosis									
	Class									Percentage of Total Population
	Psychosis			Neurosis			Organic			
	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	
1-4 Times	35%	27%	48%	73%	63%	59%	61%	50%	100%	49%
5-8 Times	30	37	35	0	13	19	13	0	0	24
9-12 Times	10	22	13	18	9	11	0	50	0	13
13-16 Times	10	2	0	0	3	0	13	0	0	3
17-20 Times	0	8	0	9	3	3	0	0	0	4
21 or more Times	15	4	4	0	9	8	13	0	0	7
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

For those diagnosed as psychotic, a higher percentage of upper class patients (25%) received more follow-up contacts as compared to either the middle (14%) and lower (4%) classes, respectively. For those diagnosed as neurotic, there was little significant difference between classes.

TABLE 19

LENGTH OF FOLLOW-UP TREATMENT BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS EXPRESSED IN PERCENTAGES

Length of Follow-up in Months	Diagnosis									Percentage of Total Population
	Class									
	Psychosis			Neurosis			Organic			
	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	
0-2	25%	13%	26%	55%	53%	45%	0%	50%	20%	34%
3-5	30	20	17	18	13	16	0	0	20	20
6-8	10	13	14	9	3	11	0	50	0	11
9 & over	15	9	17	0	3	14	0	0	0	9
Continuing	20	44	26	18	28	14	0	0	60	26
Total %	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%

A higher percentage of upper class patients (55%) diagnosed as psychotic, received fewer follow-up contacts than either the middle (33%) or lower (43%) class patients. The same trend is apparent for those diagnosed as neurotic: upper class, 73%; middle class, 66%; lower class, 61%. A smaller percentage of the middle class patients diagnosed as psychotic (22%) than either the lower class patients (31%) and the upper class patients (25%) received six or more follow-up contacts. The same situation is found for those patients diagnosed as neurotic: middle class, 6%; upper class, 9%; lower class, 24%. We cannot consider those continuing follow-up treatment, as we have no idea as to the actual number of contacts. For example, some patients may have just started follow-up treatment at the time of our data collection, whereas others may have been receiving treatment for a long period of time.

TABLE 20

PERCENTAGE OF PATIENTS RE-ADMITTED AND LENGTH OF TIME BETWEEN DISCHARGE AND RE-ADMISSION BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS

Length of Time Between Discharge & Re-admission by Months	Diagnosis									Percentage of Total Population
	Class									
	Psychosis			Neurosis			Organic			
	Upper	Middle	Lower	Upper	Middle	Lower	Upper	Middle	Lower	
0-3	6%	9%	8%	4%	15%	10%	0%	3%	3%	9%
4-7	13	7	5	0	1	5	0	3	3	5
8 & Over	6	4	1	0	0	1	0	0	0	2
No Re-admission	75	80	86	96	84	84	100	94	94	84
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

During the time period of our study only 16% of our total population were re-admitted to the Psychiatric Institute. Of those diagnosed as psychotic, a higher percentage of upper class patients were re-admitted than either the middle or lower class patients. However, these upper class patients were re-admitted later than patients from the other two classes. Of those diagnosed as neurotic and as having organic conditions, a higher percentage of patients from the middle and lower classes were re-admitted than from the upper class.

CHAPTER V

CONCLUSIONS

Our hypothesis that a patient's social class will influence the kind of treatment he will receive for psychiatric disorders is supported by much of our data, although certain other factors do not support this relationship.

In examining our sample, our findings indicate that the greater proportion of our hospital population falls within the middle and lower socio-economic classes. The small percentage of upper class patients (12%) could possibly be attributed to the tendency of the upper class people to obtain psychiatric help privately. In a more intensive study of a similar nature, Hollingshead and Redlich found that the upper class is more aware of psychological problems and is more willing to utilize the help of a psychiatrist to overcome self-perceived disturbances. On the other hand, the lower class patients tend to attribute psychological problems to external factors and/or physical causes and it was also found that the worst thing that can happen to a lower class person is to be labelled "bugs, crazy or nuts". As a consequence, Hollingshead and Redlich conclude that far more abnormal behaviour is tolerated by the lower classes and therefore they would be less likely to seek out and utilize the help

of a private psychiatrist until their situation is crucial.[60]

From our interviews with the staff it was learned that the Psychiatric Institute is an acute treatment hospital for patients suffering mainly from psychotic disorders. However, our sample has shown an almost equal distribution of psychotic and neurotic patients.

From our data analysis, the following factors emerge in support of our hypothesis regarding treatment.

Seventy-seven percent of the total population received some form of psychotherapy while hospitalized. However, the number of sessions indicates that this therapy was not a major form of treatment as 84% of those involved in psychotherapy received six sessions or less, while 50% received three sessions or less and only 3% received thirteen or more sessions. From our discussions with the psychiatrists at the Institute we found that much of what we have labelled psychotherapy consists primarily of brief counselling session and/or assessment of prescribed drug therapy. Although there is little variation between the classes regardless of diagnostic category as to number of psychotherapeutic sessions, we have found that a larger proportion of upper class patients received psychotherapy than lower class patients -- 87% of the upper class psychotics as compared to 81% of the lower class psychotics, and 83% of the upper class neurotics as compared to

60. Hollingshead and Redlich, Op. Cit., pp. 172-175.

77% of the lower class neurotics.

