SOCIAL FACTORS AND COMMUNICATION IN PSYCHIATRIC PATIENTS

I: Choice and Results of Therapy - Max Pollack Ph.D.

II: Duration of Hospitalization and Diagnosis - Robert L. Kahn Ph.D.

III: Observations in an Interview Setting - Joseph Jaffe M.D.

From the Department of Experimental Psychiatry, Hillside Hospital, Glen Oaks, L.I., N.Y.

Presented October 19, 1958, at Hillside Hospital.

III: 9-29-58

Social Factors and Communication in Psychiatric Patients

I: Choice and Results of Therapy

Recent investigations by Hollingshead, Redlich, Frank, Levinson and others have indicated a relationship between social class and psychiatric disorder with respect to type and incidence of mental illness, selection and maintenance of treatment and therapeutic outcome. The present report is concerned with the role of social factors in the selection and efficacy of therapy in Hillside Hospital.

The most intensive analysis of the relationship of social class to mental illness has been recently reported by Hollingshead, Redlich and their co-workers. In their studies the population of New Haven was divided into five social classes on the basis of weighted criteria of education, occupation and place of residence. Of the residents who were under psychiatric care, those from the upper social classes were more frequently treated with psychotherapy, while organic treatment or custodial care was more common among the lower classes. Of the psychotherapies, psychoanalysis was entirely restricted to the two upper groups. Social class was the predominant determinant of the type of treatment selected even when the diagnosis was held constant. They summarize their observations as follows: ".... it is found that treatment does not depend on psychological and medical determinants alone, but on the status position of the patient as well. Psychotherapeutic methods are applied in disproportionately high degree to the upper social levels. The data of this study would seem to indicate that most

psychotherapy takes place in a setting where the background of the patient is similar to that of the therapist."

It is possible, however, to relate the results obtained from these community studies to such selective factors as the patient's financial resources or the extent and type of treatment facilities available. A more critical test of the importance of social factors affecting choice of treatment would be in a setting where the same therapeutic techniques and services are available to all patients, regardless of their ability to pay.

This requirement is met at Hillside Hospital. One of the main criteria for accepting patients is their "ability to participate profitably in psychotherapy." Individual psychoanalytically oriented psychotherapy is regarded as the primary method of treatment with organic therapies available when needed. Thus a patient is seen in regular therapeutic sessions throughout his hospital stay even when undergoing a course of somatic therapy. The average length of hospital stay is six months, with some patients remaining from 12 to 16 months.

The purpose of the present report is to summarize the relation between the factors of age, education, place of birth, and social attitude (as measured by the California F scale) to the selection of treatment and the ratings of improvement at time of discharge in this environment.

Population: The entire in-patient adult population of March 7, 1957 was studied. This consisted of 171 patients, 57 men and 114 women, ranging in age from 16 to 68 years, with a mean of 35 years.

Procedure: The patients were tested with a ten-item modification of the California F scale suggested by Levinson. The F scale is a questionnaire which has been related to such factors as authoritarianism, acquiescence, ethnocentrism and rigidity. The patient reads ten statements and indicates whether he agrees or disagrees with each statement and to what extent. The score given for each item ranges from one to seven and the total score range is 10 to 70. The greater the agreement the higher the score obtained. The statements themselves are extreme, uncritical or stereotyped expressions. For example, one of the statements is: "If people would talk less and work more, everybody would be better off."

Choice of Therapy:

We will first take up the relation of these social and psychological factors to selection for treatment. During the period of this study, (Table I) approximately one-third of the patients received convulsive therapy and two-thirds were treated with psychotherapy only. The small group of patients who received insulin coma and drug therapies are not represented on the slide. When compared to psychotherapy patients, the convulsive group were older, had fewer years of education - many had not completed grade school - and were frequently foreign born. They also had a higher F score, which indicates that these patients tended to agree with social stereotypes.

At this time, the psychiatric residents and their supervisors were also tested. Their average F score was 21.8 with a mean age of 33.9, thus more closely approximating the psychotherapy group than the

electroshock group.

This figure has dealt with group averages for each of the factors mentioned. There was however marked variability within each of the groups, with patients at each end of a wide range. One method of sub-grouping the patients is shown in the analysis of the electroshock group with respect to length of hospitalization prior to receiving convulsive therapy. As illustrated in the next table (Table II), the electroshock patients were divided into three groups: 1) those who were treated within three months after admission, 2) between three and six months, and 3) after six months. There is a definite correlation between length of stay prior to convulsive therapy and F score, age, education and birthplace. It is of interest that there is a gradient for each of the social factors. As a group the patients referred for convulsive therapy after six months of hospitalization are most similar to the psychotherapy patients with respect to each of the factors.

