THE SOCIAL ACTIVITIES OF PATIENTS REFERRED TO AN
OUT-PATIENT PSYCHIATRIC CLINIC COMPARED WITH THOSE
OF A CONTROL GROUP

by

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ABSTRACT

THE SOCIAL ACTIVITIES OF PATIENTS REFERRED TO AN OUT-PATIENT PSYCHIATRIC CLINIC COMPARED WITH THOSE OF A CONTROL GROUP

In this enquiry an attempt has been made to assess social activity enjoyed by a group of psychiatric out-patients and a control group.

A review has been made of some sociological work -

(a) comparing the behaviour patterns of various societies and sub-groups within societies,

(b) concerned with factors in Western society which appear to lead to social ill-health,

(c) concerned with social factors which are claimed to be associated with mental illness.

The results are presented of the study of 51 out-patients at the time of their referral to a Psychiatric Out-Patient Clinic, and of 51 controls matched in several ways.

The two groups were studied (by means of a written questionnaire and interviews) in relation to household make-up, contacts with the extended family, work, friends, leisure-time activities both organised and unorganised. Histories were obtained relating to limited areas; absence from home; changes of residence in the past 5 years; work and service life; membership of social groups. Subjects were also asked for details of school and training.
Similarity between the two groups was noticeable in several areas: size of family, housing, work history, membership of social groups. Differences occurred in the number of contacts with the extended family, possession of "close" friends, attendance at social groups, membership of evening classes, and in the level of education and training. An important difference between the groups lay in the relative social "rigidity" of patients compared with controls in several areas of choice. This "rigidity" is seen as a function of illness and is contrasted with the flexibility more often displayed by controls.

The conclusion drawn is that the groups are not differentiated significantly by the amount of social activity enjoyed but by a more complex factor, centering on the ability or inability to make and keep satisfactory social relationships.

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I. INTRODUCTION

This research is concerned with social relationships and the part they play in human functioning.

Concern with, and interest in, these relationships has grown during the past forty years and has accompanied another development of our society in the same period. This is the decline in the observance of conventional forms of religion. Nowadays only a minority of the population regards the observance of these conventional forms as vital. Religion formerly helped the individual during the personal crises of his life, and religious organisations provided him, particularly in the case of the Free Churches, with opportunities for a very active and responsible social life of a kind which was acceptable to the Victorian conscience.

Today it is seen that the decline has left a gap in our social fabric. The individual in the personal crises of his life must rely more on his own resources, those of his family or a small group of friends.

If any social life beyond this small group appears necessary to him the individual must create it through membership of professional organisations, political groups, clubs and classes. His attempt to extend his social life often gives rise to conflict within the family where mothers of small children, in particular, often prefer their husbands to stay at home in the evening to give them some of the adult
company of which they feel deprived in the daytime. Whereas church social activities in Victoria days were approved, membership of secular groups today are sometimes frowned upon and both husbands and wives are uncertain and divided as to their "duty."

This conflict arises partly out of the type of family which is regarded as "ideal" today in Western society. This is the small elementary family consisting of parents and one or two children. An Indian writer, Nayantara Sahgal, refers to this in an autobiographical book *From Fear Set Free*. She quotes an American friend as saying, "It's the immediate family that counts. The husband and wife live and plan in close co-operation. So many marriages break up because a couple doesn't realise how important this is." Later on, when Mrs. Sahgal is living in India with her husband and two small children and following the Western pattern, she says, "'A family', my American friend said, 'is a husband, a wife and their children,' but I missed the presence of an older person. Each moment with its insistent demands claimed us, involving us in the pressures of the present, while there was perspective and calm about a generation older than one's own. Between the children and me there were tensions that were the very substance of our relationship. I noticed that the tension eased when my mother-in-law..."
visited us. The children revolved about her, drawing a
satisfaction from her presence which I could not provide."
The tightly knit small family is often the one which frowns
on an extended social life for its individual members. This
environment can prevent a son or daughter from growing up
emotionally. The protection of the home makes it impossible
for the adolescent to face the painful process of emerging
into a strange, cold world from which he has been largely
shielded during childhood. Rather than face the difficulties
he becomes schizophrenic.

Freud in his "Three Essays on the Theory of Sexuality"
(1905) states that neurotics have been conditioned to an
inadequacy of social response by the inadequacy of their
social surroundings in infancy and pre-adolescence. He
claims that the child should be exposed to vigorous social
discipline, and adds that family life by itself provides an
insufficient discipline for the individual: he needs social
relationships beyond.

The research here undertaken examines broadly the social
relationships of 102 men and women. It attempts to show,
among other things, the results of decisions made by them in
regard to the membership of social groups of all kinds.

It also gives a picture of their unorganised social
relationships: their friendships, their visits with friends
to the pub, their outings to the theatre, films etc. It
shows how individuals in family situations, struck or failed
to strike, a balance between the needs within the family
circle, and their own need to share in wider social groups.
Family pressures of one kind or another are often hidden behind the decisions about membership of social groups. The family circle for those who live in it provides, in varying degrees, meaningful social contact for its members. At certain periods of life, however, e.g. adolescence, social contacts outside the home with the peer group or with unrelated adults are likely to be much more meaningful and satisfying. Most people find in friendships certain social satisfactions that seem difficult to attain in close family relationships. Friendships usually have ingredients that are different from those found within the family. An attempt will be made later in this report to define these differences.

The individual finds his friends mainly at work, in the neighbourhood, in the extended family, or in leisure-time activities. As a result of clinical experience it was found that psychiatric patients, at the time of their referral, often complained of inability to mix with other people. Many of them appeared to lack satisfactory social relationships of any kind and it was thought that this might be a contributory factor in their illness. Some of them were in contact with a large number of people, yet felt no satisfaction. Many were aware of this and had sought companionships through social clubs, music groups, etc. but felt dissatisfied, and were, in
fact, socially isolated. They sometimes had a deep sense of loyalty to parents or relatives with whom there was an emotional inter-dependence. This attachment helped to raise a barrier to prevent the formation of socially satisfactory friendships in which people often need to describe and explore personal attachments and antagonisms in order to place them in their true perspective. Patients were then in a state of conflict in which they needed to make socially satisfactory relationships, but were prevented from doing so by their dependence on, and loyalty to, close relatives.

The opportunity for discussing personal problems afforded by the clinical setting often meant that the professional worker acted temporarily as the confidential friend so badly needed by the patient. This was one of his most important functions, particularly when it was possible to follow up individual interviews by channelling the needs of the patient into selected and appropriate social groups.

**Objects of the research**

The research was planned with two objects in view:

1. To get a factual account from each individual of his social activities in order to see the fields within which he was operating socially.
(2) To compare the "close" friendships of patients with those of a control group.

(1) The research was designed to throw light on the individual in his social relationships at the time of the interviews, but some attempt was also made to understand changes that had occurred in certain periods during the life of the subject:

(a) Living away from home at any age.
(b) Living conditions during the five years prior to the interviews.
(c) A complete work history for each subject.
(d) A history relating to membership of social organisations during the subject's lifetime.

(2) The criterion used for defining friendships as "close" or otherwise will be described in the chapter on "Method" (page 60) together with the reasons for selecting this particular criterion. It was necessary to try to make an assessment of "socially satisfying" relationships for each person, and to see whether people not under treatment possessed these relationships in greater numbers than the patients. If an individual recognised a friendship as "close" in the way defined here, he felt able to communicate some of his anxieties and problems and to gain relief.
Background of the research

The urban community from which the patients in this research are drawn is an ancient one with its roots as far back as the 11th century. It has become a suburb of London but it still has a strong sense of identity and a wide variety of social groups. The inhabitants tend to live in the area for many years of their lives, and it is regarded as a socially desirable neighbourhood.

It became clear, however, that four particular reasons for anxiety were present in this urban area:

(a) It has already been pointed out that the elementary family pattern has its drawbacks. The two adults in the group may apply pressures to one another that are not only reflected in their behaviour to the children but may limit the participation of either adult in healthy social activities beyond the family circle. This is likely to give rise to greater or lesser degrees of conflict and anxiety.

(b) In the small family unit people are very much aware of their neighbours and often know a great deal about them, even if they do not share social activities with them. They are highly sensitive to their criticism. People who feel they are failures by the standards of their neighbours feel also that this failure is well known; they have no extended family around them to give support. Such a situation is anxiety provoking.
(c) With the steep rise in population during the past thirty years there are insufficient opportunities for higher education, and both parents and children become anxious over the consequent acute competition.

The research includes an enquiry into education and training of subjects. It will be seen that the patient group as a whole had a shorter period of education and less further training than the control group, although the two groups were matched for social class. (Registrar General's Classification 1951).

(d) Many wives in the patient group married into a higher social class and struggled to live up to standards that were new to them. This situation in an urban area must be productive of anxiety and make satisfying social relationships more difficult to achieve.

It has been postulated in this Introduction that human beings need meaningful social contact with others, both in the family and beyond it. The research will show that patients seem to be quite as aware of this need as the control group; they aspire to friendship more often but they succeed less than the controls. In many areas their lives show a remarkable similarity to that of the controls, but many of them have faced anxiety-provoking situations, sometimes in early childhood sometimes at a much later stage. These experiences
appear to have robbed them of their power to contribute
to satisfying social relationships.

The research shows the social functioning of a group
of patients contrasted with that of a group of controls
as it was revealed by each individual.
II. REVIEW OF LITERATURE

1. Social Influences in the Lives of Normal People

The study of social environment and its effects on human beings has received an increasing amount of attention during the present century. In a research which attempts to investigate the social activities of psychiatric patients and of matched controls it is necessary to consider some of the work which drew attention to the importance of social factors in shaping the customs and activities of different groups of people. It would be impossible, however, to attempt a review of the total field for it covers the whole of social anthropology.

A more modest course has therefore been taken and little of this work considered before passing on to review the sociological work which seems particularly related to this research.

The work which was considered was pioneered by Margaret Mead whose well known books "Coming of Age in Samoa" (1928) and "Growing up in New Guinea" (1930) drew attention to the social patterns of these societies and showed the effect on their individual members. Her work was continued by Ruth Benedict whose studies, published in her book "Patterns of Culture" (1935) are equally well known. The societies she studied showed how a well-marked pattern produces, on the whole, individuals who conform but also a minority of deviants.

Mead and Benedict were early exponents of a method of study which has been adopted by numerous later workers in
Whiting and Child in "Child Training and Personality" (1953) studied two aspects of culture and personality: the effect of culture on personality and the effect of personality on culture. This study was carried out through a consideration of the child-training practices in more than 50 societies and a comparison of the customary responses to illness in these societies.

Five systems of behaviour were taken into account: the oral, anal, sexual, dependent and aggressive and societies were judged on several factors including the initial and progressive satisfactions allowed to children in each system of behaviour and the degree of severity exerted in socialisation in each system.

The work of Whiting and Child was carried out partly to test the psycho-analytic assumption of the life long influence of early experience.

Accepting Behaviour Theory that what is learned can be unlearned, they postulated that a high degree of indulgence (or severe frustration) in early childhood does not necessarily mean that the satisfaction potential (or the anxious anticipation of deprivation or punishment) continues to be high throughout life.

Their results showed that the role of early training seemed to be less important in establishing life long personality tendencies in positive fixation (resulting from
satisfaction) than in negative fixation (resulting from frustration). There is greater resistance to "unlearning" behaviour based on punishment than to that based on satisfaction.

This book was important, not only because it drew together for comparative purposes knowledge in the field of child training in more than 50 societies but also because of its implications for the practice of infant care and education.

With regard to their original problem of the effects on one another of culture and personality, Whiting and Child came to the conclusion that both kinds of relationship probably occurred, i.e. child training influenced the adult personality and the adult personality (and other important factors such as economics, politics, forms of marriage and the structure of the family unit) influenced child training. Kluckhohn and Mowrer (1944) gave a useful description of personality as "the organism moving through a field which is structured by culture and by the physical and social world in a relatively uniform manner but which is subject to endless variation within the general patterning due to special or idiosyncratic determinants introduced by accident or fate."

The research undertaken here represents an attempt to see the cultural and social factors which are influencing the lives of patients and controls at the present time. Additionally, in enquiring into limited fields of individual
history, it has also been possible to see some of the "special or idiosyncratic determinants" mentioned above.

A good deal of work has been carried out in Britain in the social study of local communities. Emphasis on particular aspects varies with the interest of the authors. Raymond Firth in "Two Studies of Kinship in London" (1966) pays attention to kinship ties in the extended family and asks how significant these still are in this country. In a London "working class" neighbourhood in which 25 households were studied he finds that these ties are important for social relations. Their importance lies not only in an exchange of services, but they also provide a ready-made channel for social intercourse of a meaningful kind, comprising companionship, the exchange of information and the exercise of moral judgment. Personal selectivity in this kinship system was very marked but there was almost always an enduring link both between children and the mother and between siblings.

The present research included an enquiry into contact with the extended family (beyond the home). Controls had a significantly greater range of contacts with the extended family, particularly in face to face meetings (as distinct from letters and phone calls). Social exchanges between relatives occurring monthly or oftener appear to give a right to criticise actions. Patients found face to face contacts difficult because they feared and shrank from the
questioning, moral censure and advice which relatives often offer as by right. Firth's point that social intercourse among selected kin provides an opportunity for exercising moral judgment was felt to be confirmed in this research.

Young and Willmott in "Family and Class in a London Suburb" (1960) set out to find whether relationships in a middle-class London suburb (Woodford) were warm and close (as in Bethnal Green) or showed anxiety, less sociability with neighbours and more isolation from relatives. They found that the suburban family (as in the present research) usually consists of the elementary family (parents and children only), that it is more independent and more self-sufficient than the Bethnal Green family which is centred on the wider extended family. The bond between the two generations (grandparents and parents) is still very close in Woodford, but the authority of the grandmother is less.

Although the elementary family is more independent and strives for self-sufficiency in Woodford, there is a strong sense of filial duty to aged parents. This fact was confirmed in the present research and it will be seen in the Chapter on the Extended Family that relationships with parents and parents-in-law of subjects, though often giving rise to tension are almost invariably maintained by frequent contact (i.e. more than once a month).

Young and Willmott defined friends in their enquiry as people who visited subjects. Mary Woodward (1956)
in her enquiry also used this criterion. Young and Willmott concluded that friendship in Woodford took the place of the extended family in Bethnal Green finding that 73% of their 939 subjects had had a friend or neighbour to visit them within the previous week against 57% who had had relatives.

The criterion of "visiting" differs from that used in the present research where an attempt has been made to divide friends into "close" and others. The definition of a "close" friend is discussed in Chapter 1. For the purposes of this research it was felt to be more useful to try to judge the number of "close" friends claimed by subjects rather than to assess the number of visiting friends. "Close" friends play a special and probably therapeutic part in people's lives and it was this quality in the present context that it seemed valuable to probe.

Whyte's "Organisation Man" (1951) portrays the suburban American family with its emphasis on sociability and pressure towards "alikeness" which such a society applies to the individual. Whyte suggests that the uniformity of housing, schools, dress and behaviour in this society makes it difficult for the non-conforming individual or family to live happily.

Subjects in the present research did not give evidence of suffering from the necessity to conform except in one or two instances (Patient No. 28 re marriage and the necessity of spending leisure always together. "It ought not to be like that but it is...".). This is not to say that this type of suffering does not exist in Britain today but it is more likely to arise.
in a housing estate or in blocks of flats where there are many people living in identical physical conditions and "keeping up with the Jones" is a real thing. In this research the physical conditions of living varied widely from the married medical secretary living in intimate contact with both her own and her husband's families to the laboratory technician who shared a large flat with four friends and had almost severed all family links.

Elizabeth Bott in the book "Family and Social Network" (1957) attempted with others to describe the social and psychological organisation of 20 ordinary families living in an urban setting. All her families had children under 10 and she was particularly interested in analysing the differing or similar roles of husband and wife in various situations. Her work was similar in intention to this research in that both attempted to make an intensive study of the social setting of a limited number of adults. It resembled this research in avoiding direct therapeutic or advice-giving roles and in stressing fact-finding. This is referred to again in the Chapter on Method (page 57) where the argument is advanced that the stressing of fact-finding both from patients and controls appears to facilitate the expression of attitudes on the part of subjects.

Miss Bott's work differs from the present study in that she selected "ordinary families" as the subjects in contrast to "psychiatric and normal individuals" who are the subjects of this research. She traced out 3 areas of living:
(a) The internal organisation of the family both economic and social.
(b) Informal relationships outside the family with relatives, friends and neighbours.
(c) Formal social relationships with school, church, clubs and other neighbourhood associations.

One of Miss Bott's conclusions was that the external social environment provided much choice and that within broad limits individuals could construct their own environment in accordance with their own conscious and unconscious needs.

The present research will show that although patients live in a world of choice, they are rigidly held to a particular pattern of life and their symptoms condemn them to occupation of a narrowly defined social environment from which they are unable to break out.

In comparison with simple societies, Miss Bott finds that urban societies provide no group which controls all the aspects of a family's life. There is more freedom and more privacy than for the family in a simple society. This point will be referred to again where mention will be made of writers who suggest that the greater areas of choice may be partly responsible for the high level of mental illness in our society.

Personal decisions that are difficult to make and complex in character put a strain on the individual, particularly the one who is less secure because of early deprivation.

Studies of group participation abound. Many of these have reference to membership of voluntary associations. A few
of these undertaken in the last 30 years may be cited as examples:

(a) Komarovsky (1946) studied affiliation to voluntary associations in New York City through material collected from 2,223 adults in 1934-35.

(b) Dotson (1951) studied the same question among 50 working class families in New Haven, U.S.A.

(c) The same author repeated his study among 415 inhabitants of the second largest city of Mexico in 1953.

(d) Reissman (1954) studied social class position and social participation in groups in Illinois.

(e) Bottomore (1954) studied membership of clubs in a small English town, which was predominantly middle class.

(f) Young and Willmott included the same enquiry in their work at Woodford in 1960.

All these studies showed that a varying proportion of adults do not belong to any voluntary association and that "working class" people particularly are often not interested. The proportions of working class people belonging to an association of any type vary from 20% (women) found in Dotson's 1951 study to 74.3% found in Reissman's work. Dotson, Komarovsky and Young and Willmott all suggest that close family and kinship ties make the membership of social organisations less important.

Both Reissman and Bottomore found that members from the higher social classes occupied positions of leadership in voluntary groups more often than "working class" members.
Peter Mann in a work entitled "Concept of Neighbourliness" (1954) reported on two random samples of housewives interviewed in the Wirral Peninsula, West Cheshire. He draws attention to the fact that latent neighbourliness may exist and be more important than manifest neighbourliness. This may well be true but it is difficult to see how latent neighbourliness could be tested. Techniques would be needed of a different and more searching kind than those employed for surveys relating to social group membership.

2. Literature dealing with factors in our society which appear to lead to social disintegration.

After considering some of the literature concerned with social influences in the lives of normal people, it is also necessary to consider some studies which could be termed "transition" literature i.e. work which is not concerned specifically with mental illness but which draws attention to certain factors in our society which may tend to isolate people and prevent them from leading rich and varied social lives.

Trigant Burrow in 1930 examined "so called Normal Social Relationships expressed in the Individual and the Group and their bearing on the problem of neurosis." He distinguished two kinds of communication - the first of a primary type between people at a physiological level and the second which he calls
the secondary psychological system which occurs through symbols and language and employs physiologically only sight, hearing and speaking. Burrow goes on to suggest that neurosis (individual or social) has to do with the habitual substitution of the second mode of communication for the first and the consequent blocking and distortion of feeling life. He believes that emotional factors operative in our relationships can be approached only through direct physiological expressions and pleads for the use of the whole organism in contra-distinction to the use of a part only.

Burrow's ideas are certainly applicable in the upbringing of children but it is difficult to see how they could be put into practice on a wide scale in relationships between adults in our society. He is quoted here, however, because he appeared to be the forerunner of a group of writers of whom Elton Mayo is perhaps the most famous. Mayo writing in 1937 in "Psychiatry and Sociology in Relation to Social Disorganisation" says that modern industrial society has thrown the individual back on the family and encouraged an exaggerated capacity for logical thinking at the expense of man's capacity for effective social collaboration.

Claude Bowman in "Loneliness and Social Change" (1955) finds that urban society of the twentieth century is characterised by a decline in face-to-face contacts through smaller families and greater mobility - not only in relation to locality but also "vertical" mobility which takes people from class in which they were born and makes them strangers
in a new class to which they have "risen". One of the control subjects in the present research described himself as "déclassé". His father had been a train driver, he was an only child and had gone late to University. He shared a flat with friends and complained that although his parents wanted to see him, there was nothing to say when they met. He described himself as profoundly unhappy.

Bowman believes that some degree of loneliness is normal and indigenous to our society, but we may be paying too heavy a price in mental health for us to accept this and he suggests that we may be able to distinguish between deviant and "normal" types of loneliness. He appears to see no alternative to accepting the diminution in social contacts although he suggests that one of the tasks of psychiatry in relation to "deviant" loneliness is to make people aware of their isolation and to try to help them to alter it.

Robert Faris in an article entitled "Ecological Factors in Human Behaviour" (1944) defines ecological order as order emerging from competition such as we find in an industrial city. He opposes to this cultural order which he says is found only among humans and this is based on similarities, mutual affection and sentiment - like Bowman, Faris finds that ecological factors are tending to eat into the cultural order and are a major cause of social disorganisation.

Karen Horney in "The Neurotic Personality of Our Time" (1937) points to three contradictions in our social life which she believes are culturally determined. These are:
(a) Competition and success (factors already emphasised by Bowman and Faris as likely to lead to loneliness) versus Principles of brotherly love and humility (preached in our churches).

(b) Stimulation of needs, particularly through advertisement versus Factual frustration in satisfying them.

(c) Alleged freedom of the individual versus Factual limitations.

She believes that the neurotic is he who has experienced these contradictions in an accentuated form and has either not reconciled them or done so at great cost to his personality. She cites 3 qualities found in neurotics, two of which are noticeable in the patients who are subjects in the present research:

Rigidity in reaction.

Discrepancy between potentialities and accomplishment.

Difficulty in making decisions.

It has not been possible in this research to prove the presence of the second of these factors but the first and third will both receive comment later.

An interesting study on contrasting attitudes to life was made by Dr. J. C. Carothers in 1947. He considered all Africans admitted for the first time to a mental hospital in Kenya over the period 1.1.39 to 31.12.43. These numbered 609
which gives a rate of 3.4 per 100,000 population per annum compared with 57 per 100,000 per annum in England and Wales in 1938 and 161 per 100,000 negroes in Mass. U.S.A. during the period 1917-1933.

In considering these figures it must be borne in mind that Africans attempt to look after their insane relations at home and only bring them to hospital if they become unmanageable.

Dr. Carothers broke down the figures for admission to mental hospitals and found that just over half of the patients came direct from their homes in reserves; the rest came from other places. The respective proportions are 2.3 per 100,000 (from homes in reserves) and 13.3 per 100,000 (from elsewhere).

In analysing the types of illness of African patients he finds no sustained depression of the psychotic type and no cases of obsessive-compulsive neurosis nor anxiety neurosis. Dr. Carothers relates the absence of these illnesses to certain life patterns in Africa. In primitive agricultural-pastoral society, the prevailing feeling is one of equality; nobody suffers from feelings of inferiority and attitudes to sex are self-assured and healthy. The African lives in a difficult natural environment but an easy social one where he seldom has to think for himself. Dr. Carothers relates the rarity of insanity in primitive life to the absence of problems in the social, sexual and economic spheres. He believes that obsessional neurosis develops only when the individual "stands alone" and must develop his own ethical code. In Western
Europe directed thinking and a higher minimum level of intelligence are required. Personal choices and personal decisions are constantly needed. Carothers' work tells us facts about the level of insanity in a society which makes little demand for the qualities needed in present day Western society: qualities pointed out by writers such as Burrow, Faris, Bowman.

Reissman, Glazer and Denney in "The Lonely Crowd" (1950) point to the dilemma of modern man in Western society. The behaviour of earlier generations (e.g. medieval) was guided by tradition and that of later generations (e.g. in the Renaissance period) by "inner" direction which was possible because of the greater field of personal choice and opportunity. In contrast to these, the authors see the members of our present day society as "other-directed". The struggle with the environment for survival has largely been won and people are concerned with the opinions held by their peers. They show intense anxiety to conform and need for approval.

The authors of "The Lonely Crowd" see most hope for the "autonomous" individual who though capable of conforming feels free to choose whether to do so or not.

The dilemma of the Western type of society (and that of our psychiatric patients in particular) is how to reconcile the need for higher education to deal with technical development everywhere with the need for satisfactory social development which seems easier to achieve in simpler societies.
3. Literature dealing with Social Factors leading to Mental Illness.

Most of the literature in this section refers to schizophrenia. In relation to the total incidence of disabling mental illness in the U.S.A. and Great Britain, it is the commonest type and has therefore attracted the attention of students. Faris and Dunham, in a well-known work entitled "Mental Disorders in Urban Areas" (1937), examined the economic and social levels of the districts contributing 7,253 schizophrenic patients to State hospitals in Chicago during the period 1922-1931. They also considered other types of mental illness but their work on schizophrenia attracted most attention. They found that high rates for schizophrenia were concentrated in the communities of extreme social disorganisation in Chicago. These communities are described as hobo-hemia, rooming-house, foreign-born and negro. Many people living an isolated existence live in these areas.

The rates for schizophrenia decline with improvement in socio-economic conditions towards the outskirts of the city. Faris and Dunham put forward the view that extended isolation of the person produces abnormal traits of behaviour and mentality and that these schizophrenic traits can be seen to proceed from the one condition of extreme seclusiveness. After discussing the development of the individual and mental abnormality, they suggest that "sufficiently normal mental
organisation requires a normal family life, normal community life, reasonable stability and consistency in the influences and surroundings of the person all supported on a continuous stream of intimate social communication."