Our hypothesis that the lower class patients will receive less service than upper class patients is borne out in the fact that a considerably higher proportion of upper class neurotics (66%) and those diagnosed as having organic conditions (83%) received social work contacts as compared with lower class patients of the same diagnosis (42% and 38% respectively). However, for those diagnosed as psychotic, this relationship is not evident - 57% and 58% respectively.

In discussing follow-up, we will be considering only psychotics as we found little significant difference between classes in those diagnosed as neurotics.

In considering cases for which follow-up was recommended, our hypothesis is borne out for those patients diagnosed as psychotic, in that follow-up was recommended for a significantly higher percentage of upper class (77%) than lower class patients (45%). This could be partially explained to the limited resources available for treatment and the fact that in this situation, psychiatrists will naturally tend to recommend treatment for those whom they feel will benefit the most, i.e. the upper classes or people with verbal skills.[61]

61. James T. McMahon, Op. Cit. pp. 283-302.
Betty Overall and H. Aronson, Op. Cit. pp. 421-430.
Frank Riessman, Jerome Cohen and Arthur Pearl, eds. Op. Cit.
G. J. Sarwer-Foner, Op. Cit.
William Snyder, Op. Cit.
Eugene Gallager, Myron Sharaf and Daniel Levinson, Op. Cit., pp. 297-310.

Our findings that a significantly higher percentage of upper class patients diagnosed as psychotic received some form of follow-up (67%) as compared to 38% of the lower class verifies our hypothesis. Furthermore, psychotherapy was the chosen follow-up treatment for a significantly higher percentage of upper class psychotic patients (60%) than lower class psychotics (36%). Also our findings that a higher percentage of upper class psychotics (25%) received a greater number of follow-up contacts (thirteen or more) as compared to lower class psychotics (4%) further supports our hypothesis.

On the other hand, certain of our findings do not support our hypothesis. We found no significant difference by social class and diagnosis as to use of drug therapy. However, treatment in general at the Psychiatric Institute concentrates heavily on drug therapy as we found that ninety-one percent of the total population received some type of drugs. There is little differentiation by class in type of drug administered.

In considering electroshock as a form of treatment we did not find that relationship which we hypothesized -- that is the lower class is more likely to get organic therapy. However, our findings cannot be conclusive due to the fact that on first admission a relatively small proportion of our population (14%) received electroshock treatments. However, we noted during our data collection that upon readmission a significantly higher proportion of patients received this

form of treatment.

In considering psychological assessments, we found no difference in referral by diagnosis or social class. As confirmed by our interviews with the psychiatrists and psychologists this could possibly be explained by the fact that a psychological referral as we have recorded it, is usually for assessment purposes only and is not part of actual treatment. In regards to hospital therapy we found no significant difference between classes regarding participation. Because of the small number of patients involved we could not draw any conclusions from our data.

In summary, the following factors would seem to support our hypothesis: the upper class patients of the same diagnoses received more psychotherapeutic sessions while hospitalized than lower class patients; more upper class neurotics received social work services than lower class neurotics; follow-up was recommended for a higher percentage of upper class psychotics than lower class psychotics; upper class psychotics received more follow-up contacts than lower class psychotics, and in addition follow-up for this group consisted of psychotherapy more than for the lower classes.

Although we have found evidence for the validity of our hypothesis and lines of reasoning, some of our findings were inconsistent with our expectations. For this reason we feel there may be other relevant factors in operation which we have not considered and therefore recommend further exploratory research in this area.

APPENDIXES

APPENDIX I

I. Questionaires Administered to Hospital Staff and Patients.

PSYCHIATRISTS

1. Does the hospital generally follow a uniform classification in diagnosing mental illness?
2. Do the psychiatrists accept and follow this scale?
3. Do the psychiatrists presently practising at the Psychiatric Institute generally follow a similar pattern of treatment?
    a. If so, would you say that there is a general philosophy of treatment for the hospital as a whole?
    b. If not, does the hospital verbally adhere to a general philosophy of treatment?
4. What factors are involved in determining the type of treatment for a given diagnosis (e.g. patient's motivation, ability to verbalize and follow treatment)?
5. How are patients assigned to a particular psychiatrist? Is a team approach used?
6. Are cases conferenced during treatment? For what purpose?
7. When would a patient be referred to a psychologist? How frequently do you refer (frequently, seldom, etc.)?
8. Are patients referred to the Social Service Department?
9. What do you see is the role of the social worker?
10. Are patients followed up after discharge?

10. Do you have any policies about patients who refuse to be followed?
11. Do you feel the patients treated are representative of the various social classes? Is any class over-represented?
12. We are interested to know approximately what proportion of the psychiatrist's time is spent interviewing patients and what other activities are performed by the psychiatrist?
13. What is the connection between the Winnipeg General Hospital and the Psychiatric Institute?

