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SOCIAL CLASS, ETHNICITY AND TREATMENT EXPECTATIONS

by

Douglas S. Robbins

A dissertation submitted to the Graduate Faculty in Social/Personality Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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"Now let us assume that by some kind of organization we were able to increase our numbers to an extent sufficient for treating large masses of people. Then on the other hand, one may reasonably expect that at some time or other the conscience of the community will awaken and admonish it that the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving life; and that the neuroses menace the health of a people no less than tuberculosis, and can be left as little to the feeble handling of individuals. Then clinics and consultation-departments will be built, to which analytically trained physicians will be appointed, so that the men who give way to drink, the women who have nearly succumbed under the burden of privations, the children for whom there is no choice but running wild or neurosis, may be made by analysis able to resist and able to do something in the world. This treatment will be free. It may be a long time before the state regards this as an urgent duty. Present conditions may delay its arrival even longer; probably these institutions will first be started by private benificence; some time or other, however, it must be done."

S. Freud, 1919.

"Psychotherapy, at least as presently constituted, is a treatment process, the efficacy of which is confined to middle and higher class patient populations."

R.G. Hunt, 1960.

Abstract

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Douglas S. Robbins

Adviser: Professor Barbara Dohrenwend

Empirical studies of social class related differences in prepatient expectations about mental health treatment have produced contradictory results. Some studies have reported differences, others have not. Interpretation of these results is made difficult by the intrusion of methodological differences between studies and by the possibility of interactions between social class and ethnic differences. More important, no studies have examined the assumption that upper and middle class expectations more accurately reflect actual treatment practice. The present study is designed to determine the current status class differences in treatment expectations, to investigate the relationship between ethnicity and expectations, to evaluate the contribution of methodological differences to differences in results, and finally, to examine the relationship between class-linked patient expectation and actual staff treatment activity.

Results indicate that there are significant social class differences in expectations about the degree of therapist diagnostic, directive and supportive activity. There are no differences in expectations about

medical or organix content in treatment, about the inclusion of psychological content ot about treatment duration. Those social class differences which emerge are primarily confined to differences between the lowest social class and all others. The only ethnic difference found was an expectation of greater therapist activity among Jewish patients. There were significant differences between the expectations of all of the prepatient groups and staff self-reported activity. All prepatient groups expected significantly more therapist activity and support than the staff reports itself as providing, and all prepatients expect shorter treatment than the staff reports as ordinary.

Methodological differences were found to explain contradictory results among previous studies. Factor analysis failed to reproduce previous factor patterns, although some factors were highly correlated with previous factors. Hypothesis tests performed using items grouped by previous factors reproduced previous results, including contradictions. These findings indicate that in order for results to be compared there must be agreement among researchers about the measuring instrument used and about the variables used in tests for differences.

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CHAPTER I

INTRODUCTION

The state seems to be moving toward some kind of "free" service, either in the form of a national health insurance plan or health service, sixty years after Freud wrote on the issue. A resolution of the tension between the need for services, as expressed by Freud, and reservations about the utility of psychotherapy as a treatment technique for large segments of the population as expressed by Hunt, must now be achieved. The issue specifically is whether or not provisions for psychotherapeutic as well as organic forms of treatment will be included in such a national plan.

Within the field of psychology, the debate over the inclusion of psychotherapeutic forms of treatment is centered sround the contention by some that psychotherapy is a form of treatment consonant with and imbedded in only the culture of the middle and upper classes. In this view it is a treatment form inappropriate for the majority of the population, composed of working class people and the poor (Albee, 1977; Bernstein, 1964; Cobb, 1972; Gursslin, Hunt and Roach, 1960; Hollingshead and Redlich, 1958; Hunt, 1960; Marx and Spray, 1972; McMahon, 1964; McSweeney, 1977; Prince, 1969; Rabkin, 1972).

A significant part of this argument deals with the issue of patient expectations about the nature of psychotherapeutic treatment. It has been suggested that there exists a "clash of expectations" (McSweeney, 1977) between psychotherapists and patients from poor and working class

backgrounds. This assertion raises an issue that has, for decades, been part of the research literature on the relationship between patient social status and the delivery of mental health services.

The following material will demonstrate that, in spite of the frequency with which assertions about social class differences are made, studies collecting direct empirical evidence on the nature of patient expectations about psychological-psychiatric treatment are few, and their findings are contradictory. Interpretations of those differnces found is difficult due to the presence of methodological problems. In addition, the status of differences between the conceptions held by the staff of adequate treatment and the expectations of variuos patient groups has seldom been explored, although it is these differences that have the potential to produce a "clash of expectations."

The following study is designed to examine the present status of differences in expectations about treatment for psychological disorders between the major social class and ethnic groups and to resolve some of the methodological problems that have made the interpretation of previous studies difficult. In addition the study includes data from the staff on the nature of the treatment actually offered and compares this with the expectations of patient groups.

CHAPTER II

REVIEW OF THE PREVIOUS LITERATURE

The issue of social status differences in access to, and attitudes toward mental health services gained the attention of the social science community with the publication of Social Class and Mental Illness by Hollingshead and Redlich in 1958. Although previous studies had noted the problem (Schaffer and Meyers, 1954; Imber, Nash and Stone, 1955; Redlich and Hollingshead, 1953; Robinson, Redlich and Meyers, 1954; Windner and Hersko, 1955) the Hollingshead and Redlich volume proved to be truly seminal. It raised the issue of social class differences in prevalence, type of illness and type of treatment. It also asserted social class differences in attitudes toward treatment and illness. In addition the authors developed research techniques which have been widely used and remain standard in this field of inquiry and in related ones.

Among the hypotheses the authors tested was one concerning the relationship between the social class of the patient and the type of treatment undergone. Hollingshead and Redlich's Hypothesis #3 stated that the type of psychiatric treatment a patient receives is connected with his position in the social class structure. It is this finding, relating social class to type of treatment, that produced speculation about social class differences in expectations about treatment. However, before examining these results it is necessary to examine the data collected and the operations used to define social class and

treatment type.

Data

The data are based on a survey the authors conducted on patients in psychiatric treatment from the New Haven, Connecticut area. The authors requested and obtained information from all those New Haven area psychiatrists in private practice and at psychiatric hospitals and clinics, public and private, about their New Haven area patients. Data were collected on all those patients in treatment between May 31 and December 1, 1950. The study includes data collected from 46 private practitioners, 7 psychiatric clinics and 11 state and veterans administration hospitals. Information was gathered on almost 2,000 patients.

Social Stratification System

The patients were stratified into five social status groups, using Hollingshead's Index of Social Position (Hollingshead and Redlich, 1958). The index position is derived from a weighted scoring of (1) area of residence, (2) occupation and (3) education of head of household. The weights were established from multiple regression equations predicting classification made by the authors on the basis of extensive interviews with community informants.

The criteria and weights are as follows:

1. Residence - "Ecological area of residence," based on the work of J.K. Meyers and M.R. Davie during the period from 1930 to 1950 was used to establish residence score. Residential areas were ranked on a 6 point scale, ranging from "the finest homes" to the poorest tenements. This factor was assigned the weight 6.

2. Occupation - The occupational scale was based on a modification of the Alba Edwards system of classifying occupations into socio-economic groups used by the U.S. Bureau of the Census at that time. Increased differentiation was made among levels of professions and among size and value of businesses. The occupational groups designated were:

1. Executives and proprietors of large concerns, and major professionals.

2. Managers and proprietors of medium-sized businesses and lesser professionals.

3. Administrative personnel of large concerns, owners of small independent businesses and semi-professionals.

4. Owners of little businesses, clerical and sales workers and technicians.

5. Skilled workers.

6. Semi-skilled workers.

7. Unskilled workers and the chronically unemployed.

The weight assigned to occupation was 5.

3. Education - Educational levels were grouped as follows:

1. Graduate professional training.

2. College or university graduation.

3. Partial college.

4. High school graduation.

5. Partial high school.

6. Junior high school - 7th through 9th grade.

7. Less than 7 years of school.

Education was assigned a weight of 9.

The index score was then divided into 5 social classes. Table 1 summarizes the major characteristics of the classes, as defined by Hollingshead and Redlich in 1958.

The index was revised to simplify its use with a population whose areas of residence were unranked, and the Two Factor Index of Social Position was developed (Hollingshead, 1957). This index omits area of residence and only education and occupation are scored and weighted. Correlation between the two forms of the Index is reported as .91 (Hollingshead, 1957). The Two Factor Index is included in the Appendix.

Subsequent studies using social class as a variable, especially those in closely related areas of inquiry, have often used this index for categorizing social classes. It has functioned, without revision, as a standard procedure. This is so in spite of the fact that there have clearly been major changes in employment patterns and educational statistics in the intervening two decades. The basic utility of the index appears intact, however. Recent studies indicate that ratings of occupational prestige have remained stable over the years.

Treatment Type

Hollingshead and Redlich divided treatment into three categories.

1. Psychotherapeutic treatment included two sub-types. These were psychoanalytic and other analytic psychotherapies based on concepts more or less Freudian, such as insight, unconscious forces and defenses, and directive therapies based on support, reassurance,

Table 1

Income, Occupation and Education Level for Five Social Classes

Class	% of Population	Occupational Level	Educational Level
1	2.7	High income, primarily inherited. Also upwardly mobile "arrivistes" and highly educated professionals with moderate income (Yale professors). Highly placed business executives and high prestige private practice professionals.	Professional degrees; A.B. level and above.
2	9.8	Lower executives with salary positions in businesses controlled by class 1 members. Minor professionals and managers and proprietors of medium sized businesses.	A.B. or partial college.
3	18.9	"Middle class." Salaried administrators, small businessmen, semiprofessionals, clerical workers, technicians.	High School.
4	48.4	"Working class." Skilled and semiskilled manual workers, with some white collar workers and owners of little businesses.	Average, less than high school graduate to 9th grade.
5	20.2	"The poor." Semiskilled and unskilled manual workers in non-union settings. Irregular employment. Includes 2% chronically unemployed.	Low, with many less than 8th grade.

suggestion, direct advice and manipulation of the environment. The authors described the directive techniques as not based on the insight of the patient but ". . . rather they stem from the authoritative position of the therapist, his general clinical experience . . . as well as the dependent and trustful role of the patient" (255-256). Group psychotherapy was considered an adaptation of essentially analytic orientation.

2. The second major group of treatments were considered organic. They included psychosurgery and electro convulsive therapy as well as the use of insulin coma. Sedation, physiotherapy and hydrotherapy were listed as organic treatment even though, as the authors state, "strictly speaking, hospital authorities ordinarily resort to those techniques to keep a patient quiet and to maintain order on the wards rather than as aids to the patient's rehabilitation" (256).

3. The third type of treatment listed is custodial care, referring to those hospitalized patients who receive no organic or psychotherapeutic treatment, but who do receive medical or nursing care (257).

Unfortunately, at the time of this study tranquilizing and other psychoactive drugs were just in the process of being introduced and therefore were not included as a separate category. They were tabulated as organic treatment.

Where patients had more than one therapy type prescribed they were categorized by the dominant one.

The authors found significant relationships between kinds of therapy psychiatrists prescribed and the social class of the patient.

It is the results of the analysis of this relationship that

produced the speculation that patient expectations about the nature of treatment were an important component of the psychiatrist's decision to assign a treatment modality, and that these putative expectations were class linked. For this reason these data will be presented in detail.

Results of the Hollingshead and Redlich Study

For patients diagnosed as neurotic, there was no significant relationship between race, sex, age, previous treatment history or particular diagnosis and treatment category; however, significant relationships were found between treatment facility, dominant form of therapy and social class position.

With facility held constant, the results were as follows:

PRINCIPAL TYPE OF PSYCHIATRIC THERAPY
RECEIVED BY NEUROTIC PATIENTS BY CLASS

Type of Treatment	1 & 2	3	4	5
Analytic	46.9	20.9	5.1	4.9
Directive	51.0	65.2	72.6	72.3
Organic	2.0	9.6	16.6	9.8
Custodial	0.0	4.3	5.7	23.0
n	98	115	175	61

$x^2 = 128.72$, df = 9, p .001

These results indicate that although some form of psychotherapy is

the predominant treatment method in each class, analytic psychotherapy is concentrated in class 1 and 2, directive therapy is clustered disproportionately in classes 3 and 4, class 4 and 5 neurotics receive considerably more organic treatment than classes 1 and 2, and custodial care is largely limited to class 5 patients. When organic and custodial care combined are compared with the psychotherapies, the differences are sharper. Only 2% of class 1 and 2 neurotics receive organic or custodial treatment compared with 14% of class 3 patients, 23% of class 4 patients, and 33% of class 5 patients.

When the statistics for private practitioners only are examined, accounting for the treatment of 65.5% of neurotic patients, the following relationship emerges:

Type of Treatment	1 & 2	3	4	5
Analytic	45.4	19.0	1.8	0.0
Directive	53.4	72.7	88.7	86.4
Shock and Sedation	1.1	8.3	9.5	13.6
n	88	84	110	12

$x^2 = 89.33$, df = 4, p .001

The results for psychotic patients are more complex, with diagnosis significantly related to treatment type. With diagnostic group held constant, a significant class relationship was found for schizophrenics, by far the largest diagnostic category, accounting for 61% of the total

psychotic patients, and for alcoholics (6%). No significant relationships were found for the remainder, composed of affective psychotics, organics and senile psychotics.

The figures for schizophrenics are as follows:

Type of Treatment	1 & 2	3	4	5
Psychotherapy	51.7	20.5	15.3	9.1
Organic	24.1	48.2	47.7	33.7
Custodial	24.1	31.3	36.9	57.2
n	29	83	352	383

$x^2 = 74.53$, df = 6, p .001

For alcoholics:

Type of Treatment	1 & 2	3	4	5
Psychotherapy	100.0	71.4	72.0	33.0
Organic	0.0	21.4	24.0	29.2
Custodial	0.0	7.1	4.0	37.8
n	4	14	25	48

$x^2 = 19.20$, df = 4, p .001

It was only possible to control for treatment agency in the case of schizophrenic patients in state and Veterans Administration hospitals,

due to the small number of cases in other treatment settings. With agency controlled the following pattern emerges:

Type of Treatment	1 & 2	3	4	5
Psychotherapy	16.7	12.1	9.6	8.5
Organic	25.0	53.6	50.6	33.8
Custodial	58.3	34.3	39.8	57.7
n	12	66	322	376

$x^2 = 27.14$, df = 4, p = .001

The authors point out that the class 1 and 2 schizophrenic patients in state and V.A. hospitals constitute a small number of "burned out" long term chronics no longer maintained by their families in Private facilities. In contrast, 64 (17%) of the class 5 patients in custodial care had no previous treatment history.