This book stimulated a great deal of further work on social factors in mental illness but at least 4 criticisms must be considered:

(a) Stuart Queen (1940) raises the question of differential diagnosis and states that Faris and Dunham agreed that errors of diagnosis in this work may have been as high as 30 - 40%.

Diagnosis in mental illness is undoubtedly extremely difficult in many cases. A group of three American psychiatrists, Page, Landis and Katz, in a study involving 125 schizophrenics, 100 manic depressives and 240 "normals" (1934) found that there was a general similarity in the three groups when tested for 50 schizophrenic traits. Many accepted schizophrenic traits were given more frequently by the "normals" than by the schizophrenic patients, but the likelihood of errors of as much as 30-40% in the work of Faris and Dunham makes it of less value than it otherwise would be.

(b) Mary B. Owen (1941) in criticising Faris and Dunham's work put forward the important point that they had assumed that their data represented all cases in local areas, whereas these were only the ones discovered. This is particularly important in relation to the areas of higher-income level where families often refuse to consider admission of one of their members to a State hospital because of the stigma. People living in comparative
isolation e.g. in a lodging house might well be admitted to hospital earlier because their behaviour would not be tolerated by strangers.

Faris and Dunham's study is therefore based on only part of the total field of mental illness in Chicago during the period in question.

(c) A criticism which is related to the second one above: Faris and Dunham find physical isolation and lack of social relationships to be an important factor in schizophrenia. Isolation of a less obvious kind resulting in failure to make social relationships may well be equally or more important in causing schizophrenia. The patients suffering this less obvious kind of isolation may well have been those considered by Miss Owen the ones who are "hidden" by their families. Such people are no less isolated and lacking in satisfactory social relationship although they may be living in the midst of an apparently affectionate and caring family. These are the people to whom reference will be made more than once in this research, particularly in the Chapter on "Attitudes to People" where under-development in the social field is discussed. Harry Stack Sullivan in "Clinical Studies in Psychiatry" (1956) and Laing in "The Divided Self" (1960) have both drawn attention to the isolation of the schizophrenic living in the family situation.
(d) It has been suggested that the behaviour of psychotics and incipient psychotics leads to a descent from middle and upper class living areas to poorer ones. This would mean that mental illness causes a drift to areas of social isolation and conflicts with Aris and Dunham's hypothesis that social isolation causes mental illness.

Goldberg and Morrison (1963) surveyed a group of schizophrenic male in-patients aged 25-34 and found that there was a predominance of Social Class V members although the social class of their fathers (at the time of the birth of the patients) showed a distribution similar to that of "normals".

At the time of admission to hospital 27% of the Class V patients came from families in that class.

This work seems to confirm the fourth criticism of Faris and Dunham's hypothesis. It must be remembered, however, that Goldberg and Morrison's work only takes account of hospital in-patients and excludes schizophrenics "hidden" by their families or failing to come to the notice of the students in other ways.

The work of Faris and Dunham stimulated at least two kinds of research:

(i) Repetition of their work in other areas of America, often with variations of their hypothesis.

(ii) Attempts to assess the amount of psychiatric disability in relation to the socio-cultural level in various areas, including not only hospital admissions but also out-patient illness and untreated illness.
(i) Studies repeating the work of Faris and Dunham.

(a) Shroeder (1942) gives an account of research carried out in 5 mid-Western cities based on admissions to mental hospitals - results were found to be similar to those of Faris and Dunham i.e. there were high rates of mental hospital patients drawn from the centres of these cities and progressively less in the outer more prosperous areas.

(b) Tietze, Lemkau and Cooper in 1941 emphasised the importance of heredity in the genesis of both schizophrenia and manic depressive illness but stated that "environment promoted or prohibited (ibid) the development of psychoses."
They found schizophrenia more prevalent in areas of low socio-economic status - manic depressive illness more prevalent in areas of high economic status. Their remarks are once again based on hospital admissions and are subject to the same criticism as the work of Faris and Dunham.

(c) Mowrer (1939) studying personal disorganisation in the depression and commenting on suicide in Illinois and insanity in the Psychopathic Hospital, Chicago, found that Faris's theory relating to areas of disorganisation held up except for two areas - one predominantly middle class area and the other an immigrant labourer area both of which had higher rates than the surrounding areas.

(d) Kohn and Clóusen (1955) described work carried out on 45 schizophrenic and 16 manic depressives and a matched group of normal controls. They enquired into social participation in adolescence to try to determine whether social isolation at the
age of 13-14 appreciably influenced the development of mental illness. They found that isolates, partial isolates and non-isolates had all been admitted to hospital at approximately the same ages and that isolates had not required longer nor responded less well in hospital than others. The crucial element in this research depended on subjects or subjects' families being able to remember correctly patterns dating back at least 16 years. It seems doubtful whether this material would be sufficiently reliable for solid conclusions to be based on it.

(e) Gerard and Houston (1953) took as their subject matter 305 male schizophrenics admitted to Worcester (Mass.) State Hospital between 1931 and 1950. They investigated (i) the mode of living of the patient at the time of his overt disturbance in terms of his family setting and (ii) residential instability of patients. They were able to obtain histories for 146 of the 305 subjects.

(i) In relation to the 146 subjects the authors found that 79% of these were living in some family setting at the time of their admission to hospital. 21% were not living in a family setting and this section also showed marked instability of residence.

(ii) Taking the group of 146 patients as a whole, they did not show a striking degree of residential instability. 75% of the patients were living one year before at the addresses from which they were admitted to hospital and 52% were living 5 years before at the same addresses.
The authors point out that the patients not living in a family setting (i.e. 21%) showed a marked central concentration in the city, i.e. this result agreed with the finding of Faris and Dunham. The residences of the remaining 79%, coming from family settings, were distributed at random throughout the city.

Gerard and Houston rated each ward of the city in relation to the housing level, dividing these into 5 areas, numbering from 1 for poor housing to 5 representing a high level. They found that family structures relevantly associated with schizophrenics were not correlated with particular levels of housing as measured on their scale.

Their work seems to add weight to the third criticism of Faris and Dunham's work i.e. social isolation in the development of schizophrenia may be of a more subtle but no less devastating kind than physical isolation.

(f) Clark (1949) was interested in the relationship between occupational prestige and psychoses and based his work on 12,168 male first admissions with psychoses, aged 20-69, to state and private hospitals in Chicago between 1922 and 1934. He found an inverse relationship between rates for psychoses and factors of occupational income and prestige, which held true for all kinds of psychoses except manic-depressive. He states, however, that choice of work is dependent on many factors including possibly those which segregate men according to the likelihood of becoming psychotic. His results agree on the whole with those of Faris and Dunham.
(g) Tietze, Lemkau and Cooper (1942) studied the relationship between personality disorder and spatial mobility with special reference to moving house. Their work was done in Baltimore with 1,022 individuals gathered from a wider population than that tapped by most other students. Their sources included private and public mental hospitals, psychiatric clinics, social agencies and juvenile courts and the authors found that the population in more mobile households furnishes more than its share of psychoses, neuroses and psychopathic personalities. This conclusion is open to two interpretations:

(i) Mobile families have adjustment difficulties and personality disorders resulting from moving.

(ii) Families with a tendency to mental deviation may not adjust well and therefore move more often.

(h) Hyde and Kingsley (1944) studied the relationship of mental disorders to the Community Socio-Economic level in Massachusetts. Their subjects were 60,000 selectees for the Army and therefore excluded many psychotics who were in hospital or known to be ill prior to examination. The study is useful because the subjects were not drawn from a special population such as in-patients of hospital or social agency clients. The authors drew up a scale of desirability in relation to the socio-economic level ranging from A (very good) to F (poor). They found that the percentage rejected on grounds of mental ill-health increased from 7.3% rejected from socio-economic level A to 16.6% rejected from level F.
This increase in mental ill-health from the richest to the poorest members of the population held good for all types of mental illness except psycho-neurosis for which no relationship of this kind could be found.

Hyde and Kingsley (1944) carried out a further study with the same subjects related to population density and found that the highest incidence of mental ill-health occurred at the two ends of the scale, i.e. in poor rural, thinly populated areas and in the poor urban densely populated areas. The lowest rate of ill-health occurred in small cities.

(ii) Work which attempted to assess the amount of psychiatric disability related to socio-economic level in various areas, including untreated illness.

(a) The aim of Dorothea Leighton's research (1956) was to determine the relationship between socio-cultural environment and the distribution of psychological disorders in a small town (pop. 3,000) in the U.S.A. She not only searched the records of general and mental hospitals but took a random sample of the adult population who were not already known as having been admitted to hospital. 283 people were interviewed in an enquiry about health (including psychosomatic complaints) and cultural details. The subjects were interviewed by a team of psychiatrists who rated them as to their degree of mental illness or health. On these ratings it was estimated that 370 people in every 1,000 were showing symptoms of mental illness either treated or untreated.
(b) The above research was part of a larger one conducted by Alexander Leighton and a team from Cornell University (1963). This research surveyed 1,000 individuals in a Canadian Maritime province. Amongst the 1,000 individuals 31% showed "clear psychiatric disorder", 26% showed some disorder and only 17% were fit.

The report makes no mention of the remaining 26%.

These are high figures for psychiatric disorder and most of them were psycho-somatic or neurotic rather than psychotic. Most of the adults interviewed did not consider themselves in need of psychiatric treatment and had never had any. The authors believed that at least 20% of the general population had definite need of psychiatric help and that a larger percentage would be assisted by preventive or therapeutic measures.

Leighton believes that the size of the population has a bearing on the amount of illness but, more important, its results suggest that there is less risk of psychiatric disorder for the person who is a firm member of a local well-integrated group. The individual needs to feel that he is a worth-while member of a worth-while group.

This is no doubt true, but it is also necessary to remember the experience reported by Whyte in "The Organisation Man" referred to on page 15. Pressure to conform to the group can be damaging to the individual and mental health is likely to be achieved only if tolerance and a wide variety of expressions of personality are encouraged.
(c) Pond, Ryle and Hamilton (1963) examined social factors and neurosis in a working class population. The subjects were drawn from the National Health Service list of a doctor and consisted of families with at least one child at primary school. The families were drawn mainly from Social Classes III and IV and included 89 fathers and 98 mothers. Interviews covered social factors (class, income, consumer status, housing amenities etc.) childhood experience and an assessment of neurosis (measured on the Cornell Medical Index). The results showed an association between recollection of an emotionally disturbed childhood and neuroticism, but no significant association between neuroticism and social factors.

Another field of study which has bearing on the present research is that of the relationship between social mobility and mental illness.

Myers and Roberts in a book entitled "Family and Class Dynamics in Mental Illness" (1959) examined two hypotheses:

(i) The social and psychodynamic factors in the development of psychological disorders are correlative to an individual's position in the class structure.

(ii) Mobility in the class structure is associated with the development of psychological disorders. The sample used consisted of 50 patients admitted to mental hospital and drawn from each of the two Social Classes III and V. Mobility was measured by a comparison between the patient's social class
and that of his family of origin. The authors found that the first hypothesis was supported by the findings and the second one was partially supported i.e. it held up for Social Class III patients (more mobile than brothers and sisters) but not for Class V ones.

This study is particularly interesting in relation to the present research in which mobility in married women has been found to be greater in patients than in controls though not significantly so. The measurement of mobility in this research was, however, between pre-marriage social class (determined by the individual's work) and post-marriage class (determined by the husband's occupation).

Myers and Roberts drew attention to another factor which is possibly contributory to mental illness: discrepancy between achievement and aspiration. Achievement is defined as the position attained; aspiration is defined as the position which the subject said he wished to achieve.

The authors found that Class III patients showed discrepancy in the educational field, the occupation and in leisure time activities. The aspirations of these patients often originated with the parents. Myers and Roberts found that the aspirations of schizophrenics were significantly higher than those of neurotics and the difference between the aspirations of schizophrenics and their siblings was greater than that between neurotics and their siblings.
In the present research 5 out of the 9 schizophrenic, pre-schizophrenic or leucotomised patients came from over-protective homes in which the aspirations of the parents were driving the children to an "over-consciousness" of their need to succeed.

Probably one of the reasons for the aspirations of parents in relation to their schizophrenic children is that these schizophrenic children often appear to have intelligence above the average. Unfortunately their emotional maturity is at a low level and they are unable to fulfil the promise held out by their intelligence level.

Mary Lystad carried out work which was concerned with social mobility among schizophrenic patients. She studied 94 schizophrenic patients with a good prognosis who were admitted to a State hospital in 1953 and 1954 and compared them with 94 non-psychiatric patients attending O.P. clinics in a semi-private hospital in New Orleans. Anyone who had had psychiatric care or who had contemplated this was eliminated from the second group.

Miss Lystad compared the achievement (measured in upward status mobility from the father's social class) of two sub-groups of middle class, female, white patients with education going beyond the grammar school. The two groups were drawn from her two sources, i.e. a State mental hospital and a semi-private hospital. She found that the achievement of the second group was greater than that of the first.
At the other end of the social scale, Miss Lystad compared the achievement of a sub-group of lower-class negro male patients with education stopping before grammar school level. The groups were drawn from the two hospitals as before. Miss Lystad found here that the non-mentally ill achieve no more than the mentally ill.

With regard to geographic mobility to middle-class white, younger patients in the semi-private hospital show a greater degree of this than the mentally ill patients matched for class, colour and age.

Miss Lystad asks whether failure to achieve in the middle class leads to schizophrenia or does schizophrenia tend to prevent persons from attaining a higher degree of success in the middle class?

Two criticisms can be levelled at this work:

(i) Miss Lystad compared a group of schizophrenic patients in a State hospital with a group of allegedly non-psychiatric patients in a semi-private hospital. The economic status of these two groups is different. Patients in a semi-private hospital (presumably paying for part of their treatment) are a selected group and may be more upwardly mobile than patients in a State hospital. Information on this point is inadequate in the article.

Where comparisons regarding mobility are to be made, it is particularly important that the matching groups should be drawn from the same type of institution.
(ii) Miss Lystad selected a group of allegedly non-psychiatric patients for her control group. She excluded those who had had psychiatric care or who had contemplated this. The contribution of psychiatric disability in the causation of a wide range of "physical" illnesses is acknowledged. These illnesses include asthma, gastric ulcer, fibrositis, migraine, ulcerative colitis, double vision, nervous dyspepsia, and many others which can be tentatively included such as arthritis, rheumatism, hypertension.

Medical science is not yet in a position to state how great or small is the psychiatric factor in these illnesses but they cannot be included under an omnibus label of non-psychiatric.

Miss Lystad suggests longitudinal studies of schizophrenic patients and controls which include the aspirations of the individual and his parents in early childhood, adolescence and when overt symptoms develop.

This work seems essential in order to understand more clearly the development of schizophrenia and the part played by the pressure of ambitious parents on individuals who may be constitutionally predisposed to this kind of illness. One of the main difficulties in carrying out such work would be in singling out the children and adolescents who are at risk in this way.
A beginning has been made on this task by Andrew McGhie (1961) who published work dealing with the differences between the mothers of subjects in three groups:

A. Schizophrenic  20 subjects  
B. Neurotic   20 "  
C. Normal    20 "

McGhie was particularly careful to prepare the mothers by two long preliminary interviews aimed at reassuring them and minimising anxiety. This was particularly necessary with the mothers of the schizophrenics.

His most interesting finding was that these mothers "accepted, approved and actively encouraged deviant features in their children's development" whereas the mothers of the neurotics showed a more rational and insightful attitude to their children's difficulties. Aside from this the schizophrenics' mothers had often suffered from a disrupted parental home themselves (13 out of 20) and, since marriage, had centred their interests narrowly on the home and family.

The mothers of the neurotic group described themselves as nervous and easily frightened in childhood and their children as having suffered from numerous physical ailments during early childhood. They felt that they had over-protected them in the first place because of these physical illnesses.

McGhie goes on to say that the genetic and environmental views in relation to schizophrenia are not inconsistent with each other; whereas inheritance sets the limit of the individual's capacity for development, his environmental
experience will determine the degree to which these capacities or incapacities will actually be realised. He believes that this may account for the "mental survival" of the siblings of schizophrenics.

4 Conclusion

This review of literature relevant to the present research has fallen into three sections:

(i) A short section discussing social factors in the lives of normal people. Reference was made to other cultures.

(ii) A study of some of the literature dealing with social factors leading to mental illness. In Western society these factors included:

(1) The influence of economic expansion on social life. Industrial development and the acquisition of wealth hold a position of priority in the values accepted in western society today.

(2) Economic expansion has led to greater mobility both geographic and vertical - geographic because people are often willing to move to a different area for the sake of promotion. If this happens too frequently, the capacity to make roots in a locality is likely to be weakened.

Vertical mobility (which is often involved in geographic mobility) occurs when people move from one social class to another. A period of adjustment is necessary and this adaptation may be difficult or impossible for one or other member of a family group.
Emphasis on economic values has resulted in an alteration of social values, so that these become mixed with economic values ("keeping up with the Jones's") or attenuated with the result that people lead extremely narrow lives within the boundary of their homes and concentrate their attention on the small family group to the detriment both of society at large and the small family itself.

This narrowing of social life and insistence on "getting on" has caused an "intellectualising" of life and an emphasis on the need for logical thinking and personal decisions. These represent a reversal of the emphases in primitive societies where material conditions may be very poor, but people often live an intensely social life shared with a group and are responsible for few personal decisions. The non-existence of obsessional neurotic illness and chronic depression has been attributed to this difference in emphasis in the lives of primitive people.

(iii) The last section of this review has been devoted to literature concerned with the social factors in mental illness. Most of this work has related to schizophrenia and some of the areas investigated include:

(1) Population Density - Areas sparsely inhabited and those densely populated both show a high rate of mental illness whereas the medium sized town has the lowest rate.
(2) **Socio-economic conditions** - Contradictory conclusions have been reached with regard to the relationship between schizophrenia and socio-economic conditions.

On the one hand it has been found that incidence of illness is in inverse relationship to the possession of property and prestige and that it is related to physical isolation and downward mobility.

On the other hand, evidence has been brought forward to show that it is unrelated to physical isolation and that the aspirations of schizophrenics are higher than those of their siblings and of neurotics.

The common feature found in both these situations is isolation: physical in the first and social in the second. Although living in the family, the schizophrenic is often isolated and maintaining only a minimal contact with his family.

(3) **The family situation** - The social orbit, including family and friends, of the mentally disturbed person has been found to show a high proportion of disturbed people: "mental illness is the most contagious of all illnesses." (Burrow)

The mothers of schizophrenics in particular were found to have suffered family deprivation in childhood and to have shaped a narrow family situation for themselves in which they were the dominant figures. More disturbing, they appeared to have accepted and encouraged the deviant traits in their children.
(4) **Class mobility.** Class III Social Class subjects in an American study were found to have more aspiration towards mobility than their siblings. The gap between aspiration and achievement in this group of Class III schizophrenics is wide.

The factors mentioned in the last section "The Family Situation" may well link with this observation. It seems plausible that the mother of a schizophrenic, shaping a narrow social environment and blocking his ability to understand and accept the real social world, may also encourage aspirations which, though not necessarily impossible of achievement intellectually, are unrelated to the situation of her child.

The three sections of this review all deal with the part played by social factors, in the broadest sense, in determining the behaviour of men. It must be added that innate constitutional factors have not been forgotten. The dilemma of social psychiatry is in understanding the extent to which each of these factors, the social and the constitutional, contribute to behaviour. It can be said that innate factors set the limit in development and the environment determines what use is made of these factors. We are not yet in a position to assess the innate factors at all accurately and environment plays its part from the moment of conception. There still appears to be much room for study of the ways in which environmental factors help or hinder the progress of the individual towards mental health or the reverse.
III. METHOD

1. Introductory

It will be remembered that the research was planned with two objects in view:

(1) To get a factual account from each subject of his social activities in order to see the fields within which he was operating socially.

(2) To compare the "close" friendships of patients with those of a control group.

2. Pilot Studies

Two pilot studies were undertaken.

(a) The first pilot study consisted of unstructured interviews with 8 patients and 4 volunteers. Subjects were seen two, three or four times, and were asked to describe their social relationships from childhood on. The fields covered school, work, marriage, friendship and social activities undertaken in leisure. The material collected in this way proved unwieldy and information from patients and volunteers could not be easily compared. Additionally no attempt was made in this first study to guard against possible effects of the interviewer's preconceptions. Eliciting of a social history from each subject had, however, proved of value in revealing contrasts in social activity within the lifetime of a subject. It was possible by this method to observe the effect on social activities of a personal crisis in the life of the individual
and for this reason the taking of a history within limited areas was retained in the research proper.

(b) The second pilot study was organised differently. In the first place it sought to deal with the question of interviewer bias in the following way:

A short questionnaire (No.1) requiring written answers was given to 8 patients by colleagues of the interviewer. The completed questionnaires were retained by colleagues until after interviewing had taken place. The interviews took place about six weeks after completion of the forms and were open-ended covering the same areas as the questionnaire. Opportunity was given for full statements by the subjects. Subsequently the written replies and interview material were compared.

Out of a total of 28 questions given to each of 9 patients, i.e. 252 questions, 17 contradictions were noted as between written and verbal answers. Of the 17 contradictions, 7 referred to Section 1 (living conditions), 5 referred to Section 2 (relatives), 1 referred to Section 3 (work), 2 referred to Section 4 (leisure time activities) and 2 referred to Section 5 (friends).

Omissions were also considered. These referred to items of information given in the interview and omitted in the written questionnaire or vice versa. 31 such omissions were noted among the total of 252 questions given to the
1. How many people make up the household in which you are living? Please give the sex, approximate age and relationship to you of each one.

What is your position in the household? Are you keeping house, householder, lodger or child of the householder?

Who do you get on best with?

Do you combine your entertainment with others at home, or go your own way?

Are you more contented at home or outside?

Are you happy about this situation or would you like it to be different?

2. Have you a relative outside the household with whom you are in close touch?

Do you visit this person? How often?

Are you visited by this person? How often?

Do you go out with him/her? How often?

Do you write or 'phone him/her? How often?

Are you happy about this situation or would you like it to be different?

3. What is your work?

How many people work in the same room as you?

Do you like, dislike, or put up with your work?

Do you get on well with the people at work?

Do you avoid as far as possible the people at work?

Do you put up with them?

Are you alone when you are working because of the circumstances of the work?

Do you like this, dislike it or put up with it?

Are you happy about your work situation or would you like it to be different?
4. Do you belong to a church, Trade Union, club or other leisure time group? If so, please give details of membership.

How often do you go to a service or meeting?

Are you actively interested in the groups to which you belong?

Are you happy about this situation or would you like it to be different?

5. Have you any friends? If so, please give sex and approximate age of each:

Do you talk to people you meet in shops, on buses or trains, in the public house?

Are you happy about this situation, or would you like it to be different?

Section 5 of the questionnaire, relating to friends, appeared to give rise to anxiety and self-consciousness. It was difficult in most cases to gauge the depth of friendships. The section is a most important one but it was decided, because of the anxiety aroused, that in the research itself friendship should be approached through the leads of work relationships, and this proved more satisfactory.
9 subjects. These occurred as follows:

6 in Section 1. Living conditions
3 " 2. Relatives
2 " 3. Work
10 " 4. Leisure time activities
10 " 5. Friends

It will be noted that whereas contradictions occurred most frequently in the sections relating to living conditions and relatives, omissions occurred most often in the sections relating to leisure time activities and friends. The more severely disturbed subjects tended to show more contradictions and omissions than the more stable.

The verbal answers, as one would expect, gave a much fuller picture of the subject than the written answers. Section 5 of the questionnaire, relating to friends, appeared to give rise to anxiety and self-consciousness. No patient was prepared to admit that he was friendless but it was difficult in most cases to gauge the depth of friendships. The section is a most important one but it was decided, because of the anxiety aroused, that in the research itself friendship should be approached through the lead of work relationships, and this proved more satisfactory.
(c) **Conclusions from Pilot Studies**

The experience gained in the two pilot researches showed:

(i) That the field of enquiry into social relationships needed to be strictly limited if it was to yield useful comparisons.

(ii) That history-taking within limited areas, e.g. work, absence from home etc., could be of value in lighting up different facets of the lives of patients and controls, and helping to show the foundations on which their present lives were laid.

(iii) That the presentation of a simple questionnaire for completion by the subject in writing, at the first meeting, served to focus his mind on the enquiry and to guard against effects of the interviewer's preconceptions.

(iv) That questions relating to friendship needed to be framed with extreme care. Indications from the two pilot researches showed that factual replies could be expected more often if the word "friend" were not used in the short questionnaire requiring written answers, for the word had proved to be an emotionally loaded one.

(v) That unhurried interviews with subjects were likely to yield much more information on the subject of social relationships than the written questionnaire. Much valuable information was offered spontaneously when a subject had replied to a question and continued to exemplify
his attitude from his own experience. Examples of such spontaneously offered remarks are included under "Vivid remarks made by subjects".

(d) **Research Proper**

(i) **Plan**

As a result of the two pilot studies it was decided to retain a modified form of the questionnaire which was given to subjects to complete in writing at the first meeting (Enclosure 2). It will be seen that it is divided into four sections:

1. The immediate household usually consisting of the family of the subject.
2. The extended family or relatives outside the home.
3. Work.
4. Leisure-time occupations, such as Church or Trade Union membership, evening classes, attendance at films, theatres or other organised activities, and unorganised leisure-time activities and contacts with friends.

The completion of the questionnaire was followed by open-ended interviews using a guide (Enclosure 3). It will be noticed that most questions ask for factual answers and few are directed to the measurement of attitudes. It was felt that these were better gauged by the interviewer on the basis of facts supplied by the subjects. For example, a deeply
No. 2

I. 1. How many people make up the household in which you are living? Please give the following facts about each person in the household.

<table>
<thead>
<tr>
<th>Relationships to you</th>
<th>Sex</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Please underline the person in the household with whom you think you get on best.