One set of data not shown in the slide is the ratio of male to female patients referred for somatic therapy during each of these hospitalization periods. Although the ratio of females to males in the hospital population is two to one, 44 per cent of the patients in the group treated within three months were male. In the group hospitalized for six months prior to convulsive therapy, however, only 7 per cent are males. Thus, male patients are referred for electroshock earlier in their hospital stay than female patients.

As expected, a larger proportion of depressed patients - 52 per cent - received electroshock than did those with other diagnoses. To

control for the factor of diagnosis in choice of treatment, the psychotic depression patients were subdivided into those who received electroshock and those who were given psychotherapy alone. The results are shown in the next slide (Table III). While the two groups are comparable for age and education, the electroshock patients had a significantly higher mean F score and a higher percentage were foreign born. Thus, it may be that persons classified as having a psychotic depression are not necessarily referred for electroshock because they are older or less educated, but rather that they come from cultural backgrounds that are more commonly associated with psychologic processes that make successful communication in the psychoanalytically oriented psychotherapeutic relationship less likely. These findings are consistent with previous studies which have shown that patient-therapist differences in systems of values may hamper therapeutic relationship. As Hollingshead and Redlich note: "We are not sure what attributes a good patient must have, but they include sensitivity, intelligence, social and intellectual standards similar to the psychiatrist's, a will to do one's best, a desire to improve one's personality and status in life, youth, attractiveness and charm. Rarely will such standards be admitted by psychiatrists. On the contrary, psychiatrists claim that the selection for treatment is based on purely psychiatric criteria....."

Results of Therapy:

Social factors are as significantly related to treatment result as they are to treatment selection. To analyze the effects of the hospital treatment on the 171 patients, we selected the discharge

evaluation as the criterion of improvement. At time of discharge a patient is classified in one of four categories: recovered, much improved, improved or unimproved.

The relation of social factors to the discharge evaluations is presented in the next slide (Table IV). There is a definite, almost linear relationship, between the improvement rating and these four social factors. The recovered group of patients had the highest F scores, were oldest, least educated and showed the highest incidence of foreign birth. In contrast, the unimproved group had the lowest F scores, were younger and better educated - almost all having gone to college - and were primarily native-born.

Analyzing the data for patients treated with convulsive therapy (Table V) the improvement ratings parallel those for the total population. Again, the recovered group had the highest mean F scores, was the oldest, most poorly educated with the highest incidence of foreign birth. The next slide (Table VI) illustrates the relation of these observations to time of referral for treatment. Within the electroshock group 67 per cent of those who were treated early in the course of hospitalization were rated as recovered or much improved, whereas those treated after six months only 30 per cent were classified in these two groups. As was noted earlier, patients in this latter group were more similar to the psychotherapy group with respect to these social factors. It is not surprising, therefore, that they were treated with somatotherapy only after an extensive course of psychotherapy.

In summary, the observations that social factors are related to type of therapy received as well as therapeutic outcome are consistent with the studies of Hollingshead, Redlich and their co-workers. Furthermore, the present studies extend their findings in demonstrating that these factors are also significant in a hospital setting where ability to pay is not a criterion of therapeutic selection and where all forms of therapy are equally available to the entire population.

While the relation between social factors and treatment selection are clear, and are consistent with previous findings, the relation of these factors to improvement ratings appears paradoxical. The observations that those patients with high F scores, who were older and less educated, more often received convulsive therapy and were discharged more frequently as recovered are consistent with the results reported in 1956 in a follow-up study of Hillside Hospital patients conducted by Rachlin, Goldman, Lurie, Gurvitz and Rachlin. It is possible that the differences in communication between therapist and patient that result in referral for convulsive therapy may also influence the discharge rating. Thus, Kahn and Fink have previously shown that verbally uncommunicative persons, prone to denial, evasion, stereotypy and use of cliches are most likely to receive and benefit from electroshock. Such language patterns appear more frequent in persons in the lower socioeconomic groups. Because of the differences between therapist and patient, the therapist may set different criteria for improvement for the older less educated patients than he does for the young, sophisticated ones.