These data clearly established the class-linked assignment of patients to treatment categories. Systemically, lower class patients were less frequently directed to psychotherapeutic treatment than were their upper and middle class counterparts in symptoms and setting. When placed in psychotherapeutic treament, they were more likely to be treated with directive rather than analytic techniques.

Other Studies

The finding of class related treatment assignment, especially with regard to the psychotherapies, was reported by many other researchers, most of them stimulated by the Hollingshead and Redlich findings

(Bailey et al., 1960; Brill and Storrow, 1960; Cole et al., 1962; Fink et al., 1969; Harrison, 1965, Lief et al., 1961; Meyers and Bean, 1968; Robinson et al., 1954; Rosenthal and Frank, 1958; Schaffer and Meyers, 1954; Siegal et al., 1962; Srole and Langer, 1962; Winder and Hersko, 1955; Yamamoto and Goin, 1966; Yamamoto et al., 1967; Bookbinder and Gusman, 1964; Raskin, 1961). These studies, spanning over two decades, cover a wide variety of settings and client groups, including university outpatient clinics, Veterans Administration inpatient and outpatient facilities, community mental centers and child guidance clinics. Many of these facilities charge a minimal or no fee, and therefore greatly mitigate the effect of ability to pay as a factor in producing class differences.

There are few exceptions to the finding of class related differences in treatment assignment. Hart and Basset (1972) report no differences by social class in a community mental health center, but the group made up class 4 and 5 patients assigned to "individual therapy" is apparently composed ofopiate addicts maintained on weekly "therapeutic" doses of methadone administered "individually."

In the most recent study, Stern (1977) finds:

> In approximately one third of the Mental health centers, statistically significant but rather weak relationships between education and type of treatment were found . . . . The assignment of a particular type of client at some centers seems sometimes to include a consideration of the client's social class." (p. 323)

She maintains that this indicates a lessening of the class linked bias seen in previous studies.

Alone in reporting no differences at all in treatment assignment

are Albronda et al. (1964) who report that all applicants were accepted for psychotherapy at a Utah clinic with predominantly class 3, 4, and 5 patients, and that therefore there was no bias in treatment assignment.

In addition to being less frequently assigned to psychotherapeutic treatment, class 4 and 5 patients may be more likely to refuse such treatment when it is offered to them than are patients from other social classes (Rosenthal and Frank, 1958).

There is also indication that class 4 and 5 patients may drop out of treatment in a shorter time than patients of the other social classes do (Rosenthal and Frank, 1958; Schaffer and Meyers, 1954; Lake and Levinger, 1960; Lief et al., 1961; Yamamoto and Goin, 1966; White et al., 1964; Cole, 1962; Bailey, 1959; Imber, Nash and Stone, 1955; Rubenstein and Lorr, 1956; Sullivan et al., 1956).

The findings on social class differences in treatment duration, however, are not so clear cut. A number of studies have reported no differences in dropout or "premature termination" rate. (Albronda et al., 1964; Tuckman and Lavell, 1959; Williams and Pollack, 1964; Meyer et al., 1967; Lorr, 1962). The most recent study (Stern, 1977) reported no difference in the number of visits made by patients of differing social class at a group of community mental health centers.

In conclusion, the general trend of the findings is clear. Class 4 and 5 patients are consistently less likely to be found in psychotherapeutic treatments than are patients from the higher social classes, at least where there are other forms of treatment available and where not all patients are assigned to psychotherapy.

In the words of Schaffer and Meyers (1954), in one of the earlier reported studies:

> . . . the experience of patients in this clinic where the economics of treatment is largely inconsequential for those eligible is to a large degree a function of their social class position in the community. In other words to a significant degree the higher a patient's social class was in the community the greater were his chances of being accepted for psychotherapy, of being assigned to a relatively experienced therapist occupying a high status position within the clinic and of maintaining contact with the clinic.

There is some indication that contributing phenomena are the possibility that class 4 and 5 patients may be more likely to refuse such treatment if it is offered, and to leave treatment after fewer sessions than other patients do. These latter findings, however, are less clear and consistent than the general under-representation of class 4 and 5 patients in psychotherapeutic treatment.

Explanations for the Results: the assertion of a class-related difference in treatment expectations

In the attempt to account for these findings, two forms of explanation have been offered:

(1) The attributes of those who make the recommendation for treatment is critical; that is, they are biased against providing class 4 and 5 patients with psychotherapy.

(2) The characteristics of those who come for treatment are critical; that is, class-related characteristics of class 4 and 5 patients make other treatment recommendations preferable.

Cobb, in his review of outpatient studies (1972) points to these two possibilities:

> Some authors have suggested that a social class bias in the selection of patients for therapy may be due to the operation or irrational factors prejudicial to lower-class patients receiving the most beneficial and appropriate treatment. An equally tenable assumption, however, is that the judgments resulting in lower class patients being accepted for psychotherapy less often in some clinics are sound, and based upon a recognition of the inappropriateness of the types of treatment available for members of the lower socioeconomic classes.

Although it is not within the focus of the present study, there is evidence of bias against patients from the working class and the poor. Psychotherapists have been found to prefer patients from middle and upper class backgrounds (Rosenthal and Frank, 1958; Schofield, 1964), to find it difficult to be empathetic with poorer patients (Auld and Meyers, 1955; Kaplan, Kurtz and Clements, 1968) and even to consider them untreatable (Brill and Storrow, 1960; Heine and Trosman, 1960). Some authors have suggested that low income patients are actively, if subtly, discouraged from entering and maintaining treatment (Adams and McDonald, 1968; McMahon, 1964). There is also evidence that psychiatric residents presented with case histories indicating working class background label them as more severely disturbed than they do middle class case histories with identical symptoms (Haase, 1964; Lee and Temerlin, 1970).

Most researchers, however, have offered explanations of the second sort, attributing to class 4 and 5 patients qualities which make them "inappropriate" for psychotherapy.

Hollingshead and Redlich account for the bias in treatment prescription as follows:

> . . . a number of different social and cultural factors operate on the psychiatrist, the patient, his family and the community to produce the relationship reported here. Relevant factors include differential evaluation of psychiatrists by different classes, the attitudes of patients towards psychiatrists and the ability of persons in various classes to pay for psychiatric care. Another major factor is the different ways members of the several classes conceive of the nature and treatment of mental disorders. (301-302)

In the view of Hollingshead and Redlich, therefore, patient attitudes toward and evaluation of psychiatrists and their treatment techniques, coupled with differential ability to pay, are seen as the factors that produce class linked relationships to treatment modality. The issue of differential ability to pay is partially ruled out in the substantial number of studies in settings in which there is no fee. Commenting further on the importance of patient expectations about the nature of psychiatric treatment and increasing the stress on this explanation to account for class differences, the authors raise the specific issue of attitudes toward and expectations about psychiatric treatment. The following explanation in terms of patient expectations is very important, because the authors assert that it is with regard to psychotherapy as a form of treatment that class-linked differences are greatest. They state, in a widely quoted paragraph:

> "All too often, psychotherapy runs into difficulties when the therapist and patient belong to different classes. In these instances the values of the therapist are divergent from those of the patient, and communication becomes difficult between them.... The most frequent source of difficulty between the lower status patient in psychotherapy and the therapist is the patient's tacit or overt demand for an authoritarian attitude on the part of the psychiatrist, and the psychiatrist's unwillingness to assume that role because it runs counter to certain therapeutic principles....

> "The essential principles underlying insight therapy are shared most frequently by psychiatrists and patients in classes 1 and 2.... Class 4 and 5 persons seek matieral help in the form of pills, needles, obscure rays and ritual; some actually seek support and sympathy." (345-346)

Schaffer and Meyers, admittedly speculating about issues not logically deducible from their data, state:

> "The psychiatrist then is supposed to provide essentially instrumental remedies in the form of 'something to quiet the nerves,' 'tonics,' 'injections,' or occasionally 'shock therapy'.... Furthermore the patient expects such items (advice or formulae for success) to be supplied extemporaneously by a presumably omnicient stranger on the basis of minimal information and a very brief acquiantanceship. Whether the psychiatrist is regarded as some kind of magician, as a 'nerve doctor' or as a 'mind doctor' it is frequently singularly remote from the dynamically-oriented psychiatrist's conception of himself and his role as a therapist.... Therapists describe a distinct 'lack of rapport' with such patients."

In conclusion, the basic findings from the Hollingshead and Redlich study, as well as those form the great preponderance of others reporting on the same problem, is that poorer patients are disproportionately likely to be found receiving organic or custodial treatment, while higher status patients more often are assigned to psychotherapeutic treatment. The authors and researchers primarily attributed this division in treatment pathway to corresponding differences in patient attitudes toward and expectations about psychiatrists and mental health treatment. Lower social class patients were seen as viewing their problems as somatic in origin, and as expecting a treatment based on the standard medical model of an expert and authoritarian doctor who actively intervenes with organic techniques to cure a passive, obedient patient. Patients of higher social class status are assumed to expect treatment congrument with that seen as appropriate by those

trained to perform psychotherapeutic forms of treatment.

If this is the case, then the division in treatment pathway discovered in the data does not represent an arbitrary or discriminatory assignment of patients to treatment on the basis of their social class membership, but represents sound and realistic judgment on the part of clinicians. The assumption is that only those patients who hold a proper and appropriate set of expectations about the nature and process of psychotherapy could be expected to seek, sustain or benefit from it. In this view it is the assumed relationship of expectations and attitudes to social class that produces the disparity in treatment type.

The assertion of social class differences in expectations about psychological-psychiatric treatment, however, was not based on quantitative, empirically derived data. It was based on the unsystematized clinical experience of researchers investigating the relationship between social class and aspects of psychiatric, especially psychotherapeutic, techniques.

Empirical Research on Patient Held Expectations

In an attempt to further examine the drop-out rate of patients of lower social class background, and to test the assumption that inappropriate attitudes and expectations about the nature of psychotherapeutic treatment held by these patients was related to what the staff considered premature termination, Overall and Aronson (1963) constructed a 35 item questionnaire designed to elicit patient expectations about therapist behavior. The questionnaire was administered to 40 "lower class" (class 4 and 5) respondent-patients appearing for their first visit at the out-patient psychiatric clinic of a university general hospital.

The respondents were asked whether or not they expected the doctor who would treat them to engage in a series of behaviors grouped into five categories "chosen to represent the points suggested by Hollingshead and Redlich." The five categories and their descriptions are as follows:

1. Active, Directive - "The therapist actively instructs or directs the patient."

2. Medical - "The therapist focuses on the organic or physical problems of the patient."

3. Supportive - "The therapist avoids charged matieral in an attempt to bolster or comfort the patient."

4. Passive - "The therapist leaves the direction of the discussion to the patient, encouraging all patient communication."

5. Psychiatric, Psychological - "The therapist focuses on emotional or charged material."

Table 2 presents the full set of questions, grouped by category. The percentage of agreement with each item is included. Those items showing significant class related differences in a later study are indicated.

The results of this study, confined to class 4 and 5 subjects, are that respondents answered in the affirmative to most questions, even those that seemed incompatible. The authors state:

> "...it could reflect an actual expectation that the therapist be simultaneously active, medical, supportive, passive and psychiatric.... The particularly high percentage of affirmative responses to questions in the psychiatric category strongly indicates that contrary to the Hollingshead and Redlich conceptualization and to a greater degree than we ourselves foresaw, these patients do generally anticipate that psychiatric issues will be raised." (p. 424)

In addition it was demonstrated that those patients whose expectations

Table 2

Treatment Expectation Questionnaire
(Overall and Aronson, 1963)

Q#	Items by Category	% Agreement Class 4&5 1st study	% Agreement Class 4&5 2nd study	% Agreement Class 1,2,3 2nd study
	Do you think the doctor will...			
	Active, Directive (8 items)			
3.	tell you what is wrong with you?	60	59*	22*
5.	not want your opinion?	20		
7.	give you definite rules to follow?	68	67*	28*
12.	tell you what is causing your trouble?	63	62*	20*
17.	ask you a lot of questions?	70		
20.	tell you ways to solve your problems?	75	74*	28*
21.	have a list of things he will want to check over?	65	67*	35*
28.	tell you what is wrong with what you do?	70	69*	32*
	Medical (11 items)			
1.	give you medicine?	58	56*	18*
2.	not ask questions about your personal life?	23		
9.	ask what medicines you have been taking?	80		
13.	ask what physical illnesses have been in your family?	83		
16.	want to know what other doctors you have seen lately?	83		
18.	be interested in your digestion?	70	72*	42*

Table 2 (continued)

Q#	Items by Category	% Agreement Class 4&5 1st study	% Agreement Class 4&5 2nd study	% Agreement Class 1,2,3 2nd study
	Do you think the doctor will...			
Medical (11 items) (cont'd)				
24.	be particularly interested in your aches and pains?	68	67*	40*
26.	ask questions about any operations you have had?	70		
30.	ask you to describe they physical illnesses you have had?	78		
32.	take your pulse and blood pressure?	55	54*	25*
34.	tell you what kinds of food you should eat?	45	46*	10*
Supportive (4 items)				
4.	try and cheer you up?	78	77*	48*
8.	avoid subjects which might upset you?	54	53*	15*
14.	want you to look at the bright side of things?	87	87*	65*
25.	try to get your mind off your troubles?	80	79*	35*
Passive (3 items)				
6.	listen more than he talks?	75	77*	100*
23.	expect you to do most of the talking:	68	67*	92*
33.	listen to your troubles?	93		

Table 2 (continued)

Q#	Items by Category	% Agreement Class 4&5 1st study	% Agreement Class 4&5 2nd study	% Agreement Class 1,2,3 2nd study
	Do you think the doctor will...			
Psychiatric, Psychological (9 items)				
10.	want to know what your childhood was like?	78		
11.	want to know what kinds of things make you unhappy?	90		
15.	want to know about your thoughts and feelings?	85		
19.	want to know how you get along with people?	90		
22.	want to know how happy you are?	95		
27.	be interested in hearing any personal problems you have?	88		
29.	not give you a physical examination?	50	51*	78*
31.	want to know what your friends are like?	80		
35.	be interested in knowing if some things make you afraid or nervous?	98		

*Significant differences between social class groups. Other agreement figures not reported.

were most inaccurate, or least fulfilled, based on a comparison of their initial responses with the responses of the therapists they saw (Did you . . . ?) and with the patient's own perception of the actual interview (Did the Doctor . . . ?) were least likely to return for treatment.