3. When you are home do you enjoy your own company or do you prefer to be with other people?

4. About how many years have you lived in this district?

5. What is your position in the household? Put a cross next to the position which describes yourself.

   - Chief wage-earner
   - Keeping house
   - Keeping house and wage-earning
   - Lodger
   - Child of the head of the household
   - Other (please give particulars)

6. Please put a cross beside whichever of the following statements seems to be more true for you.

   - I am satisfied with conditions at home.
   - I would like conditions at home to be different.

II. 1. Do you keep in touch with any relatives outside your home? Please give relationship to you and other facts as asked for.

<table>
<thead>
<tr>
<th>Relatives</th>
<th>Age</th>
<th>Sex</th>
<th>District where relatives live</th>
<th>How keep in touch, e.g. visiting, meeting, letters, 'phone etc.</th>
</tr>
</thead>
</table>

III. 1. Have you a job outside your home? If so, what sort of work do you do? Please describe in detail.

2. Would you say you enjoy doing it or not?

3. How long have you been doing this particular sort of work?
4. Have you ever done any other sort of work? If so, what?

5. About how many people would you say that you spend some time with, at least once a week, apart from relatives and people you work with?

IV. 1. What sort of things do you do in your leisure time?

2. Do you belong to any sort of social group such as a sports club, social club, church club? If so, please give particulars.

3. Do you go with other people or alone?

4. Do you belong to any other associations such as trade union, or evening class?

5. Do you think you would like to join other social groups or clubs?

6. What kind of entertainments do you go to at some time or other? Please put a cross beside the ones you go to.

   - Films
   - Football or cricket matches
   - Theatres
   - Dancing or Jazz Clubs
   - Dog-racing
   - Concerts
   - Other (please give particulars)

7. Would you say you enjoyed going to places where there are other people or preferred your own company?
No.3

I. 1. Household
   2. Get on best with
   3. Enjoy own company at home or prefer other people
   4. Is it hard to leave family to be in own room?
   5. Have you ever lived away from family? For how long?
   Pattern of activity
   6. How many years in this district?
   7. Details of moves in last 5 years
   8. What do you live in?
   9. How many rooms?
   10. How many rooms for sleeping in?
   11. ? Garden
   12. Position in household
   13. ? Satisfied with conditions at home or not?

II. 1. In touch with relatives outside home.
   2. Details including method of contact and locality.
   3. Who takes initiative?
   4. Depth of relationships.

III. 1. Job outside home?
   2. If not working, how long since? What work?
   3. Intend to work again? When?
   4. Enjoy work?
   5. If not, what would you like to do?
   6. ? Practicability of this.
   7. How long present work?
8. How long this job?

9. How many people working with?
   Expansion

10. Enjoy contact with people at work?

11. Meet people at work outside working hours?

12. Friends through work or vice versa?

13. Level of friendship

14. Ever done any other sort of work?

15. Experience in services?

16. Main wage-earner's work?

17. How many people spend time with at least once a week apart from relatives and people you work with?

18. Initiative

19. Where did you meet them? At school, work, leisure, living near, or other ways?

20. Are some of them close friends? How long known?

21. Have you lost touch with people whom you used to know, e.g. through moving, illness etc.

22. Enjoy meeting new people or prefer old ones?

23. Easy to talk to strangers?

24. Ever wanted to know more people?

25. Can you remember what you felt like in relation to people when you were in your teens?

26. Made any friends recently?

27. Do you want to go to your friends when worried or depressed or wait till you feel better?

IV. 1. Leisure time activities

2. Social group
3. How did you come to join?
4. Used to belong to more or different?
5. How often do you go?
6. With other people or alone?
7. Ever alone?
8. T.U., Church, Evening Class?
9. How did you join?
10. Part played, e.g. active etc.
11. Like to join other social groups?
12. Entertainments?
13. Museums, etc.
14. How often?
15. Alone, etc.
16. Whose idea?
17. Other members of household?
18. Their leisure?
19. Special reference to partner
20. Enjoy places where there are people or prefer own company
21. Enjoy life?

V. 1. How old when left school?
2. Marital state
3. Age
4. Sex
5. Occupation

This subject threatens to colour the testimony of individuals in respect of the attempt to elicit every attitude as well as possible a "factual" one. Reference to concluding remarks included may indicate the results. The attempt to elicit every attitude as well as possible a "factual" one. Reference to the research almost entirely to the finding of facts was a major one. It yielded fruitful
disturbed male patient of 20 years replied to Question 20 (Section III): "I don't know what you mean by friend," and continued a little later, "I don't trust anybody". Another subject, a young married woman of 27 years divided her "friends" into (1) acquaintances with whom she shared common interests in babies, home and dressmaking (2) friends of long standing who had been colleagues in the teaching profession and (3) her husband with whom alone she was prepared to share her problems and anxieties. This subject threw out: "I don't like the acquaintances much" - they were, nevertheless, included among friends and quite clearly served a social purpose.

Emotional attitudes colour the testimony of individuals in relation to facts, but if one is to accept evidence from the individual at all, the choice lies between the attempt to elicit facts and the attempt to elicit overt attitudes as well as facts. In this research, which included many disturbed subjects whose underlying emotional attitudes were quite often unknown to themselves, it was decided to make the enquiry as far as possible a "factual" one. Reference has already been made in the Review of Literature (Chapter II) to Elizabeth Bott's book (Family and Social Network) in which she also followed the "factual" method of enquiry. The student was clinically experienced and the decision to limit the enquiries in this research almost entirely to the finding of facts was a major one. It yielded fruitful
results, however, in that subjects realising that no advice would be offered, were often prepared to express their attitudes freely.

(ii) Use of History

The areas in which it was considered useful to obtain a history were limited to four:

1. An enquiry of the facts relating to periods in which the subject had lived away from home. This covered evacuation, boarding school, university career, service career, etc.

2. A detailed enquiry relating to living conditions during the five years prior to the interview. This revealed the number of household moves and type of accommodation in each case. This information also threw light on the social condition of the subject during this period.

3. A work and service history for each subject. This proved valuable particularly in relation to disturbed patients who often spoke rationally and with interest of their work in the past.

4. A history relating to membership of organised social groups such as Scouts, Guides, Youth Club. This helped to show whether the individual felt that he had changed from being a solitary to a "mixer" or vice versa, or felt that he had carried the same characteristics throughout life.
(iii) **Note on Friendship**

An attempt was made to get some information on the varying depth of friendships. One method of doing this was by enquiring about people seen (aside from relatives and co-workers) at least once a week. In the first part of the research proper the question was asked in this way. The answers indicated that full information on friends was not being obtained, so in the last part of the research (19 patients and 35 controls) the question was extended to include people seen less often than weekly.

The frequency with which friends are seen, in certain circumstances, determines the depth or shallowness of the feeling involved. Such a criterion could be valid in dealing with children or simple societies, but is not particularly useful in the area in which this research was undertaken. Busy subjects with large families temporarily lose contact with neighbours who move away, but may pick up the threads again and find close relationships still existing after several weeks' intermission. In a suburb of London, such as the one where this research took place, subjects may work with people living at a long distance. When they change their jobs regular contact is broken with friends made at work, yet many people retain the link and meet each other three-weekly, monthly or even six-monthly. Such friendships may still be valued and important.
After considering various criteria, it was decided to try to gauge the "closeness" or otherwise of friendships by defining a "close friend" as "someone with whom you would be prepared to discuss a personal problem".

It is true that one meets people by accident on a train, at a bus-stop, or in a cafe, who are prepared to describe to a complete stranger the personal problems confronting them at that moment. They usually do not require from the listener more than a sympathetic nod or shake of the head, and they appear unworried by the private nature of their revelations. These occurrences have certain characteristics which separate them from friendship: the acquaintance on the train rarely or never gives his name or any identifying facts; he rarely or never asks his listener for these details but is content to "let off steam" and continue his life elsewhere. He uses the listener in a way similar to that in which a more sophisticated or reserved person writes a letter or uses a diary, to state the facts as he sees them, and perhaps get them in better perspective by so doing. This represents the first stage of a conversation with a close friend but this is normally followed up in the latter case by requests for advice or confirmation of the rightness of the speaker's actions. In the case of "close" friendship, both partners must contribute to the conversation, whereas an acquaintance can conduct a monologue with only a very slight degree of encouragement to enable him to continue. "Close" friend was defined by the interviewer...
in this research as "someone with whom you would be prepared to discuss a personal problem". Most subjects responded to this, although there was great variety in the number of "close friends" claimed by various subjects.

Much fuller information was given in the interviews than in the written questionnaires. The interview material was therefore mainly used in assessing the results but a comparison of the material from both sources has been carried out and comments will be made about this.

When the form was completed it was handed to the student and an appointment made for the first interview. Occasionally this took place at once but more often an interval of a few days or a week elapsed between the completion of the form and the first interview. Most interviews lasted about an hour.

A slightly different method had to be used for introducing the research to control subjects. They were told that the work had originated in an attempt to explore the social activities of psychiatric patients and that subjects "not under treatment" were needed as well, so that the results of the two groups could be compared.

The majority of control subjects completed the questionnaire at the beginning of the first meeting and the first interview (using the Interview Guide 3) followed immediately, an interval of a week or ten days often elapsing between the time of the first and second interviews.
3. Procedure

The research was introduced to the patients at the time of their first appointment with the consultant in the psychiatric clinic. The research student introduced herself as the Clinical Psychologist and asked each patient to complete the questionnaire (2), explaining that there would be an opportunity to discuss the questions raised later. She invited patients to ask questions if they were in difficulty about the completion of the form but as this is fairly simple no serious problems were encountered.

When the form was completed it was handed to the student and an appointment made for the first interview. Occasionally this took place at once but more often an interval of a few days or a week elapsed between the completion of the form and the first interview. Most interviews lasted about an hour.

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The majority of control subjects completed the questionnaire at the beginning of the first meeting and the first interview (using the Interview Guide 3) followed immediately, an interval of a week or ten days often elapsing between the time of the first and second interviews.
Most subjects were interviewed on two occasions in order to cover the ground and not to give a feeling of haste, but occasionally three, four or even five interviews were necessary because of the disturbed state of the patients.

Interviews took place mainly in the psychiatric clinic (patients) or at home (controls), but a minority of subjects were seen either at their place of work or at Bedford College.

Distribution of the interviews was as follows:

**Patients:**
- Clinic interviews ... 102
- Home " ... 13 because of severely disturbed state or advanced pregnancy. 115

**Controls:**
- Clinic interviews ... 26
- Home " ... 50
- Bedford College interviews ... 20
- At work ... ... 10

The majority of interviews took place with no one but the student and the subject present, but in five instances control subjects had small children present and in one interview with a patient, her husband was present for a short time at the end. (No.53).

Subjects were seen in the following order:

Phase 1, 25 patients
" 2.  25 controls
" 3.  26 patients
" 4.  26 controls
During Phases 1 and 2 interviews started with Section 1 (Form 3) and proceeded through to Section V, Biographical Information.

As a result of experience, however, it was felt to be better to start the interviews with Section IV and V relating to leisure time activities and biographical information, and to leave Sections I, II and III until later. These sections referred to personal living conditions and it was considered better to leave questions about these until the subject was more familiar with the interviewer. During Phases 3 and 4 the order of interviewing was therefore changed and Sections IV and V were dealt with the first time, and Sections I, II and III later.

4. Subjects

Men and women of ages of 17 to 40 inclusive living in an urban community.

(a) Source of Patients

51 patients within the required age-range were taken in chronological order as they were referred to the clinic. A small number who were asked to take part in the research did not, in fact, do so for the following reasons:
Too disturbed ... 2 (1 male, 1 female)
Refused ... ... 2 (2 female)
Consultant advised against 2 (1 male, 1 female)
Moved away ... 1 (male)
Failed appointments 4 (2 male, 2 female)

The source of patients who were used is as follows:
- Referred to Consultant by General Practitioner 41
- Attempted suicide .... ... .... 6
- Referred for intelligence test ... ... 1
- Referred by other Consultants ... ... 3

Total ... ... 51

The age of the people who had attempted suicide varied very considerably:

1. Female aged 34. Pregnant with second child.
2. Female 18. At school, overworking for A level and very run down physically.
3. Female 25. Swedish wife with marital difficulty.
5. Female 30. Divorced with custody of child.
6. Male 37. Unmarried and out of work after 20 years with one firm.
(i) Diagnosis

Anxiety state ... ... 15
Chronic anxiety state ... 2 (unable to travel)
Depression ... ... 13
Attempted suicide ... ... 6
Schizophrenia ... ... 5
Pre-schizophrenia ... ... 3
Post-leucotomy ... ... 1
Delinquent ... ... 2
Alcoholic ... ... 2
Psychopath ... ... 1
Adolescent instability ... 1
---
51

(ii) Duration of Illness

The patient group was drawn from people presenting themselves for the first time at the Out-patient Psychiatric Clinic. They were not asked for details of previous psychiatric illness but at least 9 are known to have had treatment previously and in addition 2 had been chronically delinquent. The 9 patients who had had previous treatment are listed below:

Female now aged 37 Puerperal breakdown and in-patient treatment at 29 years of age.

Female " " 28 Child guidance treatment in adolescence. In-patient treatment at a mental hospital at 24 years of age.
Female, now aged 28  Short period of out-patient treatment one year previously.

Female " " 23  Out-patient treatment including E.C.T. two years previously.

Female " " 20  In-patient treatment at Netherne Hospital at 18 years of age.

Female " " 19  Child guidance treatment from 8 - 12 years of age.

Male " " 31  Breakdown at 18 years of age and leucotomy then.

Male " " 17  Child guidance treatment at 8 years of age.

(b) Source of Controls

There is no satisfactory way of finding a small group of controls who are not selected as being members of a particular social group.

Two methods were considered before arriving at the one used. In the first, out-patients attending hospital were to be asked to act as controls, but it was realised that these frequently suffer from psychosomatic illness.

In the second, parents and relatives of children attending state schools were to be used. The School Welfare Officer was approached to contact parents, but although the Head Teachers were co-operative the Welfare Officer was unable to help.

Finally, a chain of enquiries through friends, fellow-students and colleagues produced sufficient control subjects. It is realised that subjects gathered in this way are likely to be more socially conscious than the general population.
They may have other characteristics distinguishing them, such as a half-recognised desire for psychiatric treatment. These problems will be considered later.

Matching Areas of the Two Groups of Subjects

Subjects were matched for:

(i) Sex

(ii) Marital status

(iii) Number of children under 5

(iv) Possession of school children

(v) Age within 10 years

(vi) Social class. (Registrar General's Classification from the Census, 19XX)

(vii) Urban residence

(ii) Marital Status

Controls were matched with patients for marital status but in a minority of cases a person with a broken marriage (and therefore not living with a spouse) was matched with a single person. It was felt that the living conditions in these cases were similar and that the subjects were comparable. Particulars of these few cases are given below:

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Irregularities</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.41 (patient) Male, separated.</td>
<td>Matched with No.20 (Control) Male, single.</td>
</tr>
<tr>
<td>No.54 (patient) Male, single.</td>
<td>Matched with No.49 (Control) Male, divorced.</td>
</tr>
<tr>
<td>No.58 (patient) Female, separated.</td>
<td>Matched with No.50 (Control Female, single.</td>
</tr>
</tbody>
</table>
(iii) Number of children under 5

Subjects were matched exactly in respect of the number of children under 5 except in one case where a patient (No. 56) with 3 children at school was matched with a control (No. 54) with 4 children at school and 1 under 5.

Opportunities for social relaxation vary a great deal with the number of children under 5. Mothers with one baby can often make arrangements, if they so wish, for a friend to take care of the child while they go out shopping, attend a class or go to an entertainment with their husbands. It becomes much harder to arrange for child-minding when there are two children under 5 and virtually impossible if there are three. The possibilities of pursuing social interests aside from the children therefore vary a great deal with the number of under-fives involved.

It was felt, however, that where the children were of school-age, matching the exact numbers mattered less, particularly at a time when school dinners are popular and children are often out of the home from 9.0 a.m. to 4.30 p.m. So in this research patients with one child at school were matched with controls having 1, 2 or 3 children at school, and vice versa.
(v) **Age within 10 years**

The age range under consideration was 17–40 inclusive and only one subject (No.31 Female control group aged 42) fell outside this range. At first glance a margin of 10 years within which to match subjects appears wide. When one takes into account, however, that as a matching factor, it is combined with matching of marital status and with exact matching of the number of children under five, it becomes apparent that this limit is sufficiently narrow. It excludes the pairing of a very young mother with a child and a mother who married late and produced her first child at, say, 35. It does not exclude the pairing of a bachelor of 25 with one of 34; taking into account the fact that social class is matched, the opportunities for social activities for two men with this variation in age are probably not dissimilar.

When one takes the two groups as a whole the average age of patients is very close to the average age of controls. The average age of the 51 patients was 28 years 3 months, that of controls, 28 years.

(vi) **Social class**

The Registrar General's Classification drawn from the 1951 Census was used. This is based on occupation and length of time required for training. The main disadvantage of this particular classification is that it includes a wide variety of occupations within Social Class III (skilled occupation).
Within this particular class are included people with very different types of education, homes and available social facilities. It includes manual workers such as bricklayers, carpenters and shoe repairers, inspectors of electrical goods and also secretaries (of all types) from copy typists to private secretaries and Local Authority officials.

It is very difficult to arrive at a satisfactory classification of social class, however, and it was felt that this one prepared by the Registrar-General had much to commend it, was easily accessible, and was recognised generally, so it was used in this research.

Married women subjects were classified by their husbands' occupations.

Subjects who were still at school were classified by their fathers' occupations but students were classified according to the occupations for which they were training.

Two cases deserve mention in relation to social class.

In one the Registrar-General's classification was not accepted. The wife of a tea-taster (No.64) should have fallen into Social Class IV according to the Registrar-General's classification. This was felt to be inappropriate in that tea-tasting requires a preliminary training and the style of the patient's home was not appropriate to Social Class IV. She was therefore listed as Social Class II.
In the second case the patient's husband, a Ukrainian, was working as a waiter by day and a journalist at night. This patient (No. 21) was listed as Social Class II as journalism was felt to be the career of choice.

There were a few irregularities in social class matching and these are listed below. The work done by the person in each pair was often similar, and it was felt that the difference in social class was not significant.

**MEN**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Social Class matched w</th>
<th>Control</th>
<th>Social Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 31</td>
<td>III (Post Office)</td>
<td>No. 12</td>
<td>II (N.A.B. Executive Officer)</td>
</tr>
<tr>
<td>No. 65</td>
<td>III (Student School)</td>
<td>No. 59</td>
<td>I (Student University)</td>
</tr>
<tr>
<td></td>
<td>Father merchant</td>
<td></td>
<td>Father farmer.</td>
</tr>
</tbody>
</table>

**WOMEN**

| No. 4    | I (Husband Quantity Surveyor) | No. 14  | II (H. Asst. Lecturer Tech) |
| No. 37   | IV (Usherette) Illiterate     | No. 3   | V (Sweeper) Illiterate      |
| No. 62   | III (Hairdresser)            | No. 38  | II (N.A.B. Trainee)         |
| No. 24   | III Not working because of illness (Mother silk screen printer) | No. 28  | IV Not working because of physical handicap (Father bus conductor) |

(vii) Urban Residence

The patients in this research live in one of the South East suburbs of London. The subjects in the control group also came from urban areas with similar facilities for leisure-time activities.

+ Husband
(c) **Review of Subjects**

Demographic details of the patient and control groups are given below:

1. **Patients**
   - (i) Men
   - (ii) Women

2. **Controls**
   - (i) Men
   - (ii) Women

<table>
<thead>
<tr>
<th>Social Class</th>
<th>No. of Subjects</th>
<th>Married</th>
<th>Single or Separated</th>
<th>Subjects with no children</th>
<th>No. of children under five</th>
<th>Children at school</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 Sep.</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 Single</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>8</td>
<td>6 single</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>IV</td>
<td>2</td>
<td>2 single</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>V</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>17</td>
<td>7</td>
<td>1 sep. single</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>
## 2. Controls

*(i) Men*

<table>
<thead>
<tr>
<th>Social Class</th>
<th>No. of Subjects</th>
<th>Married</th>
<th>Single or Separated</th>
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2. Controls

(ii) Women

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<tr>
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<td>13</td>
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IV. STATUS OF SUBJECTS

1. Factors that influence treatment: Patient or Control?

In the course of seeing the control subjects it became clear to the interviewer that a few of these were as much in need of treatment as the patients. A more correct description of the control group is therefore "a group not under treatment".

Certain people appeared to be living in circumstances of considerable stress; others had been in this situation but described a particular decision which they had made, usually in regard to work, leaving home or moving away from the vicinity of difficult relatives which they felt had been crucial in altering the pattern of their relationships. One is inevitably led to ask the questions: "What are the determining factors that cause some people to seek treatment and not others?" "How do some people manage to effect the necessary changes in their lives which reduce the stress whilst others break down?"

A personal crisis may precipitate treatment, e.g. the patient with four dependants who falls seriously ill with a gastric ulcer, and who is then sent to a psychiatrist by the surgeon. The threat of chronic physical ill-health in such a case compels the patient to seek treatment. The presence of other psychosomatic symptoms, such as asthma, migraine, colic, may provide patients with the justification
for consulting a doctor when they would hesitate to go to him with purely "psychological" symptoms like irritability, depression or feelings of unreality.

The attitude of general practitioners to psychiatry is very important in determining the number of patients who are referred to a specialist clinic. Since doctors act as a "sieve" for specialists, their knowledge of, and sympathy for, mental illness, or the reverse, must determine the numbers of people who reach the psychiatrist.

The attitude of general practitioners is partly conditioned by, and also in its turn, conditions the attitude of the general public towards psychiatry.

During the last thirty years mental illness has received a great deal more attention than it had previously enjoyed, and new methods of treatment by out-patient therapy, chemotherapy, social rehabilitation, have all received publicity, so that the illness itself can now be discussed more widely perhaps than ever before. The fact that more attention has been focused on mental illness has meant that television, radio and the press have given space and publicity to new forms of treatment, and this has led to some breaking down of the barriers which separated the mentally sick from other people. Sometimes such publicity leads the relatives of the chronically mentally sick to seek further help. This happened to at least one of the subjects in this research, and indirectly this led to
another subject receiving treatment. Patient No.24 came to the clinic because her sister had seen a television programme describing the work done there. The patient in her turn asked if a neighbour could be seen "because she suffers from the same illness as I do".

The advance in understanding of new drugs has probably had a great effect on the numbers of people seeking treatment, and the numbers who have been able to remain out-patients during an attack of illness, where formerly they would have been admitted to hospital.

There is one factor in the causation of mental illness, however, which is likely to cause ambivalence in the attitude to treatment both of the patient and his family. R.D. Laing in his books on schizophrenia, The Divided Self and The Self and Others, has drawn attention to the close interweaving of attitudes within the family. Post also in his review of the Social Orbit of Psychiatric Patients found that 54 of the 121 contacts of his 40 patients showed signs of psychological abnormalities. Social factors which hold the family in a particular pattern of behaviour are extremely important in preventing patients from seeking treatment. Insofar as an individual, by his sickness, fulfils certain needs of members of the family, discomfort will arise in the family when he is treated and his attitudes change. For this reason when undertaking treatment one is forced to accept that families need help, rather than individuals. A simple example comes to mind. A patient aged 28 (No.24) had only worked for three
years since leaving school at 15; otherwise, she had looked after the house and cooked for her widowed mother and divorced brother. This was undoubtedly partly responsible for the continuation of her illness in that in so doing she was protected from the normal life of an adult in her circumstances. The mother had first gone out to work when the patient was very young, and, whilst the patient was still at school, had separated from the father on account of his drinking. Obviously both the mother's and brother's lives had been made much more comfortable by the patient's domestic services. Nevertheless, it is essential in the interests of the patient for her to receive a training and go out to work. In these circumstances both the mother and brother will have to effect quite a considerable adaptation in their personal lives which may, when the patient goes away to be trained, adversely affect them and certainly result in strained relationships, even possibly in neurotic behaviour in the mother or brother. It has not been possible in these circumstances to treat the patient as a "social isolate" but only as a member, in this case, of a small interdependent tightly bound group, all of whom will have to change if the patient is to get better.

We have, therefore, in assessing the willingness of patients to accept treatment, to weigh the attitudes of the family, the social attitudes of the patient himself, as well as the influence of the general practitioner, the effects of
greater knowledge of mental illness and the multiplicity of methods.

2. Problems in the Control Group.

Bearing in mind that a variety of factors influence a person, who is under stress, to try to deal with it himself or to become officially a patient, it is not surprising to find that one third of the 51 control subjects were noticed as suffering from some form of psychosomatic illness, neurosis or difficulty in personal or social relationships. Thus two subjects suffered from migraine, one from asthma and another had what she described as "an asthmatic cough".

Amongst the neurotic symptoms one control subject "couldn't stand heights" and in discussing art galleries stated that she regarded the painting of adult bodies as "obscene". A male subject stated that he hoped for a violent death because "he couldn't bear illness leading to death", and another male subject complained of people "getting on his nerves".

Problems encountered in social relationships among the controls included difficulty in meeting new people (4 subjects), and a high degree of dependency between husband and wife which seemed to be fostered, in some cases, by one or the other partner: "If I am in the kitchen doing something when my husband is at home, he comes to see what I am doing."
He doesn't like it"..... "I am dead to the world when I read: my husband doesn't like it, so I read very little."

3. **Health in the Patient Group**

Just as some controls were living under some degree of stress, so were some patients found who had healthy social attitudes. 18 out of the 51, by their own account, were enjoying good social relationships at the present time, or had had very satisfying contacts with people in the past.

Those enjoying good social relationships in the present included a patient who belonged to St. John's Ambulance Brigade, and who spent two evenings per week on this work. He had found this substitute for outings with his wife, who, in spite of persuasion on his part, refused to go out and was mainly interested in the house and gardening. Another patient was friendly with her husband's two male friends (unmarried) and usually went out to entertainments and meals as a "foursome".