The lower class patient may also set goals for himself that are qualitatively different from the upper class patient. The patient's aspirations for himself and the therapist's expectancy for the patient are an interactive process. Ratings of improvement at time of hospital discharge are relative in that they refer to a baseline of premorbid functioning. Thus the rating of recovered is defined as, "the reasonable expectation that the patient will be able to return to his community and function as well, or better, than he did before he became ill." The therapist's perception of the patient's premorbid functioning may be influenced by the distance between his value system and that of the patient and both influenced by their social class. The greater the social distance between therapist and patient the less rigorous the requirements for behavioral change. For example, for older, lower class patients, ability to resume work may loom as the major criterion of improvement. For the upper class patient work adjustment may be only one of a host of criteria, including such intangibles as work gratification, ease of sociability, etc..

This presentation has dealt with a few of the relationships between social factors and psychiatric treatment in a voluntary, psychotherapeutically-oriented hospital. The other speakers will deal with many of the questions left unanswered in this report.

TABLE I

THERAPY SELECTION

Groups	F Score (Mean)	Age (Mean)	Yrs. of Education (Mean)	% Foreign Born
Electroshock (N=57)	43.6	40.3	11.2	26%
Psychotherapy (N=102)	36.4	32.6	11.8	9%

TABLE II

LENGTH OF HOSPITALIZATION PRIOR TO ADMINISTRATION OF ELECTROSHOCK

Groups	F Score (Mean)	Age (Mean)	Yrs. of Education (Mean)	% Foreign-Born
Less than 3 mos. (N=34)	48.3	44.5	10.1	41%
3 to 6 mos. (N=10)	42.7	39.8	11.7	30%
More than 6 mos. (N=13)	32.9	29.5	13.4	0

TABLE III

SELECTION OF THERAPY IN PATIENTS WITH PSYCHOTIC DEPRESSION

Groups	F Score (Mean)	Age (Mean)	Yrs. of Education (Mean)	% Foreign-Born
Electroshock (N=31)	50.3	48.6	10.6	42%
Psychotherapy (N=29)	41.0	47.6	10.0	24%

TABLE IV

SOCIAL FACTORS AND DISCHARGE EVALUATION

	F Score (Mean)	Age (Mean)	Yrs. of Education (Mean)	% Foreign-Born
Recovered (N=17)	42.9	44.5	10.7	41%
Much Improved (N=82)	39.0	35.6	11.2	22%
Improved (N=63)	36.1	31.2	11.2	16%
Unimproved (N=9)	31.1	31.2	13.2	11%

TABLE V

DISCHARGE EVALUATION IN CONVULSIVE THERAPY

	F Score (Mean)	Age (Mean)	Yrs. of Education (Mean)	% Foreign-Born
Recovered (N=8)	53.1	51.6	9.4	50%
Much Improved (N=26)	42.0	43.8	10.6	35%
Improved and Unimproved (N=23)	39.7	32.3	12.3	17%

TABLE VI

LENGTH OF HOSPITALIZATION PRIOR TO ELECTROSHOCK AND DISCHARGE EVALUATION

Groups	Recovered & Much Improved	Improved & Unimproved
Less than 3 mos. (N=34)	68%	32%
3 to 6 mos. (N=10)	70%	30%
More than 6 mos. (N=13)	31%	69%

Social Factors and Communication in Psychiatric Patients

II: Duration of Hospitalization and Diagnosis

You have just heard a presentation of factors associated with the selection and results of treatments. I will next consider the relation of these factors to length of hospitalization and to diagnosis.

It is obvious that the length of time a patient stays in a mental hospital is related to the particular function and philosophy of the institution. In an institution such as Hillside Hospital which admits only voluntary patients and emphasizes psychoanalytically oriented psychotherapy, the length of hospitalization is limited. In the particular population studied the range was from one to 16 complete months in the hospital, with an average stay of slightly over six months.

Several factors can be postulated which might be related to the duration of hospitalization. Since it commonly takes less time to produce behavioral change with convulsive therapy than with psychotherapy, one would expect to find that the convulsive therapy patients are kept in the hospital for the shortest period while the psychotherapy patients are here longer. The data, as presented in Table VII, shows no significant difference between the two groups. If anything, there is a slight tendency for psychotherapy patients at Hillside to be institutionalized for the shorter period.

