Social Class and Group Therapy in a Working Class Population

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ABSTRACT: *In a clinic in which the assignment of patients to therapy was demonstrated as not affected by social class and in which no patient was excluded as unsuitable, 45% of those referred to group therapy stayed 2 or more years. The only category that consistently correlated with not remaining in treatment was that of unemployment. When unemployed persons were included there appeared to be a significant correlation between a stay of 2 or more years and social class. When only employed persons were considered, this significance disappeared*

Since Hollingshead and Redlich (1958) published their extensive analysis of the differing psychiatric treatment received by different social classes, there has been a volume of literature available in mental health clinics that focuses on modes of treatment for the lower classes. Albronda, Dean, and Starkweather (1964) found that lower-class patients are more likely to be treated with medication and less likely to be assigned to psychotherapy, stressing that the value system of upper—class therapists tends to lead them to see as untreatable many patients of the lower classes and thus no treatment is offered. Many studies (Brill & Storrow; Frank, Gliedman, Imber, Nash, & Stone, 1957; Goin, Yamamoto, & Silverman, 1965; Garfield & Afflect, 1959; Lief, Lief, Warren, & Heath, 1961; Meyer, Spiro, & Slaughter, 1967; Rosenthal & Frank, 1958) indicate that alcholics, psychotics, or those who require medication are often excluded. Lorr, McNair, and Russell (1960) note in their study that patients treated with only tranquilizers were often psychotic and less educated.

It would seem of interest to see what kinds of patients made use of psychotherapy in a clinic with therapists sympathetic to lower-class values and in which no patient is excluded by staff decision and no limit is placed on the number of sessions. The literature (Brown and Kosterlitz, 1964; Frank, et al, 1957, Phillipson, 1958; Rubenstein & Lorr, 1956; Sethna, 1971; Sullivan, Miller, & Melser, 1958; Taulbee 1958) suggests that patients with affect and with the ability to relate to groups of people, and those dissatisfied with self, more educated, more anxious, and better integrated are the ones who remain in treatment. Some authors (Sullivan Miller & Melser, 1958; Taylor, 1956) report a tendency to drop out between the 9th and 21st interviews. Others (Nash, Frank, Gliedman, Stone, & Imber, 1957; White,

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Fichtenbaun, & Dollard, 1964) state that the individual therapist is a factor. Phillipson (1958) in evaluating improvement in group therapy among a highly selected semiprofessional population chose 2 years as the minimal period to expect lasting changes. Beck (1969) reports on the advantages of group therapy with the poor and their own perceptions of each other's potential. Two studies (Imber, Frank, Nash, Stone, & Gliedman, 1958; Luborsky, Chandler, and Auerbach, 1971) demonstrate that no differences in results can be shown between patients treated with group and those seen individually. There would seem to be some value, then, in looking at how long term group therapy can be used in a community mental health clinic.

A CLINICAL STUDY

The East Providence Mental Health Clinic operates in a working-class community. No patient is judged unsuitable for psychotherapy. There is no waiting list. Each patient is seen individually for a period of six interviews, one of which is with a psychiatrist. At this point a decision is made as to whether or not there is a short-term goal. If it is felt that there is a personality disorder of a chronic nature requiring over a year of therapy, the patient is referred to a group. There are ten ongoing groups, most of which meet in the evening for 1 ½ hours weekly. Should the patient refuse group therapy, he is offered the alternative of individual treatment weekly up to a year or interviews bimonthly for long periods. Therapists are psychiatric social workers with master of social work (MSW) degrees who are sympathetically oriented to lower-class values.

This study does not deal with the issue of improvement with treatment. Rather, it attempts to evaluate whether or not the bias of social class has indeed been eliminated in the assignment of patients to group or individual therapy, and what types of patients make use of the opportunity for long-term group therapy as defined by remaining 2 or more years. An evaluation is made of the effect of medication on remaining in treatment. The possibility is considered that some diagnostic categories stay longer than others. Since some patients seem to attach themselves quickly to the therapist of initial interview, an evaluation is made as to whether or not those patients who were assigned to a group therapist other than the one of initial interview tended to drop out more often. The referrals of two specific therapists are studied to see if there is a measurable difference in their ability to prepare patients for group therapy.