Patients who recalled satisfying relationships often made these at work (see chapter on work) but one chronically ill female patient had been a ballroom dancing champion in her youth and another patient had been a producer for a church drama group.
Such histories indicate that "inability to mix" is not something with which people are born; it often occurs either as a failure in developing adult social relationships because of a social deprivation in childhood or as a grave symptom of psychiatric illness, following a crisis in the person's life.

These examples show that the control group were not without symptoms of illness, nor did the patient group consist only of people who had all their lives found social contacts difficult. The facts reveal that a proportion of the control group can manage on the whole to live with illness, whereas the patients, although sometimes relating very satisfactorily to other people, have needed to seek psychiatric help.

(f) (i) Absence from home at any age,
(ii) Living quarters over the preceding five years,
(iii) Education, training and work history,
(iv) Past social activities.

(g) Wives in Social Class II.

(a) Household.

The make-up of the household, the type of dwelling, the length of time during which the subject had lived in his present district were found to be similar in the two groups. This
V. RESULTS

1. General Remarks

The research was designed to find out whether social activities in a group of patients differed from those in a matched control group. The social activities covered 5 areas of the lives of subjects:

(a) Make up and household.
(b) Contacts with the extended family.
(c) Work.
(d) Attitudes to people and friendship.
(e) (i) Leisure time activities - organised.
(ii) " " " - unorganised.

In addition to enquiries about these areas of people's lives, histories relating to limited areas were obtained. These areas covered:

(f) (i) Absence from home at any age.
(ii) Living quarters over the preceding five years.
(iii) Education, training and work history.
(iv) Past social activities.
(g) Wives in Social Class II.

(a) Household.

The make-up of the household, the type of dwelling, the length of time during which the subject had lived in his present district were found to be similar in the two groups. This
has been discussed in sub-section 2 of this chapter.

(b) Contacts with relatives in the extended family.

Contacts by 'phone, letter or meeting occurring monthly or more frequently were included. Controls were found to have a significantly greater number of these contacts than patients. This is in fact the first area in this research which uncovers the social difficulties of patients in comparison with the control group. The results are discussed in sub-section 3.

(c) Work

A larger number of controls than of patients were engaged in part or full-time work. This was due to psychiatric illness in some cases but part of the difference was attributed to the fact that many women controls had had a longer period of education and training and were in a better position than patients to take part-time work. This is particularly useful for mothers of young children. Education and training are referred to again later in paragraph

There was no significant difference between patients and controls in the number of jobs held during the working life nor was there a significant difference in the numbers of people worked with.

Controls showed a significantly higher number of people enjoying work than patients but this result was viewed with some caution. Several women patients had enjoyed their work in the past and appeared from their statements to have reached a higher level of mental health when they were working than when married. The possible reasons for this are discussed in sub-section 4.
(d) Attitudes to people and friendship.

Questions relating to attitudes to people and friendship were scattered in three areas of the research because a pilot survey had shown that this was the area in which subjects felt most self-consciousness. Social pressures made it impossible for them to confess to having no friends at all. Answers to questions relating to being with people or alone, or being with old friends or meeting new people showed a rigidity in the patients that was much less marked in the controls. Patients stated that they needed to be with people or alone, needed old friends or found new people easier, whereas controls liked variety and were flexible in their needs. This finding was an important one and seemed to be intimately related to psychiatric illness and its symptoms.

The number of friends (defined as people seen each week aside from relatives or people worked with) differed significantly in the two groups. A small number of subjects (18 patients and 35 controls) were asked about friends and whom they saw less frequently than weekly and there was a significant difference in the numbers claimed by the two groups here. Suggestions are made in Chapter V, § as to why patients seem to find these less frequent contacts hard to maintain.

Patients are significantly poorer than controls in close friends (defined as someone with whom one could discuss a personal problem). This fact is linked to the social difficulties of patients already mentioned but an important
finding was that patients had more aspirations to friendship than controls. It seemed as though they were aware of their social poverty but unable to remedy it. These attitudes to friendship and mixing are discussed in sub-section 5.

(e) Leisure time activities (i) Organised.

This section related to:

1. Membership of church, trade union or professional organisation, evening class or other social group.
2. Attendance at films, theatres, football and cricket matches, dog-racing, dancing and concerts.
3. Finally to attendance at museums, picture galleries or exhibitions.

The most striking difference between patients and controls related to evening class membership - controls taking a far greater interest in this activity than patients. This is related to educational level and is discussed under Education and Training, sub-section 7.

Apart from this difference, controls show a significantly higher attendance than patients at theatres and films but otherwise there is little difference in their degree of interest in organised entertainment or in their membership of social groups. Actual attendance at social groups (aside from membership) is higher in the control group and they are more adventurous about going to exhibitions, picture galleries and museums than patients. These activities are discussed in sub-section 6 (1).
Leisure time activities (ii) Unorganised

This section related to hobbies undertaken at home either alone or with the family and to informal meetings with friends such as visiting the pub, playing cards, going swimming. The two groups differed, though not significantly in the number of activities undertaken. Both groups gave evidence of very few informal meetings with friends. Results discussed in sub-section 6 (a).

(f) Histories

In regard to the limited areas of history, three of these and part of the fourth are considered in sub-sections already mentioned, i.e.:

(i) Absence from home at any age. ) See sub-section (1)
(ii) Living quarters over preceding 5 years. ) Household
(iii) (a) Education and training
(b) Work history. See sub-section (4) Work.
(iv) Past social activities. See sub-section (6) (i).

(iii) (a) Education and Training

Enquiries about the period of education enjoyed by subjects brought to light another very important difference between the two groups. A significantly larger number of patients than of controls suffered from an anomalous family situation in childhood or youth. "Anomalous" is here taken to include loss of a parent in childhood or adolescence, illegitimacy, adoption or breakdown of the family home through divorce or separation.
The fact that many more patients than controls suffered from such deprivation is important not only because of the resulting emotional insecurity but also because of the likely by-products in the shape of financial stress leading to early school-leaving, failure to take up entrance to grammar school, and in a few cases to a complete break in education. Comparing the education of the whole of each group of subjects, information gathered showed that the patients' period of education was very much shorter than that of controls. Most of them had little specific training for work and compared unfavourably with controls, many of whom had been to the University or been trained in other ways. In sub-section (7) Education and Training are discussed.

(g) Wives in Social Class II.

Social Class (Registrar General's Classification 1951) was matched in the two groups of subjects. Some of the women patients in Social Class II had moved into this class through marriage. The findings on this group are discussed in sub-section (8).

Summing up the results, this research shows that many features of the lives of controls and patients are very similar. The two groups differ in the fact that controls show a flexibility in relation to people and enjoyment of their company that allows them to meet social situations with a fair
degree of confidence and ease. Patients lack confidence, are susceptible to panics, fears and anxiety in relation to people, and have learnt through painful experience that they can better deal with one social situation than another. They tend therefore to stick rigidly to a pattern of behaviour that has worked best in the past and are afraid to change it. They are extremely aware of, and often ashamed of, their deficiencies.

Some at least of these social difficulties appear to stem from a short period of education which prevented patients starting work with training behind them.

Many of the differences shown in these results appear to relate back to the early lives and anomalous situations of patients. An encouraging observation is that many of them, particularly some women, with these set-backs have apparently worked well at some periods of their lives but have broken down in face of the dilemmas of marriage where relationships are less clear-cut than in work.
2. Household.

(a) Situation of the households under consideration.

The patients in this research were drawn from an urban area about 12 miles from Central London. It was previously a small country town but is now a popular suburb from which it is easy to commute to London and most residents live in it for long periods of time. It is not a transition area from which people try to escape to pleasanter surroundings; for this reason many of the inhabitants take up hobbies and social interests in the town, and a great many social groups flourish. These facts are important both in regard to satisfaction with the conditions of living and also in regard to potential leisure time activities.

It has already been pointed out in the Introduction that such an area has its drawbacks. Many of the inhabitants are ambitious, both for themselves and for their children; and the pressure on the limited number of Grammar School places is heavy. There are also strong pressures to conform to the standards of neighbours, and although people living close together may not have deep face-to-face relationships, they know a great deal about the material conditions of their neighbours' lives, and feel insecure when their own patterns of living fail to match those of their neighbours. This is one of the drawbacks of a district in which people settle for 10 to 15 years or longer in comparison with the transition areas of bed-sitting rooms and boarding houses.
In relation to this it is of interest to note that the most common diagnosis for the patient group was "Anxiety State", a condition partly attributable to the pressures of suburban living.

The control group subjects were not all drawn from the same district but they all came from urban areas, and, in a majority of cases, from the suburbs of London.

It was felt that environment was of paramount importance in determining people's work and interests and therefore the type of living area must be matched for the two groups.

Comment was made in the Review of Literature on the work of Faris and Dunham and others in America. These writers, and Sainsbury in this country, have shown that rootlessness is associated with schizophrenia and suicide; rootlessness being an isolated and transitional way of living in which the individual does not relate himself to social groups, and often lives alone. Whyte in "The Organisation Man" showed that people living in settled areas also have their problems and this research shows that such problems throw up neuroses in the patient group and particularly "Anxiety Neurosis".

(b) Nature of the enquiry on households.

This consisted in an enquiry into the social conditions of living, i.e. whether the subject lived alone, with parents, with friends, or with a spouse with or without children. He was also asked to state his position in the household, i.e. child of the householder, main wage-earner, housewife. It also covered the material conditions of living, i.e. hostel,
rented accommodation or own property, with number of rooms, amount of space for sleeping, possession of a garden.

See Tables 1 and 2.

**TABLE 1.**

<table>
<thead>
<tr>
<th>Number in Household</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
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<td>3</td>
<td>12</td>
<td>8</td>
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</tr>
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<td>4</td>
<td>18</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>5 or more</td>
<td>11</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>51</strong></td>
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Degrees of Freedom 3

\[ \chi^2 = 1.492 \] Not significantly different.

**TABLE 2.**

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<th>Type of Dwelling</th>
<th>Patients</th>
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<td>Buying (or parents) own house or maisonette</td>
<td>33</td>
<td>28</td>
<td>61</td>
</tr>
<tr>
<td>Renting (or parents) accommodation</td>
<td>18</td>
<td>23</td>
<td>41</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>51</strong></td>
<td><strong>102</strong></td>
</tr>
</tbody>
</table>

Degrees of Freedom 1

\[ \chi^2 = 1.020 \] Not significantly different.
An enquiry was made as to the length of time in which the subject had lived in his present district, and the number of moves he had had during the five years previous to the interview. He was asked for details of his living conditions during this period, so that a picture could be built up of the background for his social activities. See Tables 3 and 4.

**TABLE 3**

<table>
<thead>
<tr>
<th>Number of Years in Present District</th>
<th>Patients</th>
<th>Controls</th>
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<td>Less than 5 years</td>
<td>22</td>
<td>12</td>
<td>34</td>
</tr>
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<td>68</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>51</td>
<td>51</td>
<td>102</td>
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Degrees of Freedom 1

\[ \chi^2 = 4.412 \]

Difference significant at 5% level.

**TABLE 4**

<table>
<thead>
<tr>
<th>Number of Moves in the Last 5 Years</th>
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<th>Controls</th>
<th>Total</th>
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<td>47</td>
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<td>One</td>
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<td>12</td>
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<td>Two</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>More than two</td>
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<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>50</td>
<td>51</td>
<td>101</td>
</tr>
</tbody>
</table>

* One unknown

Degrees of Freedom 3

\[ \chi^2 = 0.907 \]

Not significantly different.
Although the number of controls living in the present district for more than 5 years was significantly greater than the number of patients, there was no significant difference in the number of moves made by the two groups in this period.

A further enquiry covered the occasions of living away from the family, e.g. evacuation, period in the Services, University training, or work away from home. Subjects were asked for details of the periods covered in this way and also for their attitudes to these events. They were asked for a short history of their lives during these periods, e.g. if they had served in the Forces they were asked where they had been stationed, how many moves they had had, and whether they enjoyed this period of their lives. Again, there was no significant difference in the two groups. See Table 5.

**TABLE 5.**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>32</td>
<td>36</td>
<td>68</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>18</td>
<td>14</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>50</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

(1 unknown in each group)

**Degrees of Freedom 1**

\[ \chi^2 = 0.735 \] Not significant.
Subjects were also asked whether they were satisfied with conditions at home, or would like them to be different. In completing the written questionnaire some people enquired whether this related to material or social conditions, and were told that they could regard the question in whichever way they chose, and that this point would be discussed in the interview. Replies to this question were not significantly different in the two groups. See Table 6.

**TABLE 6**

<table>
<thead>
<tr>
<th>Conditions at home regarded as satisfactory or not</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>26</td>
<td>36</td>
<td>62</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>22</td>
<td>15</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48</strong> *</td>
<td><strong>51</strong></td>
<td><strong>99</strong></td>
</tr>
</tbody>
</table>

* One unknown. Two contradictory

Degrees of Freedom 1

\[ \chi^2 = 2.849 \] Not significant.

A question in this section which produced variation in response had reference to relationships (1.2): "Who do you get on best with at home?" The question had little meaning for subjects unless the household consisted of more than two members. There were 41 patients living in a household of more than two, compared with 40 controls. Discussion on the replies to the question is, therefore, confined to these groups of 41 and 40 subjects.
Perhaps the most interesting finding was that 7 of the control group were unable to differentiate, and said that they got on equally well with all members of the household at different times, whereas none of the patients gave this reply. They often mentioned one person but sometimes stretched to include two of the family. The patient group showed less flexibility in adjustment, which emerges at several points in the research and will be mentioned again. See Table 7.

**TABLE 7**

<table>
<thead>
<tr>
<th>Person in household with whom subjects get on best</th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Wife</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Mother</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Child</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>More than 1 person</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Other single indiv.</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Not relevant unless there are more than 2 in the household. Relevant for 41 patients and 40 controls.

Table continued ...
### Comparing numbers who get on best with one person or more than one (of the 41 and 40 relevant households.)

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best with one</td>
<td>33</td>
<td>29</td>
<td>62</td>
</tr>
<tr>
<td>Best with more than one</td>
<td>8</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>40</strong></td>
<td><strong>81</strong></td>
</tr>
</tbody>
</table>

Degrees of freedom 1

\[ \chi^2 = 0.720 \quad \text{Not significantly different.} \]

The 41 patients and 40 controls living in households of more than two can be split into two groups:

(i) 21 in the patient and 20 in the control group were single (or in a small minority of cases separated from the spouse) and most were living with parents with, or without, siblings.

(ii) 20 patients and 20 controls were married and living with a spouse and children in most cases. There were 3 cases in which 3 generations were living in the same household.

Of the first group (i) twice as many patients (10) as controls mentioned the mother alone as the favourite member in the home, and she was included fifteen times (out of a possible 18) by patients, against six times by controls. This represents a difference significant at the 0.5 level.

See Table 8.
TABLE 8

Person in household with whom subject gets on best.
Group (i) - 18 households where subject is single and the mother is a member of the household.

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother included in choice</td>
<td>15</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Mother not included in choice</td>
<td>3</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>18</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

Degrees of Freedom 1

\[ \chi^2 = 9.26 \]

Difference is significant at \( p < 0.005 \) level.

The mother is the person with whom a baby first makes a relationship. With emotional growth his social world broadens to include the father, siblings, other relatives and the outside world. The fact that patients mention the mother so frequently as the favourite member of the household makes one suspect that the social relationships of patients are tied to an earlier stage of emotional development than those of controls. In these cases there is a two-way defect in that the mother has been unable to allow the child to grow up and has failed to effect a psychological weaning, which is necessary for the development of growing children.

This finding must be related to the earlier statement (in the Chapter on "Method", page 79.) that mental illness affects families rather than individuals, and that it is...
necessary in treatment to give consideration to the other members of the family as well as to the patient.

Of the second group (ii) subjects living with spouse and children, a significantly larger number of controls mentioned the spouse (or included him with others) as the favourite member of the household. See Table 9.

### TABLE 9

Person in household with whom subject gets on best

<table>
<thead>
<tr>
<th>Group (ii) - 20 households where subject is married and living with spouse and other members of the family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse included in choice</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>Spouse not included in choice</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Degrees of Freedom 1

\[ \chi^2 = 4.8 \]

Difference is significant at \( \% \)

\( p < .05 \)

This indicates that there was less sympathy felt between husbands and wives in the patient group and therefore less feeling of support. Several patients (husbands and wives) spoke of difficulties within their marriages and lack of understanding which contributed to their feelings of isolation in the family situation.
One further question in this Section (I.3) has received comment in the chapter on "Attitudes to People", page 30:

"Do you enjoy your own company at home, or prefer other people?"

This question is related to a later one on the enjoyment of places where there are people, or of one's own company, and the two are dealt with together.

An important section of the research concerned contacts with relatives beyond the home. These included parents, siblings, cousins, etc. in the patient’s own family and in-laws.

Subjects were asked to list the relatives they were in touch with, the district where each lived and the method of contact, i.e. letters, visits, phone calls. Contact that was less than monthly was discounted. Although a relative contacted occasionally might be much liked by a subject, it was felt that the influence on his everyday social life was not sufficiently important for him to be included in this research. Aside from providing factual evidence of subjects’ relationships this section provided in many cases very useful information regarding the childhood of the subject. It was possible in this way to bring to light such factors as the position in the family of the subject, the marital status and employment of siblings, employment (and whether retired) of parents. Also, it brought to light the area of residence of each relative, and indicated whether visiting or letter-writing was the most practical form of contact; it often gave information on the part of the country from which the subject came, the social patterns of his childhood, and on occasions the contrast between these and the patterns of the subject’s present-day living, e.g. a control subject who was born and grew up in Yorkshire maintained that her social relationships had been more free and easy in the north. Since her marriage and consequent removal to London, she
found that people were "stiffer" and needed definite invitations to visit and could not "drop in".

A small number of control subjects and one female patient regarded certain relatives as friends, and volunteered this information. A male control subject regarded one of his sister-in-law and her husband as friends, and a married female control subject, with four sisters living elsewhere, regarded them as friends, and had little social life beyond the family; they visited frequently and she discussed all her problems with them. A married female patient living in difficult circumstances with her husband, children, and her own mother, was very fond of her sister-in-law and confided in her because she felt that she could trust her.

On the other hand, many subjects revealed difficulties with relatives, particularly parents or parents-in-law. Most subjects, in both groups, showed a strong sense of responsibility towards their elderly parents, although many felt irritation, sometimes to the point of exasperation with them. Among the 51 subjects in the group of patients, 24 described difficulty in family relationships, of whom 22 experienced this with parents, or parents-in-law. In 6 cases they were living with the relative whom they found difficult. In 5 of the 24 cases a relationship with either a parent, or parent-in-law had broken completely, the patient not seeing the relative in question at all.

In the control group of 51, 19 described difficulty in family relationships and 18 of these referred to parents or
parents-in-law. In only 2 of these cases were the subjects living with the difficult relative, although in a further 2 they occupied a flat adjacent to that of the subject. In only one case had the relationship broken completely. There was a significant difference in the actual number of contacts with relatives outside the home, the controls having almost twice as many as patients. (See Table 10). The reason for the difference in number of contacts is certainly related to the illness of the patients. Many subjects were loath to tell their relatives that they had sought treatment and tried to conceal the symptoms of their illness when in contact with them. This inevitably led to strain and some artificiality of manner, and often an avoidance of meeting relatives on the part of the patient. Relatives in the extended family often assume that they have a right to criticize or exercise moral judgment, particularly in the case of younger members of the family. This was referred to in Chapter 11. (Review of Reading, page 123) where Firth in studying London families noticed that people selected the relatives with whom they kept in touch. They sometimes avoid those who exercised this prerogative of passing moral judgment. In the same way patients undoubtedly avoided contact with some relatives because of the enquiries and criticism which would be levelled at them. Difficulty in mixing with people has already been noticed as a common symptom of patients. Mixing with relatives or relatives-in-law can be even harder as the
TABLE 10

The Extended Family

Number of relatives (outside the household) with whom subject is in contact more than monthly (children under 14 not included)

<table>
<thead>
<tr>
<th>Number of relatives</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>113</td>
<td>180</td>
<td>293</td>
<td></td>
</tr>
</tbody>
</table>

Average difference is 1.26

The standard error is 3.5

*: the difference is significantly at the 1% level.

<table>
<thead>
<tr>
<th>Method of Contact</th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>13 cases</td>
<td>3</td>
</tr>
<tr>
<td>Letters</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Visit or meet relatives</td>
<td>31</td>
<td>69</td>
</tr>
<tr>
<td>Being visited by relatives</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>
patient is often afraid that a change in his manner will be noticed more easily by people with whom he is familiar. He usually wants to avoid this and any subsequent discussion of his illness.

Subjects not in touch with relatives outside the home

There were 14 patients, compared with 4 controls, who were not in touch with any relatives beyond the home.

Relatives living locally or in the Greater London area

An analysis was made of the areas in which subjects' relatives lived and it was found that 27 patients were in contact with 46 groups of relatives living locally or in the Greater London area.

Amongst the controls 40 subjects were in contact with 75 groups of relatives living locally or in the Greater London area.

Methods of contact for the two groups were as follows:

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>13 cases</td>
<td>3</td>
</tr>
<tr>
<td>Letters</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Visit or meet relatives</td>
<td>31</td>
<td>69</td>
</tr>
<tr>
<td>Being visited by relatives</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>
It is noticeable when comparing these two sets of figures that the patients tend to use the telephone more frequently and to have many fewer face-to-face meetings than the controls.

Relatives living away from London

Among the patients, 13 subjects were in contact with 17 groups of relatives living away from London, mainly in England but in two cases in Portugal and Sweden. In the control group, 17 subjects were in contact with 21 groups of relatives away from London, in one case in Malta. The methods of contact for the two groups were as follows:

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>1 case</td>
<td>3</td>
</tr>
<tr>
<td>Letters</td>
<td>14 cases</td>
<td>9</td>
</tr>
<tr>
<td>Visit or meet relatives</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Being visited by relatives</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Once again it is noticeable that controls have more face-to-face meetings than patients, although the opportunity for these must be rarer in both groups.
4. Work

(a) General Review.

A work history was obtained for all subjects, irrespective of the fact that they might not be working nor seeking work at the time of the interviews. Table 19 gives particulars of the number of subjects, working or not, at the time of the research.

The seven subjects not working in the control group were not seeking work because they were either pregnant or caring for children at home.

Of 21 not working in the patient group, 11 were not seeking work for the same reasons as the control group subjects, i.e. pregnancy or the care of children at home. This left 10 patients who, through illness, were unable to work at the time of interviewing. One of these (aged 26), No.24, was chronically ill, and had worked for only 3 years since leaving school at the age of 15. With the exception of this one patient the remaining 9 had all been working for considerable periods of their lives and had only stopped in recent months because of illness.

A valid comparison of the number of jobs since leaving school held by the two groups is, therefore, possible; and this shows that there is in fact no significant difference in these figures. (See Table 11)
### TABLE 19

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working</td>
<td>30</td>
<td>44</td>
<td>74</td>
</tr>
<tr>
<td>Not working</td>
<td>21</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>51</td>
<td>51</td>
<td>102</td>
</tr>
</tbody>
</table>

Degrees of freedom 1

\[ x^2 = 9.649 \quad \text{Significant at 1% level} \]

Χ² = 9.649  

Significant at 1% level

It appears that this group of psychiatric patients is no longer all the holding work in the same way. The present patient group may be an atypical one in that it is drawn from an out-patient clinic where evening interviews are possible. It is likely to attract patients of a more stable type who are holding down regular jobs and who do not wish their employers to know that they are seeking psychiatric help. A cross-section of in-patients from a mental hospital might show a different work history, and before generalisation is possible a much more extensive enquiry would need to be undertaken.

Hearing these facts in mind, it is still worth while noticing that the patient group includes (1) a civil servant who had been in this work for 34 years (2) a storekeeper who
TABLE 11

Number of jobs excluding Services and vacation jobs.

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>201 (excluding 2 patients at school)</td>
<td>171 (excluding 2 controls - 1 in training and 1 with &quot;many&quot; jobs)</td>
</tr>
</tbody>
</table>

Average difference is .574

The standard error is 3.606

The average difference is therefore not significantly different from zero.

It appears that this group of psychiatric patients is no less stable in holding work than the control group. The present patient group may be an atypical one in that it is drawn from an out-patient clinic where evening interviews are possible. It is likely to attract patients of a more stable type who are holding down regular jobs and who do not wish their employers to know that they are seeking psychiatric help. A cross-section of in-patients from a mental hospital might show a different work history, and before generalisation is possible a much more extensive enquiry would need to be undertaken.

Bearing these facts in mind, it is still worth while noticing that the patient group includes (1) a civil servant who had been in this work for 24 years (2) a storekeeper who
had held his job for 17 years (3) a woman who had been in one department of a factory for 16 years. Three subjects who had worked in banking, engineering and insurance for 13 years each.

The control group shows parallels to these examples with:
(1) an official of the N.A.B. for 8 years (2) a tool setter for 24 years (3) a tailor's cutter for 18 years (4) a secretary for 7 years and (5) a teacher for 15 years.

The two groups show similarity also in the following respects:

(i) Length of time in present job (See Table 12)

(ii) Number of people with whom subject is working i.e. people with whom he comes into contact at work. It does not seem to be a characteristic of patients to select jobs where they have few contacts, nor the reverse. (See Table 15)

TABLE 12

<table>
<thead>
<tr>
<th>Length of time in present job</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>6</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>6</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>9</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>7</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>44</td>
<td>72</td>
</tr>
</tbody>
</table>

Degrees of freedom 3.