A second possible factor is the severity of the patient's illness. It may be that those patients who are more intractable will necessarily be maintained in the hospital further to receive additional treatment. Examination of the data, however, as shown in Table VIII, demonstrates that while those patients hospitalized for the shortest period do have

a higher incidence of discharge ratings of Recovered and Much Improved, the differences are within a chance variation and are not significant. In the Hillside follow-up study of Rachlin et al. it was also found that there was no relationship between discharge evaluation and length of time in the hospital.

On the basis of the data and discussion presented by Dr. Pollack, we can advance the further hypothesis that there should be a relationship between a patient's social background and the duration of hospitalization. With Hillside's stress on psychoanalytically oriented psychotherapy we would expect that those patients who are most like the therapists with regard to these factors would be kept in the hospital for the longest period. The data is presented in Table IX. Patients who were hospitalized for the shortest period had the highest F scores, were oldest, had the fewest years of education and the smallest percentage of native born. Conversely, those who were in the hospital the longest had the lowest F scores, the youngest ages, the most years of education and the smallest percentage of foreign born. These differences are statistically significant.

In Table X a similar analysis is shown for only those patients receiving electroshock. Again, each of these factors is related to duration of hospitalization.

The same results are obtained when the data of those patients receiving psychotherapy only is analyzed separately, as shown in Table XI. While these patients as a group, as Dr. Pollack indicated, have low F scores, are younger, have more education and more native born than the electroshock patients, there is still a significant difference within the group in the predicted direction according to the length of time in the hospital.

These same relationships of social factors to hospitalization are found even when the patients were subdivided according to their final diagnosis. In Table XII the data is shown for the F score and months in the hospital for each diagnostic group. The diagnoses were subdivided into four major groups and include all but three patients in the population studied. For each group there is a significant difference between those in the hospital for the shortest and the longest periods, with those in the longest having the lowest scores. Similar results are shown when the data is analyzed for each diagnostic group with respect to age (Table XIII). It is also shown for education (Table XIV), with the exception of the schizophrenic patients who had about the same education for each length of stay. It should be noted, though, that many of the schizophrenic patients who were here for ten months or more were quite young - around 16 or 17, and so did not have the opportunity to receive education beyond the middle of high school.

Analysis of place of birth for each diagnostic group and length of hospitalization is shown in Table XV. Increase in length of hospitalization is associated with a marked decrease in the number of foreign born, again with the exception of the schizophrenics, who as a group, had very few such persons.

The previous tables have indicated that not only is there a significant relation between each of the social factors studied and length of hospitalization, but that there are large differences between the diagnostic groups themselves, even when comparing patients with the same period of hospitalization. The summary data comparing the diagnostic groups is shown in Table XVI. It is clear that patients diagnosed as involutional psychosis

have the highest F scores, the oldest ages, the least years of education, and the highest incidence of foreign born. In contrast, the schizophrenics have the lowest F scores, were the youngest, had the most education and the least number of foreign born. The manic-depressive and psychoneurotic patients fell in between, with the manic-depressive closer to the involutionals and the psychoneurotics most like the schizophrenics.

This marked relationship between these social factors and diagnosis is not surprising. Certainly the relationship of age and diagnosis is an established concept in clinical psychiatry. In the involutional disorders and in dementia praecox the names themselves have a chronological connotation. What is unexpected, however, is that age should also be related to the diagnosis of manic-depressive and psychoneurotic disorders, and that the other social factors of education, place of birth and F score should significantly differentiate all the major diagnostic groups in this hospital.

We have postulated two hypotheses to account for these relationships. The first is based on the fact that persons from different social backgrounds acquire different habitual modes of adaptation and patterns of communication and expression. Accordingly, under conditions of stress, damaged brain function, or other etiological conditions associated with the onset of mental illness, a person will show those behavior patterns or symptoms which are of the same type as his habitual patterns. Thus, a person from a lower class social background is more apt to communicate in non-verbal, physical terms, while upper class people are more likely to do so in ideational and verbal terms. Thus, anger may be shown by lower class people by physical violence, while those from upper classes are more likely to resort to exhortation or argument. Hollingshead and Redlich

have noted that these differences among people of different classes lead to different psychodynamic patterns in psychoanalytic terms. Thus, aggressive and sexual behavior is more acceptable to lower class parents, while such behavior is restricted among the upper classes, lending to considerable variation among the different social classes in superego development.