PSYCHOLOGISTS

1. What is the role of the Psychology Department at the Psychiatric Institute?
2. What types of treatment are you involved in? (e.g. hypnosis, behavior modification, family therapy, psychotherapy)
3. What is the basis of referring to the Department? Are referrals strictly from the hospital?
4. Is the Psychology Department involved in ward group activities? What is the nature of the involvement?
5. Is your Department part of the diagnostic and treatment teams?
6. What is your relationship to the psychiatrists?
7. Are you involved in follow-up? Do you treat patients on an out-patient basis other than regular follow-up?
8. Do you feel the patients you treat are representative of the various social classes? Is any class over-represented?

SOCIAL SERVICE DEPARTMENT

1. What is the role of the Social Service Department at the Psychiatric Institute?
2. What is the basis of referring to the Department?
3. Specifically, what is the focus of the Department?
4. Is a social history obtained for every patient referred?
5. How is a history obtained in the hospital? From whom and by whom?
6. Is any type of family therapy initiated by Social Services?
7. Is Social Services involved in ward group activity? (e.g. Young Adults, Occupational Therapy) What is the nature of the involvement?
8. Is Social Services involved on the ward in any other way?
9. What do you see is the role of the psychiatrist?
10. Is a team approach used in the Institute?
11. Do you feel the patients treated are representative of the various social classes? Is any class over-represented?

NURSING STAFF

1. What is the role of the psychiatric nurse?
2. What is the responsibility of the psychiatric nurse re:
    a. organized group activities
    b. progress notes on patients?
3. What is the nature of the relationship to
    a. psychiatrists
    b. social workers?
4. Do you feel the patients treated are representative of the various social classes? Is any class over-represented?

IN-PATIENTS

1. Could you describe a typical day in the hospital?
2. What activities are available to you?
3. What activities do you participate in? (If none, why not?)
4. What other activities would you like to see available?
5. How often do you see your Doctor? Do you think you see him often enough?
6. Do you have a social worker in the hospital?
7. How long have you been in the hospital? Have you ever been here before?

APPENDIX II

Blishen's Socio-Economic Class Index

Occupation	Socio-Economic Index
Chemical Engineers	76.69
Dentists	76.44
Professors and College Principals	76.01
Physicians and Surgeons	75.57
Geologists	75.49
Mining Engineers	75.42
Lawyers and Notaries	75.41
Civil Engineers	75.16
Architects	74.52
Veterinarians	74.46
Electrical Engineers	74.34
Professional Engineers, n.e.s.	74.27
Physicists	73.81
Optometrists	73.77
Biological Scientists	73.22
Physical Scientists, n.e.s.	72.94
Pharmacists	72.87
Mechanical Engineers	72.78
Judges and Magistrates	72.24
Economists	71.90
Chemists	70.94
Industrial Engineers	70.43
Osteopaths and Chiropractors	70.25
School Teachers	70.14
Accountants and Auditors	68.80
Owners and Managers, Education and Related Services	68.32
Actuaries and Statisticians	67.78
Computer Programmers	67.50
Owners and Managers, Services to Business Management	67.28
Agricultural Professionals, n.e.s.	66.96
Owners and Managers, Chemical and Chemical Products Industries	66.79
Advertising Managers	66.05
Air Pilots, Navigators and Flight Engineers	66.04
Owners and Managers, Electrical Products Industries	65.78
Owners and Managers, Primary Metal Industries	65.29
Owners and Managers, Paper and Allied Industries	64.78
Owners and Managers, Finance, Insurance, Real Estate	64.52

APPENDIX II

2.

Occupation	Socio-Economic Index
Authors, Editors, Journalists	64.23
Owners and Managers, Rubber Industries	64.09
Owners and Managers, Machinery Industries	63.76
Librarians	63.75
Owners and Managers, Petroleum and Coal Products Industries	63.02
Sales Managers	62.04
Owners and Managers, Mines, Quarries, and Oil Wells	61.99
Owners and Managers, Textile Industries	61.96
Owners and Managers, Transportation Equipment Industries	61.75
Professional Occupations, n.e.s.	60.93
Credit Managers	60.81
Office Managers	60.42
Owners and Managers, Health and Welfare Services	60.07
Security Salesmen and Brokers	59.91
Radio and Television Announcers	59.81
Owners and Managers, Printing, Publishing and Allied Industries	59.69
Owners and Managers, Federal Administration	59.60
Owners and Managers, Knitting Mills	59.28
Clergymen and Priests	59.20
Owners and Managers, Miscellaneous Manufacturing Industries	58.29
Other Health Professionals	58.27
Artists (except commercial), Art Teachers	58.21
Inspectors and Foremen Communication	58.17
Draughtsmen	57.82
Owners and Managers, Metal Febricating Industries	57.60
Owners and Managers, Leather Industries	57.23
Social Welfare Workers	55.62
Owners and Managers, Non-metallic Mineral Prod. Industries	55.41
Advertising Salesmen and Agents	55.37
Purchasing Agents and Buyers	55.22
Insurance Salesmen and Agents	55.19
Owners and Managers, Clothing Industries	54.77
Science and Engineering Technicians, n.e.s.	54.75
Brokers, Agents and Appraisers	54.74
Owners and Managers, Provincial Administration	54.54
Artists, Commercial	54.06
Owners and Managers, Transportation, Communication, and other Utilities	53.85
Owners and Managers, Wholesale Trade	53.80
Owners and Managers, Local Administration Surveyors	53.25