\( \chi^2 = 1.332 \)  Not significant.
### Table 13

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone or 1-2</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>3-10 people</td>
<td>12</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>10-20 people</td>
<td>5</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>More than 20</td>
<td>6</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>44</strong></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>

* 2 Patients at school
* 1 Variable

**Degrees of freedom 3.**

\[
\chi^2 = 4.725 \text{ Not significant.}
\]

### Service career.

Again, the numbers of subjects who had served in the Forces and the length of time served did not differ significantly in the two groups. (See Table 13)

### Table 14

**Experience in the Services**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>No</td>
<td>39</td>
<td>35</td>
<td>74</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>51</strong></td>
<td><strong>102</strong></td>
</tr>
</tbody>
</table>

**Degrees of freedom 1**

\[
\chi^2 = .80 \text{ Not significant}
\]
There were two female subjects from the control group, and one from the patient group, who looked back on their Service careers (in the Army in each case) as a critical period in their lives which had enabled them to "grow up". This information was given spontaneously in reply to an enquiry as to whether they had enjoyed life in the Services. Most subjects appreciated this experience, at least in retrospect, and some spoke of it as the happiest time of their lives.

(b) Friendship through work.

An enquiry into two other aspects of work which came under a loose heading of friendship through work gave similar results in both the control and patient groups.

These were:

(i) Enjoyment of contact with people at work. (See Table 14)

(ii) Friends made through work. (See Table 16)

<table>
<thead>
<tr>
<th>TABLE 14</th>
<th>Past and Present.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyment of contact with people at work.</td>
<td>Patients</td>
</tr>
<tr>
<td>Yes</td>
<td>42</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>47*</td>
</tr>
</tbody>
</table>

* 2 Patients at school and 2 "unknown"
1 Control "unknown"

Degrees of freedom 1

\[ \chi^2 = 0.200 \]

Not significant.
### TABLE 16

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31</td>
<td>39</td>
<td>70</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>46 *</td>
<td>51</td>
<td>97</td>
</tr>
</tbody>
</table>

* 2 subjects at school
3 "unknown"

Degrees of freedom 1

\[ \chi^2 = 1.1 \quad \text{Not significantly different} \]

(i) Enjoyment of contact and friends made

The fact that there is no significant difference in the figures for the two groups in this area links up with an impression which was gained whilst interviewing was in progress. This was that a number of women in the patient group with chronic symptoms looked back on their pre-marital work and work relations with enthusiasm and interest. This does not mean that they were always symptom-free at this time.

Three examples are given:

One subject, No.64, complained of being painfully shy until she was 16 years old; at this age she took secretarial work in the Town Clerk’s Department of a Local Authority, where she remained for 9 years. She worked in a room with 15 other girls, all typing, and found it noisy. Travelling
was difficult to and from work and going out at lunch-time presented problems. Nevertheless, this subject said that she was happy and found her work interesting. She spoke of a little group of girl friends that she had made at work and of their regular attendance at Penge Empire each week, and of their enjoyment of this; she had gone on holiday with one of them. She had thought of leaving her job for a quieter one and had applied and been accepted, but lack of confidence prevented her from taking the post.

Although she was at this time suffering from neurotic symptoms she was sufficiently well to enjoy life with her girl friends, and she still retains one or two friendships from this period.

Another patient, No. 19, left school at 14 years of age to take residential work helping to look after children. She remained in this work for 3 years and enjoyed it. During the second half of this period she also did part-time nursing with the Red Cross.

At 18 she joined the Fire Service and was stationed at Dartford, Lambeth and Gravesend, specialising in wireless. She remained in this work for five years living the community life of the Fire Service in war-time. By her own account she enjoyed this experience. From 23-26 years of age she worked for a shipping firm in the City and continued full-time work as a telephone operator and clerk after her marriage for two years until 15 months before her first child was born. She spent nearly five years with this firm and "loved it".
Allowing for the fact that "distance lends enchantment to the view", and that this woman may be painting her past as rosier than it seemed to her at the time, she gives evidence of having spent 13 years of her life in three different jobs, two of them away from home, and a third combined for part of the time with marriage. All of them were described with interest and enjoyment, as were her leisure-time activities at this time: Red Cross work, swimming, netball, table-tennis and ballroom dancing.

At the time of this research all these activities had been dropped except for an occasional dance at the Parents' Association.

The pattern of her life since the birth of her first child eleven years ago caused her to give up her outside work and she has in the interval become a chronic patient at her local hospital. In the space of twelve years (from the age of 26-38) her life appears to have changed from one in which she enjoyed activity of many kinds to one in which she housekeeps for her husband and two schoolchildren, has practically no friends and is a constant attender at three different departments of the hospital.

Patient No.68: This woman's career was different. She had a difficult childhood with parents who separated when she was 3 and her school-life was unhappy. She described herself as being extremely "uncomfortable" at school and she left at 14 years of age.
She worked for a few weeks in a glove factory which she "loathed". She says that the wireless was on all day "blaring"; she was waiting to go into a clerical work at Tilling's Bus Depot in the Old Kent Road. An aunt was working here and got the post for her. Here again she described the work as "ghastly" because she found it "complicated" and did not understand what she was doing. She was given instruction on the telephone switchboard, however, and liked this. She was given the work of relief telephonist in lunch-time and enjoyed the work. She remained with Tilling's for about two years.

After this she took the initiative of going to an agency and applying for work as a telephone operator. She obtained work with a music company and so much enjoyed this that she remembers "looking forward to going to work". She was recommended for a better job and started on this after 18 months - 2 years with the music company.

She liked the new job but was called up by the Government after six weeks and went into the Ministry of Aircraft Production, which she again "loathed". The irregular hours of shift-work here prevented her from continuing the shorthand classes which she had started whilst in her previous job. She got on well with her colleagues in the Ministry and they seem to have banded together to "enjoy" grumbling. She was there for 18 months. Her fifth job was again as a telephonist in a small publishing firm in London where she reports that she was very happy. She left here to get married at the age of 21.
After marriage she worked for about a year typing with a local firm, but gave it up because it was "too much". She developed severe migraine at this time.

Her husband had attended a public school and during the sixteen years of marriage this subject reports constant difficulty in her relationship with her mother-in-law and with her husband's friends. The circumstances of her own early upbringing made it particularly hard for her to adjust to the demands of marriage into a higher social class.

It is noteworthy that the difficulties within the marriage seem to have been reflected into her last work situation. In spite of the fact that prior to marriage she had reached a pitch of confidence which enabled her to look forward to going to work, in her last job she "was always uneasy that others were doing better than she was".

(ii) Meeting people from work outside working hours.

Level of friendship with friends made at work.

Although both patients and controls enjoyed contacts with people at work and formed friendships with them, there were significant differences in the numbers who met people from work outside working hours and also in the level of friendship with work friends. (See Tables 18 and 18 b.)
TABLE 18

Number of subjects meeting people from work outside working hours

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26</td>
<td>38</td>
<td>64</td>
</tr>
<tr>
<td>No</td>
<td>22</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>48 *</td>
<td>51</td>
<td>99</td>
</tr>
</tbody>
</table>

* 2 Subjects at school
1 "unknown"

Degrees of freedom 1

\[ \chi^2 = 4.47 \]

Difference is significant at the 5% level

\[ \rho < .05 \]

TABLE 18 (b)

Level of friendship with friends made at work

<table>
<thead>
<tr>
<th></th>
<th>Close</th>
<th>Not close</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>15</td>
<td>22</td>
<td>37</td>
</tr>
<tr>
<td>Controls</td>
<td>28</td>
<td>14</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>36</td>
<td>79</td>
</tr>
</tbody>
</table>

* 2 Patients at school
12 "unknown"

* "Difficult to answer" - 1 control
8 "unknown"

Degrees of freedom 1

\[ \chi^2 = 6.765 \]

Significant at 1% level

\[ \rho < .01 \]
Less frequent meeting with work friends seems to imply hesitancy and a lack of confidence on the part of patients. When one couples this observation with the fact that they make significantly fewer "close" friends at work than the controls, it seems to imply an inability to commit themselves to personal relationships beyond a very limited number. The difficulty of making "close" friends will receive comment again in the findings of this research. It becomes evident for the first time in this review of relationships made at work.

(c) Deductions from study of working careers.

Contrasting the careers of these three women prior to, and subsequent to, marriage one sees that two out of the three certainly showed symptoms of neuroticism in early life, but the complicated task of marriage, with all that this involves, seems to have been an important factor in exacerbating these symptoms to an acute degree, and in one case to have provided the environment in which a healthy, active woman became a semi-invalid.

In some ways the work situation is a simpler one than the marriage situation. There is a delimiting of function at work which represents the exchange of service for money and the human relationships resulting there are a by-product of this exchange. In marriage a contract is made in which the terms are vague and the function of each partner is not delimited clearly. Only with the passage of time does the responsibility of each partner become clearer.
The education of women patients has been found to be poorer on the whole than that of the control group. It is likely that with such a poor education women tend to look to marriage to improve their position rather than to a career. To their marriages, however, these women are likely of positive value to bring little/beyond physical attraction. Remembering that anomalous family situations occur more frequently in the patient group, there is likely to be more unhappy experience in early family life and, because of this, probably less ability to create satisfactory relationships with husband and children.

The emphasis on personal relationships and ability to create these has, in the past, been regarded as work for women. "Her education doesn't matter- she'll marry anyway" is still sometimes heard, though not so frequently as in the past. It is marriage and the consciousness of their responsibility for creating these personal relationships that has proved too difficult for the three patients discussed here, and even whilst they still speak of their love and admiration for their husbands, their own state of mental health precludes the use of the term "successful" in speaking of their marriage.

(d) Enjoyment of work.

The question of "enjoyment of work" brought forth very different replies from the two groups. (See Table 17)
TABLE 17

Enjoyment of Work (Past or Present)

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33</td>
<td>44</td>
<td>77</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>49 *</td>
<td>49 *</td>
<td>98</td>
</tr>
</tbody>
</table>

* Two patients still at school
1 control "unknown"
1 "not sure"

Degrees of freedom 1

$\chi^2 = 7.333$ Significant at 1% level

Whereas 14 patients out of a total of 30 at work now express liking, or qualified liking for work, 38 controls out of a total of 44 at work express liking or qualified liking.

Table 17 gives information relating to the enjoyment of work at any time, i.e. past or present. Table 18 (a) gives information relating to present work.

TABLE 18 (a)

Enjoyment of work amongst subjects now working

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14</td>
<td>38</td>
<td>52</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>28 *</td>
<td>42 *</td>
<td>70</td>
</tr>
</tbody>
</table>

* 2 Patients at school
1 Control "unknown"
1 "not sure"

Degrees of freedom 1

$\chi^2 = 14.409$ Significant at 1% level.

$p < .001$
This question has been left to the last to discuss because the extent to which one can place value on the answers is doubtful. It will be remembered that patients were interviewed at the time of referral to the psychiatric clinic. Attendance for treatment was in all cases voluntary, but it may be assumed from the fact that they attended at the clinic that patients were in search of help for themselves. The extent to which help can be forthcoming and the shape of the help available from the psychiatric clinic is not known by the professional staff until a careful case history has been taken from each patient. The latter, therefore, cannot know what help he is likely to receive and it is quite possible that he may exaggerate his feelings about work at this stage of treatment. He may hope for magic from psychiatry and believe that if he emphasises the blacker sides of his life, a better job with more pay will be produced as from a hat. It is for this and other reasons that most of the questions in the interview relate to facts rather than feelings.

Errors in the opposite direction may colour the replies of the control group. Knowing that they have volunteered for interviews as people "not under treatment", they may have exaggerated the "satisfaction" which they felt in relation to work. Both sorts of error make the replies to this question of doubtful value.
Having made this proviso, one may examine the figures again and notice that the difference between the two groups in enjoyment of work occurs in the direction that one would expect. Poorer education and less training for work mean fewer opportunities for the adult worker, a more limited range of jobs and more anxiety in changing work. All these factors influence the attitude to work and, conversely, better education and more training give adults a greater sense of security in relation to work.

Another factor enters here too. In listening to the answers of patients one often notices an "idealistic" character, an unrealistic appraisal of their situations. This arises from the kind of teaching and experience which they have had. The family has sometimes over-protected the patient, or alternatively, over-protected and harshly punished him so that he gets a distorted view of his universe in childhood. Teaching by parents often emphasised high ideals which seem to have been unrelated to the patient's real experience. If he does not meet and take part in healthy corrective experience which teaches him about the actual world he inhabits, he continues to carry this "idealistic" pattern with him. It colours his feeling for work, friends and life, and often makes him grumble about his situation and seek a will-o' the-wisp of perfection when the real world around him cannot offer satisfaction of the kind he dreams of. The patient in this unfortunate situation is unable to put forth his best efforts because he is too critical of his environment.
5. Attitudes to People and Friendship

(a) General Remarks

The research was carried out in an urban area. The necessity for social contacts at some level in such an area is patent for the great majority of individuals; they are constantly faced with people in the street, in the shops, on the trains and buses, and in all places of entertainment, and the need to get on with people is stressed in our society from an early age. It is in this area of "getting on with people" that many psychiatric patients fail. They are afraid of them, or of the pockets of solitude that occur in the midst of urban life.

Two kinds of disability were noticed:

(i) Underdevelopment in the social field.

(ii) Partial or almost total breakdown of social relationships and reversion to an earlier stage of social development.

Although there appeared to be these two kinds of disability it is probable that the second represents an aspect of the first and that both could be seen as under-development in the social field. Sometimes this appears as a failure to develop adequate social responses from childhood onwards, and sometimes as a breakdown in apparently satisfactory responses occurring in face of a conflict and a difficult personal decision as an adult. They are both considered to be aspects of under-development because social training in infancy, childhood and adolescence should enable the adult to make necessary personal decisions without breakdown. The question of whether present day western society lays too heavy a burden of personal decision
on the shoulders of the individual has already been referred to (Review of Literature, Chapter II, pages 4, 7, 24) and will not be discussed again here. In evaluating the results, the social attitudes of society must be accepted and one must assume that the education of individuals generally prepares them for their adult roles in this society. When this preparation fails and an adult breaks down and reverts to an earlier stage of development, one must look to the particular social environment which trained him and at the circumstances of conflict which precipitated the breakdown. The two kinds of disability receive comment separately because the experience of the individual is different in the two cases.

(i) Underdevelopment in the social field.

Underdevelopment sometimes occurred as a result of over-protection on the part of parents (occasionally because of illness in childhood), sometimes in face of heavy demands and the implanting of lofty aspirations by parents, sometimes as a sequel to an unusually severe amount of misfortune in childhood which led to the subject's withdrawal from contact with people. The simple lack or limitation of physical contact with other people due to these causes meant that the child had less experience of play with others and failed to learn the social responses appropriate to his age.
Failure in social development was noticed in a minority of patients and was particularly marked in the case of two men and five women. Seven other patients could be included in this category.

One example of this type of underdevelopment may be given. A girl of 19 (No. 67) of potentially high intelligence had been adopted in infancy, had to have an eye removed at the age of 2 through disease, and lost her father through poliomyelitis when she was 6. Her adoptive mother (older than the average) had high Christian standards and provided a very sheltered home for the girl. At the time of referral as a patient she was acutely disturbed, had failed to hold four office jobs because she was "too slow" and had curiously stiff and artificial address, which made easy social relations with contemporaries almost impossible. She often exhibited a haughty attitude to cover up her lack of confidence, and this made it difficult for her to contribute to friendships. She was socially isolated, although living with her mother, grandmother and uncle.

(ii) Partial or almost total breakdown of social relationships and reversion to an earlier stage of social development.

Some patients in discussing friendship spoke of earlier periods of their lives in which they had participated in warm relationships with other people but they appeared to have lost this capacity and one sensed a feeling of grief in the loss of their friends. Sometimes this had happened through an unfortunate experience in friendship, the feeling of having been "let down". Sometimes they felt isolated through the
situation of being tied to the home by tiny children; some patients would not communicate with old friends because they were ashamed of their illnesses.

These people constituted the larger part of the patient sample. They had come to the notice of the psychiatric clinic because they had failed to deal with a social crisis in their lives and needed help in meeting this.

Patient No.23 provides an example of someone who was not seriously ill but who was finding it difficult to contain a complex social situation. She was aged 37, married with two children, including one under 5. She was doing a little part-time work looking after a friend’s child, while the mother was working. She had had a satisfactory employment record in book binding, the Army, and library work prior to marriage, but had apparently always found her father difficult. She had been unable to take up a Grammar School entrance because of financial strain in the family, although both her parents were alive. A few months before being referred to the clinic she and her husband had brought her father to their home for a holiday, and on the night of his arrival he had been taken seriously ill and admitted to hospital. The patient was visiting frequently and was continuing to do this when she was referred. She said, quite reasonably, that she was merely over-tired. The presence of her father over the period of a few months had also undoubtedly brought to her mind the difficulties of her childhood and adolescence, and the memory of these was causing her extra strain.
This patient was a well-adjusted person with good personal relationships and survived this crisis tolerably well. Others, however, became totally unable to live "normal" lives when they were faced with a conflict or necessary personal decision. Further comment will be made about this in the discussion.

(b) Friendship

(i) Factors involved

It is time now to turn to the question of friendship. It has already been noticed that this was a difficult subject to broach, because of the self-consciousness felt by subjects in relation to the possession of friends. On the basis of information given in this research it would appear to contain at least three important factors.

(1) People sharing friendship believe that their partners in the relationship are interested in them and are trustworthy.

(2) Friends must share the same values in one or more important areas of life.

(3) Friends believe that they are able to communicate meaningfully, and even adverse criticism is not destructive to the friendship.

One could sum up these factors by saying that friends derive social satisfaction from their relationship. The individual is enabled to externalise his attitudes, "try them out", see them through his friend's eyes and give a
similar service in return. Such processes are particularly necessary at times of adjustment such as adolescence, the early days of marriage, middle age and the onset of old age. Discussion with friends in a similar situation is often possible when communication with relatives is out of the question.

The number of friends made by a person must be related closely to the circumstances of his life in other fields. A person who enjoys his work may have many friendly but superficial contacts amongst his colleagues; a person deeply committed to a leisure-time activity such as a dramatic society is related in a special way to the co-members of the society. A mother tied to her home by one or two children under 5 may find in a relative the "friend" who fulfils the necessary conditions of sharing her values, allowing her to "let off steam" and being a trustworthy confidante of her problems. Friendship satisfactorily creates between the parties involved a sense of relaxation and ability to "let go". When this is achieved they are likely to be less demanding of each other or of other people's time, sympathy and understanding; they can also radiate these qualities in a wider social context outside the particular friendships in question. Conversely, the person who has a few very restricted relationships and is dissatisfied with these is not only incapable of making friends in that he demands too much of each potential relationship, killing it at birth, but is equally incapable.
of being acceptable to a wider group of people.

In view of the fact that in the section on Friendship in the first questionnaire (Second Pilot Research) direct questions appeared to arouse self-consciousness in the subjects; in the main research questions on friendship and attitudes to people were scattered throughout and no specific section was devoted to them.

(ii) Preference for solitude or company.

Two related questions (Form 3 I, 3 and IV. 20) referred to preference for being alone or in company.

The answers to these two questions are considered together and show a significant difference between patients and controls. (See Table 21).

<table>
<thead>
<tr>
<th></th>
<th>Own Company</th>
<th>Others</th>
<th>Both</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>15</td>
<td>62</td>
<td>18</td>
<td>95</td>
</tr>
<tr>
<td>Controls</td>
<td>3</td>
<td>59</td>
<td>33</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>121</td>
<td>51</td>
<td>190</td>
</tr>
</tbody>
</table>

Degrees of freedom 2

\[ \chi^2 = 13.14 \]

Significant at 0.5 level.

\[ \rho < 0.005 \]
Whereas many controls showed a flexibility, liking both states at different times, patients showed rigidity in needing to be with a person or group of people or needing to be alone because they were unable to face people. This rigidity is not limited to this aspect of life; it occurs in other areas of social behaviour and will be referred to again.

(c) Attitudes in adolescence

The question (III.25) referring to the attitude to people of the subject during adolescence drew a similar response in both groups. Shyness was very prevalent; two members of the female control group remembered desperately "wanting to be loved by someone", in order to overcome their difficulty in establishing relationships. Both these women were able to remember growing beyond this stage by about 19, one of them attributing her development to attending a mixed Polytechnic college, the second when she went to a Teachers' Training College.

(d) Attitudes during worry or depression

Another question (III.27) was phrased "When you are worried or depressed do you want to go to your friends or or wait until you feel better?" (See Table 23)
<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to friends</td>
<td>18</td>
<td>23</td>
<td>41</td>
</tr>
<tr>
<td>Wait</td>
<td>27</td>
<td>24</td>
<td>51</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
<td><strong>47</strong></td>
<td><strong>92</strong></td>
</tr>
</tbody>
</table>

* 3 Patients and 1 control "unknown" 
3 " vary

Degrees of freedom 1

\[ \chi^2 = 0.459 \]

Not significant.

Eighteen patients against twenty-three controls said that they would go to someone, whereas 27 patients against 24 controls preferred to wait and recover alone. (A small number each side varied). Four of the control group (but no patients) said they were practically never worried or depressed. Seven women in the control group talked to their husbands when worried, against only one wife in the patient group; this is indicative of the state of relationships within the home and these are discussed in the chapter on Household make-up. In the replies to the question the figures for both groups are remarkably alike, but controls, as one might expect, are more prepared than patients to consult friends, and less inclined to wait on their own until they feel better.
(e) Ease in meeting strangers

Ease in talking to strangers was discussed with subjects and revealed no significant difference in response between the two groups. (See Table 24.)

<table>
<thead>
<tr>
<th>Ease in talking to strangers</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>24</td>
<td>34</td>
<td>58</td>
</tr>
<tr>
<td>Hard</td>
<td>16</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>40 *</td>
<td>48 *</td>
<td>88</td>
</tr>
</tbody>
</table>

* 11 Patients and 3 controls "variable"

Degrees of freedom  1

$\chi^2 = 1.140$  Not significant.

Some patients find it easier to talk to strangers than to maintain a relationship. It seems as though patients find sufficient in common with other people to last a short time but fail at the point where a deeper relationship might develop. Where a patient has had a long period of illness enabling him to participate to only a very limited extent in work, classes, or any activity outside the home, he is at a disadvantage in discussing these things with others - his experience is so thin - so he withdraws often with the knowledge that his experience of neurosis will not interest a potential friend.
(f) Preference for new friends or old, or both (Form 3.22)

One of the questions in the interview was: "Do you like meeting new people or prefer being with old friends or both?"
(See Table 25)

TABLE 25

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New people</td>
<td>23</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Old friends</td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Both</td>
<td>15</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48</strong></td>
<td><strong>51</strong></td>
<td><strong>99</strong></td>
</tr>
</tbody>
</table>

* 3 "unknown"

Degrees of freedom 2.

\[ \chi^2 = 8.427 \]

Significant at 5% level.

\[ p < 0.05 \]

The answers of patients showed that they were significantly less interested in varying their situation than controls; whereas many of the latter enjoyed both experiences, patients tended to prefer one or the other. The rigidity which has already been noticed in relation to solitude and company was also shown in this choice.

(g) Specific questions on numbers of friends

The main question relating to friendship was: (1) "How many people would you say that you spent time with weekly, aside from relatives and people you work with?" (Form 3.III.17).
This was put to all subjects but a further question was added for a minority (13 patients and 18 controls) during the interview. (11) "What about people whom you see less frequently?"

(i) People seen weekly

There was a significant difference in the numbers of friends seen weekly by patients and controls. (See Table 26).

<table>
<thead>
<tr>
<th>TABLE 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with whom time is spent weekly (Friends)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>One friend</td>
</tr>
<tr>
<td>Two friends</td>
</tr>
<tr>
<td>3 - 5 &quot; &quot;</td>
</tr>
<tr>
<td>6 - 8 &quot; &quot;</td>
</tr>
<tr>
<td>More than 10 &quot; &quot;</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

* "Unknown"

Degrees of freedom 5

\[ \chi^2 = 16.042 \]

Difference significant at \( \alpha = 0.01 \) level.

Whereas 18 patients saw one or two friends weekly, the emphasis in the control group was on larger numbers. Ten controls saw three to five friends weekly and 18 controls said that they saw more than 10 friends weekly. The 18 people mentioned last often included the membership of classes which they were attending because they felt a friendly feeling for everyone in them.
(ii) People seen less frequently than once a week

Where the range of movement of a person is local, e.g. he lives in the borough where he works and rarely travels more than 5 miles from home, the question of weekly contacts is useful. Friends "up the road" are often seen very frequently, perhaps daily, but where the range of movement is wide, e.g. a person travels nine or ten miles to work each day, attends classes some distance from home, he may easily have friends whom he sees less than weekly, perhaps monthly, or even three monthly or less, and still values them highly as friends.

An analysis has been made of the two groups of subjects with reference to their "living area"; those not at work are accepted as "living locally". There are 19 patients and 8 controls in this group. Of the remainder, 14 patients were working locally, and 18 more than five miles from home; 20 controls were working locally, and 23 more than five miles from home. These figures give totals of:

<table>
<thead>
<tr>
<th></th>
<th>Living and/or working locally</th>
<th>Working Away</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Controls</td>
<td>28</td>
<td>23</td>
</tr>
</tbody>
</table>

The proportions living and/or working locally, or away, are similar for each group, and give further evidence of the close matching of the two sets of subjects. Some people, although they work some distance from home, make their home area the centre of their social life. Their friends live locally, they join local evening classes, or go to local dance halls.
Others while working some distance away, particularly those working in London, meet their friends there and make London, or their work area, the centre of their social activities.

The two groups were compared in respect of these facts and although it is difficult to be exact over this, because some people have social activities or meet friends both locally and at some distance, the figures are remarkably similar.

<table>
<thead>
<tr>
<th>Life centred locally</th>
<th>Life centred away</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>Controls</td>
</tr>
<tr>
<td>36</td>
<td>13</td>
</tr>
<tr>
<td>31</td>
<td>32</td>
</tr>
</tbody>
</table>

It is likely that people who "centre their lives" away from home will have more friends seen less often than weekly, for the reason that time, expense and opportunity bring them together less frequently. People who live "locally" will "bump into" their friends more often by accident and spend more time together without necessarily having to spend money or time, or making opportunity to see each other.