To repeat, however, this study did not explore social class differences in responses to the treatment expectation questionnaire.

In a second study (Aronson and Overall, 1966), specifically designed to examine social class differences in responses to the questionnaire, the expectations of 40 class 1, 2 and 3 patients were compared with a new sample of 39 class 4 and 5 subjects.

The results indicated that "The lower class patient generally expects more action, direction and support than the middle class patient" (p. 39). With respect to the hypothesis that lower class patients will expect more medical activity in initial treatment, the authors state ". . . although both lower and middle class patients expect to be questioned to some extent on medical history, it is mainly the lower class who anticipate an examination of or specific interest in current physical problems." The psychological-psychiatric category showed the least difference between social classes. Only one item of nine in the category reached significance, and that one is included in the category only by virtue of a negative grammatical construction. This item, "not give you a physical examination," seems to express a rejection of medical procedure, but does not include any psychological content per se.

This study is often cited as evidence for significant social

class differences in expectation about treatment, although there are major problems in the interpretation of the differences in response. As Lorion points out in his review (1974), of primary importance is the confusion of ethnic differences with social class differences. The middle class group included both Jewish and non-Jewish whites, while the lower class group was composed of non-Jewish whites and non-whites. The authors recognize the ethnic variable as a source of difficulty in the interpretation of their data. They report that the group of class 4 and 5 Black respondents differed most from the middle class group, increasing the social class difference finding.

The small number of Jewish respondents in the sample (8) made their contribution to class differences hard to evaluate, but the authors indicate that they present a picture different from that which emerges from the other groups. The particular items that they differentiate themselves on are not reported, but it is reported that they gave a much higher percentage of "no" responses than did the other groups interviewed. Because the direction of significant difference on all questions except 23, 29 and 33 is toward the middle class respondents giving more "no" responses, this ethnic difference also would magnify the social class difference.

The results with both the Black and Jewish subgroups indicate the need for a more systematic examination of the role of ethnicity in the study of treatment expectations.

In addition to the difficulty introduced by the lack of control for ethnic differences, the social class samples were drawn from

different settings. The middle and upper class group was drawn from a setting based on voluntary self referrals. The class 4 and 5 sample was drawn from a different clinic, where the patients were referred by other agencies with no opportunity for self referral. This separation by setting as well as pathway to treatment creates the possibility for differences in treatment expectation independent of social class differences.

In conclusion, the studies by Overall and Aronson seem to indicate much agreement among patients of differing social class backgrounds about the content of psychotherapy, with the exception of responses to the items on the medical subscale. The divergence of expectations between social classes is with respect to technique. The authors state, "The middle class, more than the lower class, recognizes that much of the initiation and direction in a dynamic interview must come from the patient."

That part of the results indicating that lower class patients have a medical, passive expectation about mental health treatment and their role in it is in agreement with the speculations of Hollingshead and Redlich and the other authors who asserted such a difference, although the differences seem smaller and narrower than hypothesized. Moreover, the confounding of ethnic differences, differences in treatment facility and differences in pathways to treatment with social class differences introduces the possibility that even those social class differences reported in this study are inflated.

A later, independent replication of the Aronson and Overall

study was carried out by Williams, Lippman, Uhlenmuth, Rickels, Covey and Mock (1967) (referred to hereafter as "Williams") as part of a large scale study of the effects of minor tranquilizers. They included 587 subjects from three large clinics. All subjects were new admissions, diganosed neurotic and interviewed prior to their first appointment with the treating psychiatrist. The researchers modified the questionnaire by adding 5 questions and rewording others.

Question Added	Category
Do you think the doctor will . . .	
tell you how to get along better with people?	Active
ask about how well you sleep?	Medical
sympathize with your problems?	Supportive
ask about how you get along with your family?	Psychiatric
ask about your sex life?	Psychiatric

The two questions written in the negative (2,29) had the word "not" dropped. See Table 2B for the full questionnaire and percentages of agreement for each of the items. Included are the mean scores for each of the original Overall and Aronson categories.

Williams does not present data on differences in percentage of agreement by social class for each item. The data are presented in terms of socring patterns on the original categories (termed "clusters"). A factor analysis was then performed on those items with less than 90% agreement. Since the clusters "Passive" and "Psychiatric" had such high agreement scores, the factor analysis was

Table 2B

Comparison between % agreement with each item;
Overall and Aronson, Aronson and Overall and Williams

Williams Items, by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams
Do you think the doctor will...				
Active, Directive (9 items)				
tell you what is wrong with you?	60	59*	22*	80
want your opinion?	20	-	-	91
give you definite rules to follow?	68	67*	28*	53
tell you what is causing your trouble	63	62*	20*	85
ask you a lot of questions?	70	-	-	85
tell you ways to solve your problems?	75	74*	28*	81
have a list of things he will want to check over?	65	67*	35*	85
tell you what is wrong with what you do?	70	69*	32*	75
tell you how to get along better with people?	Added by Williams			73

Mean Score (%) - 70[(1)]**

Table 2B (continued)

Williams Items, by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams
Do you think the doctor will...				
Supportive (5 items)				
try and cheer you up?	78	77*	48*	63
avoid subjects which might upset you?	54	53*	15*	27
want you to look at the bright side of things?	87	87*	65*	89
try to get your mind off your troubles?	80	79*	35*	46
sympathize with your problems?	Added by Williams			69
		Mean score (%) - 62(1)**		
Passive (3 items)				
listen more than he talks?	75	77*	100*	91
expect	68	67*	92*	88
listen to your troubles?	93	-	-	95
		Mean Score (%) - 91(1)**		

Table 2B (continued)

Williams Items, by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams
Medical (11 items)				
give you medicine?	58	56*	18*	75
ask questions about your personal life?	23	-	-	97
ask what medicines you have been taking?	80	-	-	96
ask what physical illnesses have been in your family?	83	-	-	85
want to know what other doctors you have seen lately?	83	-	-	92
be interested in your digestion?	70	72*	42*	68
be particularly interested in your aches and pains?	68	67*	40*	62
ask questions about any operations you have had?	70	-	-	78
ask you to describe the physical illnesses you have had?	78	-	-	88
take your pulse and blood pressure?	55	54*	25*	52
tell you what kinds of foods you should eat?	45	46*	10*	39
ask you about how well you sleep?	Added by Williams			99
		Mean Score (%) - 70[(1)]**		

Table 2B (continued)

Williams Items, by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams
Do you think the doctor will...				
Psychiatric, Psychological (11 items)				
want to know what your childhood was like?	78	-	-	98
want to know what kinds of things make you unhappy?	90	-	-	98
want to know about your thoughts and feelings?	85	-	-	99
want to know how you get along with people?	90	-	-	99
want to know how happy you are?	95	-	-	92
be interested in hearing any personal problems you have?	88	-	-	94
give you a physical examination?	50	51*	78*	39
want to know what your friends are like?	80	-	-	88
be interested in knowing if some things make you afraid or nervous?	98	-	-	99
ask about how well you get along with your family?	Added by Williams			99
ask about your sex life?	Added by Williams			96
	Mean Score (%) - 92(1)**			

*significant class differences.

**"Mean Score" - Percentage of items answered in the affirmative for that category.

restricted to the other three clusters (Active, Medical, Supportive).

Five factors emerged. The Active cluster was divided into two component factors, one reflecting the expectation that the therapist will diagnose what is wrong,labeled Diagnostic, the other that the therapist will tell the patient what to do, labeled Advice-Guidance. Agreement with the items in the Advice-Guidance factor is associated with class 4 and 5 membership.

The Medical cluster also produced two factors. One indicates an expectation of interest in the patient's past medical history (History of somatic illness) and the other indicates an expectation of active medical intervention in current treatment (Active-Medical). Both of these factors had a significant relationship to social class.

The final factor corresponds to Overall and Aronson's Supportive cluster, and was labeled Supportive-Optimistic. This factor is also significantly related to social class.

It is important to note that all of the evidence for social class differences in expectation presented by Williams is restricted to differences between class 5 applicants for treatment and all others. Re-analysis of their data reported by Lorion (1974B) indicates that there are no significant differences between the measured expectations of class 4 prepatients and those applicants from class 3 and above. This finding indicates the possibility that pooling the data from class 4 and class 5 subjects may obscure the fact that the true differences are between class 5 and all other patients.

The danger of discussions in which the relationship between social class and mental health and its treatment is assumed to be a simple

monotonic one had been pointed out soon after the publication of Social Class and Mental Illness. Miller and Mishler (1964) reported that their further analysis of the Hollingshead and Redlich findings on incidence and prevalence, with the data for class 5 omitted, yielded no significant differences among the other groups. The evidence indicated a discontinuity between the incidence and prevalence statistics for both neurosis and psychosis of class 5 and all others, rather than indicating a mootonic function relating social class to disorder statistics. In spite of this warning, however, many studies failed to report separate data for class 4 and class 5 subjects. This is true of the data in the Overall and Aronson studies on patient expectations. In other studies, even where separate data is presented for class 4 and 5 subjects, these data are discussed together, and as if they were homogenous. This is the case with the data reported in, and discussed by, Williams.

Williams and her colleagues interpret their data as supporting Hollingshead and Redlich's assertions about expectation differences and social class, but also point to the finding that the great majority of patients, without regard to class, expect to have psychiatric-psychological issues raised. They state that this expectation coexists in the lower class patient with expectation of an "active, medical role in the context of supportive-optimistic therapy" (p. 218). They imply that the expectations about psychotherapy held by all members of society have moved in the direction of greater accuracy, probably through the influence of the mass media.

The most recent reported use of those 21 questions from the

Overall and Aronson questionnaire which produced 90% or less agreement was by Lorion (1974). Among the new items he introduced, Lorion included in his form of the questionnaire three questions dealing with the expected duration of treatment. These questions, suggested by the work of Goin, Yamamoto and Silverman(1965), are an attempt to deal empirically with the issue of class linked differences in expectation of treatment length, a possible contributor to the "premature drop out rate" of class 4 and 5 patients.

Goin, Yamamoto and Silverman collected what they described as treatment expectations from a group of applicants at Los Angeles General Hospital Psychiatric clinic. The patients were predominantly from class 4 and 5, with some class 3 representation. Although the information collected is more accurately described as patient requests for specific forms of treatment, and although there are no data presented on social class differences in response, the study contains some interesting information. The authors state: "Much to our surprise, 52% of patients indicated their wish to solve their problems by talking about their feelings and past life. Of the 48% who expected active help from the doctor, 14% wanted pills and 34% requested advice." These findings are further evidence for the Overall and Aronson and the Williams data indicating that the view of working class and poor patients as rejecting and being unprepared for taditional psychotherapy is exaggerated.

In addition to collecting information on patient requests, the subjects were asked whether they expected treatment to last 1 or 2 visits, 3 to 10 visits, 11 to 25 visits or over 25 visits. Results

indicated 16.8% expected 1 or 2 visits, 44.4% 3 to 10 visits, 18.8% 11 to 25 visits and 20% more than 25 visits. The authors point out that these figures correspond roughly with the reported drop-out rate at their own and other clinics. 61.2% of their patients expected 10 or fewer visits and approximately 67-68% of patients at their own and other clinics reporting drop-out rates completed 10 or fewer sessions (Rosenthal and Frank, 1958; Schaffer and Meyers, 1954; Garfield and Kurz, 1952).

The incompleteness of the data reported in this study, however, make it impossible to examine the relationship between expectations about treatment duration and actual maintenance of treatment. It is clear that a possibility exists that what the staff considers "premature termination" actually corresponds to the patient's expectation about the duration of treatment. It is also possible that the expectation about treatment duration varies with social class. Lorion's inclusion of questions on treatment duration therefore represents a worthwhile addition.

Lorion's sample was made up of 90 applicants for outpatient psychotherapeutic treatment. A factor analysis performed on the data extracted a set of factors which he reports as similar to those derived by Williams, with the addition of a factor made up of those items concerning treatment duration. He reports no social class differences between the responses of class 3, 4 and 5 respondents, and concludes:

> The present findings suggest that prior assumptions concerning differences in help-seeking attitudes and treatment expectations among socioeconomic status groups must be carefully reevaluated. . . . Subjects from all social classes

> reported similar expectations about the technical aspects of treatment. They did not anticipate an active, supportive, problem-solving therapist. They were able to differentiate the role of the therapist from that of the more traditional medical caregiver. Subjects also assumed that they would discuss personal emotional issues with a therapist whose primary function would be to listen. The current findings therefore suggest that low income patients do not necessarily have more negative pretreatment attitudes and expectations than upper socioeconomic status applicants.

It is difficult, however, to compare Lorion's results with those of Aronson and Overall and Williams due to the significant alterations in basic procedure he introduced into his study. First, Lorion restricted his sample to those with no previous treatment experience, a restriction not placed on the subjects in the other studies. His other changes, however, are more serious. The questionnaire was self-administered rather than having the subject interviewed, and, more important, the lead for the questions was altered in a critical manner.

The lead for all the questions in the Overall and Aronson study and that used by Williams was, "Do you think the doctor will . . . " Lorion changed this to "Do you think the mental health worker will . . .," stating, "The term 'mental health worker' was used in place of Overall and Aronson's original 'doctor' to reduce bias toward medical expectation" (Lorion, unpublished). This alteration was not specified in the short form in which the findings were published. Lorion is apparently assuming, probably with good reason, that the original lead containing the word 'doctor' is loaded, and may produce a medically oriented set of expectations. Implicit would seem to be the additional assumption that this loading affects respondents differentially, by social class. He presents no empirical justification for this assumption, however,

nor the selection of the particular wording he chose for the lead.

It is clear that the failure to find evidence of an expectation of active medical intervention, the primary class linked difference in expectation, may be directly attributable to this change in lead, rather than to the continuation of the trend toward no class related differences in expectation about treatment produced by better education and the mass media, as suggested by Williams and reiterated by Lorion.

