SOCIAL CLASS AND MENTAL ILLNESS IN CHILDREN: OBSERVATIONS OF BLUE-COLLAR FAMILIES*

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Data are presented from the psychiatric evaluations of 263 children of "blue-collar" families divided into two groups according to the father's occupational status, "skilled" or "unskilled." These data are analyzed and compared with special reference to the clinical and social questions which are raised as the result of the differences between the two groups.

In 1919 Freud [2] called attention to the implications of social class differences when he predicted that it would be more difficult to treat lower-class patients. He felt that they would be less willing to give up their illness to face the hard and unattractive life which awaits them when they recover. Forty years later Redlich and Hollingshead [4] demonstrated that among the adult population of New Haven, Connecticut, there was, in fact, a definite relationship between social class and mental illness. We have come to accept these results and their implications, but the importance of class difference among children may be less easy to accept. Equality among children is a sacred American ideal. The implication that differences do exist and that these differences might possibly influence our attitude toward various groups of children challenges this sacred heritage.

In an attempt to explore the possibility that a relationship between social class and mental illness among children actually might exist we decided to examine the data available from our clinical experience at Children's Psychiatric Hospital over the past several years. A pilot study of these data as reported by Harrison, et al., found that there was indeed a distinct correlation between the father's occupation and the particular kind of psychiatric diagnosis and dispositional recommendation that we made.[3] Most striking were the contrasts between the extreme ends of the social scale, for example, between the children of pro-

* Presented at the 1964 annual meeting of the American Orthopsychiatric Association in Chicago, Illinois.

† The authors wish to express their thanks to Miss Sue Chilman for help in gathering the data for the study and to Mrs. Janet Lindy for editorial assistance in preparing this report.

fessional persons and those of unskilled laborers. There was, however, one finding that we had not anticipated regarding the children of the "blue-collar group."

The "blue-collar group" was divided into two subgroups: children of skilled workers and those of unskilled workers. One might have expected that these two subgroups, being neighbors on the socioeconomic scale and presumably sharing overlapping cultural factors, would have been highly similar in terms of psychiatric diagnosis. Such was not the case. Our curiosity about the basis for differential diagnosis within the "blue-collar group" led to a further investigation and the attempted explanation to be described here.

METHOD

The records of 450 children evaluated at University of Michigan's Children's Psychiatric Hospital during the year July, 1961-July, 1962, were examined. Using the father's occupation as the indicator of social class,[7] 263 of these children were assigned to the "blue-collar group." The "blue-collar group" was then further broken down into the categories of "unskilled" and "skilled." The "unskilled" group was defined as those who were employed for tasks involving either no training or a very small amount of training, e.g., janitor or assembly line worker. The "skilled" category was defined as consisting of those who were employed in a manual activity which required training and experience, e.g., machinist, self-employed small farmer.

One hundred forty-eight children fell into the "unskilled" group, and the remaining 115 into the "skilled" group. These two groups were matched for relevant variables (FIGURE 1). Code sheets which had been filled out by psychiatrists and social workers at the time of the children's evaluation were then used. These forms were employed to compare the two groups in terms of diagnosis, symptomatology and historical data. Symptoms were assigned to the categories of "benign" or "malignant" as indicated in FIGURE 3 and 4. Assignments were based on our observation of the attitudes toward these symptoms prevalent among the mental health workers at our clinic. It is our impression that these attitudes are shared by many, if not all, clinics throughout the country.

RESULTS

The variables listed in FIGURE 1 (age, sex and the like) were found to be essentially constant in both groups.

Differences emerged in the diagnostic evaluations of the two groups. (FIGURE 2). Most notably personality disorders, including borderline psychoses, were diagnosed significantly more often in the children of the unskilled workers ($x^2=3.93$, $df=1$, $p<.05$). Furthermore there appeared to be a grouping of the symptoms indicated by psychiatrists. These symptoms, although not statistically significant by themselves, suggested a trend when viewed together. Overt hostility, impulsivity, paranoid reactions, affective disturbance and withdrawal were seen to be more characteristic of the "unskilled" group. Anxiety, obsessive compulsive behavior and somatic complaints were seen to be more characteristic of the "skilled" (FIGURES 3 and 4).