Marvin Opler, studying Irish and Italian patients who were diagnosed as schizophrenic in a V.A. Hospital, found significant differences in their types of symptoms related to cultural differences in their family backgrounds. Patients coming from Irish families in which active expression of emotions were frowned upon and with dominant over-protective mothers, were passive, compliant and withdrawn, and fearful of anything which might separate them from the protection of the hospital. Patients with Italian family backgrounds that encouraged free expression of emotion and were ruled by a dominant father, showed assaultive and destructive behavior, were difficult to manage and were rebellious against authority.

In a comparable study Miller and Swanson have also noted that hospitalized schizophrenics exhibit significant social class difference in symptomatology - lower class patients showing "motoric themes," while middle class patients exhibit "conceptual or ruminative themes."

According to our hypothesis, then, we would expect that persons from lower social levels would show symptoms that are non-verbal, expressed in sensory or motor patterns. Among such types of symptoms would be psychomotor retardation, anorexia, catatonic stupor, muteness, hysterical blindness or paralysis. In this connection it is noteworthy that hysterical symptoms in the army have been reported as far more frequent among enlisted men than officers. In addition hysteria which was apparently so common in World War I was not nearly so notable in World War II, and, in fact, has been reported

on the wane in the general population. This decrease, in our view, is related to the general increase in educational level of the country as a whole. If one finds a classical case of hysteria in New York today, I understand that it will most likely be in the Puerto Rican immigrant population who have the poorest socio-cultural background. (One cannot, of course, ascribe the decrease in hysteria to a greater freedom in sexual matters; it is most common in more poorly educated people who, as Kinsey has shown, are least inhibited sexually).

In the laboratories at Hillside Hospital the investigations of persons with depressive psychoses have been more intensive. We have noted a common pattern of premorbid behavior in these people, characterized by lack of imagination, creativity and introspective capacity, and by conventionality and general rigidity. Similar patterns have been noted in a series of studies of such patients by other authors. We believe that a poor cultural background, such as that involving little or no education, spending early years in a largely illiterate environment, and meager cultural resources, is conducive to the development of such a personality pattern. When mentally disordered, such persons tend to react with a repertoire of behavior patterns consistent with their background which we term depression.

A second hypothesis concerning the relation of social factors to diagnosis has to do with the interaction between patient and psychiatrist. According to this hypothesis a diagnosis may not be based on an actual objective behavior pattern, but is to a great extent a reflection of how the psychiatrist perceives or identifies the patient. It has been noted frequently that patients with similar symptoms will be differently diagnosed and treated depending on their social class. For example, we recently studied three patients who were admitted with similar symptoms of depression, anorexia and

insomnia. All three were referred for convulsive therapy. One woman, who was 62, born in Russia, of limited education with an F score of 70, was diagnosed as involutional melancholia. The second, aged 45, born in this country, with an F score of 53 and a high school education, was termed manic-depressive, depressed. The third, aged 44, also born in this country, with an F score of 33 and a college education, was diagnosed as psychoneurosis, reactive depression.

In conclusion, in the Hillside Hospital population social factors of age, education, birthplace and F score are significantly related to the selection and results of treatment, length of hospitalization and diagnosis. These findings illustrate the importance of social factors in affecting language and communication patterns and the nature of the interaction between patient and therapist. Current data, both from our own laboratory and as reported in the work of others, indicates that psychotherapy is most likely to take place with those persons who most closely resemble the therapists in terms of cultural background and communication pattern. In Hillside, with its emphasis on psychotherapy, it is clear that patients who best meet this criteria are also kept the longest. This is true for either patients receiving convulsive or psychotherapies alone, and for all diagnostic groups.

In the evaluation of clinical improvement there may well be different expectancies towards patients in terms of these social factors. In a person with little education and different modes of expression than ourselves, we may regard, for example, the manifestation of denial as improvement. But in a patient much like ourselves in cultural background, the showing of denial will be regarded as a defense and the patient is considered unimproved. The patient, himself, may have different expectancies not only in terms of the type of psychiatric treatment, but for what constitutes improvement as well.

We believe also that the attitude of the patient's family may be crucial in both the patient's and therapist's conception of what constitutes improvement.

The relation between social factors and diagnosis was interpreted in two ways. First it was indicated that one's cultural background affects the type and pattern of symbolic expression and communication, and accordingly the possible type of symptoms that will be shown. Secondly, we believe that a diagnostic statement is not simply an objective evaluation of a given behavior pattern. Rather, it is a reflection of the interaction of the patient and psychiatrist in relation to their respective cultural backgrounds and modes of communication.