Table 2C includes the original questions and groups from Overall and Aronson (1963), the questions added by Williams (1969) and those omitted and added by Lorion (1974). The lead is phrased as Lorion presented it: "Do you think the mental health worker will . . . "

Conclusions and Unresolved Issues

A number of questions remain unanswered after a review of the literature.

1. What is the current status of social class differences in treatment expectation? Have there been, as suggested by Williams and Lorion, changes over time in the direction of more accurate expectations about psychotherapeutic treatment in all segments of society, greatly reducing or even eliminating social class differences in expectation?

2. What is the relationship between ethnicity and treatment expectation? Specifically, do Jewish applicants for treatment hold expectations different from those of other patient groups, as suggested by Overall and Aronson? In addition, are there important differences in treatment expectation held by other ethnic groups? In

Table 2C

Comparison between % of Agreement with Each item; Overall and Aronson, Aronson and Overall, Williams and Lorion

Items by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams	% Agreement Lorion
Do you think the mental health worker will...					
Active, Directive					
tell you what is wrong with you?	60	59	22	80	62
want your opinion?	20	-	-	91	omitted
give you definite rules to follow?	68	67	28	53	20
tell you what is causing your trouble?	63	62	20	85	omitted
ask you a lot of questions?	70	-	-	85	81
tell you ways to solve your problems?	75	74	28	81	66
have a list of things he will want to check over?	65	67	35	85	omitted
tell you what is wrong with what you do?	70	69	32	75	70
tell you how to get along with people?	Added by Williams			73	47
Supportive					
try to cheer you up?	78	77	48	63	48
avoid subjects which might upset you?	54	53	15	27	02
want you to look at the bright side of things?	87	87	65	89	72

Table 2C (continued)

Items by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams	% Agreement Lorion
Do you think the mental health worker will...					
Supportive (cont'd)					
try to get your mind off your troubles?	80	79	35	46	41
sympathize with your problems?	Added by Williams			69	omitted
speak to those people who make you upset?	Added by Lorion				26.5
Psychiatric, Psychological					
be interested in what happened to you as a child?	78	-	-	98	87
want to know what kinds of things make you unhappy?	90	-	-	98	omitted
want to know about your thoughts and feelings?	85	-	-	99	omitted
want to know how you get along with people?	90	-	-	99	omitted
want to know how happy you are?	95	-	-	92	omitted
be interested in hearing any personal problems you have?	88	-	-	94	omitted
give you a physical exam?	50	51	78	39	17
want to know what your friends are like?	80	-	-	88	omitted

Table 2C (continued)

Items by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams	% Agreement Lorion
Do you think the mental health worker will...					
Psychiatric, Psychological (cont'd)					
be interested in knowing if some things make you afraid or nervous?	98	-	-	99	omitted
ask about how well you get along with your family?	Added by Williams			99	omitted
ask about your sex life?	Added by Williams			96	omitted
want you to talk about people who upset you?	Added by Lorion				91
want you to decide when you no longer need to see him?	Added by Lorion				69
Treatment Duration					
Expect you to come in even when you don't feel a need to see him?	Added by Lorion				64
still be seeing you one year from now?	Added by Lorion				23
still be treating you 3 months from now?	Added by Lorion				70
still be treating you 1 month from now?	Added by Lorion				89
Medical					
give you medication?	58	56	18	75	36

Table 2C (continued)

Items by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams	% Agreement Lorion
Do you think the mental health worker will...					
Medical (cont'd)					
ask questions about your personal life?	23	-	-	97	omitted
ask what medicines you have been taking?	80	-	-	97	omitted
ask what physical illnesses have been in your family?	83	-	-	85	omitted
want to know what other doctors you have seen lately?	83	-	-	92	omitted
be interested in your digestion?	70	72	42	68	24
be particularly interested in your aches and pains?	68	67	40	62	34
ask questions about any operations you have had?	70	-	-	78	47
ask you to describe the physical illnesses you have had?	78	-	-	88	omitted
take your pulse and blood pressure?	55	54	25	52	15
tell you what kinds of food you should eat?	45	46	10	39	07
ask about how well you sleep?	Added by Williams			99	omitted

Table 2C (continued)

Items by Category	% Agreement Class 4&5 Overall & Aronson	% Agreement Class 4&5 Aronson & Overall	% Agreement Class 1,2,3 Aronson & Overall	% Agreement Williams	% Agreement Lorion
Do you think the mental health worker will...					
Passive					
listen more than he talks?	75	77	100	91	73
expect you to do most of the talking?	68	67	92	88	85
be silent even when you have nothing to say?	Added by Lorion				42

particular, Hispanic patients form an important urban ethnic group, recognized as presenting special attitudes and attributes about mental health and its treatment (Fernandez-Marina, 1961; Fitzpatrick and Gould, 1970; Karno, 1966; Karno and Edgerton, 1961; Kline, 1969; Marcos et al., 1973). Does this group hold treatment expectations different from those of other ethnic groups?

3. Has the lead "Do you think the doctor will . . . " produced a "medical model" set, and does it induce this set differentially among the social classes? Will differences emerge when this lead is varied with Lorion's form, "Do you think the mental health worker will . . . ," accounting for Lorion's failure to find social class differences, especially in expectations about medical activity?

4. What is the relationship between patient expectations and staff treatment activity? Are there social class differences in disparity between patient expectations and staff activity?

The original assumption behind much of the research in this area is that patient expectations can be differentiated by their accuracy, defined as similarity to the therapeutic activity engaged in by the treatment staff. Some expectation patterns have been seen as providing a good correspondence between patient expectations and staff treatment activity, leading to the maintenance of, and progress in, treatment. Other expectations have been seen as inaccurate, leading to premature termination of, and failure to progress in, treatment.

In the first Overall and Aronson study, patient expectations were compared with therapist self-reported treatment activity. Fewer differences were found between respondent expectations and staff

activity among those who returned than were found for those who failed to maintain treatment. The study did not vary social class, although the authors speculated that agreement between patient expectations and therapist activity was positively related to social class of the patient. Subsequent studies have not examined the corresondence between prepatient expectation and staff activity, nor has there been empirical information about the relationship of social class of the prepatient to this correspondence.

CHAPTER III

HYPOTHESES

The review of the previous literature leads to the formulation of a number of hypotheses. These hypotheses can be grouped as follows:

(1) Hypotheses about social class and ethnic differences in expectations about mental health treatment.

(2) Hypotheses about class related differences between prepatient treatment expectations and staff treatment activity.

(3) Hypotheses about the contribution of methodological differences to contradictory findings among the previous studies.

Social Class and Ethnic Differences in Treatment Expectation

Three general hypotheses will be tested:

1A. There are social class differences in expectations about mental health treatment among prepatients.

1B. Social class differences are primarily a function of differences between Class 5 prepatients and all others.

There are significant differences between Class 5 prepatients and those from Class 1, 2 and 3, and from Class 4, but no significant differences between Class 1, 2 and 3 prepatients and those from Class 4.

2A. There are ethnic differences in expectations about mental health treatment among prepatients.

In addition, two specific hypotheses about ethnic differences are

proposed. Studies not directly related to treatment expectation have indicated that Jewish respondents possess highly positive attitudes toward the psychological aspects of mental health treatment (Howard and Orlinsky, 1972), and form a major part of what has been referred to as the "friends and supporters of psychotherapy" (Kadushin, 1969).

Therefore:

2B. Jewish prepatients will differ from others with respect to expectations about psychological and psychotherapeutic content in treatment.

Specifically, they will expect greater psychological content in treatment than other respondents do.

A second specific hypothesis about ethnic differences follows from past studies. Indirect evidence from past studies indicates the possibility of an ethnically linked difference in expectations for a medical focus in mental health treatment. Marcos et al.(1973), Fernandez (1961) and Fabrega, Rubel and Wallace (1967) all discuss the frequency of somatic complaints among Mexican-American and Puerto Rican mental health patients, and Marcos et al.(1973) report high scores on the "Somatic Concern" scale of the Brief Psychiatric Rating Scale, an instrument widely used to assess psychopathology. These findings suggest that patients from Hispanic backgrounds, with greater somatization and somatic concern, would expect more medical intervention than do other prepatients.

Therefore:

2C. Hispanic prepatients will differ from others with respect to

expectations about medical content in mental health treatment.

Specifically, they will expect more medical content in treatment than other prepatients expect.

Social Class and Differences Between Prepatient Expectations and Staff Treatment Activity

The assumption of social class differences in treatment expectations implies that expectations will be differentially violated by actual treatment practice, and suggests the following:

3. There are class linked differences between prepatient treatment expectations and staff treatment activity.

Class 1, 2 and 3 prepatients hold expectations that are not violated by the treatment activity of the staff, and therefore there will be no significant overall differences between treatment expectations of Class 1, 2 and 3 prepatients and staff activity. Class 4 and Class 5 prepatients, on the other hand, hold expectations that are not consonant with staff activity, and there will be significant differences between the expectations of these respondents and the self reported activity of the staff.

Methodological Differences and Contradictory Results

As previously stated, differences between the findings reported by Lorion and those reported by other researchers may be attributable to changes in the wording of the lead and to changes in the method of administration of the questionnaire. Of primary importance is the change in the wording of the lead from "Do you think the doctor

will . . . " to "Do you think the mental health worker will . . . ". This difference will be referred to as a difference in form.

Therefore:

4A. There will be differences between the expectations elicited by the "doctor" form and those in reply to the "mental health worker" form.

The pattern of social class differences in relation to the lead wording used indicates the possibility of two different patterns, leading to the following hypotheses:

4B. No social class differences will emerge using the "mental health worker" form.

4C. There will be social class differences in response to the "doctor" form.

A less likely possible explanation for the differences between the Lorion results and the others lies in the method of administration of the questionnaire. Lorion's respondents filled out the questionnaire themselves. In other research, subjects were interviewed.

Therefore:

5. Differences in method of administration will produce differences in response pattern to the questionnaire.

A final possibility is that the particular grouping of questions into factors produce the differences between the Lorion and the Williams findings. This leads to the last hypothesis:

6. Questions grouped into the Lorion factors will produce the Lorion findings, questions grouped into the Williams factors will produce the Williams findings.

CHAPTER IV

METHOD

The study was carried out at the Maimonides Community Mental Health Center (MCMHC) of Maimonides Hospital. The Center is located at 4802 10th Avenue, in the Boro Park section of Brooklyn, New York.

The Center, opened in 1967, is considered to be one of the best mental health facilities in the New York City area. It has a reputation for excellent, humane treatment that is innovative and highly responsive to community needs. Its history and philosophy reflect the development of the community mental health concept at its best.

In 1961 the Maimonides Medical Center established the Department of Psychiatry, staffed by Drs. Montague Ullman and Mark Tarail. From 1962 until 1967, the department primarily provided adult outpatient psychiatric treatment. Under the leadership of Dr. Tarail and in conjunction with Columbia University, the Department of Psychiatry obtained a special grant to train community organizers to develop community oriented educational and preventive mental health programs. After the passage of the Community Mental Health Act of 1963, the administration and clinical staff, together with a group of community residents and leaders of community groups began the planning of what became the Maimonides Community Mental Health Center. Official designation came in 1967. The building the Center now occupies was completed in 1968, and the Center was opened at that location.

The Center's primary emphasis is placed on providing comprehensive

services to all individuals and fmailies within the cathment area, "regardless of ability to pay, sex, age, race, ethnic origin, economic or social class, diagnostic category of severity of illness." (Maimonides Medical Center Community Mental Health Center: History, Philosophy, Description of Services and Statistical Summary, 1975) These services include not only diagnostic and treatment services but also maintenance, prevention, education, rehabilitation and re-entry programs.

Included among the many programs established at the Center are two which played a role in the research reported here. The study used as respondents applicants for Adult Outpatient Services. The MCMHC provides comprehensive outpatient services, not only at the main Center location, but also through a network of neighborhood service centers and community services. These services include crisis intervention, intake, and long and short term care. Treatment includes family, group and individual therapy, chemotherapy and arts and crafts therapy.

The Center also has a very active Program Analysis Unit, directed by Gerlad S. Landsberg. The unit carries out evaluative studies and prepares reports concerning the development of management information systems, unit evaluations and studies of treatment outcome. In addition it has the responsibility for conducting studies of "consumer" characteristics and needs, and for providing feedback from service recipients.

The commitment of the administration and staff of the Center to a research program which can lead to improvements in services by increasing knowledge of the community served made the research presented here possible.

Arrangements for the Present Study

Discussions with the Director of Program Analysis and Evaluation established the interest of this unit in conducting research on patient expectations. Director Landsberg arranged a series of meetings with Dr. Mark Tarail, Director of the Mental Health Center, Dr. Hans Nieperont, Director of Inpatient Services and Dr. Raul Mujica, Director of Outpatient Services. The first meeting established the administration's interest in the need for empirical research on patient expectations about treatment. Further meetings were devoted to ensuring that the research would not interfere with patient care. The questionnaire was examined to be sure it did not contain charged material which would be counter indicated during intake.

Procedures were established to ensure the ethical treatment of applicants for service. This was accomplished by assuring all prepatients approached for interviews that their cooperation was voluntary and had no bearing on access to services. They were also to be assured that their privacy would be protected and confidentiality provided be ensuring anonymity. The requirements for respondent anonymity meant that no connections could be made between interviews and hospital records, and hospital records were not made available.

An additional meeting was held with the Adult Outpatient Services clinical staff. The research project was presented to them and their questions answered. The procedure established to provide ethical treatment of patients and to eliminate the possibility of interference with good treatment practices were explained. The staff agreed to the usefulness of the research project and their acceptance of and cooperation

with the procedures was secured.

Subjects

The data were collected from 336 adults (age 18 and above) currently not in treatment at the Center, who were interviewed prior to their intake interview. Persons obviously disoriented, agitated or intoxicated were not interviewed, nor were those patients admitted through the hospital emergency room. The sample, therefore, is almost exclusively composed of those applicants who, if accepted for treatment on the basis of catchement area, are placed in the Adult Outpatient Services division of the Mental Health Center.

The Maimonodes catchement area includes a diverse population of social classes and ethnic groups. Comparisons are possible between three levels of social class and between three types of ethnic background.

Social Class

The community served by the Maimonides Hospital is predominantly composed of lower middle class and working class individuals and families, with some professionals and a number of poverty level persons. Respondents were divided into social class groups using the Hollingshead Two Factor Index of Social Position previously described.