The close parallel of the figures of people who "live locally" and "Away" makes it possible to make a valid comparison of numbers of friends and frequency with which they are seen.

As the research progressed the question quoted above (Form 3.III.17) on weekly contacts was felt to be too limited in its scope, particularly in view of the number of people who "centred their lives" away from home, so the further question was put to the last section of patients and controls.
(18 patients, 35 controls): "What about friends whom you see less frequently?"

The 35 controls who were asked this supplementary question numbered between them 176 friends seen less frequently than weekly. The 18 patients numbered 73 friends of this type. The difference between these results is significant. (See Table 27)

<table>
<thead>
<tr>
<th>TABLE 27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends seen less often than weekly</td>
</tr>
<tr>
<td>18 Patients have 73 friends.</td>
</tr>
<tr>
<td>35 Controls have 176 friends.</td>
</tr>
</tbody>
</table>

Using the Wilcoxon Rank Sum Test, the sum of the ranks of the smaller group (patients) is equal to 341.5 which gives \( P = .05 \). The difference between the two groups is significant.

To maintain a friendship when one is able to see the other person only occasionally requires qualities that are different from those required in a "day to day" friendship. In the chapter on work it was pointed out that some patients had retained good relationships at work over a long period and these were no doubt partly based on many common interests - a similar situation, similar work, similar causes for grumbling etc. and daily contact.

A friend seen at long intervals is often in a very different situation from one's own and exploring the diversity of the two paths makes up part of the satisfaction
of the friendship. There is, however, very often a
"warming-up period" in meeting a friend in these circumstances
and it may well be that patients cannot get past it. They
usually have less confidence in personal relationships and
they cannot ease their way through this warming-up stage.
This lack of confidence is often combined with insufficient
conviction that the meeting proposed will be welcomed by the
other person and rewarding to the patient.

Another factor is important here. When enquiring about
people seen frequently one sometimes has the impression that
propinquity has given rise to the friendship. One patient,
No. 38, said: "My neighbour is very kind; she invites me in
and we make dresses together." The patient is describing a
really friendly attitude, but one feels that if and when one
of these two moves away, there will be an insufficient basis
for them to continue their friendship. It is difficult to
describe how this impression arises, although one suspects
that none of the factors mentioned on page 125 (of this
chapter) is present. If this is so, and if the quality of
patients' friendships is often like that of No. 38, it is not
surprising that many patients have no friends seen less often
than weekly. The quality of the bond is too feeble to bear
the weight of extra effort necessary when two people are
separated by distance.
(h) "Close" friends

Patients are significantly poorer in close friends than controls. (See Table 28)

<table>
<thead>
<tr>
<th>No &quot;close&quot; friends</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having &quot;close&quot; friends</td>
<td>22</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>40</td>
<td>67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td><strong>51</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* 2 "unknown"

Degrees of freedom  1

\[ \chi^2 = 33.49 \]  Significant at .1% level

This follows closely on the remarks made above in relation to patients' friends. Some patients are glad to receive warmth and a friendly attitude from someone but are not sufficiently at ease to be able to develop the link thus made; they often concentrate on their own shortcomings and fears, and require an environment specially constructed to enable them to get to know people without strain being put upon them to respond.

Out of 51 patients, 27 stated that they had close friends; the total number of close friends for these 27 was 55. 13 patients had 1 close friend each, and the greatest number claimed by a single person was 5. Subjects were asked how long they had known close friends; the shortest time given...
was two months and the longest twenty years.

In the control group, 40 out of 51 subjects mentioned close friends, the total number of friends being 127; 6 had 1 close friend each, and the greatest numbers given were 12 (a Multiple Sclerosis group) and 8. The length of time known varied between four months and thirty-five years. The difference between the two groups is significant at the .1% level.

It is noticeable that nearly half the number of patients who felt that they had close friends mentioned 1 person only, whereas only 1/7 of the control subjects with close friends were in this position.

One interesting fact in relation to close friends is not revealed by the numbers. This is the difference between the people who appear to have no close friends "from choice" and those who have none "from necessity".

At least two of the control group fall into the first category, e.g. No.24, a young man of 21 said: "I don't tell my personal problems to anyone, not even my girl friend." This was said gaily and must be coupled with the fact that this man leads a full life, working in a factory with forty men, and enjoying the contacts, reading two books per week in bed, taking his parents to visit relatives in his car etc. One is tempted to conclude that he chooses not to confide his problems to another person rather than that he finds it impossible. The impression he gave was that of a confident young man with faith in himself to solve his own difficulties.
Another control group subject, No. 19, has already been referred to. She was a young married woman with a baby of three months, and she divided her "friends" into three groups. (1) her acquaintances with whom she shares her interests in the baby. She said: "I don't always like them"; nevertheless they clearly serve a purpose in her life. (2) her old friends from her pre-marriage days, with whom she shares many interests, and (3) her husband, who is apparently the only person in whom she confides her "real" difficulties. This girl had genuine friendships but did not use them to help solve her problems. It is difficult to judge whether she chooses not to confide, or is unable to do so. The important fact is that she has friends.

Two examples may be given from the large group of patients who are unable at present to make close friends. One chronically ill woman of thirty-six years of age, No. 26, confined to the house except when her husband could take her out, was in the situation in which she could not make friends, both because of her physical and mental condition. Again, a man of thirty-eight (No. 31) who was working, married with three children, was suffering from the tensions both of an unhappy marriage and a frustrating job. He had been referred with a duodenal ulcer and was a very isolated man.

(i) Aspirations to friendship and recent friendships

One question (Form III.24) was: "Have you ever felt that you wanted to know more people?" Whereas 32 controls could not remember ever wanting more friends, over half the
patients (30) remembered wanting more friends at some stage in their lives. Although they were unable to contribute adequately, patients aspired to friendship. (See Table 29)

**TABLE 29**

Numbers of subjects who have ever wanted to know more people

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30</td>
<td>19</td>
<td>49</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>32</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>51</td>
<td>99</td>
</tr>
</tbody>
</table>

* 3 Patients "unknown"  

Degrees of freedom 1  

\[ \chi^2 = 6.304 \]  

Significant at 5% level.  

\[ \frac{P}{.05} \]  

Patients higher than controls.

A comment was made about this in the chapter on Review of Literature, page ....... A related question (Form 3.III.26): "Have you made any friends recently?" showed that 34 of the control group felt that they had done so against only 20 in the patient group. (See Table 30 showing a difference significant at the 5% level)

**TABLE 30**

Numbers of subjects who have made friends recently

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
<td>34</td>
<td>54</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>16</td>
<td>41</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>50</td>
<td>95</td>
</tr>
</tbody>
</table>

* 6 Patients and 1 control "unknown"  

Degrees of freedom 1 \[ \chi^2 = 5.357 \]  

Significant at 5% level.  

\[ \frac{P}{.05} \]
Summary

This section of the research revealed some important differences between patients and controls. The following characteristics of patients have been noticed:

1. A significantly smaller number of friends seen weekly.

2. A significantly smaller number of friends seen at longer intervals.
   (A small group of patients questioned)

3. A significantly smaller number of "close" friends.

4. Greater rigidity in the choice (a) of meeting old friends or new and (b) of being alone or in company at home.

5. More frequent aspirations towards friendship but significantly less success in achievement.

It was felt to be of value in that it would show whether subjects had changed their habits in regard to social activities or whether they had shown consistent attitudes over a long period of their lives.

One control subject (No. 49), aged 29, attended church regularly but belonged to no other group and had never taken kindly to social groups. In her own words "She found it a nuisance to be tied to anything." She had gone to Art School for a short period in her adult life but had speedily dropped out. At the other extreme, a teacher (Control No. 31) aged 49, who had been involved with Clubs, Scouts and Cadets in his school days, was now holding office in his Union and belonged to at least two other groups in which he was active.
6. Leisure time activities

(a) Organised

(i) Introductory

The investigation into leisure time activities was accompanied by an enquiry about past membership of social organisations and also about future intentions. These two sections will be discussed, and a comparison made between past and present numbers of social activities before proceeding to examine in more detail the types of leisure time activities enjoyed by subjects at the present time.

Past membership of social organisations

Enquiry into the past membership of social organisations was felt to be of value in that it would show whether subjects had changed their habits in regard to social activities or whether they had shown consistent attitudes over a long period of their lives.

It was found that some subjects, by their own account, had retained consistent attitudes for many years. One control subject (No. 45), aged 29, attended church regularly but belonged to no other group and had never taken kindly to social groups. In her own words "She found it a nuisance to be tied to anything." She had gone to Art School for a short period in her adult life but had speedily dropped out. At the other extreme, a teacher (Control No. 51) aged 40, who had been involved with Cubs, Scouts and Cadets in his school days, was now holding office in his Union and belonged to at least two other groups in which he was active.
Many people showed changes in their social habits over a period of years. Some who had led sociable lives, in which they mixed enjoyably with others, had dropped everything outside the home following a change of circumstances e.g. marriage or the birth of a child, and this cessation of social activity had accompanied, and almost certainly helped, to prolong the illness of patients, even if one cannot go so far as to say that it was the most important cause for the outbreak of symptoms. A woman patient (No. 20) aged 37, was referred on account of depression. She was pregnant with her third child and was living in a tiny house with her family and her mother whom she found difficult. She was a warm, out-going person who had enjoyed a short period in the Land Army before being called home to help because of her mother's rheumatism. She had belonged to a Women's Organisation in Stevenage, where she formerly lived, and spoke of this with enthusiasm. At the present time she had a tenuous link with a Women's Group attached to the church. She wanted more social contacts and would like to have joined a music group but her situation made this too difficult.

Again a control subject (No. 39) aged 37, had belonged to Brownies, the Y.W.C.A. (which she attended twice weekly for 5 years) and a social club connected with her husband's firm. Since the birth of her second child 5 years previously she had dropped all social activity except for a weekly visit to the public house with her husband and friends. It was clear
that she felt the need for social activity and had taken on part-time work where she could take her child, partly because of this felt need.

In the lives of many subjects there were then changes in the design of their social activities over a period of years. People who had enjoyed contact with others in leisure time missed it when different circumstances cut off their opportunities; other people, like the control subject above (No. 39) found new ways of meeting people, or as with Patient No. 20, became depressed in a situation where family problems pressed on them, and they had little outside contact.

The specific enquiry "Can you remember what groups you belonged to in the past, e.g. Scouts, Guides, Boys' Brigade, Youth Club .... ?" was made of each subject in the research and produced varying responses. No doubt some people have clearer memories than others and the answers given must often have been incomplete. It is likely, however, that groups making an impression on the subject will have been remembered. Very few people were unable to recall a single group that they had joined; 2 control subjects were in this position compared with 4 patients. The largest number of past activities recollected in the control group by a single subject was 10, and in the patient group, 7. The total number of past social activities recollected by the control group was 150, and by the patient group 110, figures which are not significantly different.
Comparison of past and present social activities

It is perhaps of greater interest to compare the pattern over a period of time of social participation in the two groups. At the time of questioning there were 25 patients (nearly half the total number) belonging to no social group or virtually no group. Nine of the control group were in this situation. Comparing these figures with those given above, the result can be shown in tabular form:

<table>
<thead>
<tr>
<th>Subjects having no social group membership</th>
<th>Past</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Controls</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

Although both groups show a diminution in interest in social groups from the past to the present, that in the patient group is very much greater than that in the control group. The difference between the two groups in present membership is significant at the .1% level. (See Table 31)

Comparison of Numbers of subjects with no social group membership at present

<table>
<thead>
<tr>
<th>None</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25</td>
<td>9</td>
<td>34</td>
</tr>
<tr>
<td>Some group membership</td>
<td>26</td>
<td>42</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>51</td>
<td>102</td>
</tr>
</tbody>
</table>

Degrees of freedom 1

$X^2 = 11.28$  Significant at .1% level

$p < .001$
Intentions relating to social group membership

An enquiry relating to intentions was phrased: "Would you like to join more social groups?" If this was answered in the affirmative subjects were asked to try to define the kind of group in which they might be interested. Eighteen patients against fifteen controls were interested in considering further groups (See Table 32).

**TABLE 32  Desire to join other social groups**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>18</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td>Uncertain</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
<td><strong>51</strong></td>
<td><strong>98</strong></td>
</tr>
</tbody>
</table>

* 3 Patients "unknown"
  1 patient would "under pressure"

Degrees of freedom 2

\[ \chi^2 = 2.179 \] Not significant

Eleven patients and ten controls were able to make suggestions as to the type of group they would like. All these controls and ten of these patients made conditions governing the joining of further groups: "if health allows", "if time", "when problem solved", "if someone could mind the children".

The number giving firm negative answers (no desire to join further groups) was greater in the control group than
in the patient group (26 against 17). Many of the control subjects were very busy people; 11 out of the 51 in the group said that they had no time to do more, and often the programmes of these 11 were very heavy, e.g. No.11 was married with no children but worked 36 hours per week as a midwife, was responsible with her husband for a flat in North London, attended two evening classes per week, did baby-sitting for a friend, and kept in regular contact with both her own parents (in Reading) and her husband's parents (local). She was an active churchgoer and belonged to two social groups attached to the church.

(ii) Present Social Activities

After examining past membership and future intentions of subjects, we can now proceed to consider in more detail the types of leisure-time activities enjoyed by subjects at the present time. These fall under two headings:

Participation in organised activities such as church; trade union or professional organisation; organised social groups; evening classes; film, theatre or concert-going, dancing, attendance at museums, exhibitions and picture galleries; participation in sport as player or spectator.

Enjoyment of unorganised activities

At home, such as reading, television, radio, needlework, gardening etc.

Informal meetings with friends, e.g. in the public house.
Present participation in organised activities such as church, trade union or professional organisation, organised social groups, evening classes.

Church

Similar numbers of patients and controls were regular churchgoers (7 against 11) whilst a further 13 patients and 12 controls were occasional attenders. Table 33 compares the number of patients and controls belonging to church, professional organisation or evening class.

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church</td>
<td>20</td>
<td>24</td>
<td>44</td>
</tr>
<tr>
<td>Trade union of professional organisation</td>
<td>6</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Evening class</td>
<td>6</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>None</td>
<td>22</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54</strong></td>
<td><strong>65</strong></td>
<td><strong>119</strong></td>
</tr>
</tbody>
</table>

Degrees of freedom 3

\[ \chi^2 = 15.717 \] Significant at 1% level

\[ P < .01 \]
Social Group

This term, as used here, covered membership of drama and music groups, young wives' groups, bowls clubs, political groups and any group formally organised and not included under the heading of church, work organisation or class. (See Table 34)

<table>
<thead>
<tr>
<th>TABLE 34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degrees of freedom 2</td>
</tr>
<tr>
<td>$\chi^2 = 5.203$ Not significant</td>
</tr>
</tbody>
</table>

The numbers belonging to such groups were not very different - 2/ patients compared with 3/ controls. More important, perhaps, membership as reflected in attendance at these groups was significantly higher for controls than for patients (at the 5% level). (See Table 35)

Comparing the number of people at work in each group (30 patients and 43 controls) there are 5 patients compared
TABLE 33

Frequency of attendance at social groups

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly or more often</td>
<td>17</td>
<td>24</td>
<td>41</td>
</tr>
<tr>
<td>Fortnightly or less</td>
<td>6</td>
<td>25</td>
<td>31</td>
</tr>
<tr>
<td>No attendance</td>
<td>31</td>
<td>21</td>
<td>52</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>54*</td>
<td>70*</td>
<td>124</td>
</tr>
</tbody>
</table>

* Some subjects belong to two or three groups so these totals are greater than the number of subjects.

Degrees of freedom 2

\[ \chi^2 = 6.958 \] Significant at 5% level

\[ r < 0.05 \]

It seems as though membership of a social group imposes a sense of greater obligation on controls than on patients. Their greater self-confidence and ability to form relationships is an important factor in enabling them to follow up membership by regular and frequent attendance.

Work Organisation

Turning to membership of Trade Unions or professional organisations, the number of subjects working must be taken into consideration. Few people who give up work, for whatever reason, retain membership of their work organisation, even if they are entitled to do so.

Comparing the number of people at work in each group (30 patients and 43 controls) there are 6 patients compared
with 17 controls belonging to a work organisation i.e. one-fifth of the patient working group against two-fifths of the control group. Such a difference is significant at the 5% level. Most people in both groups belonging to these organisations were inactive, merely paying their subscriptions and taking a nominal interest. Three control group subjects were, however, holding office in their trade unions.

**Evening Classes**

It is in evening class membership that the most striking difference between the two groups is seen. 15 controls compared with 6 patients attend between them a total respectively of 20 and 6 classes. (See Table 36)

<table>
<thead>
<tr>
<th>Table 36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at Evening Classes</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Degrees of freedom 1

$\chi^2 = 7.72$ Significant at 1% level.

$P < 0.01$
These figures must reflect the two linked characteristics of patients referred to elsewhere. The level of education of controls is much higher than that of patients. The fact that poorly-educated people take little advantage of further part-time classes has been noticed on a nationwide scale. Glass, for instance, in his "Mobility in Modern Britain" finds that people with higher education have a greater interest in increasing their knowledge than the school-leaver of 15.

Secondly, and partly arising out of their poor education, patients often have a marked feeling of inferiority in relation to learning and diffidence in mixing with people, particularly in a field where their own inferiority is likely to be uncovered. Evening classes often provide social relaxation for their members; the figures given show that nearly a third of the control group are probably enjoying the double advantage of learning and social relaxation. Only one-ninth of the patient group are availing themselves of this opportunity.

**Film, theatre or concert-going, dancing. Attendance at exhibitions, picture galleries or museums. Participation in sport as player or spectator.**

Enquiries relating to these organised entertainments showed that controls were on the whole more active than patients. There was, however, no significant difference between the groups in relation to dancing, concert-going and sport. (See Tables 37 and 38)
### TABLE 37

Dancing or attendance at jazz clubs

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>27</td>
<td>24</td>
<td>51</td>
</tr>
<tr>
<td>Sometimes</td>
<td>21</td>
<td>27</td>
<td>48</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48</strong> *</td>
<td><strong>51</strong></td>
<td><strong>99</strong></td>
</tr>
</tbody>
</table>

* 3 Patients "unknown"

Degrees of freedom 1

\[ \chi^2 = 0.836 \]

Not significant

### TABLE 38

Football or Cricket Watching or Playing

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>33</td>
<td>67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56</strong> *</td>
<td><strong>55</strong> *</td>
<td><strong>111</strong></td>
</tr>
</tbody>
</table>

* A small number of subjects were interested in both games.

Degrees of freedom 1

\[ \chi^2 = 0.101 \]

Not significant

A small number of patients found film or theatre-going impossible because of feelings of claustrophobia and the attitudes of these patients helped to give the controls a significantly greater frequency in these areas (at the 5%
level for films and at the 1% level for theatres).
(See Tables 39 and 40).

**TABLE 39**

<table>
<thead>
<tr>
<th>Attendance at Films</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly or oftener</td>
<td>13</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>More often than once a year</td>
<td>14</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>Yearly or less</td>
<td>22</td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td><strong>49</strong></td>
<td><strong>98</strong></td>
</tr>
</tbody>
</table>

* One patient and 2 controls "unknown" One patient who goes as member of St. John's Ambulance Brigade.

Degrees of freedom 2.

\[ \chi^2 = 7.198 \text{ Significant at 5\% level.}\]

**TABLE 40**

<table>
<thead>
<tr>
<th>Attendance at Theatre</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never or very rarely</td>
<td>32</td>
<td>22</td>
<td>54</td>
</tr>
<tr>
<td>More than 4 times per year</td>
<td>17</td>
<td>29</td>
<td>46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td><strong>51</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* 2 Unknown.

Degrees of freedom 1

\[ \chi^2 = 7.869 \text{ Significant at 1\% level.}\]
Interest in museums, exhibitions and picture galleries appears keener on the part of controls. (See Table 41)

**TABLE 41**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever go</td>
<td>30</td>
<td>47</td>
<td>77</td>
</tr>
<tr>
<td>Never go</td>
<td>20</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>50 *</td>
<td>51</td>
<td>101</td>
</tr>
</tbody>
</table>

* 1 unknown

Degrees of freedom 1

\( \chi^2 = 14.411 \) Significant at .1% level

Comparing the numbers who ever go to one or more of these places with those who never go, the controls show a difference significant at the .1% level. The answers of patients showed that their poorer attendance (only 30 out of 51 ever go to one or more of these places) is not, however, a sign of lack of interest, but rather of the inability to venture, noticed so frequently in this group, arising out of their fear of dealing with people and an inflated sense of their own inferiority.

(b) Unorganised (leisure time activities)

(i) At home, such as reading television, radio, needlework gardening etc.

(ii) Informal meetings with friends.
(i) At home

In addition to asking subjects about their organised activities and entertainments they were asked about their interests at home. It has already been noticed that patients are less active and adventurous than controls in attending organised groups or in visiting museums etc. This section of the research sought to find an answer to the question: in their home life how do patients compare with controls?

There was little difference in the number of activities enjoyed at home by patients and controls. Patients engaged in a total of 225 activities and controls in 291 - a difference which is not significant.

The most popular activities for patients were reading, television and radio in that order, whereas controls enjoyed reading, radio and television.

(ii) Informal meetings with friends

There was a very small number of subjects in each group who spoke of meeting groups of friends - 6 patients and 6 controls. There was an equal number of men and women in each of these small groups and their activities included:

Visiting the pub with a few friends (3 patients and 1 control)

Chatting with other mothers when meeting own child from school. (2 patients)

Playing bridge regularly with 3 friends (2 controls)

Receiving church members informally in groups at home (1 patient).
Going out with husband and two men friends for a meal and/or entertainment. (1 patient)

Visiting a children's home to give lessons in folk dancing (1 control)

Discussion and helping on decoration of flat with four flat-mates (1 control)

Sharing activities such as needlework, dancing with friends in hostel (1 control)

Subjects were not specifically asked about their participation in informal groups. This kind of social occasion resembles in many ways visiting relatives or friends, or entertaining them at home. It is mentioned here under a separate heading because activity in which people look forward to meeting a group (No. 2) or plan for themselves and their friends (Nos. 3, 4, 5) seems to be relatively uncommon in both the groups investigated. It gives evidence of the trend, noticed in the American literature, for people to live their social lives narrowly within the small family group, rather than extend their lives outside this limit.

(c) Leisure time activities of other members of the family

An enquiry was made of subjects as to the leisure time activities of other members of the family. This helped to build a picture of the subject in his setting, and as with information given on the extended family, it was most useful in giving indications of the extent to which the subject fitted in his family pattern.
In the case of married couples where one was a subject, the results in the two groups were similar, i.e. wives in the patient and control groups named a very similar number of leisure time activities engaged in by their husbands. The converse was also true; husbands in the patient and control groups named a similar number of activities engaged in by their wives. It is interesting to note, however, that the husbands' activities named by wives exceeded in both groups the wives' activities named by their husbands. There is no means of checking in this research whether this was due (1) to wives having, in fact, fewer leisure time activities than their husbands, or (2) husbands being less aware of their wives' activities, and therefore being unable to recall them when asked.

In the case of single subjects (men and women) living at home with parents, both groups named more activities for the mother than the father. This is particularly interesting in view of the results given above. There are again two possible explanations: (1) children are more aware of their mothers' activities than the husbands, (2) mothers of older children (the age of patients in this group was 17-40) have more time for activities of this kind than wives in the above group who were often caring for one, two, or three children.
7. Education and Training

In spite of the fact that the Patient and Control Groups were matched for social class it was found on enquiry that the education and training of subjects in the patient group was inferior in many cases to that of the control subjects.

Out of a total of 51 patients, 24 had left school at 15 years or younger, compared with 11 in the control group.

(See Table 42)

**TABLE 42**

Comparison of number of patients and controls who left school at 15 or earlier and those who left later

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left at 15 or earlier</td>
<td>24</td>
<td>11</td>
<td>35</td>
</tr>
<tr>
<td>&quot; after 15</td>
<td>27</td>
<td>40</td>
<td>67</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>51</td>
<td>102</td>
</tr>
</tbody>
</table>

Degrees of freedom 1

\[ \chi^2 = 7.64 \]

Significant at 1% level

\[ P < .01 \]

A comparison was made between the two groups by consideration of the following facts:

1. Number leaving school before 15 years of age.
2. Number leaving school at 15 years of age.
3. Number who obtained a place at Grammar, Technical or Central School, but who did not complete the course, leaving before the age of 16, or not taking a Leaving Examination.
4. Number who completed a course at one of the above schools, taking General Schools examination, or an equivalent.
5. Number taking a full-time training course immediately on leaving school either at University, secretarial training college or hospital nursing training school.

6. Number taking a full-time training later.

The tables below show these comparative figures for the whole group and separately for the sexes.

**EDUCATION - TABLE I**

<table>
<thead>
<tr>
<th>A = Left school before the age of 15.</th>
<th>B = Left school at 15 Secondary Modern.</th>
<th>C = Course not completed at Grammar, Central or Technical School.</th>
<th>D = Course completed at Grammar, Central or Technical School.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers</td>
<td>Patients</td>
<td>Controls</td>
<td>Numbers of Subjects</td>
</tr>
<tr>
<td>of Subjects</td>
<td></td>
<td></td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

The tables show the distribution of subjects across different educational backgrounds.
The most striking differences between the two groups in
A = Left school before the age of 15
B = at 15 Secondary Modern Patients
C = Course not completed at Grammar.
D = Completing at Grammar Central or Technical School Controls

<table>
<thead>
<tr>
<th>Table II: Education Men</th>
<th>Table III: Education Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nos. of Subjects</strong></td>
<td><strong>A</strong></td>
</tr>
<tr>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Two questions arise here: the constitution of the control

level of intelligence of the two groups.