METHOD

Chosen for study were 279 consecutive cases that applied for treatment over a 7-year period and that completed six or more interviews. Thus we were not dealing with the total clinic population but with that portion which seemed motivated for ongoing treatment. The focus was on which of these patients stayed 2 or more years and on how staff decisions did or did not influence this. Statistical analysis and data correlations were determined using release four of the "Statistical Package for the Social Sciences." A complete

description of this set of programs and their use is given by Nie, Bent, and Hull (1967). Each patient was given a social-class rating according to the formula of Hollingshead and Redlich (1958). Treatment of patients was as follows: 65.6% of the patients were referred to long-term group therapy; 44.7% of these remained 2 years or more; 34.4% were not referred either because short-term therapy seemed more appropriate or because there was not a suitable group opening; 40.1% were given medication in addition to psychotherapy; and 59.9% were given psychotherapy alone. To determine whether referral to a group for long-term therapy was influenced by class bias, a sample of patients for whom there were suitable groups was selected. Since married couples' groups have existed throughout the period of this study, the sample consisted of married patients in their 20s, 30s, and 40s. In this sample 74.4% were referred to a group; 25.6% were not; 34.1% were medicated, 65.9% were not.

RESULTS

Statistics on the entire population of 279 patients compared to those of the sample follow.

Since the sample population consisted only of married patients in their 20s, 30s, and 40s, certain categories were biased by the selection. For example, students were by and large excluded from the sample with a corresponding percentage increase in other categories. However, it will be seen that the only category in which the sample differed significantly from the entire population was that of unemployed persons. There were periods during the time when these data were collected in which there were no groups for single teenage persons, many of whom were on welfare. To see if this accounted for the decrease in unemployed persons, a correlation of marital status with employment for both males and females was made. It was found that single persons were significantly (data were considered significant at the $p < .05$ level) more likely to be unemployed in both sexes. Thus our sample eliminates a portion of unemployed persons. This would be expected to reduce the liklihood of statistical significance of data relating to the unemployed. In spite of this it was found that unemployed persons were not referred to group to a significant degree.

One would expect, since 60.9% of social class V were unemployed, that the same bias would appear when referral was correlated with social class. Surprisingly it did not. Both in the entire population of 279 and in the sample, there was no correlation between our referral process and social class.

There was also no correlation in either group between our referral process and patients who had conflict with the law or those addicted to drugs or alcohol. In order to understand this curious discrepancy, a correlation of referral process to diagnosis was made. This was significant in the total group of 279 patients, showing a tendency to refer to a group those with a diagnosis of personality disorder and not to refer those with diagnoses of schizophrenia or depression. This did not reach significance in the sample. To check this further we correlated the status of unemployment with diagnosis of schizophrenia and with that of depression. Each diagnosis showed a significant correlation with unemployment. Within class IV, where there were enough patients for statistical significance, a correlation was found

TABLE 1

Group of 279 patients			Sample
No Class I patients.			
Class II	4.7%	Class II	4.0%
Class III	34.7%	Class III	35.8%
Class IV	52.3%	Class IV	54.5%
Class V	8.3%	Class V	5.7%
Employment			
Unemployed	17.6%	Unemployed	9.1%
Employed	37.6%	Employed	40.9%
Housewives	35.1%	Housewives	46.-%
Students	8.6%	Students	1.1%
Retired	1.1%	Retired	.6%
Percentage of unemployed within each class			
Class II	15.4%	Class II	14.3%
Class III	11.5%	Class III	4.8%
Class IV	15.2%	Class IV	8.3%
Class V	60.9%	Class V	40.0%
Education			
Below High School	37.6%		31.3%
High School and Above	56.9%		52.3%
College Graduate	5.5%		5.7%
Marital Status			
Married	71.7%		100%
Single	16.8%		
Separated, widowed or divorced	11.5%		
Age			
Teens	9.0%	Teens	----
20s	36.2%	20s	36.9%
30s	26.9%	30s	39.2%
40s	17.6%	40s	23.9%
50s	7.5%	50s	----
60s	2.9%	60s	----
Sex			
Females	61.6%	Females	60.2%
Males	38.4%	Males	39.8%
Diagnosis			
Schizophrenia	9.7%		8.5%
Personality disorder	53.4%		62.5%
Depression	21.1%		15.9%
Other	15.8%		11.2%

between unemployment and the diagnosis of schizophrenia, but not that of depression. It would seem likely then that the decision not to refer to group therapy relates to a clinical judgment that it was unsuitable to the needs of many unemployed persons.