Three broad levels of social class were used for analysis. Class 1, 2 and 3 applicants for treatment were combined into a single group. The population of the catchement area is such that this group is composed almost exclusively of class 3 persons. The remaining groups, class 4 and class 5 are treated separately. This division produces

three levels of social class: Class 1, 2 and 3 combined, Class 4 and Class 5.

There were 108 (32.1%) respondents who were scored as members of Class 1, 2 and 3, there were 119 (35.4%) respondents who were placed in Class 4, and the remaining 109 (32.4%) were categorized as being members of Class 5.

Ethnic Background

The community is primarily composed of three ethnic groups. A large Jewish community, which includes many members of the ultra-orthodox Chassidic sect as well as more assimilated Jews, uses the hospital. There is also a sizable Puerto Rican community in the area. Small numbers of other Spanish-speaking people reside within the Puerto Rican community. The third major ethnic group is primarily composed of persons of Italian-American background. There are also small numbers of persons of other ethnic origin in the neighborhood, primarily from Irish or Scandinavian backgrounds, who were combined with the Italian-Americans to form the group designated "Other."

The sample includes 89 (27%) respondents from Puerto Rican or other Hispanic background and 109 (33%) Jewish respondents. The remaining 132 (40%) respondents were placed in the "Other" category.

Table 3 presents the sample divided by both social class and ethnicity of the respondents.

TABLE 3

ETHNICITY AND SOCIAL CLASS OF PREPATIENTS

	Ethnicity			
Class	Hispanic	Jewish	Other	
Class 1,2,3	18	45	45	108(32.7%)
Class 4	32	36	47	115(34.8%)
Class 5	39	28	40	117(32.4%)
	89 (27%)	109 (33%)	132 (40%)	336

Additional Background Characteristics

Information was collected on the sex, age and marital status of the respondents.

Males composed 148 (44%) of those interviewed, and 188 (56%) were females. There were 34 (10%) respondents who were under 21, 196 (58.5%) who were between 21 and 40 years old, 84 (25%) respondents who were between 41 and 65, and 22 (6.5%) who were over 65 years of age.

With respect to marital status 137 (41%) were currently married, 68 (20%) were divorced or separated, 19 (6%) were widows or widowers and the remaining 112 (33%) had never been married.

Since all persons not currently in treatment at the Center were prospective interview respondents, there is also a diversity of previous experience with mental health services within the group. Some applicants for treatment reported that they had no prior experience with mental health treatment. Other applicants reported previous treatment history either at the Center or at other services or both.

For those respondents reporting previous treatment experiences, information was obtained on how recent the treatment was, where it was obtained and the form treatment took.

No previous experience with mental health services was reported by 136 (40.5%) of the respondents. Of the 200 (59.5%) reporting previous experience 82 (24.4% of the total sample) had been treated at the Maimonides Community Mental Health Center, 72 (21.4%) had been treated at another mental health center, psychiatric facility or clinic and the remaining 47 respondents reported having been treated by private therapists.

Of the previous experience group, 86 (26% of the total sample) had been in treatment within the 12 months prior to being interviewed, 44 (13%) had been in treatment from 1 to 2 years before being interviewed, 29 (9%) reported having been in treatment 2 to 5 years before. The final group, those who had last been in treatment more than 5 years prior to being interviewed, was composed of 41 (12%) respondents.

Staff Interviews

An important set of data were collected from members of the Adult Outpatient treatment staff. Interviews were conducted with 37 of 41 therapists who provide services to that group of patients the interview sample represents. Direct comparisons are therefore made possible between the expectations of applicants for service and the self reported treatment activity of the staff they would receive services from.

The treatment staff interviewed is composed of 15 men (41%) and 22 (59%) women. Levels of training included 6 (16%) therapists with

the B.A. degree, 2 (5%) Registered Nurses, 17 (46%) Certified Social Workers, 8 (22%) with Ph.D of Ed.D degrees and 4 (11%) Medical Doctors. Ethnically, 4 (11%) were of Hispanic origin, 23 (62%) were Jewish and 10 (27%) were categorized "Other." (The proportion of Jewish therapists is inflated due to the inclusion of the staff of the "Satellite" center in the Chassidic community. The staff of the "Satellite" center in the Puerto Rican community was not interviewed.)

Other Respondents

There were also 229 college students registered in General Psychology at Pratt Institute in Brooklyn, New York, who participated in the methodological part of the study. Data from these students were not combined with the data from prepatients, nor are student data included in any of the following analyses unless specifically stated.

The student group was composed of 147 (64.5%) respondents of Class 1, 2 or 3 background, 66 (29%) of Class 4 background and 15 (6.5%) of Class 5 background. There were 12 (5%) students from Hispanic background and 37 (16%) Jewish students in the group. The 180 (79%) students making up the "Other" category were not primarily of Italian-American background but were a much more ethnically diversified group, predominantly Protestant.

There were 123 (54%) males and 106 (46%) female students in the group. 93 (41%) were under 21 years of age, 135 (59%) were between 21 and 40 and one student interviewed was over 41 years old. Only 26 (11.5%) of the student group were currently or had ever been married. The other 202 (88.5%) had never been married. Previous experience with mental health services was reported by 37 (16%) of the students. The

remaining 192 (84%) reported no such experience.

Treatment Expectation Survey

A questionnaire, the Treatment Expectation Survey (TES) was constructed to measure prepatient expectations. The questionnaire is composed of 47 items. These include the items originally developed by Overall and Aronson (1968) as revised by Williams (1969), the items added by Williams (1969) and the items added by Lorion (1972).

Form 1 - "mental health worker" and Form 2 - "doctor." In order to test the hypothesis about the contribution of differences in the wording of the lead to the presence or absence of social class differences, two forms of the questionnaire were constructed.

In Form 1, questions about treatment are preceeded by the lead "Do you think the mental health worker will...," as used by Lorion. In Form 2, the questions are preceeded by "Do you think the doctor will...," as used by Overall and Aronson and by Williams.

All other wording was identical.

Self administration form. As noted, examination of previous research indicates the need to explore differences between responses obtained through interview and those obtained by respondent self administration of the questionnaire. An additional version of the questionnaire was prepared, designed to make it possible to test for this difference. It altered the introductory statement and instructions so that the questionnaire could be self administered.

Question order. In order to test the effect of question order on responses, the questions were divided into three blocks. Versions of the questionnaire were prepared in which each block appeared in the

first, middle or final third of the questionnaire. These variations were presented in the "Self Administration" format, with the assumption that this method of administration would present the greater liklihood for an order effect.

Spanish translations. Spanish translations were prepared of the main questionnaire, for both Form 1 ("mental health worker") and Form 2 ("doctor"). Three native Spanish speaking students of Puerto Rican background were used as translators. The questions were first translated by one student and copies separately checked by the two others. Differences were then resolved in a meeting of all three translators, and the final version agreed upon.

Staff interview form. A final form of the questionnaire was prepared for the staff. The wording of the question lead was changed from "Do you think the doctor (or mental health worker) will..." to "Do you ordinarily...". Other than the change in lead, items were kept as close as possible to the original wording.

The questionnaire, in all its forms is included in the Appendix. Also included in the Appendix are the original questions of Overall and Aronson, the questionnaire used by Williams and that used by Lorion.

Interviewers. The author conducted 188 (56%) of the interviews. The remainder were conducted by 12 Pratt Institute Social Psychology student volunteers. The students were trained in the administration of the questionnaire, observed the interviewer during at least one interview andwere observed by the author during at least one interview.

Procedure

Prepatient interviews. All interviews were conducted at the main Maimonides Community Mental Health Center building. Interviewers waited in the main waiting room. Potential respondents were identified in one of two ways. "Walk-ins," with no appointment, were identified by the receiptionist after a search for medical record indicated either no previous record at the Center or termination of treatment. Those applicants for treatment who had made appointments by telephone, but who were not currently in treatment, were identified by the cashier. In a very few cases of obvious agitation, disorientation, intoxication or indications of volatility, applicants were not approached.

Requests for interviews were made in the following manner:

"Hello, I'm _____. I'm working with the research unit of the center. We are doing a survey, asking people questions which we hope will give us information which may be used to improve services here. The survey is voluntary, and you don't have to participate if you don't want to, but we would appreciate your cooperation."

When the interview was started further reassurance was offered with: "We don't take any names on this form. Any information you give is confidential and doesn't go to anyone else here."

Student interviews. Data concerning the effect of question order on responses and the effect of method of administration (self versus interview) were collected from the Pratt Institute student group.

The students were instructed to role play a visit to the Mental Health Center for help with an emotional problem. While data gathered from role playing is not completely satisfactory, there is evidence

that this technique can produce results comparable to those obtained under usual circumstances (Brown, 1965; Greenberg, 1967; Kelman, 1967; Ring, 1967).

CHAPTER V

RESULTS

Questionnaire

Previous researchers used two techniques to group the questions into dependent variables. The original Overall and Aronson studies and the Williams study used the questions divided into *a priori clusters*. Williams also performed a factor analysis to group the questions. Lorion used only a factor analysis derived grouping of questions. Both of these procedures were used in the present study. A factor analysis was performed in order to provide comparability with those studies using this technique, but the data were also analyzed in terms of the more easily interpretable clusters.

Clusters and Cluster Scores

Although Overall and Aronson and Williams used the questions divided into clusters as dependent variables, no reliability or internal consistency data were presented. In the present study, Chronbach's *Alpha* coefficient was used to examine the internal consistency of the question clusters. The final question clusters used in the analysis of the data and their corresponding *Alpha* coefficients are presented in Table 4.

Overall, *Alpha*'s are acceptable, with all coefficients above .5, except for the "Passive Therapist" cluster. Original *Alpha* for this cluster with all 5 items was .36. With question 19 removed, *Alpha*

Table 4

Clusters with Corresponding Alpha Coefficients

Clusters	Questions	Alpha
Do you think the doctor (mental health worker) will...		
1. Active Therapist (9 items)		.66
	4. ask you a lot of questions	
	10. tell you how to get along with people	
	11. tell you what is wrong with you	
	20. tell you ways to solve your problem	
	23. speak to those people who upset you	
	24. give you rules to follow	
	28. tell you what is wrong with what you do	
	34. tell you what causes your trouble	
	38. have a list he or she will want to check over	
2. Medical (12 items)		.80
	2. give you a physical examination	
	6. ask you about any oeprations you have had	
	7. give you medication	
	13. show particular interest in your aches and pains	
	14. take your pulse and blood pressure	
	16. tell you what kind of food you should eat	
	25. be interested in your digestion	
	32. ask what medicines you have been taking	
	35. ask what physical illnesses have been in your family	
	37. want to know what other doctors you have seen lately	
	41. ask you to describe the physical illnesses you have had	
	46. ask about how well you sleep	
3. Supportive Therapist (5 items)		.69
	8. try to get your mind off your troubles	
	18. avoid subjects which might upset you	
	21. want you to look at the bright side of things	
	26. try to cheer you up	
	27. sympathize with your problems	

Table 4 (continued)

Clusters	Questions	Alpha
Do you think the doctor (mental health worker) will...		
4. Passive Therapist[a] (4 items)		.44
	3. expect you to do most of the talking	
	22. listen more than he or she talks	
	29. remain silent when you have nothing to say	
	43. listen to your troubles	
5. Psychiatric-Psychological (12 items)		.85
	9. want you to talk about people who upset you	
	15. be interested in your childhood	
	30. ask questions about your personal life	
	31. want your opinions	
	33. want to know what kinds of things make you unhappy	
	36. want to know about your thoughts and feelings	
	39. want to know how happy you are	
	40. be interested in hearing any personal problems you have	
	42. want to know what your friends are like	
	44. be interested in knowing if some things make you afraid or nervous	
	45. ask about how well you get along with your family	
	47. ask about your sex life	
6. Treatment Duration (4 items)		.62
	1. expect you to come in even if you don't feel a need to see him or her	
	5. still be seeing you one year from now	
	12. still be treating you three months from now	
	17. still be treating you one month from now	

[a]With question 19, "want you to decide when you no longer need to come in," Alpha = .36

was raised to .44. Additional questions removed either produced no change or a reduced Alpha, and the cluster was left with four questions.

Following the scoring procedures used by Williams, a cluster score is calculated for each respondent for each cluster, based on the number of items agreed to in that cluster.

Factor Analysis and Factor Scores

The procedure used by the previous researchers for performing the factor analysis was followed. This procedure included two stages.

Percentages of agreement with each item, over the total sample, were first calculated. Only those questions with less than 90% agreement were included in the factor analysis. Table 5 presents the percentage of agreement data. The 13 items starred were not included in the factor analysis. These items are predominantly from the "Psychiatric-Psychological" cluster, indicating high levels of expectation for this content in mental health treatment. This finding corresponds to those of the previous researchers.

In the second stage, a factor analysis was performed on the remaining 34 questions. Following the procedures used by the previous researchers, a principal components factor analysis with normalized varimax rotation was utilized. The factor analysis produced seven factors which met the criterion of containing at least three questions loading above .40. The factors, the questions they contain and the factor loading for each question are presented in Table 6.