In the section on Subjects it was stated that by such a

method people would be selected to a large extent their level

of social co-operation and would, therefore, be different

from a random group. On the other hand, a group selected

randomly becomes more selective, for the people who are able

to participate can be said to be of the same quality of people

as the group in this respect. It also appears that people

of the same age, and perhaps even more so in the younger

groups, are more likely to have the same level of intelligence

as the group in this respect. Therefore, similar in many ways and this similarity is

reflected in the results.
The most striking differences between the two groups is in the level of education and training enjoyed by the women, and in the number of people who went on to train for work after leaving school.

**Level of education in the female group**

Table III shows that 18 of the female patient group left school at 15 or younger, compared with 7 of the control group. Two questions arise here: the composition of the control group and the level of intelligence in the two groups.

In the section on Subjects the method of finding controls was described. It was pointed out there that by such a method people would be selected partly through their degree of social co-operation and would, therefore, be different from a random group. On the other hand, a group collected at random becomes selective, for only people who are willing to participate can be used. These people are likely to have the same quality of social co-operativeness as the group used in this research. It must also be remembered that the patient and control group were matched for social class, urban dwelling, marital status, number of children under five, and possession of school children. Their conditions of living were, therefore, similar in many ways and this similarity is reflected in the results.

**Level of intelligence.**

The question that naturally comes to mind here can be phrased: is the difference between the education women in the patient and control groups due to a lower level of intelligence in the former group?
Reliable results of intelligence tests are notoriously difficult to obtain in the case of disturbed people and particularly so when education has been interrupted. Patients with a short period at school have grown up and spent a further often or fifteen years of their lives believing that they have "no brains" and it is impossible to get a true assessment of ability in these circumstances.

Intelligence tests were not carried out on the whole group but as they were needed in the course of treatment as indicators, for a small number reference can be made to the results in these cases.

No. 16 I.Q. 105 Wechsler Bellevue Adult Intelligence Scale

24 " 94 " " " "
38 " 122 " " " "
44 " 121 Stanford Binet. Terman Merrill (revised version)
65 " 114 Stanford Binet " "

As "indicators" of the level of intelligence these results show that this small number of patients came within normal or higher range of ability and could as far as intelligence goes, have benfitted from more formal education than they received.

Anomalous family background

"Anomalous" is here used to describe the family background in which a child is adopted, loses one or both parents in childhood or early adolescence, is illegitimate or has a step-parent.
In the patient group, 13 subjects had such an experience. Two further patients were considered to have had the equivalent of such an experience; in one case the father had had chronic physical ill-health going back at least as far as the birth of the children and the mother had chronic mental ill-health going back at least as far as the time when the patient was five or six years old. In the second case the parents' marriage was extremely unhappy; the father was interested in drink and other women and the mother had gone to work from the time when the patient was three or four years old. These two subjects are added to the total of 13, making 15 patients who had anomalous or similar family background.

Four subjects in the control group had an anomalous family background and a further fifth subject has been added to this group as this woman remembered her parents quarrelling constantly during her childhood. This makes a total of 5 subjects compared with 15 in the patient group, a difference significant at 2.5% level. (See Table 43)

TABLE 43

<table>
<thead>
<tr>
<th>Anomalous family background in the two groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Degrees of freedom 1

\[ \chi^2 = 6.22 \] Significant at the 2.5% level.

\[ p < 0.025 \]
Of the 15 patients, 9 left school at the age of 15 or before, whereas 4 of the 5 controls were able to complete Grammar School courses. In the case of the 9 patients, this short period of education can be specifically related to the death or absence of one or both parents. The atmosphere in the home, aside from the likely financial stringency, often failed to give the child the encouragement and impetus necessary to allow him to go forward to, and take advantage of, higher education.

In addition to the 15 patients mentioned above, another patient obtained a grammar school place but could not take it up because of financial stress and another refused a Central School place.

Two patients and one control leaving school at the age of 15 or before, reported never having taken the 11 plus examination.

The figures show that an anomalous family background had particularly effect on the women patients. Whereas four out of five male patients with such backgrounds remained at school beyond the age of 15, seven out of ten female patients left school at 15 or younger. These figures reflect the traditional view that education and a career are important for men but not for women.

Full-time training for work either at Technical School or after leaving school

Table 44 gives a comparison of the numbers of subjects in the patient and control groups who did or did not have full-
time training for work. This table shows that there is a difference between the two groups significant at the 2.5\% level. Nearly twice as many controls as patients received training. (See Table 44)

Comparison of the numbers of subjects who received full-time training for work at some time.

This table includes training at Technical School or University and also secretarial, nursing or other vocational training, e.g. hairdressing

<table>
<thead>
<tr>
<th>Training</th>
<th>Patients</th>
<th>Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>13</td>
<td>25</td>
<td>38</td>
</tr>
<tr>
<td>No training</td>
<td>38</td>
<td>26</td>
<td>64</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>51</strong></td>
<td><strong>102</strong></td>
</tr>
</tbody>
</table>

Degree of freedom  1

\[
\chi^2 = 6.02.
\]

The difference is significant at 2.5\% level

Males

In the small group of 17 male patients, four received training compared with 6 controls (out of the same number). The control group included two men who went to University after a period of work, in one case after a period of 10 years.

Females

In the group of 34 female patients, 9 received training compared with 19 controls (out of the same number). Two of these controls were able to take a training after a period of work.
Teen-age patients and controls

The transition from school to work is still difficult, however, much parental effort is usually spent in attempting to prepare children. Shorter holidays, longer hours of work in different kinds of ways, possible that are new to the school-leaver, and these are faced during adolescence when he has individual physical and psychological problems to meet as well. Table IV Full-time Training for Work

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nos.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
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<tr>
<td>22</td>
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<td>21</td>
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<td>20</td>
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<td>19</td>
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<td>18</td>
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<td>17</td>
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<td>16</td>
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<td>15</td>
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<td>14</td>
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<td>13</td>
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<td>11</td>
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<td>10</td>
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<td>9</td>
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<td>8</td>
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<td>7</td>
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<td>6</td>
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<td>5</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
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<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table IV

Men Women

It may be of interest to mention the type of illness which brought the teen-age patients into the treatment situation.
Teen-age patients and controls

The transition from school to work is still difficult, however much parents and schools attempt to prepare children. Shorter holidays, usually a stricter discipline, longer hours of work, association with adults of many different kinds, possibly tiring journeys, are factors that are new to the school-leaver, and these are faced during adolescence when he has individual physical and psychological problems to meet as well.

Teen-age Patients

There were 7 teen-agers in the patient group, 3 boys and 4 girls. Of the 5 who were at work only one had received a short period of secretarial training. The remaining two were still at school.

Teen-age Controls

Of the 6 teen-agers in the control group - 1 boy and 5 girls, one was doing a year's secretarial training, two others had been through a secretarial training at Technical School and a fourth was "filling in time" at the local hospital whilst waiting to train for nursing. The fifth control subject, who had left school at 19 with 3 'A' levels, had joined the National Assistance Board as a trainee executive officer.

Teen-age illness

It may be of interest to mention the type of illness which brought the teen-age patients into the treatment situation.
It is mentioned here because four out of the 7 patients were having difficulty in their work situations, and this is almost certainly related to lack of training, to unsuitable training or to the reasons given above. Of the 3 boys referred, one was at Grammar School working for 'A' levels and having difficulty both with the school and with his father. A second came from a grossly disturbed home (regarded as anomalous, see page 17) and was having great difficulty in settling down at work and the third was a very intelligent boy from an extremely sheltered home, who was finding it overtly difficult to get to work.

Of the 4 girls referred, one was at Grammar School working for 'A' levels and had made a suicidal attempt whilst in a state of exhaustion from overwork and physical debility. A second came from an anomalous background and had pilfered. A third was also the product of an anomalous background and was grossly disturbed, finding it impossible to settle down in work. The fourth was a rather dull girl who came from a sheltered home and had pilfered at work, probably on impulse.

**Conclusions**

The facts given in this chapter are important as social causes of mental illness. Patients suffer significantly more frequently than controls from an anomalous family background, short period of education and little training for work. In all probability these three facts are related but to prove this conclusively would require intelligence test results on
all patients to show that intellectually they might have
benefitted from a longer period of education preceding
training for work.

Only a very small proportion of patients used in this
research were tested. As already shown, these people were
found to have normal or above normal intelligence in spite
of the emotional illness which handicapped them.

In discussing present day Western society (Review of
Literature, page ??.) it has been pointed out that a premium
is put on logical thinking and ability to make personal
decisions. Both of these capacities are brought to fruition
by suitable and adequate education in the widest sense.
If the group of patients interviewed in this research have
normal, or above normal, intelligence but have been deprived
of a suitable education they are likely to be aware of this
disadvantage and be less able to make satisfactory social
relationships as adults. They live in an urban competitive
society in which the advantages of higher education are
constantly being brought home to them and many of them are
striving to offer their children an education which they lack
themselves. One patient who reported that she was evacuated
and did not take the 11 plus exam said spontaneously: "I
suffer from depression over lack of education."

In a society which places emphasis on higher education and
training, it is not surprising that patients with neither of
these advantages suffer and continue to suffer from feelings
of inadequacy in their personal relationships.
Patients

This is a small group of nine subjects which has been singled out for a more detailed analysis. It was chosen for this purpose because characteristics which distinguish the patient group from the controls are more clearly thrown into relief by this section.

Controls

There were 11 subjects in this group. It will be remembered that it was found impossible to match the numbers in the five social classes exactly - see note on this on page 172 (Chapter on Method).

One of the extra subjects in this group was the only single woman in the whole of Social Class II women. The second extra subject (Control No. 38) was matched with a Social Class I patient (see page 172, Method) No. 24.

These two will not be considered in this analysis. This leaves a group of nine controls to compare with the same number of patients. Certain demographic characteristics of Social Class II women are set out in the table below.
<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Anom.</th>
<th>Left school before 15</th>
<th>No. of children under 5</th>
<th>School</th>
<th>Work</th>
<th>Church</th>
<th>Club</th>
<th>Class</th>
<th>T.U.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 *</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>P.T.</td>
<td>Yes + helps</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>38 *</td>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
<td>None</td>
<td>P.T.</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>21 *</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td>None</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>16 *</td>
<td>No</td>
<td>Yes</td>
<td>1</td>
<td>2</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>50 *</td>
<td>No</td>
<td>No</td>
<td>1</td>
<td>1</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>52</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>None</td>
<td>No</td>
<td>Occ.</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>19 *</td>
<td>No</td>
<td>Yes</td>
<td>None</td>
<td>2</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>64 *</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>1</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>68 *</td>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
<td>2</td>
<td>No</td>
<td>Occ.</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>CONTROLs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 *</td>
<td>No</td>
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* = Married into different social class
P.T. = Part time
F.T. = Full time
Occ. = Occasional
Anomalous family situation, i.e. adoption, loss of one or both parents in childhood or early adolescence, illegitimacy. Broken Home.

Four out of nine of the patient group had an anomalous family situation in childhood or adolescence, compared with one out of nine in the control group.

Education

Five of the patient group left school before the age of 15; this included one woman who did not sit the eleven plus.

Of the remaining four, one went to a Grammar School and stayed till she was nearly 18. She obtained four credits in the G.C.E. and three passes, but felt that she had been badly advised by the staff at school. She felt that they took no interest when she expressed her intention of sitting for a Civil Service examination.

A second patient who passed into the Grammar School left at 15. She said that she did not have a "Grammar School brain" and took a secretarial course.

In the control group, no one had left school before 16. Eight had attended Grammar School and three managed to get into the University. Two others had had three years further training after leaving the Grammar School.

Marriage

The number of women who married out of their social class is greater in the patient group than in the control group. Rated on the work they were doing prior to marriage
in comparison with their husbands' social class, 8 of the 9 patients married into a higher social class.

In the control group, four women married into a higher class. The other 5 were in a similar class to their husbands.

The social class of origin of the married women subjects is not known. This information would be useful for the above comparison. Parents are often less interested in ensuring that daughters are educated up to the limit of their ability than sons and this would mean that daughters are more often encouraged to take secretarial, clerical or other work falling into Social Class III. Additionally, and partly as a result of the attitude of their parents, many girls are not interested in a career. They are seeking profitable work which will occupy them for the period before and after marriage until they become mothers. Their pre-marital occupation is a doubtful indicator of their social class.

The ease with which a woman, who falls into Social Class III on her pre-marital work, enters into marriage with a man in Social Class I or II, will depend largely on her social class of origin. If she has grown up in a family of which the main wage-earner falls into Social Class I or II she will easily accept her husband's position; it will be much harder for her if her class of origin was III or IV. It is likely that some of the present group of Social Class II wives fell
by origin into each of the Classes I, II, III and IV but
exact information on this would make the present comparison
more meaningful.

Reference was made in the Review of Literature to Myers
and Roberts' book "Social Class, Family Dynamics and Mental
Illness" (p 35) Their findings on mobility agree with
the findings in the present research but this comparison
must be viewed with caution. Whereas Myers and Roberts'
patients were classified according to the occupation of their
fathers (i.e. social class of origin) the patients in the
present group, as already stated, were classified on their
pre-marital occupation. In the cases where the class of
origin is known to have been much lower than that acquired
by marriage, the stress arising from attempts to "live up to"
the husband's social class (as in Patient No.68 described on
pages 115-117) undoubtedly exacerbated the patient's symptoms.

Work

Two patients from the group of nine were doing some part-
time work. Neither had children.

In the control group, five were working of whom one was
doing full-time and four part-time work. Three of these women
had children; in two cases these children were under five.

The possibility of working part-time for Social Class II
wives is probably largely determined by their education and
training. Both the wives from the control group with children
under five who were working had University degrees and were
coaching or teaching. The remaining part-timer with a child
at school had a University appointment which she could adjust to the needs of her child.

Because of their poorer education, the women patients in Social Class II did not have the opportunity for taking part-time work of this nature. Marriage to sales managers, consulting engineers and supervisors put social barriers in the way of their seeking domestic or factory work which both provide popular sources of part-time work. One of the control group wives in this class was addressing envelopes at home but this work is badly paid and does not bring the worker in touch with any other people and is not to be recommended widely. The fact that this woman had taken such work demonstrates the difficulty that wives in this social class without higher qualifications find when seeking appropriate work.

Membership of Church, Clubs, Classes, T.U. or professional organisations.

Church attendance in the two groups was similar; three patients attended church regularly, including one who additionally helped to clean the church once a month; and two others attended occasionally. In the control group three people attended.

Membership of clubs varied widely in the two groups. Whereas 8 patients had no club affiliation at all and the remaining one had just started acting as National Savings Collector in her road, 8 of the control group belonged to a club of some description and two people belonged to two each.
Attendance at classes was uncommon in both groups but whereas no one in the patient group attended a class, two people in the control group attended between them five classes.

No patient was a member of a trade union or professional organisation, whereas four controls belonged to such an organisation.

Taking the membership of church, clubs, classes and trade union or professional organisation as a whole, 5 patients out of a total of 9 were involved in six organisations; 9 controls, on the other hand, were involved in a total of twenty-two organisations.

Disturbance. Degree of Mental Illness

Of the group of nine patients, four were regarded as severely disturbed and a fifth was chronically hypochondriacal.

No.16 was in an acute schizophrenic episode, showing symptoms of depersonalisation. No.38 was severely depressed and had had L.S.D. treatment two years previously before presenting herself for help on this occasion. She had had an illegitimate child prior to her marriage and was having difficulty within this marriage. She has since left her husband. No.64 and No.68 had both suffered from chronic anxiety states for many years. Both had intense difficulty in meeting people although their work histories before marriage were satisfactory. These histories are discussed earlier (p 63, 65)
No.19 was hypochondriacal. She had a long history of hospital attendance for trouble with her back and menstrual periods and she had now added attendance in the psychiatric clinic for giddiness and other psychosomatic manifestations.

Amongst these more severely disturbed patients, one was an occasional church attender and one had started collecting savings in her road. Otherwise they belonged to no social groups.

This small group of Female Social Class II patients exemplify the multi-causational nature of mental disturbance. The causes are in all probability linked but we cannot at the present time distinguish the factors which finally drove them to the recognition of their own disturbance and hence to the out-patient psychiatric clinic.

The factors which have been mentioned in this short analysis include the anomalous family situation, limited educational opportunities, little training for work, marriage to a man in a higher social class and failure to become associated with social organisations in the community, such as church, club, class, trade union or professional organisation.
CHAPTER VI

COMPARISON OF RESPONSES TO QUESTIONNAIRE (WRITTEN) AND TO INTERVIEWS AND EXTRA MATERIAL

The questionnaire represents the "bare bones" of the research and was given to each subject at the time of first meeting. Each person was asked to answer in writing and it was explained that there would be opportunity to discuss answers which the subject felt were inadequate. The purpose of the questionnaire was to get a "skeleton picture" of the subject's social activities before he had had any lengthy contact with the student, who might, relying on interviews alone, bias the replies given.

The time taken in writing answers to the questionnaire varied greatly. One subject took 25 minutes and several gave the questionnaire a great deal of thought - one subject listing 24 relatives outside the household and giving details of how they were all contacted.

A copy of the questionnaire and the interview form (used by the student) are attached and a comparison of the two will show that Sections III (Work) and IV (Leisure time activities) are designed to bring out much more material in the interviews than in the questionnaires.

It is interesting to note that some subjects suggested extra areas of investigation, e.g. holidays, ways in which money is spent etc.
Differences between the answers in the written questionnaire and in the interviews have been examined and considered under the following headings:

1. **Contradictions**
   A subject has given an answer on the questionnaire and the opposite in interview.

2. **Omissions**
   A subject has answered a question in writing but in the interview it has transpired that the answer was incomplete e.g. in Section II, a subject's own relatives have been listed but he has omitted to record the relatives of his spouse with whom he is in contact.

   In Section III the full details relating to previous jobs given in interviews have been accepted as indicating omissions in the questionnaire answer.

3. **Corrections**
   A subject has amended a questionnaire answer - not to the extent of contradiction but giving a different "slant" in relation to the information offered.

An analysis of the differences found in the written questionnaire and the interviews is appended (See Table 4). Where five or more subjects have differed in their replies detailed information on the section is given, otherwise the differences are summarised.
**TABLE NO. 45**

Section numbers refer to *Written Questionnaire (Form 2)* figures.

### CONTRADICTIONS

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### OMISSIONS

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<tr>
<td>III. 4</td>
<td>27 (previous jobs)</td>
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<tr>
<td>III. 5</td>
<td>5</td>
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<tr>
<td>IV. 1</td>
<td>31 (leisure time activities)</td>
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<tr>
<td>IV. 6</td>
<td>14 (types of entertainment)</td>
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</tr>
<tr>
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### CORRECTIONS

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<tr>
<td>Distributed 17</td>
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</table>
Contradictions

The sections in which most contradictions have occurred are I.3 and III.5 for patients and IV.6 for Controls. Sections I.3 and III.5 both relate to contact with other people and preference for being alone or with others - an area of difficulty for patients and one that is likely to give rise to contradiction.

Section IV.6 relates to attendance at places of entertainment - a factual enquiry in which contradiction could arise when the subject is pinned down to stating when he last attended a theatre, film, concert etc.

Omissions

The high figures found in Section II.1 relate mainly to relatives of the spouse, "in-laws", who had not been included in replies to the written questionnaire.

Section III.4 relates to previous jobs and as a work history was taken from every subject, the interview was the more suitable occasion on which to ask for details of this.

Section IV.1 relates to leisure time activities. All subjects were asked about their interest in radio and television. Many had omitted these from their written replies, although they devoted a certain amount of time to these interests.
Corrections

These are conspicuous in the clinic group only and occur in Section I.6, III.2 and IV.7. With regard to Sections I.6 and III.2, the interviews often revealed a rather different attitude of mind from that shown in the questionnaire e.g. "Satisfied at home?" "I have to be ...."

Similarly with work, e.g. "Do you enjoy it?" "It's all right" spoken in a tone which indicated that the job was better than nothing.

Section IV.7 relates to contacts with other people and indicates the uncertainty experienced by patients in this field.

Summary of differences

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<td>Omissions</td>
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<td>Corrections</td>
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<td>17</td>
</tr>
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<td>161</td>
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</tbody>
</table>

The total number of differences in the two groups varies very little - the most striking difference being in the section labelled "Corrections".
QUESTIONNAIRE

I. 1. How many people make up the household in which you are living? Please give the following facts about each person in the household.

   Relationships to you  Sex  Age
   (a)  
   (b)  
   (c)  
   (d)  

2. Please underline the person in the household with whom you think you get on best.

3. When you are home do you enjoy your own company or do you prefer to be with other people?

4. About how many years have you lived in this district?

5. What is your position in the household? Put a cross next to the position which describes yourself.

   Chief wage-earner
   Keeping house
   Keeping house and wage-earning
   Lodger
   Child of the head of the household
   Other (please give particulars)

6. Please put a cross beside whichever of the following statements seems to be more true for you.

   I am satisfied with conditions at home.
   I would like conditions at home to be different.

II. 1. Do you keep in touch with any relatives outside your home? Please give relationship to you and other facts as asked for.

   Relatives  Age  Sex  District where relatives live  How keep in touch e.g. visiting, meeting, letters phone etc.
III. 1. Have you a job outside your home? If so, what sort of work do you do? Please describe in detail.

2. Would you say you enjoy doing it or not?

3. How long have you been doing this particular sort of work?

4. Have you ever done any other sort of work? If so, what?

5. About how many people would you say that you spend some time with, at least once a week, apart from relatives and people you work with?

IV. 1. What sort of things do you do in your leisure time?

2. Do you belong to any sort of social group such as a sports club, social club, church club? If so, please give particulars.

3. Do you go with other people or alone?

4. Do you belong to any other associations such as trade union, or evening class?

5. Do you think you would like to join other social groups or clubs?

6. What kind of entertainments do you go to at some time or other? Please put a cross beside the ones you go to.

   Films
   Football or cricket matches
   Theatres
   Dancing or jazz clubs
   Dog-racing
   Concerts
   Other (Please give particulars)

7. Would you say you enjoyed going to places where there are other people or preferred your own company?
INTERVIEW GUIDE

FORM 3

I. 1. Household
   2. Get on best with
   3. Enjoy own company at home or prefer other people.
   4. Is it hard to leave family to be in own room?
   5. Have you ever lived away from family? For how long?
      Pattern of activity.
   6. How many years in this district?
   7. Details of moves in last 5 years.
   8. What do you live in?
   9. How many rooms?
  10. How many rooms for sleeping in?
  11. ? Garden.
  12. Position in household.
  13. ? Satisfied with conditions at home or not?
  14. ? How did you get them? At school, work, or other ways?
  15. Initiative.
  16. ? Has anyone ever been in service?
  17. Experience in service.
  18. ? Main wage-earner's work?
  19. ? Ever done any other sort of work?

II. 1. In touch with relatives outside home.
   2. Details including method of contact and locality.
   3. Who takes initiative?
   4. Depth of relationships.

III. 1. Job outside home?
   2. If not working, how long since? What work?
   3. Intend to work again? When?
   4. Enjoy work?
   5. If not, what would you like to do?
   6. ? Practicability of this.
   7. How long present work?
   8. How long this job?
9. How many people working with?
   Expansion

10. Enjoy contact with people at work?

11. Meet people at work outside working hours?

12. Friends through work or vice versa?

13. Level of friendship.

14. Ever done any other sort of work?

15. Experience in services?

16. Main wage-earner's work?

17. How many people spend time with at least once a week apart from relatives and people you work with?

18. Initiative.

19. Where did you meet them? At school, work, leisure, living near, or other ways?

20. Are some of them close friends? How long known?

21. Have you lost touch with people whom you used to know, e.g. through moving, illness etc.

22. Enjoy meeting new people or prefer old ones?

23. Easy to talk to strangers?

24. Ever wanted to know more people?

25. Can you remember what you felt like in relation to people when you were in your teens?

26. Made any friends recently?

27. Do you want to go to your friends when worried or depressed or wait till you feel better?

IV. 1. Leisure time activities.

2. Social group.

3. How did you come to join?

4. Used to belong to more or different?
5. How often do you go?
6. With other people or alone?
7. Ever alone?
8. T.U., church, evening class?
9. How did you join?
10. Part played, e.g. active etc?
11. Like to join other social groups?
12. Entertainments?
13. Museums, etc.?
14. How often?
15. Alone, etc.?
16. Whose idea?
17. Other members of household?
18. Their leisure?
19. Special reference to partner.
20. Enjoy places where there are people or prefer own company?
21. Enjoy life?

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<tr>
<td>20. Enjoy places where there are people or prefer own company?</td>
<td>27</td>
<td>35</td>
<td>12</td>
<td></td>
<td></td>
<td>114</td>
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</table>

V. 1. How old when left school?
2. Marital state.
3. Age
4. Sex
5. Occupation
Extra Material Elicited at Interview

Extra material offered at the interview varied in extent from a detailed history of the subject's education to an almost complete life history offered by one or two subjects.

It is almost impossible to reduce to figures material of this type, but an attempt has been made to analyse the areas of the research into which the extra material falls. This gives the following results:

| TABLE NO. 46 |
|--------------|---|---|---|---|---|---|
| Number of subjects offering extra material at interview |
| *Section | I | II | III | IV | V | Total |
| Patients | 22 | 18 | 27 | 35 | 12 | 114 |
| Controls | 18 | 17 | 35 | 35 | 15 | 120 |
| Total | 40 | 35 | 62 | 70 | 27 | |

* Section numbers refer to Interview Guide Form 3.

It will be noticed that the numbers of subjects offering extra material differs very little in the two groups.

Severely disturbed subjects (i) Patients

There were 21 patients who were considered to be more severely disturbed than the rest. Four of these offered no extra material but the others offered material under
various sections, the commonest being those referring to
the household, work and leisure-time activities.