APPENDIX II

Occupation	Socio-Economic Index
Commercial Travellers	52.68
Owners and Managers, Furniture and Fixtures Industries	52.11
Teachers and Instructors, n.e.s.	52.07
Stenographers	51.96
Owners and Managers, Food and Beverage Industries	51.70
Radio and Television Equipment Operators	51.51
Physical and Occupational Therapists	51.11
Athletes and Sports Officials	51.11
Musicians and Music Teachers	50.93
Nurses-in-training	49.91
Bookkeepers and Cashiers	49.55
Funeral Directors and Embalmers	49.47
Foremen, Transportation Equipment Industries	49.21
Foremen, Primary Metals Industries	49.11
Real Estate Salesmen and Agents	48.74
Medical and Dental Technicians	48.56
Photoengravers	48.26
Photographers	48.07
Engravers, except Photoengravers	47.95
Ticket, Station and Express Agents, Transport	47.61
Batch and Continuous Still Operators	47.60
Office Appliance Operators	47.12
Owners and Managers, Construction Industries	46.95
Foremen, Electric Power, Gas and Water Utilities	46.75
Power Station Operators	46.20
Locomotive Engineers	45.99
Conductors, Railroad	45.68
Owners and Managers, Wood Industries	45.52
Owners and Managers, Miscellaneous Services	45.48
Foremen, Paper and Allied Industries	45.36
Owners and Managers, Motion Picture and Re-creational Services	45.19
Linemen and Servicemen -- Telephone, Telegraph and Power	45.05
Foremen, Other Manufacturing Industries	45.01
Lithographic and Photo-offset Occupations	45.00
Toolmakers, Diemakers	44.82
Inspectors, Construction	44.76
Interior Decorators and Window Dressers	44.37
Foremen, Trade	44.32
Foremen, Mine, Quarry, Petroleum Well	44.27
Telephone Operators	44.20

APPENDIX II 4.

Occupation	Socio-Economic Index
Owners and Managers, Forestry, Logging	44.00
Actors, Entertainers, and Showmen	43.85
Owners and Managers, Retail Trade	43.69
Mechanics and Repairmen, Office Machines	43.05
Clerical Occupations, n.e.s.	42.98
Mechanics and Repairmen, Aircraft	42.76
Nurses, Graduate	42.57
Compositors and Type-Setters	42.30
Deck Officers, Ship	42.13
Religious Workers	41.84
Members of Armed Forces*	41.43
Locomotive Firemen	40.92
Electricians, Wiremen, and Electrical Repairmen	40.68
Auctioneers	40.48
Canvassers and Other Door-to-Door Salesmen	40.23
Brakemen, Railroad	40.22
Paper Makers	40.17
Owners and Managers, Personal Services	40.14
Printing Workers, n.e.s.	40.13
Mechanics and Repairmen, Radio and T.V. Receivers	40.12
Photographic Processing Occupations	40.05
Engineering Officers, Ship	39.86
Millwrights	39.83
Inspectors, Graders and Samplers, n.e.s.	39.82
Inspectors, Examiners, Gaugers--Metal	39.76
Patternmakers (except paper)	39.75
Typists and clerk typists	39.66
Postmasters	39.65
Well-Drillers and Related Workers	39.55
Foremen, All Other Industies	39.54
Pressmen, Printing	39.49
Telegraph Operators	39.37
Inspectors and Foremen, Transport	39.21
Projectionists, Motion Picture	39.15
Foremen, Textile and Clothing Industries	39.03
Lens Grinders and Polishers; Opticians	38.82
Bookbinders	38.54
Foremen, Food and Beverage Industries	38.21
General Foremen, Construction	37.90
Operators, Electric Street Railway	37.80

* Includes Commissioned Officers, Armed Forces; and Other Ranks Armed Forces.

APPENDIX II

Occupation	Socio-Economic Index
Stationary Enginemen	37.79
Rolling Mill Operators	37.76
Chemical and Related Process Workers	37.75
Prospectors	37.73
Foremen, Wood and Furniture Industries	37.63
Sales Clerks	37.14
Machinists and Machine Tool Setters	36.90
Jewellers and Watchmakers	36.55
Civilian Protective Service Occupations++	35.80
Stewards	35.32
Farm Managers and Foremen	35.05
Other Occupations in Bookbinding	34.97
Baggagemen and Expressmen, Transport	34.85
Metal Treating Occupations, n.e.s.	34.79
Mechanics and Repairmen, n.e.s.	34.77
Riggers and Cable Splicers, except Telephone and Telegraph and Power	34.77
Furnacemen and Heaters--Metal	34.75
Cellulose Pulp Preparers	34.69
Stock Clerks and Storekeepers	34.63
Logging Foremen	34.61
Beverage Processors	34.44
Plumbers and Pipefitters	34.38
Heat Treaters, Annealers, Temperers	34.09
Paper Making Occupations, n.e.s.	34.07
Hoistmen, Cranemen, Derrickmen	34.06
Inspectors, Graders, Scalers--Log and Lumber	33.80
Electrical and Electronics Workers, n.e.s.	33.80
Switchmen and Signalmen	33.76
Fitters and Assemblers--Electrical and Electronics Equipment	33.57
Sheet Metal Workers	33.49
Metal Drawers and Extruders	33.40
Miners	33.38
Bartenders	33.29
Insulation Appliers	33.22
Roasters, Cookers and Other Heat Treaters, Chemical	33.14
Furriers	33.06
Boilermakers, Platers and Structural Metal Workers	32.93
Welders and Flame Cutters	32.79
Timbermen	32.61

++Includes Firemen, Fire Protection; Policemen and Detectives; and Guards, Watchmen, n.e.s.