In order to compare the obtained factors with the original clusters and with the factors used by Williams and by Lorion, Pearson's correlation coefficients were calculated. Correlations between the factors

Table 5

Percentages of Agreement with Questionnaire Items

Question	Percent Agreement
Do you think the doctor (mental health worker) will...	
1. expect you to come in even when you don't feel a need to see him or her	66.4
2. give you a physical examination	36.4
3. expect you to do most of the talking	85.7
4. ask you a lot of questions	83.9
5. still be seeing you one year from now	48.1
6. ask you about any operations you have had	53.3
7. give you medication	59.5
8. try to get your mind off your trouble	70.4
9. want you to talk about people who upset you	90.5*
10. tell you how to get along with people	67.7
11. tell you what is wrong with you	64.0
12. still be treating you three months from now	80.6
13. be particularly interested in your aches and pains	51.7
14. take your pulse and blood pressure	39.5
15. be interested in what happened to you as a child	92.3*
16. tell you what kinds of food you should eat	32.2
17. still be treating you one month from now	87.9
18. avoid subjects which might upset you	27.3
19. want you to decide when you no longer need to come in to see him or her	53.5
20. tell you ways to solve your problem	73.9
21. want you to look at the bright side of things	82.8
22. listen more than he or she talks	82.0
23. speak to those people who make you upset	33.3
24. give you definite rules to follow	49.8
25. be interested in your digestion	32.5
26. try to cheer you up	66.8
27. sympathize wtih your problems	60.8
28. tell you what is wrong with what you do	74.0
29. be silent even when you have nothing to say	36.3
30. ask questions about your personal life	95.1*
31. want your opinions	88.1
32. ask what medicines you have been taking	90.2*
33. want to know what kinds of things make you unhappy	92.7*
34. tell you what is causing your trouble	74.5
35. ask what physical illnesses have been in your family	74.8
36. want to know about your thoughts and feelings	93.0*
37. want to know what other doctors you have seen lately	90.6*

Table 5 (continued)

	Question	Percent Agreement
38.	have a list of things he or she will want to check over	70.6
39.	want to know how happy you are	87.0
40.	be interested in hearing any personal problems you have	91.3*
41.	ask you to describe the physical illnesses you have had	71.9
42.	want to know what your friends are like	84.5
43.	listen to your troubles	94.1*
44.	be interested in knowing if some things make you afraid or nervous	99.0*
45.	ask about how well you get along with your family	95.1*
46.	ask about how well you sleep	95.8*
47.	ask about your sex life	91.2*

*Question not included in factor analysis

Table 6

Treatment Expectation Factors and Factor Loadings

Factor		Questions	Factor Loading
I	Medical		
	2.	give you a physical examination	.60
	6.	ask questions about any operations you have had	.64
	7.	give you medication	.45
	14.	take your pulse and blood pressure	.49
	25.	be interested in your digestion	.43
	35.	ask what physical illnesses have been in your family	.73
	41.	ask you to describe the physical illnesses you have had	.66
II	Treatment Duration		
	5.	still be seeing you one year from now	.45
	12.	still be treating you three months from now	.81
	17.	still be treating you one month from now	.65
III	Support		
	18.	avoid subjects which might upset you	.63
	26.	try to cheer you up	.50
	27.	sympathize with your problems	.76
IV	Diagnostic		
	11.	tell you what is wrong with you	.77
	24.	give you definite rules to follow	.46
	28.	tell you what is wrong with what you do	.56
	34.	tell you what is causing your trouble	.71

Table 6 (continued)

Factor	Questions	Factor Loading
V Active Therapist		
3.	expect you to do most of the talking	-.42
23.	speak to those people who make you upset	.73
38.	have a list of things he or she will want to check over	.46
VI Psychiatric-Psychological		
31.	want your opinions	.76
39.	want to know how happy you are	.41
42.	want to know what your friends are like	.63
VII Supportive-Optimistic		
8.	try to get your mind off your troubles	.77
10.	tell you how to get along with people	.45
20.	tell you ways to solve your problem	.51
21.	want you to look at the bright side of things	.58
26.	try to cheer you up	.43

Table 7

Correlations between Clusters and Present Factors

Present Factors	Clusters					
	Medical	Treatment Duration	Supportive Therapist	Active Therapist	Psychiatric Psycholog.	Treatment Duration
I Medical	.95	.13	.21	.32	-.09	.13
II Treatment Duration	.11	.93	.01	.00	.23	.93
III Supportive Therapist	.20	.05	.88	.38	.16	.05
IV Diagnostic	.32	-.02	.37	.87	-.04	-.02
V Active Therapist	.27	.01	.21	.47	-.02	.01
VI Psychiatric-Psychological	-.02	.14	.22	.17	.78	.14
VII Supportive Optimistic	.19	-.02	.83	.70	.24	-.02

and the clusters are presented in Table 7. Table 8 contains the correlations between the present factors and those used by Williams. Correlations between the present factors and those used by Lorion are presented in Table 9.

Factor I, Medical, is made up of only Medical cluster items and contains seven of the nine items in this cluster included in the factor analysis. The presence of only one predominantly medical factor is in contrast to the results of the previous factor analyses, both of which produced two medically related factors, although each was composed of different item combinations. A correlation of .95 between responses to this factor and to the medical cluster was obtained. The corrrelations are also high with both of the Williams medical factors (r's = .93 and .77) and with the Lorion "Medical Diagnosis" factor (r = .81)

The second factor, Treatment Duration, is made up only of items from this cluster and contains three of the original four items. Correlations with the Treatment Duration cluster and with the identical Lorion factor from which the cluster is derived is .93. This set of questions was added by Lorion and therefore there is no corresponding Williams factor.

Factor III, Supportive, is made up solely of Supportive Therapist cluster items, and contains three of the five cluster items included in the factor analysis. It is highly correlated (.88) with this cluster. The factor has only moderate correlation with any Williams factor (r = .67 with "Supportive-Optimistic) or with Lorion's supportive factors (r's = .55 and .52).

The fourth factor is made up only of items from the Active

Table 8

Correlation between Williams' Factors and Present Factors

Present Factors	Diagnostic	Somatic Illness	Active Medical	Supportive Optimistic	Active Guidance
I Medical	.25	.93	.77	.09	.13
II Treatment Duration	-.15	-.02	.00	-.01	.00
III Supportive Therapist	.16	.11	.41	.67	.38
IV Diagnostic	.84	.32	.47	.32	.61
V Active Therapist	.18	.32	.37	.18	.15
VI Psychiatric Psychological	.00	-.10	-.16	.33	.28
VII Supportive Optimistic	.37	.12	.26	.92	.76

Table 9

Correlations between Lorion Factors and Present Factors

Present Factors	Lorion Factors: Dynamic Orientation	Medical Diagnosis	Medical Support	Supportive Directive	Treatment Duration	Passive Therapy
I Medical	.09	.81	.64	.36	.16	.49
II Treatment Duration	.07	.17	.27	.15	.93	.25
III Supportive Therapist	.33	.10	.55	.52	.09	.18
IV Diagnostic	.06	.25	.47	.80	.22	.27
V Active Therapist	-.02	.45	.40	.20	.07	-.10
VI Psychiatric Psychological	.02	.12	.16	.18	.12	.06
VII Supportive Optimistic	.12	.17	.64	.78	.16	.15

Therapist cluster and contains four of the nine cluster items included in the factor analysis. The Active cluster yielded two factors in this analysis, as it did in the Williams analysis. This factor, which correlates .87 with the Active Therapist cluster, corresponds closely to the Williams "Diagnostic" factor (r = .84) and has been labeled Diagnostic. It is also closely related to the Lorion "Supportive Direction" factor (r = .80).

The fifth factor contains three items. Two are Active Therapist cluster items and the third is a negatively loaded item from the Passive Therapist cluster. It is labeled Active Therapist. Correlation between this factor and the cluster of the same name is only moderate, r = .47. It is not strongly correlated with any other cluster or with any factor from previous studies.

Factor VI contains the three items from the Psychiatric - Psychological cluster with less than 90% agreement, and which were therefore included in the factor analysis. This factor has been labeled Psychiatric - Psychological. Correlation with the cluster is .78. It has only low correlations with factors from previous studies.

The final factor, Factor VII, contains five items. Three of the items are from the Supportive cluster, the other two from the Active cluster. Correlation with the Supportive cluster is .83. This factor has three items in common with the Williams Supportive - Optimistic factor, and has been given the same designation. Correlation with the Williams factor is .92.

In summary, the factor analysis produced seven factors from the six clusters. With the exception of the Active Therapist cluster,

each cluster produced one factor with which it is strongly correlated. The Active Therapist cluster produced two factors. There is a strong correlation between the cluster and the second associated factor. The primary difference between the present factor analysis and previous ones is the failure of the medical cluster to produce two factors in this analysis, as it had done in the past.

There is no simple correspondence between the results of the present factor analysis and those of previous studies. Comparing the results with those of Williams, the present medical factor is strongly correlated with both of their medical factors, r = .93 and .77. The Diagnostic factor is close in both studies, r = .84, and the present Supportive-Optimistic factor is correlated .92 with their factor of the same name and with their Advice-Guidance factor, r = .76. The three remaining present factors have little in common with any Williams factor.

In the case of the Lorion factors, there are strong relationships between the present medical factor and his Medical Diagnosis factor, r = .81, and between his Supportive Direction factor and the present Diagnostic factor, r = .80. In addition, the correlation between his Supportive Direction factor and the present Supportive-Optimistic factor is .78, and the Treatment Duration factors are very similar, r = .93. The remaining three factors have no strong relationship to any Lorion factors.

In assessing the results of the factor analysis and its only partial correspondence with previous reports, it is important to note the disparities between the factors emerging from the two previous studies.

As indicated earlier, although Lorion states that his results "correspond closely to the factor solution reported by Williams et al." (Lorion, unpublished ditto), the correspondence seems moderate at best and no correlation coefficients are reported. Lorion's Passive Therapist and Dynamic Orientation factors correspond to nothing in Williams, whose Diganostic and Supportive-Optimistic factors have only small similarity to any in the Lorion result. Of the remaining three factors in each, there is similarity in that Medical mixed with Active Therapist cluster items appear in two of the Williams and all three of the Lorion factors.

The factor analysis presented here continues this trend. It shows only partial correspondence with previous results, but does bear similarity to each.

Once again relying on the scoring procedures established in previous research, a factor score is calculated for each respondent for each factor, based on the number of items answered in the direction of the factor loadings of items in the factor.

Statistical Treatment of the Data

A Multivariate Analysis of Variance (MANOVA) approach was followed in the great majority of the hypothesis tests to be presented. In each comparison an Analysis of Variance (ANOVA) is presented for each of the six clusters and seven factors used as dependent variables. In addition, however, an overall multivariate F is presented for the clusters taken as a whole and for the factors as a whole.

The multivariate technique permits a single statistical test of significance to be made across a group of dependent variables

simultaneously. In the case of the present data, separate MANOVA's must be conducted for the factors and the clusters because these two sets of variables are primarily composed of shared items.

Wilks' Criterion Exact F is the multivariate statistic used in the following data analyses.

The present research is not concerned only with the presence or absence of overall differences between groups. Each of the independent variables separately represents an area of expectation which is of interest. For this reason the separate analysis of variance for each variable will be examined even in the absence of overall significance on the multivariate level.

Question Order

Results of the multivariate analysis of variance for the effect of item position on the questionnaire are presented in Table 10. These data are based on student responses to self-administered forms. There are no significant overall effects for question order on either clusters or factors. In addition, there are no significant differences for any of the clusters or factors examined separately.

Examination of percentages of agreement with items presented in Table 5 indicates that 11 of the 13 items agreed to by 90% or more of the sample are in the final third of the questionnaire. Most of these items also produced high percentages of agreement in the Williams study, and were not included, for that reason, in the Lorion questionnaire. Since the question order followed in the present questionnaire contains the Lorion items first, then those additional items used by Williams and Overall and Aronson not previously included, these high

Table 10

Question Order Effects

MANOVA and ANOVA Tests

MANOVA for Clusters F (12,288) = 1.43 p = .15

MANOVA for Factors F (14,302) = 1.39 p = .15

Variable	Source	SS	MS	F	p
Clusters					
Active Therapist	Order [a]	25.52	12.76	2.57	.08
	Error [b]	738.42	4.96		
Medical	Order	17.08	8.54	1.35	.26
	Error	939.66	6.31		
Supportive Therapist	Order	5.99	2.99	1.36	.26
	Error	328.53	2.20		
Passive Therapist	Order	1.17	.58	.70	.50
	Error	125.04	.84		
Psychiatric-Psychological	Order	9.08	4.54	1.75	.18
	Error	386.78	2.59		
Treatment Duration	Order	1.84	.92	.57	.57
	Error	240.14	1.61		
Factors					
Medical	Order	9.05	4.52	1.35	.26
	Error	526.98	3.36		
Treatment Duration	Order	2.42	1.21	1.04	.36
	Error	182.96	1.16		
Supportive Therapist	Order	1.40	.70	.81	.45
	Error	135.57	.86		
Diagnostic	Order	7.53	3.77	2.01	.14
	Error	293.57	1.87		
Active Therapist	Order	2.78	1.39	2.10	.13
	Error	103.67	.66		
Psychiatric-Psychological	Order	1.15	.57	1.17	.31
	Error	76.75	.49		
Supportive-Optimistic	Order	3.46	1.73	.60	.55
	Error	453.98	2.89		

[a] df Order = 2

[b] df Error = 152

percentage of agreement questions are at the end of the questionnaire.

Results of the analysis of the effect of question order indicates that rates of agreement with these items does not vary with position of the item on the questionnaire, and therefore cannot be attributed to fatigue or to some other order effect.

Summary of Results on the Questionnaire

In summary, the 47 item questionnaire is divided into two groups of dependent variables for the purpose of hypothesis testing. Chronbach's Alpha coefficients indicate that the original a priori clusters are composed of items grouped in an internally consistent fashion. These clusters are also easily interpretable. The questionnaire items are also divided into seven empirically derived factors, following the techniques used by previous researchers. Multivariate analysis of variance indicates no significant effect of question order on either cluster scores or factor scores, individually or tested overall.

Replications of Previous Factor Analyses

Two additional factor analyses were performed in order to clarify the relationship between the particular items used and the factors which emerge. The input into the three factor analyses performed on versions of the questionnaire--the present analysis and those of Williams and Lorion--differ from one another in two important ways. First, different sets of questions are included in the matrices and second, different forms of wording of the lead were used. In an attempt to examine whether the emerging factors were specific to these combinations of wording and included items, separate factor analyses were performed for the questions used by Lorion with the lead he used

and for the questions and lead used by Williams.

Williams factor analysis replication. For the Williams replication, a factor analysis was performed on the 22 items he used, based only on those interviews using the "doctor" lead. The results of this factor analysis are presented in Table 11.

The replication factor analysis produced five factors meeting the criterion of at least three items with factor loadings of .40 and above, the same number of factors reported by the original authors. However, the factors differ in content. Table 12 contains the correlation matrix relating the original Williams factors to the replication factors.

The medical items remained together on the first factor, rather than dividing into two factors as they did in the original Williams study, and the first replication factor is a single medical factor similar to that produced in the factor analysis based on all interviews. Like that factor, it is highly correlated with the Williams "History of Somatic Illness," r = .91, and "Active Medical," r = .82, factors.

The second replication factor contains items in common with present Factor III, Supportive Therapist, and like that factor is moderately correlated with the Williams factor of the same name.

The third replication factor is similar to the present Factor VII, labeled Supportive-Optimistic and like that factor is strongly correlated with Williams' factor of the same name, r = .85, and with their Advice-Guidance factor, r = .79.