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</tr>
</tbody>
</table>

* Section numbers refer to Interview Guide Form 3
Aside from these severely disturbed patients two others (Nos. 31 and 48) both offered a great deal of extra information practically amounting to a life history.

Disturbed subjects (ii) Controls

Six controls gave the impression during interviews of being disturbed. They all offered extra information under various sections, the commonest being that referring to leisure time activities.

TABLE NO. 4C

Extra material offered by disturbed controls

<table>
<thead>
<tr>
<th>Number of interviews required to complete information</th>
<th>Reference Number of Subject</th>
<th>Section</th>
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<th>II</th>
<th>III</th>
<th>IV</th>
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</tr>
</tbody>
</table>

* Section numbers refer to Interview Guide Form 3.

Disturbance generally seemed to cause subjects to talk more than the apparently healthy, although there were
exceptions in both directions i.e. a few disturbed subjects were almost monosyllabic in their replies and some apparently healthy subjects found it hard to keep to the point and offered a great deal of extra information. The student had tried to put subjects at their ease and to give them ample time but it was necessary sometimes to check both disturbed patients and the more garrulous controls and to bring them back to the question at issue.

PATIENTS

No.15. Female aged 20. Married with 3 children. (Very disturbed).

Enjoy own company at home or prefer to be with other people?

"I can't bear to be alone. I feel so unsafe and insecure. Then I am with someone really human I want to wear my hands at them."

No extended family.

"My father said I was like a parcel being picked up and dumped in different places. ... My mother has always put my life right for me. I even thought she could help me out of life."

Friends or book work?

"No. Lived on my family - had my brother's friends."

No.24. Female aged 28. Married with two children under 5. In family yet on post natal?

"Some of them please me... I am torn with everybody."

Enjoy own company or prefer other people's?

"I hate to be on my own. I get terribly depressed. I tend to do silly things like running away. Mother was surprised about me now. I often cry when I am alone. I find something to cry about - it was not for a real reason."
VII. VIVID REMARKS

Some subjects made vivid remarks in reply to questions in the interviews. These remarks often epitomise a point of view, particularly in the case of very disturbed people. It was considered useful to include a selection of these so as to give some impression of the atmosphere during interviews with patients and controls.

"So, I don't... I think it's horrible."

PATIENTS

No.16. Female aged 28. Married with 3 children (Very disturbed).

Enjoy own company at home or prefer to be with other people?

"I can't bear to be alone. I feel so unsafe and insecure. When I am with someone really human I want to warm my hands at them."

Re extended family:

"My father said I was like a parcel being picked up and dumped in different places ... My mother has always put my life right for me. I even thought she could help me out of life."

Friends through work?

"No. Lived on my family - had my brother's friends."

No.21. Female aged 32. Married with two children under 5.

In family get on best with?

"None of them please me. I am torn with everybody."

Enjoy own company or prefer other people's?

"I hate to be on my own. I get terribly depressed. I want to do silly things like running away. Nothing ever sensible about me now. I often cry when I am alone. I find something to cry about - it may not be a real reason."
Re feelings in adolescence:

"I trusted everybody. If anyone said a soft word to me I thought they were wonderful. I was never a good judge of character."

No. 24. Female aged 28, single. (Too ill to work)

Re intention to work again:

"I know I shall never work again."

Re enjoyment of life:

"No, I don't. I think it's horrible."

No. 26. Female patient, aged 37.

Married with 2 children at school.

Re relationship with husband:

"It's mostly a case of armed neutrality."

No. 28. Male aged 20, single. (Very disturbed).

Re relationship to people while adolescent:

"They were all above me, like. I don't respect them so much now. I can't trust them."


Re going to friends when worried or depressed:

"I never tell anyone anything."

No. 36. Female aged 28. Married, no children.

Re feelings in adolescence:

"I tended to be very much in myself. Very bitter, aggressive and nasty."

No. 38. Female, aged 28. Married, no children by marriage.

Re losing touch with people:

"Yes, through negligence."

"Don't want to belong to a lot of people anyway."

"Can't bear the thought of being tied to people in any way. That goes for my husband too."
Re enjoyment of life:

"No. I sometimes get a glimpse of what it could be like."

Re visits to picture galleries etc:

"The awful thing about marriage is that you do everything together. It shouldn't be like that but it is."

No. 46. Male aged 34. Married, no children.

Re feelings in adolescence:

"Didn't enjoy it at all. Felt I might die at any minute. Felt that every other bloke could get along with girls but I couldn't."

No. 66. Female aged 20. Had twice recently been in a mental hospital.

Re wanting to know more people.

"Yes. I want to know more now. I wish I could ring someone up."

Re reason for joining social group.

"Mother kept on nagging about joining something."

No. 68. Female aged 37. Had married into a higher social class.

Re relatives in the extended family:

"I feel that my mother-in-law squashes me flat."

Re attendance at entertainment, sport:

"My husband said: 'Don't be jealous of my outside world because you haven't got one.'"

No. 12. Female aged 37.

Re enjoyment of life:

"I would enjoy life if I could forget about myself. Something must always stop me."

No. 23. Female aged 37.

Re satisfaction with home conditions:

"I get tired and in a huff and can't deal with the family rationally."
No.53. Female aged 32. (Very disturbed)

Re friends made at work:

"You wonder what are your likes and dislikes.

No.55. Female aged 34.

Re adolescence:

"Hated people. Terrified of groups."

No.56. Female patient aged 30.

Re enjoyment of life:

"Not always. I get into pitches. I'm all right at work - once I sit down I get a terrible feeling. My husband is jealous of the children. I suffer from depression over lack of education."

No.59. Female aged 36. (Unmarried)

Re feelings in adolescence: Depending on whether she was with her father, when he was there she "couldn't be herself."

"He made mountains out of molehills," when away from father she felt different. Met many friends. When living with sister from age 16 - 20 "never lacked friends."

No.62. Female aged 18. (Single)

Re feelings in adolescence:

Likes people but feels "wary of them". "You never know the other side."

No.64. Female, aged 33. (Severe neurotic but with good employment record prior to marriage)

Re husband's work:

"He has a lovely life. He couldn't stand my life, he says."

Re wanting to know people:

"Wants to do something worth while especially when I feel half-dead." Feels she is "better with new people. Doesn't want old friends to know what a fool she is."
No. 67. Female aged 19. (Very disturbed)
Re father (died when patient 6 years old):
"I would give my soul to have him back."

No. 48. Man aged 40. (Depressed)
Re enjoyment of life:
"Not in the last three months. I have thoroughly enjoyed life prior to this spell. I accept that my life has been too self-centred."

No. 1. Female aged 27. Married.
Re close friends:
"I don't honestly think I have ever had a close friend."
"I will talk to any one about family problems."

No. 6. Male aged 38.
Enjoy new, or prefer old friends?
"I don't like meeting people on close terms at first. I 'stalk' them."

No. 8. Female aged 35. Married.
Re dancing:
"Loathe it - something false about dances."

No. 11. Female aged 27. Married.
Re evacuation:
"My foster parents took no notice of me at all. They chose me so that their child could get used to 'someone in glasses'."

No. 8. Female aged 24. Engaged. (One of 9 children)
"My mother gets very irritable if she hasn't enough to do."
No. 23. Female aged 17 - single

"Since starting work I can put people into groups and discern them more easily."

No. 27. Female aged 37. Married with 3 children.

Was a "terribly shy child" because of sheltered upbringing - made a complete break when she joined the Services and "enjoyed this life better than any."

No. 32. Male aged 25. Unmarried.

Re enjoyment of new people or old friends?

"New people, get tired of old ones, like girls."

No. 34. Female aged 20. Engaged.

Re feelings in adolescence.

"Everyone else is efficient and can cope but I can't. Afraid of what people would think."

Re close friends:

"No one with whom I discuss personal problems but with several of my older friends I can discuss in general terms how to do things."

No. 37. Female aged 18. Single

Re sex education:

"I asked my girl friend and she told me. I never asked mother questions - I don't know why. Mother gave me books but I didn't read them."

Re adolescence:

"They treat me better now. They used to talk down to me, which I can't bear."


Re satisfaction in conditions at home:

"I'd like my parents to treat me more as an adult and to do what I like."

Re feelings in adolescence:
"Resented a lot of things - people treated you like a child, especially my father."

No. 43. Female aged 18. Single, engaged.

Re adolescence:
"Now parents treat me as an adult."
"Woman at work nags me but that's how she is made."
"People treat me all right. They confide in me."


Re living at home or away:
"Have realised it makes no difference to my freedom where I am." (Living with family or away).

No. 55. Female aged 28. Married with 2 children (disturbed)

Re close friends:
"I fluctuate between telling every one my business and telling no one."

Re adolescence:
"Very withdrawn. Nervous of groups of people."

No. 57. Female aged 35. Married with 2 children.

Re adolescence:
"Terrible feeling of inferiority though don't know if I showed it."


Re adolescence:
"Regard adults cautiously - could I emulate or would I get like them in spite of any efforts to the contrary?"

No. 48. Female aged 37. Married with 2 children.

Re adolescence:
"Very observant and very critical of people. Never spoke. Felt they were silly."
CHAPTER VII A

A Note on Manifestations of Physiological Instability

A limited number of subjects in the research (17 patients and 22 controls) were asked about the incidence of symptoms of physiological instability.

Morgan (1949) in a study of physiological instability in 525 children between the ages of 6 and 14 stated that constitution, diet, mild chronic infections and emotional factors were closely related factors in the production of many clinical pictures. He expressed the opinion that each disease entity is the product of multiple factors operating within the individual and within his society.

The present enquiry was added to the main study in an attempt to throw light on possible constitutional differences in the two groups. It has been pointed out that the multi-causational nature of mental illness is now recognised and that, in this research, the main interest has been focused on social causes. It was felt, however, that a limited enquiry into physiological instability might be useful.

Form of the Enquiry

The physiological instabilities included:

- Recurrent bronchitis in childhood
- Asthma
- Hay fever
- Travel sickness
- Bilious attacks
- Abdominal pains particularly in the morning before going to school
Migraine
Blushing
Excessive pallor
Heat bumps
Chilblains

Subjects were asked, at the end of the interviews on the main study, whether they had ever suffered from these manifestations of instability. The list was given verbally and subjects were not asked for details beyond those given spontaneously. The occurrence of a symptom on one occasion only was ignored.

The seventeen patients had suffered from a total of 54 of these symptoms and at the present time suffered from 35.

The twenty-two controls had suffered from a total of 74 with a total at the present time of 49.

So far as this enquiry goes, therefore, there is no significant difference in the incidence of physiological instability in these two groups. Nevertheless, a far more detailed enquiry over a broader sample of the community will have to be undertaken before it can be assumed that such constitutional factors are not related to mental illness.
VIII. DISCUSSION AND CONCLUSIONS

1. General Factors in Mental Illness

One aspect of this research illuminates the old problem of the respective roles of heredity and environment in determining the behaviour of the individual.

It will be clear that the hereditary factors in the subjects were random. There could be no matching in this area except the crude selection based on sex and on the fact that all the subjects were drawn from the field of normal intelligence. Apart from this and the small investigation mentioned below (page 203), the hereditary factors contributing to the development of these subjects were unknown and uninvestigated.

This research has been concerned with environmental differences in the two groups of patients and controls which are discussed below. This is not to say, of course, that the hereditary factors with which the student has not been concerned are less important in the aetiology of mental illness. In fact this investigation supports the widely accepted view of the multi-causational nature of mental illness. Somatotypic and metabolic factors undoubtedly play an important part in determining which members of the population become mentally ill. These factors also help to determine the "shape" and type of illness, so that every patient has his individual illness which shows characteristics common to the illnesses of other people, but which also shows features unique to the individual.
The importance of the inherited metabolic and somatotypic factors in determining mental illness or health is accepted but this research has brought out the importance of the social setting, perhaps the most crucial element in the environment, in determining the degree to which the individual in the outcome realises, or fails to realise, his potential, and achieves mental health, or falls into mental illness. The metabolic and somatotypic factors are loading agents which make it harder or easier for the subject to withstand the results of social reversal and are not causes of mental illness. To assess the somatotypic loading, a further research would be necessary in which each subject was fitted to his somatotype. In fact a limited attempt was made in this research to gauge constitutional factors in the incidence of psychosomatic illness in the case of 17 patients and 22 controls. The enquiry showed that an equal number of patients and controls suffered from these illnesses at some time in their lives. More elusive constitutional factors may have been present but it seems from the evidence of this small group that social factors created a situation in which certain people became mentally ill and their proneness to some form of psychosomatic illness further loaded the situation against them, so that they were less able to overcome the disadvantages of their social situation.

2. Environmental Factors.

The research set out to compare the social functioning of a
group of patients and those of a control group. The results show that the difference between the two groups lies rather in their attitudes to people, in the flexibility with which they establish social relationships, than in the number of social activities enjoyed.

The individuals in the control group were carefully selected to be strictly comparable with the patients in regard to the factors originally mentioned (see chapter on "Method - Choice of Subjects"). They were also similar in having the same number of people living and/or working locally, or at a distance (i.e. more than five miles from home). This means that the time and opportunities available for leisure time activities were similar in the two groups.

The material obtained is derived from evidence from two fields:

(a) The present situation at home, work and in leisure.

(b) Histories related to four areas of the subjects' past lives:

(i) Absence from home.

(ii) Changes of residence over the past five years.

(iii) Work, education and training.

(iv) Social activities.

There were statistically significant differences in certain areas of the enquiry relating to these two fields.

(a) The Present Situation.

Results showed at first sight a striking similarity between the two groups in Field (a), a similarity which, on closer
inspection, dissolved into difference in inter-relationships with other people. Controls often had a rich and well-marked network of relationships with the extended family, with close friends including many friends rarely seen but much appreciated. Patients, on the other hand, had few, weak and strained relationships in these areas, and often felt them a burden to maintain. We find that patients are in touch with significantly fewer members of the extended family than controls, that they claim significantly fewer "close friends" and that their work relationships, although enjoyable, appear to be more superficial than those of controls.

In organised leisure-time activities, controls went to evening classes significantly more often than patients, and also showed more initiative over going to museums, exhibitions and picture galleries.

A group of three questions relating to preferences adds to our knowledge about the capacity of patients to form relationships. These referred to:

(i) Meeting new people or seeing old friends.
(ii) Spending time alone at home or with the family.
(iii) Picking out a member of the family with whom the subject got on best.

The answers to these questions showed that patients were often tied to one particular situation by their symptoms; the control group displayed a flexibility in enjoying different experiences in relation to people at different times.
In reply to Question (iii) it was only among controls that the answer "All of them" was given. This occurred several times, often with the additional information that all members were liked in different ways. Patients selected one member of the family or sometimes two, and displayed less interest in adapting to different members.

(b) Histories

We can relate the differences in the present situation of the two groups to differences in their histories; it seems that a difficult start often associated with a poor education leads on to a thinner network of relationships later, and to an inability to extend education in adult life by classes or by visiting museums etc.

The histories showed:

(i) Significantly more patients who had suffered from an anomalous family background.

(ii) Significantly more women patients than controls who had left school at 15 or younger.

(iii) Significantly less training for work among patients than controls.

(iv) More frequent marriage into a high social class among women patients than controls. The possible relation of this to illness has been discussed in Chapter 7. Histories of the patients, however, revealed that in relation to work and service careers, a number had lived socially and satisfactorily over long periods of time so long as conflicting
interests were few and personal decisions had presented no difficulty.

It seemed that difficult family situations in childhood coupled with a poor education often made it hard for patients to define their own roles and to arrive at satisfactory personal decisions in a complicated situation. They appeared to find it difficult to reconcile conflicting interests within a situation, and developed acute disabling symptoms at the times when personal decisions were essential. Conflict will be referred to again as the catalytic agent in mental illness.

In the patient group in contrast to the control group an anomalous family background and a poor education seem to have been the prelude to a paucity of personal relationships in adult life. Patients are rigidly held to a narrow range of social situations by their illness. The research showed that they were dissatisfied and aspired to living more richly in relation to friends and social groups and were aware of their failure. Their experience in handling people was less than that of the controls, and they were less confident in making personal decisions.

3. Social Factors in Breakdown

In view of the past disadvantages suffered by patients, how was it that many of them were able to maintain equilibrium over long periods of time, but broke down acutely at a particular crisis in their lives? Why was it that some of the control group who also suffered social disadvantages were able to get by?
Examination of the limited areas of history revealed that situations favourable to the maintenance of mental equilibrium were often those where difficult personal decisions did not appear to be called for.

(a) Examples of people who maintained equilibrium over certain periods of their lives.

(i) The control subject No. 27, who was an only child of a difficult marriage, joined the Forces at the age of 18. She enjoyed her life there and felt that it had been a critical phase in her development. She was removed from the discords of her home to a situation in which she had to make few personal decisions but in which she was given the opportunity to make many and varied social contacts.

(ii) Two men patients who had both had 4-year periods of service in the Navy spoke with enthusiasm of these periods. Both would like to have remained in the Navy except for certain difficulties and both broke down in civilian life in face of conflict over their personal relationships.

(iii) In the chapter on work, attention was drawn to three patients (drawn from a large number of examples) who since leaving school had worked and played apparently very happily for long periods of time (at least 5 or 6 years). They were potential patients during these years when mental illness was kept at bay through relatively straightforward and simple social situations in which they did not have to deal with conflict. At some point after marriage they faced difficult conflicts and broke down.
(b) Examples of people who broke down at personal crises

(iv) Patient No. 28 broke down at the birth of her second child. Her marriage had been unhappy and she had considered breaking it. The birth of her second child faced her with an acute conflict in which, on the one hand, she must choose to keep the family unbroken and on the other she must leave her husband, and solve the difficulties connected with bringing up her children single-handed. The conflict produced mental illness which kept this patient virtually tied to the house for 8 years.

(v) Another situation which provoked conflict was that of Patient No. 48, a man of 40, married with 3 children. This man was highly intelligent but suffered misfortunes in his early youth through the death of his father and also through unsuitable advice from his grammar school teachers. He was in the Civil Service and had recently moved from a job which interested him and which entailed absence from home for 3 or 4 nights at 3-weekly intervals. He had enjoyed the company of his colleagues during these absences and had been very satisfied with his work. Before his breakdown he had changed to less interesting work which gave him no opportunity of change from home, and he was worried by the purchase of an expensive house. He had a fair relationship with his wife but they lacked common interests and the patient was struggling to maintain and strengthen his own interests within the home. His conflict lay between the temptation to succumb to the interests of his wife and the rest of the family within the home and the attempt
to establish social links elsewhere. On account of the less interesting nature of his present work, leisure time interests were of vital importance. Questions relating to the conduct of the marriage and the upbringing of the children lay behind this apparently superficial conflict. The patient, in face of this, suffered a severe attack of depression. Conflict, which appears to be insoluble, precipitates the onset of symptoms and undermines the self-confidence which patients have been precariously building up.

It is clear from these cases that breakdown occurred at a time of conflict when patients were faced with the need to make important personal decisions of far-reaching effect in the family. Conflicting interests within the situation made it impossible to arrive at a decision and to define a fresh role. Acute symptoms occurred at this point and enabled the patient to escape the necessity of making a decision and solving his problem.

4. Conclusions

We can see, therefore, from the evidence under headings (a) and (b) (Pages 207-10) the main differences between the two groups revealed in two main areas of life.

The essential capacities for a healthy adult life in society are generally recognised to be related to early experience. The capacities here shown are:

(a) The capacity to make and keep friends.

(b) The capacity to make necessary personal decisions and
to define one's role at appropriate times.

These capacities cannot be developed without the experience of warmth and affection at home during babyhood. Satisfactory relationships in childhood enable the child to move into an adult world expecting to form friendships and enjoying a steadily increasing capacity to contribute to these.

The child, on the other hand, who has experienced the types of adverse social setting described in the examples in Chapter V, has been deprived of warmth in early life, or meets with a serious setback in forming early relationships, subsequently experiences great difficulty in contributing to a friendship, even though he aspires to this. One patient aged 20, when asked about friends, said: "I don't know what you call a friend." Another patient who had had a very unhappy childhood said: "I don't trust people at all; sometimes I don't want to know them." Failure to make friends undermines the confidence of the patient to try again. Such failure often occurs because the patient is too demanding. His need for understanding, warmth, tolerance and sympathy is such that it leads to his making demands which strain his relationships. This is not surprising since as we have seen the patient has usually been starved of these satisfactions in earlier life, but he is unable to get them until he has learnt to give them in return. This makes the vicious circle which must somehow be broken if he is to recover.

Patients who find themselves in this predicament have often lived in a narrow social environment in which they have not
become weaned from an emotional attachment to their mothers. They demand from potential friends the qualities which a mother shows to a baby or small child. They appear critical and unrealistically idealistic in their outlook, not having learned to face the rigours of the real social world.

Reference has already been made to the unmarried patients who selected the mother as the member of the family with whom they got on best, in contrast to controls who were less inclined to include the mother but often appreciated all members of the family.

Variation is seen in other cases. Some patients in a situation of conflict such as that described on page 212 (No.28) revert to an earlier stage of social development and demand care (usually from their husbands) which parallels the care demanded of a mother by her child. The patient described felt unable to stay alone in the house and unable to go out alone. She prevailed upon her husband to change to night work so that he was at home in the daytime and the school-children were at home at night. Such a situation can continue indefinitely and had already gone on for several years when the patient came to the notice of the Psychiatric Clinic. This patient had reverted to the situation of a child in face of severe conflict. Prior to this, and particularly during her adult years, she had lived an apparently socially successful life in work and the Services, and had become a ballroom dancing champion.
This research leads to the conclusion that psychiatric patients, through deprivation of warmth and/or security in early life, suffer degrees of social incapacity. Some patients are so severely handicapped that they have failed to develop a capacity for relationships beyond a very limited number. They are often uncomfortable except in a fixed social setting, which is familiar to them and are held back from broadening their experience by the knowledge of their past failure, their lack of confidence and the severity of their symptoms.

Other patients live long periods of their lives satisfactorily making good relationships at work, or in leisure time. Their roles are defined and necessary decisions are simple. They fail at the point where a conflict of interests confronts them and they have to deal with a difficult personal situation. They are then unable to redefine their role and break down. Such a breakdown may be very slight as in the patient mentioned in Chapter 27 (Attitudes to People), or so severe that the patient is reduced to a state which is similar to those described in the paragraph above. The conflict in which they are involved holds them rigidly. Every aspect of social life is affected and the few personal relationships remaining to them become tense and uncomfortable, because too much weight attaches to them. These patients show in more extreme form the characteristic which was discussed at the beginning of this report: "An inability to mix."

In contrast to the patients, controls often showed a capacity to make critical decisions at important junctures of their lives.
which carried them forward to new experience and the acquisition of new friends. This does not mean that there is a firm dividing line between controls and patients. It is possible that some of the controls, faced with conflict and difficult personal decisions in the future, may need psychiatric help. If circumstances deteriorate beyond a critical point they will break down. Some of their neurotic symptoms were mentioned in the chapter on "Status of Subjects", Chapter IV; we can see in them the seeds of a possible neurosis. Many of them were, however, building social relationships and allowing their children to develop these in a healthy way. Their experience would be of lifelong value to them and would help them to deal with conflict when this occurs, for experience gained in one field can often be used in another.

The research was designed to compare the social activities of a group of patients and a group of controls. The results showed that a more subtle difference than the number of social activities separated the two groups. The difference lay in their contrasting ability to handle and enjoy relationships. Whereas patients at this time were fearful of people, lacking in flexibility to enable them to enjoy a range of social situations and scornful of their own abilities, the controls could experiment with classes and outings, enjoying solitude and company as the situation demanded.
5. Action Needed

Patients' difficulties, as we have seen, were often traced back to childhood and school situations of deprivation, and as they originated in this way it is likely that the offer of shelter and warmth in the social field will give them the maximum opportunity for recovery. Experience has shown that if such an environment can be offered over a period of time they appear to be able to make good the gaps in their early social education. Time is needed for this and the offer of a suitable opportunity. This can usually only be given in the sheltered environment of a hospital out-patient clinic or therapeutic training centre or club. Patients cannot make it for themselves but having received help in such a setting they are often able to teach and encourage others to move forward.

It was said earlier that controls use the experience gained in building social relationships to help deal with conflict when it occurs. Patients likewise who are able to learn new social relationships in a therapeutic setting can pass on to apply their experience in the real world.
SUGGESTIONS FOR FURTHER RESEARCH

1. An important finding in this research was that patients had a shorter period of education than controls. It is not known whether this is due to patients being less intelligent than controls or to other factors. A small number of patients in the group were given intelligence tests (where these were needed in connection with treatment) and their intelligence quotients were found to be normal or above normal. A further small number obtained entrance to Grammar or Central Schools but were unable to take them up.

   Although tests given to disturbed patients are likely to give unreliable results, it would be useful to have an indication of the intelligence levels of both groups in this type of research. This would help to show whether patients have had a poorer education because they were duller than controls, or because other factors influenced the situation such as frequent changes of school, illness in childhood, loss of parents and emotional disturbance in early life or financial strain.

   Additionally, personality tests or social maturity tests given to both groups might throw further light on the differences between them.
2. A number of subjects in the present research had children of school age or younger. The environment offered by parents who are patients must be affected in greater or lesser degree by their illness. It would be instructive to pursue the present research with the children of patients and controls over a long period of time (seeing them at 3 or 5-yearly intervals) to observe whether and in what ways their social lives are affected by the illness of their parents.

3. It would be informative to study two communities of different types, one with many social facilities that are well supported and one with very few or none. One could then measure the amount of mental illness in the two communities by reference to mental hospital admissions and out-patient statistics and/or by using the Cornell Medical Index (mentioned by Pond, Ryle and Hamilton) to measure mental ill-health in the communities.

4. It is suspected that the causes of delinquency and of mental illness are similar but that the environment determines whether the person takes one or the other path. It would be useful to extend the present research to a Prison or Borstal population to find out whether the social background of the latter resembles that of the patient or control groups already examined.
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