APPENDIX II

Occupation	Socio-Economic Index
Tire and Tube Builders	32.34
Fillers, Grinders, Sharpeners	32.18
Service Workers, n.e.s.	32.17
Nursing Assistants and Aides	32.14
Shipping and Receiving Clerks	32.14
Millmen	32.13
Bus Drivers	31.86
Forest Rangers and Cruisers	31.85
Metal Working Machine Operators	31.67
Quarriers and Related Workers	31.61
Moulders	31.32
Porters, Baggage and Pullman	31.30
Mechanics and Repairmen, Motor Vehicle	31.30
Mechanics and Repairmen, Railroad Equipment	31.29
Fitters and Assemblers -- Metal	31.28
Crushers, Millers, Calenderers -- Chemical	31.12
Electroplaters, Dip Platers and Related Workers	31.07
Cutters, Markers -- Textiles; Garment and Glove Leather	31.06
Production Process and Related Workers, n.e.s.	31.00
Lodging and Boarding Housekeepers	30.94
Barbers, Hairdressers, and Manicurists	30.94
Cabinet and Furniture Makers, Wood	30.88
Driver -- Salesmen	30.74
Labourers, Primary Metal Industries	30.68
Metalworking Occupations, n.e.s.	30.60
Deck Ratings (ship), Barge Crews and Boatmen	30.56
Paper Products Makers	30.53
Postmen and Mail Carriers	30.52
Service Station Attendants	30.48
Butchers and Meat-cutters	30.48
Meat Canners, Curers, Packers	30.48
Motormen (vehicle) (except railway)	30.48
Waiters	30.47
Hawkers and Peddlars	30.43
Oilers and Greasers--Machinery and Vehicles (except ship)	30.43
Tobacco Preparers and Products Makers	30.39
Upholsters	30.27
Tailors	30.26
Labourers, Trade	30.19
Bleachers and Dyers -- Textiles	30.18
Painters (Construction and Maintenance), Paperhangers and Glaziers	30.08

APPENDIX II

Occupation	Socio-Economic Index
Taxi Drivers and Chauffeurs	30.07
Operators of Earth-Moving and Other Construction Machinery	30.03
Painters (except Construction and Maintenance)	30.00
Coremakers	30.00
Baby Sitters	29.99
Labourers, Mine	29.96
Blacksmiths, Hammermen, Forgemen	29.93
Bricklayers, Stonemasons, Tilesetters	29.93
Attendants, Recreation and Amusement	29.92
Plasterers and Lathers	29.90
Other Food Processing Occupations	29.89
Bottlers, Wrappers, Labellers	29.80
Clay, Glass and Stone Workers, n.e.s.	29.77
Materials -- Handling Equipment Operators	29.76
Labourers, Paper and Allied Industries	29.73
Carpenters	29.71
Vulcanizers	29.62
Fruit and Vegetable Canners and Packers	29.60
Other Rubber Workers	29.51
Labourers, Communication and Storage	29.51
Milk Processors	29.49
Cooks	29.43
Construction Workers, n.e.s.	29.43
Longshoremen and Stevedores	29.41
Truck Drivers	29.31
Gardeners (except farm) and Groundskeepers	29.27
Bakers	29.26
Labourers, Electric Power, Gas and Water Utilities	29.26
Messengers	29.23
Warehousemen and Freight Handlers	29.18
Polishers and Buffers -- Metal	29.12
Boiler Firemen (except ship)	29.10
Labourers, All Other Industries	28.96
Launderers and Dry Cleaners	28.93
Other Agricultural Occupations	28.93
Dressmakers and Seamstresses	28.77
Riveters and Rivet-Heaters	28.76
Millers of Flour and Grain	28.75
Furnacemen and Kilnmen, Ceramics and Glass	28.69
Knitters	28.68
Transport Occupations, n.e.s.	28.63
Labourers, Other Public Administration and Defence	28.61