It is important to keep in mind that while the relationship between social factors and the psychiatric aspects described is probably applicable as a generalized principle, the specific findings may vary in different settings or institutions. For example, in a study using the F score at the Boston Psychopathic Hospital, the same relationship to type of treatment was noted as in our report, i.e., the electroshock patients had higher F scores than those receiving psychotherapy. Since the average score of the patients there, however, was higher than at Hillside, their psychotherapy patients had the same mean score as our electroshock cases. Another example is the finding of Hollingshead and Redlich that schizophrenia was a more common diagnosis proportionately among lower than upper classes, while at Hillside the schizophrenics had the highest education. This discrepancy can probably be accounted for by the variation in composition of the two populations, the Hillside patients being drawn largely from the middle groups with relatively few from the upper or lower social classes.

In Hillside the diagnosis of schizophrenia may indicate an "interesting" patient, while in a State Hospital population the same diagnosis may represent a "hopeless" patient.

It remains for the hypotheses raised by these studies to be tested and for further studies of the psychological processes involved. In particular we have been working on studies of communicative interaction. Some of the details and findings of this work will next be presented by Dr. Jaffe.

TABLE VII

DURATION OF HOSPITALIZATION AND TYPE OF TREATMENT

	Months in Hospital		
Treatment Groups	1 - 5	6 - 9	10 or more
Electroshock (57)	26%	30%	44%
Psychotherapy (102)	32%	42%	25%

$Chi^2 = 5.73$
df = 2
p = N.S.

TABLE VIII

DURATION OF HOSPITALIZATION AND DISCHARGE EVALUATION

Months in Hospital	Discharge Evaluation	
	Recovered or Much Improved	Improved or Unimproved
1-5 (49)	69%	31%
6-9 (64)	55%	45%
10 or more (58)	52%	48%

$Chi^2 = 3.83$
df = 2
p = N.S.

TABLE IX

DURATION OF HOSPITALIZATION AND F SCORE, AGE, EDUCATION AND PLACE OF BIRTH

	Months in Hospital		
	1 - 5 (N=49)	6 - 9 (N=64)	10 or more (N=58)
Mean F Score	43.9	40.5	31.0
Mean Age	45.5	32.5	27.9
Mean Years Education	10.0	11.9	12.8
% Foreign Born	41%	19%	10%

TABLE X

DURATION OF HOSPITALIZATION AND F SCORE, AGE, EDUCATION AND PLACE OF BIRTH IN PATIENTS RECEIVING ELECTROSHOCK

	Months in Hospital		
	1 - 5 (N=15)	6 - 9 (N=17)	10 or more (N=25)
Mean F Score	58.2	45.6	34.9
Mean Age	51.7	42.2	32.1
Mean Years Education	6.5	12.3	13.2
% Foreign Born	67%	24%	16%

TABLE XI

DURATION OF HOSPITALIZATION AND F SCORE, AGE, EDUCATION AND PLACE OF BIRTH IN PATIENTS RECEIVING PSYCHOTHERAPY ONLY

	Months in Hospital		
	1 - 5 (N=33)	6 - 9 (N=43)	10 or more (N=26)
Mean F Score	40.2	38.6	27.8
Mean Age	43.2	29.1	24.8
Mean Years Education	11.4	11.7	12.4
% Foreign Born	30%	16%	8%

TABLE XII

MEAN F SCORES FOR DIAGNOSTIC GROUPS ACCORDING TO DURATION OF HOSPITALIZATION

Diagnostic Group	Months in Hospital		
	1 - 5	6 - 9	10 or more
Involutional Depression	58.2	50.9	35.0
Manic Depressive	40.02	46.1	33.1
Psychoneuroses	40.05	36.6	36.1
Schizophrenia	36.3	38.5	27.6

TABLE XIII

MEAN AGES FOR DIAGNOSTIC GROUPS ACCORDING TO DURATION OF HOSPITALIZATION

Diagnostic Group	1 -5	6 - 9	10 or more
Involutional Depression	58.8	54.5	52.3
Manic Depressive	46.8	39.1	35.5
Psychoneuroses	41.0	27.1	27.1
Schizophrenia	27.8	27.8	24.1

TABLE XIV

MEAN YEARS OF EDUCATION FOR DIAGNOSTIC GROUPS ACCORDING TO DURATION OF HOSPITALIZATION

	Months in Hospital		
Diagnostic Groups	1 - 5	6 - 9	10 or more
Involutional Depression	7.1	9.6	16.0
Manic Depressive	11.0	11.7	12.3
Psychoneuroses	8.7	12.5	12.5
Schizophrenia	13.3	12.3	12.9