Children in the "unskilled" group were characterized by the evaluators as coming from "unstable, conflict-ridden

VARIABLES	PERCENT OF UNSKILLED GROUP (N=148)	PERCENT OF SKILLED GROUP (N=115)
AGE - UNDER 4 YEARS	3	3
4 - 6 YEARS	14	15
7 - 10 YEARS	48	41
11 - 14 YEARS	35	41
SEX - MALE	70	74
RACE - CAUCASIAN	90	96
NEGRO	10	4
RELIGION - PROTESTANT	68	64
CATHOLIC	23	28
JEWISH	1	1
SIZE OF COMMUNITY (OVER 10,000)	52	47
NUMBER OF SIBLINGS		
NONE	10	10
1 - 2	44	44
3 - 4	30	34
WORKING MOTHER (PAST OR PRESENT)	34	30
PHYSICAL HEALTH ALWAYS GOOD	53	55

FIGURE 1

homes," in contrast to those of the "skilled" group ($x^2=10.29$, df=1, $p<.005$) (FIGURE 6).

A comparison of the history of the groups pointed up the following factors. Although the families of both groups rated their children alike with respect to adjustment at home, they reported a marked difference in the children's adjustment to the "academic" standards of the school. The upper end of the rating scale (doing very well at school) was weighted by the "skilled" group ($x^2=5.45$, df=1, $p<.02$) and the lowest (doing very poorly at school, failing grades) by the "unskilled" ($x^2=4.57$, df=1, $p<.05$) (FIGURE 7).

In fact, general school maladjustment more frequently was considered the primary reason for referral to the clinic in the unskilled group ($x^2=5.90$, df=1, $p<.025$). Home maladjustment was the chief complaint just as often in both groups (FIGURE 5). Finally, it was found that there was a significantly longer delay in referral of the "unskilled" group to the clinic from the time that their problems first became apparent ($x^2=6.70$, df=1, $p<.01$) (FIGURE 5).

DISCUSSION

How are we to account for the differences between the children of "unskilled" and children of "skilled" workers? One explanation may lie within the heterogeneity of the blue collar group itself.