APPENDIX II

Occupation	Socio-Economic Index
Woodworking Occupations, n.e.s.	28.56
Stone Cutters and Dressers	28.52
Apparel and Related Products Makers	28.44
Tanners and Tannery Operatives	28.42
Sawyers	28.29
Woodworking Machine Operators	28.29
Labourers, Other Manufacturing Industries	28.22
Janitors and Cleaners, Building	28.22
Labourers, Food and Beverage Industries	28.12
Kitchen Helpers and Related Service Workers	28.11
Engine-Room Ratings, Firemen and Oilers, Ship	28.11
Newsvendors	28.08
Labourers, Railway Transport	28.03
Finishers and Calenderers	27.97
Elevator Tenders, Building	27.96
Shoemakers and Repairers, Not in Factory	27.87
Sewers and Sewing Machine Operators	27.87
Cement and Concrete Finishers	27.86
Guides	27.79
Farm Labourers	27.77
Labourers, Transportation, except Railway	27.72
Labourers, Wood Industries	27.57
Labourers, Transportation Equipment Industries	27.49
Other Textile Occupations	27.44
Carders, Combers and Other Fibre Preparers	27.37
Labourers, Construction	27.25
Other Leather Products Makers	27.19
Fishermen	27.17
Leather Cutters	27.10
Loom-Fixers and Loom-Preparers	27.09
Lumbermen, including Labourers in Logging	27.01
Spinners and Twisters	26.94
Weavers	26.77
Teamsters	26.71
Labourers, Local Administration	26.71
Winders and Reelers	26.63
Sectionmen and Trackmen	26.57
Labourers, Textile and Clothing Industries	26.56
Shoemakers and Repariers -- In Factory	26.56
Fish Canners, Curers, and Packers	26.09
Trappers and Hunters	25.36

APPENDIX II

Blishen's Socio-Economic Class Divisions

Classes	Socio-Economic Index
Class 6	70.00 ǂ
Class 5	60.00 - 69.99
Class 4	50.00 - 59.99
Class 3	40.00 - 49.99
Class 2	30.00 - 39.99
Class 1	Below 30.00

ǂ Bernard Blishen, "A Socio-Economic Index for Occupations", Canadian Society: Sociological Perspectives, (3rd edition), Bernard Blishen, Frank Jones, Kasper Naegele, John Porter (Eds.). (Toronto: MacMillan of Canada, 1971) p. 499-506.

APPENDIX III

DISTRIBUTION TABLES

TABLE 21

DISTRIBUTION OF POPULATION BY SOCIAL CLASS (N = 504)

Social Class	Distribution
Upper	61
Middle	200
Lower	175
Unknown	68
Total	504

TABLE 22

DISTRIBUTION OF AGE LEVELS BY SOCIAL CLASS (N = 504)

Age Group	Social Class				Total
	Upper	Middle	Lower	Unknown	
Under 15	3	5	4	4	16
15-24	19	59	54	27	159
25-34	12	32	37	14	95
35-44	10	35	20	6	71
45-54	5	23	19	4	51
55-64	4	9	8	2	23

TABLE 22--Continued

	Social Class				
Age Group	Upper	Middle	Lower	Unknown	Total
65-74	3	22	13	8	46
75+	5	15	20	3	43
Total	61	200	175	68	504

TABLE 23

DISTRIBUTION OF PERSONS IN VARIOUS ETHNIC GROUPS BY SOCIAL CLASS (N = 504)

	Social Class				
Ethnic Group	Upper	Middle	Lower	Unknown	Total
British Isles	22	61	38	12	133
French	4	19	18	8	49
Other Western European	8	27	18	2	55
Northern European	1	10	4	2	17
Southern European	0	2	2	0	4
Eastern European	8	24	34	5	71
Asiatic	0	3	0	1	4
Native Indian, Eskimo & Metis	0	9	18	12	39
Other and not Stated	18	45	43	26	132
Totals	61	200	175	68	504

TABLE 24

DISTRIBUTION OF TYPE OF ADMISSION BY SOCIAL CLASS (N = 504)

	Social Class				
Type of Admission	Upper	Middle	Lower	Unknown	Total
Voluntary	26	84	53	23	186
Compulsory	21	78	73	29	201
Unknown	14	38	49	16	117
Totals	61	200	175	68	504

TABLE 25

DISTRIBUTION OF DIAGNOSIS BY SOCIAL CLASS (N = 504)

	Social Class				
Diagnosis	Upper	Middle	Lower	Unknown	Total
Psychoses	30	86	62	23	201
Neuroses	24	80	75	29	208
Organic Conditions	6	30	34	12	82
Undiagnosed	1	4	4	4	13
Totals	61	200	175	68	504

TABLE 26

LENGTH OF STAY IN HOSPITAL BY DIAGNOSTIC CATEGORY
AND SOCIAL CLASS (N = 504)

Length of Stay in Hospital	Diagnosis																				
	Psychosis					Neurosis					Organic Conditions					Undiagnosed					
	Social Class																				
	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
0-1 Week	7	16	11	8	42	8	33	29	16	86	0	4	6	3	13	0	2	2	2	6	147
2-3 Weeks	10	37	32	10	89	7	35	31	8	81	3	10	7	6	26	0	2	1	1	4	200
4-5 Weeks	12	20	13	3	48	7	10	12	4	33	2	5	13	0	20	0	0	1	0	1	102
6-7 Weeks	0	9	2	1	12	2	2	2	1	7	1	6	5	2	14	0	0	0	1	1	34
8 or more Weeks	1	4	4	1	10	0	0	1	0	1	0	5	3	1	9	1	0	0	0	1	21
Total	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 27

DISTRIBUTION OF TYPE OF DRUG BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