TABLE XV

PERCENTAGE FOREIGN BORN FOR DIAGNOSTIC GROUPS ACCORDING TO DURATION OF HOSPITALIZATION

	Months in Hospital		
Diagnostic Groups	1 - 5	6 - 9	10 or more
Involutional Depression	57%	43%	0
Manic Depressive	39%	23%	0
Psychoneuroses	50%	19%	13%
Schizophrenia	10%	8%	12%

TABLE XVI

DIAGNOSIS AND F SCORE, AGE, EDUCATION AND PLACE OF BIRTH

	Diagnosis			
	Involutional Depression (N=24)	Manic Depressive (N=39)	Psycho-neuroses (N=37)	Schizophrenia (N=68)
Mean F Score	52.3	40.8	36.9	32.8
Mean Age	56.7	41.9	29.4	26.1
Mean Years Education	8.9	11.5	11.9	12.7
% Foreign Born	46%	26%	22%	10%

Effects of Social Factors on the Patient-Doctor Relationship: Observations in an Interview Setting

In this report I will illustrate how the social factors discussed this morning affect communication in the clinical interview. Our hypothesis is that these factors limit the possible ways in which patient and doctor can communicate, and that this is why they are relevant to the choice and results of psychiatric treatment. One way to test such a hypothesis would be to demonstrate that psychodynamically important events, in an actual interview setting, are significantly related to factors such as age, education, nativity and F score. A first step might be the study of a clearly defined event, which is representative of the kind of communication that is relevant to psychotherapy.

This report deals with one such communication pattern. The phenomenon studied is whether or not the patient explicitly mentioned the tape-recording during an experimental interview. This spontaneous transaction may bear upon the transference situation which develops in experimental interviews and in psychotherapy as well.

METHOD:

The setting in which the observations were made was an initial clinical interview. This was part of the screening procedure of patients referred for drug and convulsive therapies in this hospital. All interviews were performed in the Department of Experimental Psychiatry, during the same week as a battery of physiological and psychological tests. It was the first meeting of the doctor and patient. The patient was asked to tell about his difficulties, and a generally unstructured procedure was

followed. The purpose was to get an impression of the patient's communication patterns, and to secure a tape recording of the interaction.

Several months ago, it was noted that some patients mentioned the fact that the interview was being tape-recorded, whereas other patients said nothing about the procedure. Since that time, I have systematically recorded this data at the conclusion of each session. In addition, the following experimental structure was purposely introduced.

A Tanberg tape-recorder was prominently placed beside the desk at which the interview took place. This instrument was turned on just before the patient entered the room, and was clearly in his line of vision. It was about the level of the desk, at a distance of about seven feet from the patient's chair. The red neon glow bulb, the revolving reels of tape, and the operating noise of the machine could all be observed. An unconcealed wire ran directly from the instrument, across the desk, to a microphone which lay in clear view between doctor and patient. However, the interviewer made no mention of the recording set-up unless the subject was introduced verbally by the patient.

OBSERVATIONS:

Since this experimental structure was introduced, 31 initial interviews have been recorded. The tape-recording was mentioned by 14 patients, while 17 others made no such observation. They will henceforth be referred to as the "Mention" and No Mention" groups respectively.

a) Qualitative: The patients who mentioned the recording expressed a variety of attitudes. The most common was curiosity, with inquiry as to the purpose of the interview, and the use to which the recordings might be put.

A minority expressed overt suspicion, either refusing to proceed with the interview for several minutes, or voicing their fears of humiliating or incriminating uses which might be made of the recordings. One patient said, "I did'nt know the room was bugged." A physician in this group of patients requested that the recorder be turned off for a moment so that he could ask a question as a colleague, "off the record." After a spontaneous mention of the recording, an attempt was made to explore the attitude underlying the remark. This varied from definite hostility and suspicion, through mild objection and uneasiness, to passive acceptance of the procedure. Only one patient expressed delight, saying, "I'm glad this is being recorded, it's like a confession." In addition to these subjects who explicitly mentioned the recording, one mute patient is included in the "Mention" group. She pointed to the recorder, then to the microphone, shook her head as if to say "no," and covered her mouth with her hand.