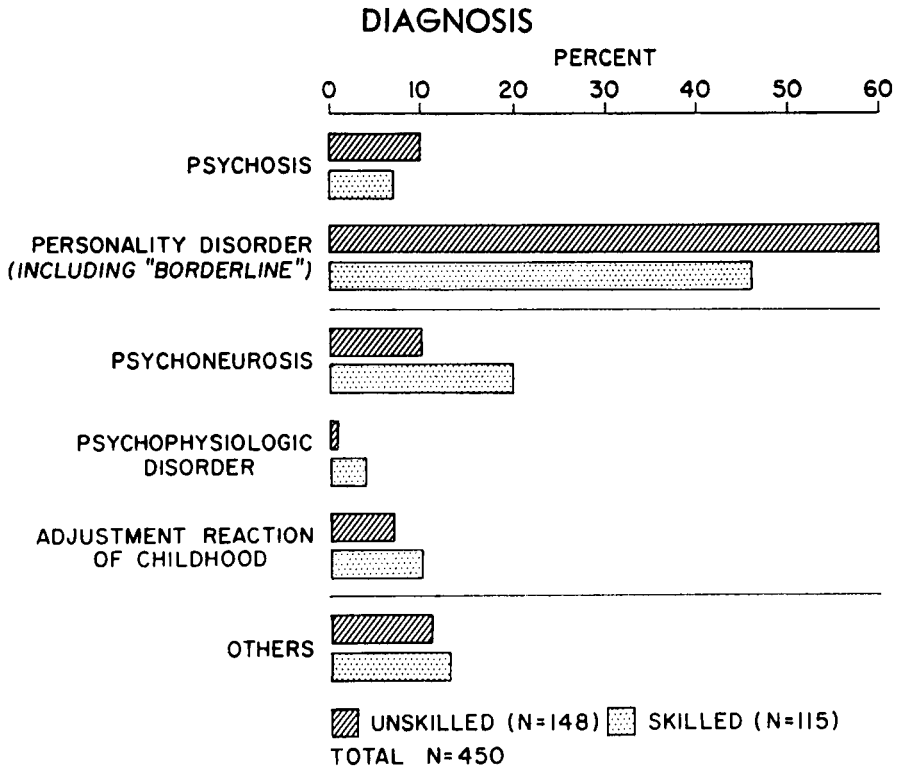

FIGURE 2

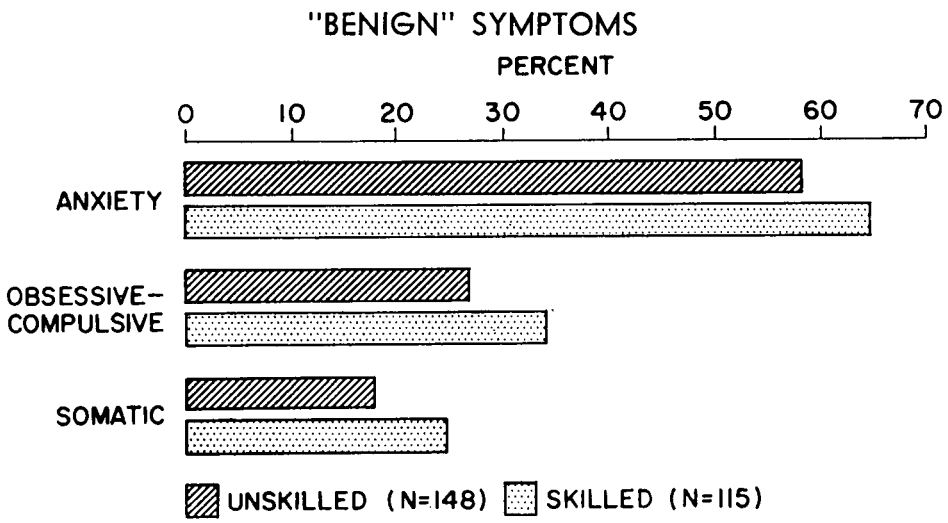

FIGURE 3

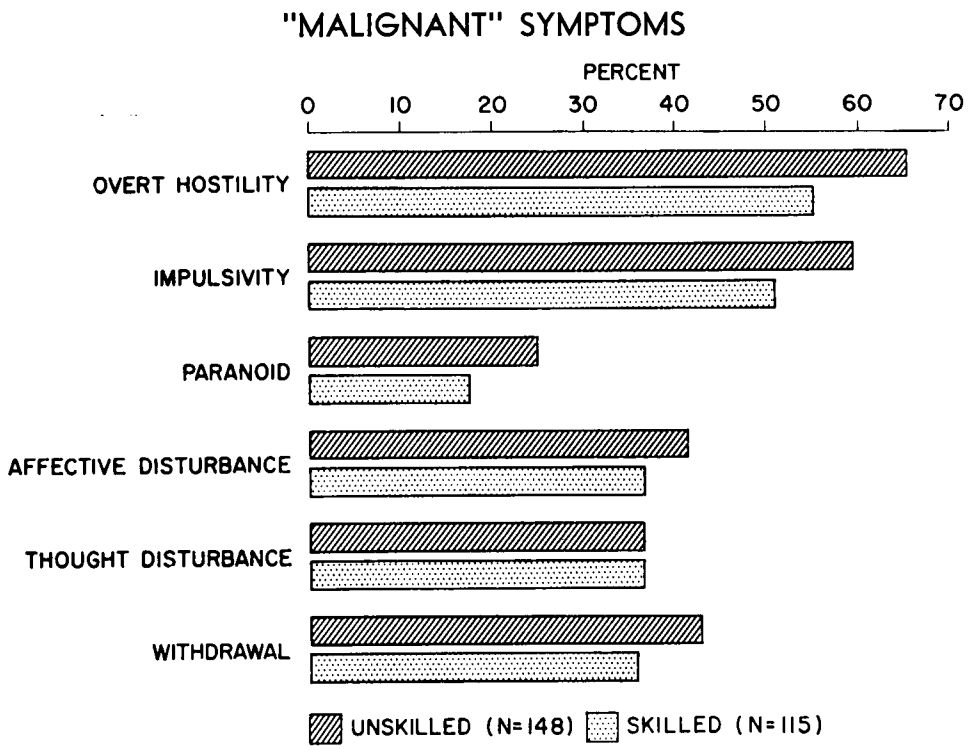

FIGURE 4

In our complex and changing social system traditional class distinctions have become more difficult to identify and follow. Blue-collar workers no longer can be considered a homogeneous group. Redlich and Hollingshead,[4] in their development of an index which employs a five-point social scale were able to place the "unskilled" workers in one category without much difficulty. But they found that "skilled" workers spanned at least two positions on the social scale and were much harder to define according to education and residential area. Thus, the traditional blue-collar classification has become blurred, with the skilled worker absorbed into the other classes. Perhaps the change leaves the unskilled worker even more isolated from the main stream of American life.