Type of Drug	Diagnosis																				
	Psychoses					Neuroses					Organic					Undiagnosed					
	Social Class																				
	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
Neuroleptics	24	67	47	15	153	12	27	20	6	65	6	13	16	4	39	0	1	2	1	4	261
Tranquilizers (Sedatives)	1	8	2	0	11	6	23	21	6	66	0	11	4	3	18	0	2	1	1	4	89
Anti-Depressants	4	7	3	1	15	3	12	8	3	26	0	1	3	0	4	0	0	0	0	0	45
Stimulants	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other and Unknown	0	3	5	3	11	0	8	15	7	30	0	5	8	4	17	0	1	1	1	3	61
No Drugs	0	1	5	4	10	3	10	11	7	31	0	0	3	1	4	1	0	0	1	2	47
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 28

DISTRIBTUION OF ELECTROSHOCK TREATMENTS BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

	Diagnoses																				
	Psychoses					Neurosis					Organic					Undiagnosed					
	Social Class																				
Number of Electro-Shock Treatments	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
1-3 Times	3	7	7	2	19	1	0	2	0	3	1	0	0	0	1	0	0	0	0	0	23
4-6 Times	5	15	8	2	30	2	0	1	0	3	0	2	0	0	2	0	0	0	0	0	35
7 and Over	3	5	5	1	14	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	15
No Treatments	19	59	42	18	138	21	79	72	29	201	5	28	34	12	79	1	4	4	4	13	431
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 29

LENGTH BEFORE ELECTROSHOCK WAS GIVEN BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 73)

	Diagnoses																				
	Psychoses					Neuroses					Organic					Undiagnosed					
	Social Class																				
Length Before Electroshock	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
1-3 Days	4	0	3	1	8	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	9
4-6 Days	1	6	6	1	14	0	1	1	0	2	0	1	0	0	1	0	0	0	0	0	17
7-9 Days	3	6	3	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12
10-12 Days	1	3	3	3	10	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	12
12 & Over	2	12	5	0	19	2	0	0	0	2	1	1	0	0	2	0	0	0	0	0	23
Totals	11	27	20	5	63	3	1	3	0	7	1	2	0	0	3	0	0	0	0	0	73

TABLE 30

DISTRIBUTION OF PSYCHOTHERAPEUTIC SESSIONS BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

	Diagnosis																				
	Psychoses					Neuroses					Organic					Undiagnosed					
	Social Class																				
Number of Psychotherapy Sessions	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
1-3 Times	10	30	20	7	67	11	37	33	17	98	1	7	15	3	26	1	2	1	1	5	196
4-6 Times	10	27	18	1	56	6	24	19	3	52	5	10	4	4	23	0	0	0	1	1	132
7-9 Times	2	10	8	1	21	1	4	3	0	8	0	5	1	1	7	0	1	0	0	1	37
10-12 Times	4	3	3	0	10	1	1	1	0	3	0	1	0	1	2	0	0	0	0	0	15
13 & Up	0	0	1	1	2	1	2	2	0	5	0	2	2	0	4	0	0	0	0	0	11
No Sessions	4	16	12	13	45	4	12	17	9	42	0	5	12	3	20	0	1	3	2	6	113
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 31

DISTRIBUTION OF PATIENTS RECEIVING STUDENT HISTORY
BY SOCIAL CLASS (N = 504)

	Social Class				
Student History	Upper	Middle	Lower	Unknown	Total
Yes	19	79	57	21	176
No	42	121	118	47	328
Totals	61	200	175	68	504

TABLE 32

DISTRIBUTION OF RESPONDENTS RECEIVING SOCIAL WORK CONTACT BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

	Diagnosis																				
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
Social Work Contact	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
Yes	17	50	36	5	108	16	38	32	5	91	5	14	13	6	38	0	1	0	2	3	240
No	13	36	26	18	93	8	42	43	24	117	1	16	21	6	44	1	3	4	2	10	264
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 33

DISTRIBUTION OF RESPONDENTS REFERRED TO PSYCHOLOGY BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

	Diagnosis																				
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
Psychological Referral	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
Yes	6	10	12	2	30	7	18	18	8	51	0	4	2	2	8	0	0	1	2	3	92
No	24	76	50	21	171	17	62	57	21	157	6	26	32	10	74	1	4	3	2	10	412
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 34

DISTRIBUTION OF RESPONDENTS TAKING PART IN HOSPITAL THERAPY
BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

	Diagnosis																				
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
Hospital Therapy	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
Occupational Therapy																					
Yes	0	0	3	1	4	3	2	1	0	6	0	0	0	0	0	0	0	0	0	0	10
No	30	86	59	22	197	21	78	74	29	202	6	30	34	12	82	1	4	4	4	13	494
Alcoholic Program																					
Yes	0	2	0	0	2	3	12	10	2	27	0	0	0	1	1	0	0	0	0	0	30
No	30	84	62	23	199	21	68	65	27	181	6	30	34	11	81	1	4	4	4	13	474
Young Adult Program																					
Yes	2	4	5	3	14	2	9	7	4	22	0	0	1	0	1	0	0	0	0	0	37
No	28	82	57	20	187	22	71	68	25	186	6	30	33	12	81	1	4	4	4	13	467
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12		1	4	4	4		504