The question arose as to whether or not this was a valid judgment. Taking only those patients who were referred for group therapy (183), the unemployed were compared with the employed (including housewives and students as employed) as to the number who stayed 2 or more years. The difference was significant in spite of the fact that the referral process might have selected out some of the more unsuitable candidates. Staying 2 or more years was then correlated with social classes. Here, too, there was statistical significance. The question arose as to how much the factor of unemployment influenced this. To test this only the employed persons who had been referred to group therapy were selected; social class was then correlated with a stay of 2 or more years. There was no longer significance without the unemployed persons. A correlation of diagnosis with staying 2 or more years showed no significance.

It would seem, then, that although unemployment persons in a predominantly white working-class community are more likely to have diagnoses of schizophrenia or depression, these diagnoses in themselves are not predictive of whether or not persons will make use of "talking therapies." Neither is social class per se, although obviously in a community in which there are larger numbers of class V patients, these two factors will seem to coincide. It is possible that in situations in which employment is not easily available, such as times of recession or because of minority status, that this would not apply. The question arises as to what it is about the unemployed status that seems to separate out those schizophrenic and depressed persons for whom group psychotherapy is not useful. One possibility is that it serves as a measure of ability to relate to the needs of other people, that is, employers, and to respond appropriately enough to receive gratifying feedback, that is, wages. Perhaps therapy based on verbal interactions cannot take place unless this degree of coping ability is present. Education has been thought to correlate with the use made of psychotherapy. In both the entire group and in the sample group the referral process showed no significant correlation with education. This was checked within class III and IV, where there were enough patients to be statistically significant, with the same result.

It was thought that since some patients seem to attach themselves readily to the therapist of initial intake, there might be a correlation between those who had gone into a group with the same therapist and those remaining two or more years. There proved to be no significance in these areas. With two specific therapists there were no significant differences in their ability to engage patients in long-term group therapy. There was also no significance in whether or not patients had had conflict with the law or were addicted to drugs. As stated above, 40.1% of the patients were given medication in addition to psychotherapy and 59.9% psychotherapy alone.

Those patients who were medicated were correlated with social class, with referral to group therapy, and with remaining in group therapy 2 or more years. There were no significant correlations in any of these areas.

IMPLICATION FOR HEALTH INSURANCE

Many insurance policies attempting to incorporate coverage for psychiatric care limit available coverage to 20 sessions. What proportion of the population of this study does this cover? Among those who did not stay 2 years or longer, the median or 50% of the patients used 20 interviews. The mode or greatest frequency was was 15 sessions. This corresponds with the work of those (Sullivan, Miller & Melser 1958; Taylor, 1956) reporting a tendency to drop out between the 9th and 21st sessions. Separating those not referred to group therapy from those referred to it, the mode for those not referred was again 15 sessions and the median 17 sessions. Among those referred to group therapy, the mode was still 15 sessions and the median was 23 sessions, reflecting a need for longer treatment. This argues against the idea that the process of group referral causes patients to drop therapy.

Taking all those who did not stay 2 years, whether referred to group therapy or not, by the 20th session only 52.5% felt ready to stop. By the 30th session, 74.7% had stopped. This suggests that in a working-class population 30 sessions would take care of 75% of patients needing therapy. There is no evidence to suggest that the process of group referral interrupts ongoing therapy. Therefore in a plan in which the patient paid for the first 5 sessions, the solution of continued group therapy after 30 sessions would seem a viable alternative for an insurance plan that would offer long-term group therapy to those needing it.

CONCLUSIONS

In a clinic for working-class people, in which there was no staff decision to exclude any type of problem, no waiting list, and no limit on the number of sessions, 44.7% of those referred to group therapy after six individual interviews remained 2 or more years. The process of referral to group therapy was not influenced by social class in these patients but was influenced by the status of unemployment. The status of unemployment correlated significantly with the diagnoses of schizophrenia and of depression in the total patient population and with that of schizophrenia within class IV. Of the patients referred to group therapy, those remaining 2 or more years correlated significantly with social class when unemployed persons were included, but was not significant when only employed patients were considered. This suggests that the concept that the "talking therapies" are not appropriate for the lower classes may apply more accurately to those patients whose copying capacity is sufficiently impaired for unemployment to have occurred.

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