Although the isolation of the "unskilled" might account for differences within their offspring, we have yet to speculate about the nature and direction of these differences. Should we conclude that weaker egos and lessened ability to check impulses (the significance often assigned to the diagnosis of personality disturbances and psychoses) actually exist in the "unskilled" group? If so, why should there be a correlation with the father's work skill?

Knowing the influence of such factors as loss or absence of primary parental figures, we look naturally to the home environment for clues in the development of disturbed object relationships. It often is assumed that the lower the socioeconomic position, the more frequent is disruption of the family unit by

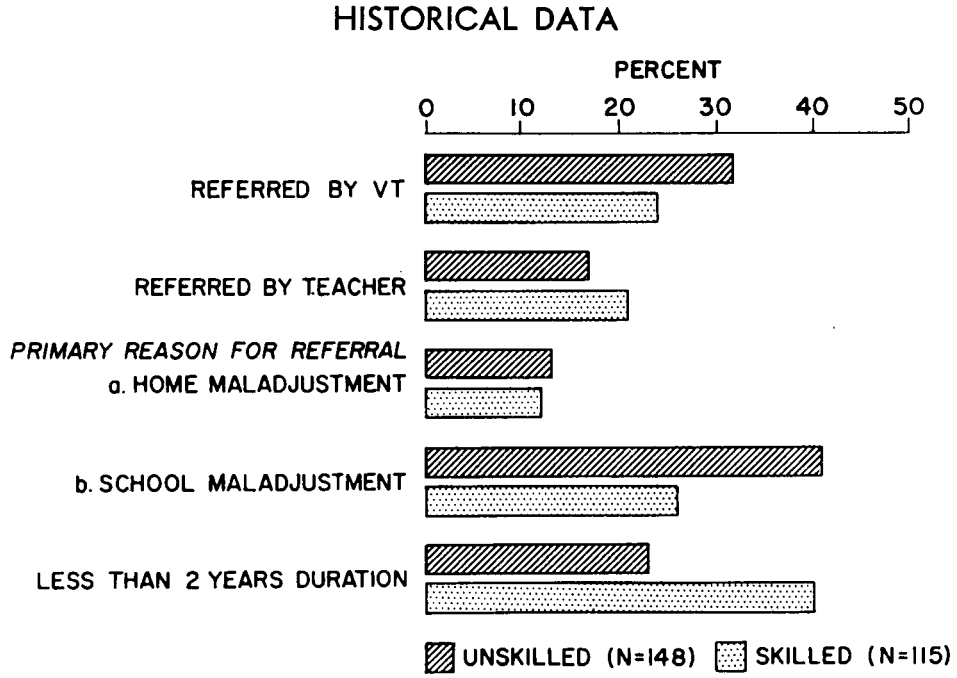

FIGURE 5

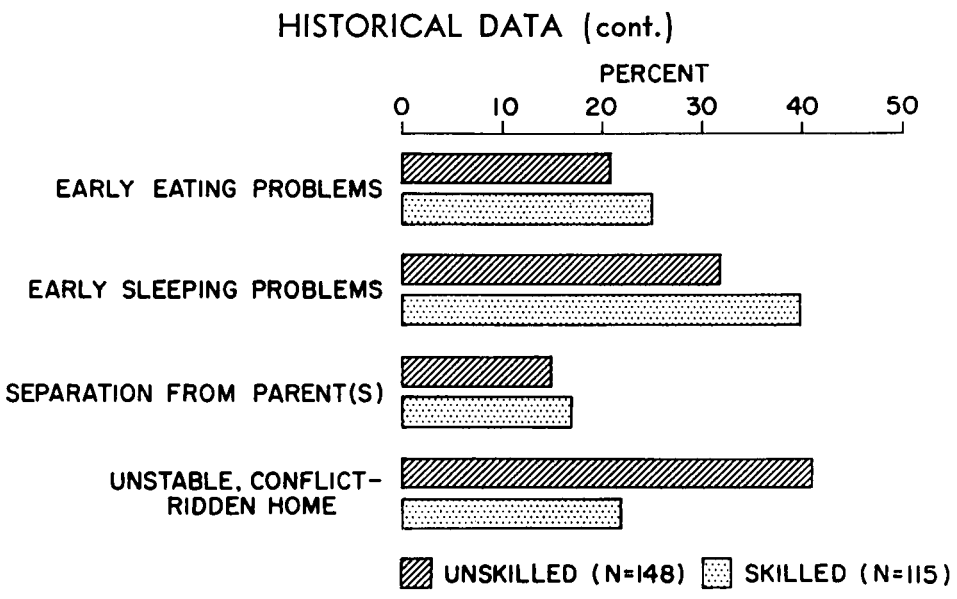

FIGURE 6

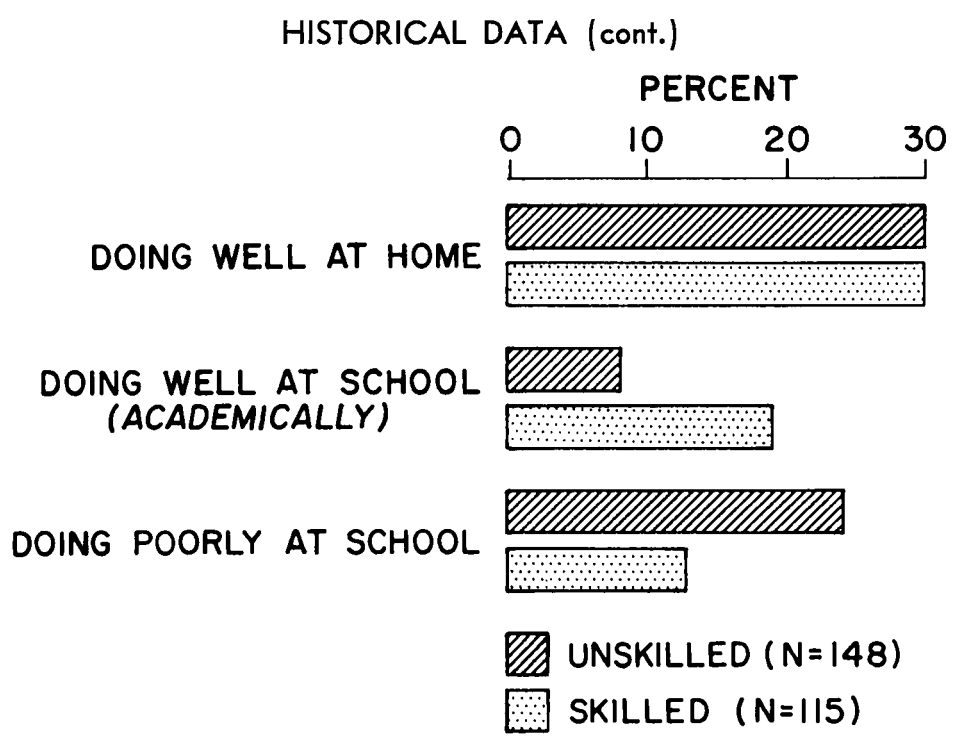

FIGURE 7

desertion, divorce or a generally inconstant makeup. Yet a similar, large majority of children in both of our groups were living with both parents at the time of evaluation. In fact, separation from parent or parents due to all causes including divorce was noted slightly more frequently in the upper, or "skilled," group than in the lower group (FIGURE 4). On the other hand, in spite of the apparent intactness of the family units, the evaluators rated almost one-half of the "unskilled" homes as unstable and conflict-ridden (twice as many as in the "skilled" group). The subjective nature of this evaluation should be noted. The similarity of sleeping and eating problems also would seem to be inconsistent with psychopathological development of the children of the "unskilled" group.

What then accounts for our tendency to diagnose "acting out" disorders more often in the unskilled group? This question has implications, not only in terms of favorability of prognosis, but also in shaping future attitudes of the community and the kinds of help these children will be offered.