The fourth replication factor, like present Factor IV, is similar to the Williams Diagnostic factor, r = .86.

The fifth factor which emerges bears no particular resemblance to

Table 11

Williams Replication Factor Analysis

Factor and Item	Loading	Williams Factor	Present Factor
Do you think the doctor will...			
Factor 1			
2. give you a physical examination	.78	Act. Med.	I Medical
6. ask questions about any operations you have had	.47	Hist Som.	I Medical
7. give you medication	.43	"	"
13. be particularly interested in your aches and pains	.63	"	-
14. take your pulse and blood pressure	.83	Act. Med.	I Medical
16. tell you what kinds of food you should eat	.74	"	-
25. be interested in your digestion	.78	H.S. Ill.	"
35. ask you what physical illnesses have been in your family	.49	"	"
Factor 2			
24. give you definite rules to follow	.44	Act. Med.	IV Diag.
26. try to cheer you up	.81	Sup-Opt.	III Sup.
27. sympathize with your problems		-	"
Factor 3			
8. try to get your mind off your troubles	.85	Sup-Opt.	VII Sup-Opt
10. tell you how to get along with people	.75	Adv-Guid	"
20. tell you ways to solve your problem	.52	"	"
21. want you to look at the bright side of things	.42	Sup-Opt.	"
Factor 4			
11. tell you what is wrong with you	.69	Diag.	IV Diag.
34. tell you what is causing your trouble	.85	"	"
38. have a list of things to check over	.48	-	V Act.Ther.
Factor 5			
4. ask you a lot of questions	.73	Diag.	-
7. give you medication	.57	H.S. Ill.	I Medical
42. want to know what your friends are like	.60	-	VI Psych

Table 12

Correlation between Original Williams Factors and Present "Williams Replication Factors"

Original Williams Factors	Williams Replication Factors				
	1	2	3	4	5
I Diagnostic	.28	.30	.36	.86	.42
II History of Somatic Illness	.91	.20	.12	.31	.37
III Active Medical	.82	.49	.22	.36	.25
IV Supportive Optimistic	.09	.64	.85	.31	.27
V Advice Guidance	.15	.39	.79	.42	.31

any single factor from the Williams study.

Lorion factor analysis replication. The Lorion replication, containing only the 29 questions he included in his factor analysis and performed only on those interviews using the "mental health worker" lead, produced a factor analysis with important similarities to his original pattern of factors. The factors, items and factor loadings are presented in Table 13. Correlations between the replication factors and Lorion's original factors are presented in Table 14.

Six factors emerged with 3 or more items loading above .40, the smae number reported by Lorion. Of these, the first, as in the case of the two analyses discussed, is composed primarily of medical items but contains items from other factors as well. The correlation with Lorion's Medical Support factor is .78.

Factors 2, 3 and 4 have great similarity to Lorion's original factors. The second factor contains five items, all from his ten item "Supportive Direction" factor. It is highly correlated with this factor, $r = .92$. The third factor also bears close resemblance to a Lorion factor. It contains three of his four "Medical Diagnosis" items and, it should be noted, corresponds to no factor from the present factor analysis based on all questionnaires. Correlation between the two factors is .81. The fourth factor in the Lorion replication is a Treatment Duration factor. It is interesting that this factor contains all of the four original questions in Lorion's factor, only three of which combined to form the present Factor III. The remaining two factors are not similar to any of those Lorion reported. The fifth is similar to present Factor III, Supportive Therapist, and like that factor bears moderate correspondence

Table 13

Lorion Replication Factor Analysis

Factor and Item	Loading	Lorion Factor	Present Factor
Do you think the mental health worker will...			
Factor 1			
2. give you a physical examination	.43	Med Diag	I Medical
7. give you medication	.55	Med Supp	"
13. be particularly interested in your aches and pains	.48	Supp Dir	-
14. take your pulse and blood pressure	.72	Med Diag	I Medical
16. tell you what kind of food you should eat	.62	Med Supp	-
18. avoid subjects which might upset you	.67	Dyn Orient	-
24. give you definite rules to follow	.49	Supp Dir	IV Diagnostic
25. be interested in your digestion	.76	Med Supp	I Medical
27. sympathize with your problems	.59	-	III Support
Factor 2			
10. tell you how to get along with people	.40	Supp Dir	VII Supp Opt
11. tell you what is wrong with you	.75	"	IV Diagnostic
20. tell you ways to solve your problem	.63	"	VII Supp Opt
26. try to cheer you up	.43	"	"
28. tell you what is wrong with what you do	.80	"	IV Diagnostic
Factor 3			
2. give you a physical examination	.61	Med Diag	I Medical
6. ask you about any operations you have had	.87	"	"
13. be particularly interested in your aches and pains	.52	Supp Dir	-
23. speak to those people who make you upset	.60	Med Diag	V Active Ther
29. be silent even when you have nothing to say	.51	Pass Ther	-

Table 13 (continued)

Factor and Item	Loading	Lorion Factor	Present Factor
Do you think the mental health worker will...			
Factor 4			
1. expect you to come in even when you don't feel a need to see him or her	.48	Treat Dur	-
5. still be seeing you one year from now	.52	"	Treat Dur
12. still be treating you three months from now	.77	"	"
17. still be treating you one month from now	.70	"	"
Factor 5			
8. try to get your mind off your trouble	.60	Supp Dir	III Supp
21. want you to look at the bright side of things	.44	Med Supp	Iv Supp Opt
26. try to cheer you up	.79	"	III Supp
Factor 6			
3. expect you to do most of the talking	.50	Pass Ther	V Act Ther(-)
9. want you to talk about people who upset you	.52	Dyn Orient	-
22. listen more than he or she talks	.77	Pass Ther	-

Table 14

Correlation Between Original Lorion Factors and Present Replication Lorion Factors

Original Lorion Factor	Present Replication Lorion Factors					
	1	2	3	4	5	6
I Dynamic Orientation	.16	.14	.07	.03	.11	.34
II Medical Diagnostic	.62	.16	.81	.20	.17	-.03
III Medical Support	.78	.54	.49	.28	.63	-.04
IV Supportive Directive	.56	.92	.33	.11	.70	.09
V Treatment Duration	.18	.31	.16	1.00	.13	.05
VI Passive Therapist	.55	.23	.58	.25	.21	.51

with Lorion's "Medical Support," r = .63, and "Supportive-Directive" factors, r = .70. The sixth factor has little correspondence with a factor from either analysis.

Replication--Social Class Differences on Williams Factors

Hypothesis 6 predicts that using the items grouped into the Williams factors will produce their results. Social class differences were therefore examined on the items grouped into the factors they used. A summary of the overall MANOVAs and of the separate ANOVA for each factor and cluster are presented in Table 15. The complete ANOVA tables are presented in the Appendix.

The multivariate F indicates an overall significant social class difference effect. Although no multivariate statistics are used in the original study, the overall significant F supports the authors conclusions of social class differences on their factors.

Results for the factors individually considered, however, are not the same. The differences here are confined to the six items forming the Supportive-Optimistic and Advice-Guidance factors, and do not include the medically oriented items which produced differences in the original study.

Results on the first factor correspond to those reported by Williams. There were no social class differences in response to their "Diagnostic" items. This group of questions was not associated with social class differences in the original report.

Differences between the present results and those reported for the original study emerge in the next two groups of questions. The

Table 15

F Tests for Replication of Social Class Differences on the Williams Factors and Lorion Factors

Variable	F	p
Williams et al. Factors		
Overall MANOVA	F (10,308) = 1.97* [a]	.01
Diagnostic	2.25	.11
History of Somatic Illness	2.68	.07
Active Medical	1.34*	.26
Supportive-Optimistic	3.34*	.04
Advice Guidance	6.49**	.01
Lorion Factors		
Overall MANOVA	F (12,304) = 1.07 [b]	.39
Dynamic Orientation	2.69	.07
Medical Diagnosis	1.43	.24
Medical Support	1.27	.28
Supportive Direction	3.16*	.04
Treatment Duration	1.51	.22
Passive Therapist	1.37	.26

[a] df for all Williams factors = 2,165

[b] df for all Lorion factors = 2,154

* $p < .05$

** $p < .01$

second and third factors, made up of medically related items and designated "History of Somatic Illness" and "Active Medical," failed to produce social class differences among the respondents in the present sample, although Williams reports significant social class differences on these question groups.

The results on the last two of the Williams factors, Supportive Optimistic and Advice-Guidance, are the same as those of the previous report. In both studies there are significant social class differences on both of these factors.

Replication--Social Class Differences on the Lorion Factors

An examination of social class differences in response to the items grouped into the Lorion factors was also conducted. The summary of the results of the overall mulitvariate F for social class differences as well as the F and its significance for each factor is presented in Table 15. The complete ANOVA tables are presented in the Appendix.

The results of the MANOVA confirm the Lorion conclusion thatthere are no overall social class differences on the items in the questionnaire divided into the factors he used as dependent variables. This finding, as he states, is in contrast to the findings of the Williams study, which used a somewhat different set of dependent variables.

The present results, however, do not indicate that there are no differences on any of the Lorion factors, and in this way differ from his report. Lorion did not base his conclusion of no social class differences on a single overall multivariate statistic, but rather performed an analysis of variance for each factor, reporting no significant differences on any of them. Such examination of the present

data indicates a significant social class difference on his first factor, Supportive-Direction.

The combination of a significant social class difference on the Supportive-Direction factor in the context of the overall nonsignificant MANOVA is interesting. The result for the single factor is compatible with the results of the Williams et al. replication. The Supportive-Direction factor includes all of the items on the Williams Supportive-Optimistic and Advice-Guidance factors. These are the factors that produced social class differences in that replication. It should also be noted that although Lorion reported that there were no significant main effects for social class, he also examined interactions between class and sex. The Supportive-Direction factor was the only variable to produce a significant difference, which was in the form of a significant sex-class interaction. In spite of the finding of a significant social class difference on a Lorion factor, the overall F's support the differing conclusions of the previous authors with respect to social class differences.

Hypothesis 6, therefore, is confirmed by the results of the multivariate analysis. Each author's question grouping reproduces their results. Responses to particular factors, however, do not reproduce the resulting previous studies.

Main Hypotheses

Table 16 presents the results of the overall MANOVA tests of significance for the effects of social class, ethnicity, form and their interactions on prepatient responses to the clusters and factors. Mean scores for each group on each variable are presented in Appendix C.

Table 16

MANOVA Tests on Clusters and Factors for Effects of Form, Class, and Ethnicity

Source of Variation	F(df)	p
Clusters		
Form	F (6,276) = 2.47*	.03
Class	F (12,552) = 2.41**	.006
Ethnicity	F (12,552) = 1.82*	.05
Form X Class	F (12,552) = .64	.81
Form X Ethnicity	F (12,552) = 1.18	.30
Class X Ethnicity	F (12,964) = 1.32	.15
Form X Class X Ethnicity	F (24,964) = 1.42	.09
Factors		
Form	F (7,284) = 1.29	.26
Class	F (14,568) = 2.08**	.01
Ethnicity	F (14,568) = 1.39	.16
Form X Class	F (14,568) = .94	.52
Form X Ethnicity	F (14,568) = .88	.58
Class X Ethnicity	F (28,1025)= 1.15	.28
Form X Class X Ethnicity	F (28,1025)= 1.13	.29

* $p < .05$
** $p < .01$

There are significant main effects for social class, ethnic and form differences on responses to the clusters, with no significant interactions between variables. There are significant social class differences in response to the factors, but no significant ethnic, form or interaction effects.

The presence of social class differences in response to treatment expectation factors and clusters is in agreement with the results of Overall and Aronson and with those of Williams et al. The results do not support the failure to find class differences reported by Lorion.

Social class. Hypothesis 1A, predicting overall social class differences in response to the clusters and factors, is supported by the MANOVA results. Separate ANOVAs for each cluster and for each factor are presented in Table 17.

Examination of these separate ANOVAs indicates significant social class differences in scores on the Active Therapist cluster, on the Supportive Therapist cluster, and on Factor IV, Diagnostic and Factor VII, Supportive Optimistic. These factors and clusters are composed of two pairs of question groups. One pair of question groups is made up of the highly correlated Active Therapist cluster and Factor IV, Diagnostic. The other pair is made up of the Supportive Therapist cluster and the factor highly correlated with it, Factor VII, Supportive-Optimistic.