TABLE 35

DISPOSITION OF PATIENTS BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

Disposition	Diagnosis: Psychosis					Neurosis					Organic					Undiagnosed					Totals
Social Class	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	
Home	23	59	32	11	125	19	65	51	19	154	1	8	8	5	22	0	1	2	2	5	306
Nursing Home	1	2	1	1	5	0	2	0	0	2	2	8	14	1	25	0	0	0	0	0	32
Mental Hospitals	2	17	23	7	49	3	1	2	2	8	3	11	7	3	24	1	0	1	0	2	83
General Hospitals	2	0	1	0	3	0	0	1	1	2	0	1	0	0	1	0	1	0	0	1	7
Prison, Police Hold or Detension Home	0	0	2	0	2	0	3	7	2	12	0	0	0	1	1	0	1	0	1	2	17
Death	0	1	0	0	1	0	0	0	0	0	0	0	2	1	3	0	0	0	0	0	4
Against Medical Advice	2	4	2	3	11	1	4	7	5	17	0	0	0	0	0	0	1	1	1	3	31
Other Institutions	0	3	1	1	5	1	5	7	0	13	0	2	3	1	6	0	0	0	0	0	24
Totals	30	86	62	23	206	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 36

DISTRIBUTION OF RESPONDENTS FOR WHICH FOLLOW-UP WAS RECOMMENDED BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

	Diagnosis																				
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
Recommended Follow-up	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
Yes	23	48	28	7	106	14	46	45	12	117	0	3	6	5	14	0	0	2	2	4	241
No	7	38	34	16	95	10	34	30	17	91	6	27	28	7	68	1	4	2	2	9	263
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 37

TYPE OF FOLLOW-UP BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

	Diagnosis																				
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
Type of Follow-up	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
Medical	2	6	1	0	9	0	3	1	1	5	0	1	2	1	4	0	0	1	0	1	19
Psycho-Therapy	2	4	2	1	9	4	6	9	2	21	0	0	0	1	1	0	0	0	1	1	32
Medical & Psychotherapy	16	35	19	3	73	7	23	26	5	61	0	1	3	2	6	0	0	1	0	1	141
Medical, Psychotherapy & Electroshock	0	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
No Follow-up	10	41	39	18	108	13	48	39	21	121	6	28	29	8	71	1	4	2	3	10	310
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

TABLE 38

DISTRIBUTION OF NUMBER OF FOLLOW-UP CONTACTS BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 194)

	Diagnosis																				
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
No. of Follow-up Contacts	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
1-4 Times	7	12	11	2	32	8	20	21	5	54	0	1	2	4	7	0	0	1	1	2	95
5-8 Times	6	16	8	3	33	0	4	7	1	12	0	0	1	0	1	0	0	0	0	0	46
9-12 Times	2	10	3	0	15	2	3	4	0	9	0	1	0	0	1	0	0	1	0	1	26
13-16 Times	2	1	0	0	3	0	1	0	1	2	0	0	1	0	1	0	0	0	0	0	6
17-20 Times	0	4	0	0	4	1	1	1	0	3	0	0	0	0	0	0	0	0	0	0	7
21 or More Times	3	2	1	0	6	0	3	3	1	7	0	0	1	0	1	0	0	0	0	0	14
Totals	20	45	23	5	83	11	32	36	8	87	0	2	5	4	11	0	0	2	1	3	194

TABLE 39

LENGTH OF FOLLOW-UP TREATMENT BY DIAGNOSTIC CATEGORY
AND SOCIAL CLASS (N = 194)

	Diagnosis																				
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
Length of Follow-up in Months	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Totals
0-2	5	6	6	1	18	6	17	16	4	43	0	1	1	3	5	0	0	0	0	0	66
3-5	6	9	4	1	20	2	4	6	2	14	0	0	1	1	2	0	0	1	1	2	38
6-8	2	6	3	2	13	1	1	4	1	7	0	1	0	0	1	0	0	0	0	0	21
9 & Over	3	4	4	0	11	0	1	5	1	7	0	0	0	0	0	0	0	0	0	0	18
Continuing	4	20	6	1	31	2	9	5	0	16	0	0	3	0	3	0	0	1	0	1	51
Totals	20	45	23	5	93	11	32	36	8	87	0	2	5	4	11	0	0	2	1	3	194

TABLE 40

DISTRIBUTION OF RE-ADMISSION AND LENGTH OF TIME BETWEEN DISCHARGE AND RE-ADMISSION BY DIAGNOSTIC CATEGORY AND SOCIAL CLASS (N = 504)

Length of Time Between Discharge & Re-admission by Months	Diagnosis																				Totals
	Psychosis					Neurosis					Organic					Undiagnosed					
	Social Class																				
	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	Upper	Middle	Lower	Unknown	Total	
0-3	2	8	5	2	17	1	12	8	1	22	0	1	1	1	3	0	1	0	0	1	43
4-7	4	6	3	1	14	0	1	4	1	6	0	1	1	1	3	0	0	0	1	1	24
8 & Over	2	3	1	0	6	0	0	1	3	4	0	0	0	0	0	0	0	0	0	0	10
No Re-admission	22	69	53	20	164	23	67	62	24	176	6	28	32	10	76	1	3	4	3	11	427
Totals	30	86	62	23	201	24	80	75	29	208	6	30	34	12	82	1	4	4	4	13	504

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