We must keep in mind that the assessment of ego strength is partially subjective, depending upon the examiner as well as the patient. Is it possible that those of us who appraise behavior as normal or abnormal unwittingly view the "unskilled" differently because of our own values? Perhaps what is described as withdrawal, paranoid thinking, hostility and impulsivity is partially the reaction of a child who is uncomfortable in our office. He is in a totally foreign set-

ting equipped with unfamiliar objects such as desks and soft chairs, in which he is expected to "talk" about his problems or to express himself through toys and games with which he also is unfamiliar because of his background. It has been postulated that lower-class individuals have fewer alternatives available to them in adjusting to stressful situations.[1] There may indeed be cultural differences in the way in which reality is handled that do not reflect analogous degrees of individual pathology. A psychological distinction, for example, must be made between a child's ego weakness and feelings of social inferiority, since in either case he might use projection and denial of his inadequacy.

The discomfort of the "unskilled" in the psychiatric setting would seem to have its counterpart in the school, where all children must meet the standards of the prevailing middle-class culture. It is not surprising then that problems centering around maladjustment in school were given as the primary reason for psychiatric referral 50 per cent more frequently in the "unskilled" group.

In addition to standards of behavior children react to the academic process itself in various ways. We might presume from the studies of several authors [4, 5, 8] that the lower-class children hear encouragement from their parents, who earnestly express a desire for their children to have the education they missed and who are said to be *more* concerned about their children doing well in school than middle-class parents.[8] They consistently express the hope their children will finish high school to get good jobs, or even to go on to be professional persons (paradoxically, perhaps, often a doctor or a teacher). Yet our findings indicate a sharp difference in scholastic performance between the children of the "skilled" and those of the "unskilled." Twice as many of the "skilled" group are considered to be performing "well" or "very well" academically. Twice as many of the unskilled perform "very poorly or are failing" (FIGURE 7). The discrepancy between the degree of presumed parental encouragement and actual performance may partly result from unconscious parental conflict. A father may claim to want his son to rise above his surroundings and have a better future than he, but is it *really* natural for a father to wish his son to succeed where he has failed, to surpass him as a man, when he himself is insecure in his occupational role, one aspect of manliness? It has been noted that lower-class families place great emphasis on masculinity. Physical force is commonly used by the fathers, and "toughness" is stressed. Introspection (the opposite of impulsive action), learning and discussion of feelings and issues may be considered to be weak and unmasculine and may produce tension which cannot be tolerated. In any event, it is probable that educational ambition is a source of inner conflict for both father and son.*

* Another possible explanation for the discrepancy between the school achievement in children of unskilled workers and the professed expectations of their parents may lie in the difference between the expressed attitudes of lower-class parents and their *actual* expectations for the future. Although these parents may echo current standards about how they would like their children to succeed in school, they may in fact not believe it possible and convey this by subtle cues to the child. The pessimism is confirmed by the child's observations and imitations of parental social patterns which are incompatible with success in the middle-class school setting.

And yet despite the greater difficulty of the "unskilled" in making a good school adjustment, a considerably longer time elapses before professional help is requested for them. (Twice as many "unskilled" as "skilled" were seen as having problems two years or longer prior to referral.) It may indicate that difficulties actually are identified by the teacher, or family or both, but early intervention is less likely to occur with children of the lower group. Yet we generally assume that serious problems can be prevented by early identification and early application of corrective measures. This finding also may contribute to the fact that more "serious" diagnoses are made for the "unskilled" group when they finally reach the clinic.

In conclusion, it would appear that the professionals of the community *do* view these two groups of children differently both in the psychiatric clinic and in the school. It may be that this actually reflects some degree of psychological difference acquired through life experience, which becomes even more pronounced because of current social forces. Yet there may be factors in us, the community of professionals, which also must be considered.

SUMMARY

Two hundred sixty-three children of "blue-collar" families evaluated during a one-year period at Children's Psychiatric Hospital were divided into two groups on the basis of their father's occupation, i.e., "skilled" or "unskilled." Historic and psychiatric data collected on these children were analyzed and compared.

The "unskilled" group was seen as having a significantly higher incidence of diagnosed personality and borderline states. School and home adjustment also were compared for the two groups. Although the home adjustment ratings were comparable within the two groups, the "unskilled" group was seen as presenting a significantly greater problem in school. Referrals for professional treatment nonetheless were found to be made relatively later for the "unskilled."

Speculations concerning the above findings were made with special attention being given to the cultural implications of social class. A suggestion was made that subjective factors such as unwitting social biases within the professional community may be partly responsible for the differences in diagnosis characteristically assigned to the two groups.

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