In the "No Mention" group, non-verbal recognition of the recording was often apparent. Most of the patients looked repeatedly at the recorder and microphone , sometimes furtively. Several of them actually touched or picked up the microphone while speaking. I accompanied one patient back to the ward following the interview, and while chatting in a lighter vein she asked "By the way, was that all recorded?" Thus there was considerable non-verbal evidence that the "No-mention" group was aware of the recording.

Quantitative:

Quantitative data for the "Mention" and "No-mention" groups is seen in Table-XVII.It is apparent that the group who explicitly remarked about the recording were younger, on the average, by about 20 years. They were also better educated, and with only a single exception were native born. They had a lower score on the F scale and I tended to spend more time with them. All the differences between the groups are statistically significant.

TABLE XVII

	MENTION (N=14)	NO MENTION (N=17)	
AGE (years)	26.7	45.2	$p < .002$
EDUCATION (years)	14.1	10.9	$p < .02$
% NATIVE BORN	93	53	$p < .05$
F SCORE	34.1	47.2	$p < .05$
DURATION OF INTERVIEW (minutes)	39.6	29.0	$p < .05$

DISCUSSION:

Using a single objective index, i.e. an overt statement about an unexpected experimental procedure, two patterns emerge from this group of patients. The group of subjects mentioning the recording have the same sociological characteristics as those patients from the total Hillside Hospital population who are treated by psychotherapy alone. They are younger, have some college education, are native born, and are less stereotyped in their attitudes. They mention the experimental procedure in a challenging way. Gill, Newman and Redlich have described the anxiety-producing effects of tape-recording psychiatric interviews. This group of patients meet the stress by verbalization of their subjective reactions. They talk about it, ask questions, object, etc.

The group who do not mention the recording have the same sociological characteristics as those patients in the total Hillside Hospital population who are typically referred for electroshock (i.e. non-verbal therapy) or are hospitalized for the shortest period. They are older, have at most a high school education, are more likely to be foreign born, and are stereotyped in their attitudes as measured by the F scale. These patients do not question the procedure overtly, although they notice it. Their attitude is "You are the doctor, whatever you do is justified and should not be questioned." In their compliance and acquiescence they resemble surgical patients who submit themselves passively to treatment, neither resisting nor actively participating. When asked to tell about themselves their attitude often is, "I don't know what to say, but I'll be glad to answer any questions you may ask."

The "Mention" group display a different attitude toward the therapist. They do not treat the physician's procedures as completely outside their

jurisdiction. They verbalize their resistance, and express their negative feelings directly to the interviewer. The "mention" reaction indicates curiosity and the skepticism that Freud felt was required of the analytic patient. In discussing this point, Fenichel notes, that if the patient "is not skeptical at all, the suspicion is warranted that he is repressing negative transferences." It is not surprising that the interviewer, with a psychoanalytic orientation, spent about 10 minutes longer with the "mention" group.

This study demonstrates, then, that these sociological factors may be related to actual differences in the quality of patient-doctor relationship.

In this one limited aspect of the communication pattern, the sociological background allows us to predict whether the patient will verbalize his reactions or not. If this single stress situation is representative of the general behavior in psychotherapy, we can get some notion of why these factors are related to choice or length of treatment. We expect that patients who decline to mention such an obvious situation as a microphone and tape-recorder, will be equally loathe to express the variety of feelings about the therapist which are crucial for analysis of transference.

Further studies of the data are in progress which may increase our understanding of the observations reported. For example, a detailed content analysis of the <u>way in which</u> the recording was mentioned sheds light upon the deviant cases. Two of these have already been described. One was an older patient, with high F score, who in contrast to the usual pattern of such persons, <u>did</u> mention the recording. However, he differed from the other older patients in having a medical education. His way of mentioning the

recording was to suggest a change in the interview from that of doctor-patient to that of colleagues speaking "off the record." One is tempted to predict the form of his therapeutic resistances from this event. Another patient mentioned the recording, but in an unusual way. She was delighted with the "confessional" aspects. In her sociological characteristics, she too did not fit a clear pattern, being in her 20's, but with a high F score. It is to be noted that she was an ex-Catholic.

Other studies of the psychiatric interview, using experimental stresses more characteristic of psychotherapy, furnish additional evidence of the importance of sociological factors. For example, Saslow and Matarozzo found that the response to purposeful silence or to interruption by the interviewer is related to factors such as sex, age and verbal IQ.

The conclusion to be drawn at this point in the present study is, that sociological factors in the patient population must be included in any research on psychotherapeutic communication.