The Active Therapist and Diagnostic variables are composed of items which tap expectations that the therapist will be expert and informative about the nature of the presenting problem, its causes and the necessary course of treatment. The Supportive items indicate an expectation that

Table 17
Analyses of Variance Tables for Effects of Form, Class, and Ethnicity, on Clusters

Active Therapist Cluster

Source	df	SS	MS	F	p
Model	17	217.47	12.79	1.14	.33
Error	281	3153.38	11.22		
Total	298	3370.86			
Form	1	.34		.03	.87
Class	2	81.25		3.62*	.03
Ethnic.	2	13.47		.60	.55
Cl/F	2	18.18		.81	.45
E/F	2	7.63		.34	.71
Cl/E	4	47.58		1.06	.38
Cl/E/F	4	39.05		.87	.49

Medical Cluster

Source	df	SS	MS	F	p
Model	17	555.15	32.656	1.34	.18
Error	281	6847.94	24.37		
Total	298	7403.09			
Form	1	101.38		4.16*	.04
Class	2	82.86		1.70	.19
Ethnic.	2	51.18		1.05	.35
Cl/F	2	8.77		.18	.83
E/F	2	100.89		2.07	.13
CL/E	4	219.33		2.25	.07
CL/E/F	4	152.02		1.58	.18

* p .05

Table 17 (continued)

Supportive Therapist Cluster

Source	df	SS	MS	F	p
Model	17	95.51	5.62	1.08	.38
Error	281	1461.84	5.20		
Total	298	1557.35			
Form	1	5.20		.27	.61
Class	2	36.62		3.52*	.03
Ethnic.	2	3.54		.34	.71
Cl/F	2	3.54		.34	.71
E/F	2	5.10		.49	.61
Cl/E	4	8.11		.39	.82
Cl/E/F	4	15.19		.73	.57

Passive Therapist Cluster

Source	df	SS	MS	F	p
Model	17	20.19	1.19	.70	.79
Error	281	496.79	1.69		
Total	298	496.98			
Form	1	4.85		2.86	.09
Class	2	1.70		.50	.60
Ethnic.	2	4.72		1.39	.25
Cl/F	2	.47		.14	.87
E/F	2	3.94		1.16	.32
Cl/E	4	3.32		.49	.74
Cl/E/F	4	2.44		.36	.83

* p .05

Table 17 (continued)

Psychiatric Cluster

Source	df	SS	MS	F	p
Model	17	128.49	7.56	.77	.72
Error	281	2758.23	9.82		
Total	298	2886.72			
Form	1	31.41		3.20	.07
Class	2	10.99		.56	.57
Ethnic.	2	22.38		1.14	.32
Cl/F	2	6.48		.33	.72
E/F	2	5.69		.29	.74
Cl/E	4	35.37		.90	.46
Cl/E/F	4	13.35		.34	.84

Treatment Duration Cluster

Source	df	SS	MS	F	p
Model	17	72.38	4.26	1.92*	.02
Error	281	623.13	2.22		
Total	298	695.51			
Form	1	.27		.12	.72
Class	2	10.69		2.41	.09
Ethnic.	2	5.10		1.15	.31
Cl/F	2	8.07		1.82	.16
Eth/F	2	.44		.10	.90
Cl/E	4	33.79		3.81**	.006
Cl/E/F	4	24.04		2.71*	.03

* p .05

**p .01

Table 17 (Continued)

Analyses of Variance Tables for Effects of Form, Class and Ethnicity on Factors

Factor I - Medical

Source	df	SS	MS	F	p
Model	17	299.68	17.63	1.18	.29
Error	281	4197.93	14.94		
Total	298	4497.62			
Form	1	30.77		2.06	.15
Class	2	69.92		2.34	.10
Ethnic.	2	23.30		.78	.45
Cl/F	2	26.89		.90	.41
E/F	2	61.55		2.06	.13
Cl/E	4	72.31		1.21	.31
Cl/E/F	4	106.37		1.78	.14

Table 17 (continued)

Factor II - Treatment Duration

Source	df	SS	MS	F	p
Model	17	42.29	2.49	1.96*	.02
Error	281	356.68	1.27		
Total	298	298.97			
Form	1	1.26		.99	.32
Class	2	6.42		2.53	.08
Ethnicity	2	1.50		.59	.55
Class/Form	2	5.64		2.22	.11
Ethnicity/Form	2	.79		.31	.73
Class/Ethnicity	4	24.77		4.88***	.001
Class/Form/Ethnicity	4	9.85		1.94	.11

Factor III - Supportive

Source	df	SS	MS	F	p
Model	17	45.14	2.65	1.14	.32
Error	281	654.50	2.33		
Total	298	699.54			
Form	1	.77		.33	.56
Class	2	27.81		5.97**	.003
Ethnicity	2	1.35		.29	.74
Class/Form	2	1.21		.26	.77
Ethnicity/Form	2	1.96		.42	.65
Class/Ethnicity	4	2.24		.24	.91
Class/Ethnicity/Form	4	4.47		.48	.75

* p .05
** p .01
*** p .001

Table 17 (continued)

Factor IV - Diagnostic

Source	df	SS	MS	F	p
Model	17	77.60	4.56	1.40	.15
Error	281	916.21	3.26		
Total	298	993.81			
Form	1	.03		.01	.91
Class	2	20.99		3.22*	.04
Ethnicity	2	.98		.15	.86
Cl x Form	2	10.24		1.57	.21
Eth x Form	2	4.17		.64	.53
Cl x Eth	4	6.52		.53	.71
Cl x Eth x F	4	24.52		1.88	.12

Factor V - Active Therapist

Source	df	SS	MS	F	p
Model	17	22.29	1.31	1.01	.45
Error	281	377.84	1.30		
Total	298	400.13			
Form	1	1.40		1.08	.30
Class	2	3.04		1.17	.31
Ethnicity	2	8.28		3.19*	.04
Cl x F	2	.49		.19	.83
Eth x F	2	2.83		1.09	.34
CL x Eth	4	3.32		.64	.64
CL x Eth x F	4	6.08		1.17	.33

* p .05

Table 17 (continued)

Factor VI - Psychiatric - Psychological

Source	df	SS	MS	F	p
Model	17	13.90	.82	.99	.48
Error	281	232.07	.83		
Total	298	245.97			
Form	1	1.86		2.25	.14
Class	2	.76		.46	.63
Ethnicity	2	2.07		1.25	.29
Cl x Form	2	2.08		1.26	.29
Eth x Form	2	.10		.06	.96
Cl x Eth	4	1.39		.42	.79
Cl x Eth x F	4	1.29		.39	.81

Factor VII - Supportive - Optimistic

Source	df	SS	MS	F	p
Model	17	116.27	6.84	1.58	.08
Error	281	1216.38	4.33		
Total	298	1332.66			
Form	1	2.08		.48	.49
Class	2	37.99		4.39**	.01
Ethnicity	2	6.15		.71	.49
Cl x Form	2	5.71		.66	.52
Eth x Form	2	12.55		1.45	.24
Cl x Eth	4	10.91		.63	.64
CL x Eth x F	4	10.56		.61	.66

this knowledge and direction will be delivered in a sympathetic manner and with reduction of the patients' anxiety as a goal.

There is also a significant two-way interaction effect between class and ethnicity on both the Treatment Duration cluster and factor, and a significant three-way interaction effect between class, ethnicity and form on the cluster.

On the factor, the class-ethnicity interaction is due to the expectation of a very short course of treatment among Class 1, 2 and 3 Hispanics, $\underline{M}$ = 1.94, compared with the overall cluster mean of 2.18 and the expectation of a long course of treatment by class 1, 2 and 3 Jewish respondents, $\underline{M}$ = 2.72. The results for the cluster are similar, but the pattern is more extreme on the "mental health worker" form. On this form, the Class 1, 2 and 3 Hispanic respondents have a mean score of 1.30 and the Class 1, 2 and 3 Jewish prepatients, a mean score of 3.86. Responses to the "doctor" questionnaire for this cluster have much smaller differences among subgroups.

The absence of social class differences in response to the other factors and clusters provides support for Lorion's failure to find these differences in items about medical expectations, expectations about the psychological content of the treatment process, and about the patients' responsibility in exploration and discussion of issues.

Differences between Class 5 and other prepatients. Hypothesis 1B predicts that those social class differences found are primarily a function of differences between Class 5 prepatients and all others. Table 18 presents the results of MANOVA tests on Class 5 prepatients compared to all others, as well as MANOVA's for other social

Table 18

MANOVA Results for Comparisons
Between Social Classes

Comparison	Clusters F(df)	p	Factors F(df)	p
Class 5 With All Others	F(6,306) = 1.63	.14	F(7,306) + 2.74**	.01
Class 5 With Class 4	F(6,205) = 1.39	.23	F(7,205) = 2.48*	.02
Class 5 With Class 1,2,3	F(6,190) = .16	.16	F(7,190) = 2.29*	.03
Class 4 With All Others	F(6,306) = .87	.52	F(7,306) = 1.13	.35
Class 4 With Class 1,2,3	F(6,209) = .91	.49	F(7,209) = .81	.58
Class 1,2,3 With All Others	F(6,306) = 1.39	.22	F(7,306) = 1.62	.13

*p .05

**p .01

class comparisons. The results indicate that for the factors, the social class differences are primarily attributable to differences between Class 5 prepatients and others. There are significant differences between the Class 5 prepatients and all others, whether the comparisons are with the other class groups combined or with each separately. These results support Hypothesis 1B. Overall social class effects on the clusters, however, are not attributable to specific subgroup differences.

Separate ANOVAs for those clusters and factors for which there were social class differences are presented in Table 19. ANOVAs for the remaining clusters and factors are included in the Appendix.

Social class differences in response to the Active Therapist cluster are a function of differences between Class 5 and all others. Specific differences between Class 5 and Class 1, 2 and 3 are significant, while differences between Class 5 and Class 4 do not attain significance. The difference is attributable to the greater expectation for therapist activity among Class 5 prepatients. Means for the subgroups on these variables are presented in Table 20.

Social class differences in response to the Supportive Therapist cluster are exclusively a function of differences between Class 5 prepatients and others, whether compared as a whole or in separate comparisons. Means for the subgroups indicate a greater expectation of supportive therapist activity among Class 5 prepatients.

Social class differences in response to Factor IV, Diagnostic, do not show a pattern interpretable as due to differences between Class 5 and all others. The differences between Class 5 and all others combined does not reach significance, nor does the difference between Class 5

Table 19

ANOVA Results of Social Class Comparisons on Those Factors and Clusters With Significant Social Class Differences

Active Therapist Cluster

Comparison	Source	df	SS	MS	F	p
Class 5 with Others	Class	1	16.44	16.44	3.80*	.05
	Error	312	1350.96	4.33		
Class 5 with 4	Class	1	13.82	13.82	3.33	.07
	Error	213	883.95	4.15		
Class 5 with 123	Class	1	15.59	15.59	3.85*	.05
	Error	196	793.76	4.05		
Class 4 with Others	Class	1	4.35	4.35	1.00	.32
	Error	312	1354.08	4.34		
Class 4 with 123	Class	1	.44	.44	.10	.76
	Error	215	986.85	4.59		
Class 123 with Others	Class	1	6.77	6.77	1.56	.21
	Error	312	1352.09	4.33		

*p .05

Table 19 (continued)

Supportive Therapist Cluster

Comparison	Source	df	SS	MS	F	p
Class 5 with Others	Class	1	9.30	9.30	9.19**	.003
	Error	312	318.24	1.02		
Class 5 with 4	Class	1	8.25	8.25	3.99*	.05
	Error	213	440.91	2.07		
Class 5 with 123	Class	1	13.41	13.41	6.19**	.01
	Error	196	423.35	2.16		
Class 4 with Others	Class	1	1.59	1.59	.75	.39
	Error	312	661.44	2.12		
Class 4 with 123	Class	1	1.31	1.31	.68	.41
	Error	215	414.97	1.93		
Class 123 with Others	Class	1	7.34	7.34	3.50	.06
	Error	312	652.08	2.09		

*p .05

**p .01

Table 19 (continued)

Factor IV - Diagnostic

Comparison	Source	df	SS	MS	F	p
Class 5 with Others	Class	1	4.44	4.44	2.96	.09
	Error	312	468.07	1.50		
Class 5 with 4	Class	1	4.93	3.93	3.76*	.05
	Error	213	279.04	1.31		
Class 5 with 123	Class	1	4.13	4.13	2.76	.10
	Error	196	292.04	1.49		
Class 4 with Others	Class	1	2.18	2.18	1.48	.23
	Error	312	461.76	1.48		
Class 4 with 123	Class	1	.01	.01	.01[a]	.96
	Error	215	328.95	1.53		
Class 123 with Others	Class	1	1.41	1.41	196[b]	
	Error	312	455.52	1.46		

[a] There was a significant Class by Form interaction in this comparison.

($F(1,215) = 7.64$; $p = .007$)

[b] There was a significant Class by Form interaction in this comparison.

($F(1,312) = 6.21$; $p = .01$)

* p .05

Table 19 (continued)

Factor VII - Supportive-Optimistic

Comparison	Source	df	SS	MS	F	p
Class 5 with Others	Class	1	9.49	9.49	4.87*	.03
	Error	312	608.40	1.95		
Class 5 with 4	Class	1	4.17	4.17	2.60[a]	.11
	Error	213	342.93	1.61		
Class 5 with 123	Class	1	14.84	14.84	7.10**	.01
	Error	196	409.64	2.09		
Class 4 with Others	Class	1	.03	.03	.02	.89
	Error	312	627.12	2.01		
Class 4 with 123	Class	1	4.33	4.33	2.02	.16
	Error	215	460.08	2.14		
Class 123 with Others	Class	1	12.01	12.01	6.10**	.01
	Error	312	614.64	1.97		

[a] There was a significant Class by Form interaction in this comparison.

(F (1,213) = 4.85; Pr F = .03)

* p .05

** p .01

and Class 1, 2 and 3 prepatients. There is, however, a significant difference between Class 5 and Class 4 prepatients, with Class 5 prepatients expecting more diagnostic activity from the treatment staff. This factor also produces interaction effects between class and form, in comparisons involving Class 1, 2 and 3 prepatients and all others and Class 1, 2 and 3 prepatients and those from Class 4. Examination of means indicates that on the "mental health worker" form, Class 1, 2 and 3 respondents express expectations for a greater degree of diagnostic activity than do others. On the "doctor" form, on the other hand, there are no differences between respondents from Class 1, 2 and 3 and those from Class 5, but Class 4 prepatients expect more diagnostic activity than the other groups do.

The remaining variable which shows social class differences is Factor VII, Supportive-Optimistic. Examination of separate ANOVAs indicates that the differences are due not only to differences between Class 5 and all others, but also between Class 1, 2 and 3 and all others and specifically between Class 5 and Class 1, 2 and 3. Examination of the means indicates the greatest expectation for Supportive-Optimistic treatment among Class 5 prepatients, $\underline{M} = 4.08$, and the least such expectation among Class 1, 2 and 3 prepatients, $\underline{M} = 3.10$. Class 4 prepatients are intermediate between the two, $\underline{M} = 3.72$.

There is also a significant class by form interaction in the comparison between Class 5 and Class 4 responses. This effect is attributable to a lack of difference between the social class groups on the "mental health worker" form ($\underline{M}$ Class 4 = 4.11, $\underline{M}$ Class 5 = 4.13) but the presence of a disparity between the groups on the "doctor" form

Table 20

Mean Factor and Cluster Scores of Prepatients by Social Class

Variable	Class 1,2,3[a]	Class 4[b]	Class 5[c]
Clusters			
Active Therapist*	5.59	5.94	6.57
Medical	7.31	6.79	7.85
Supportive Therapist*	2.63	2.89	3.52
Passive Therapist	2.90	2.97	3.00
Psychiatric-Psychological	10.79	10.77	10.96
Treatment Duration	2.79	2.75	2.92
Factors			
Medical	4.10	3.47	4.11
Treatment Duration	2.11	2.14	2.23
Supportive Therapist	1.15	1.14	1.92
Diagnostic*	2.57	2.65	3.20
Active Therapist	1.25	1.07	1.24
Psychiatric-Psychological	2.52	2.68	2.50
Supportive Optimistic*	3.10	3.72	4.08

* Variables with significant social class differences.

a n=107

b n=113

c n=104

(M Class 4 = 3.05, M Class 5 = 4.04).

In summary, Hypothesis 1B is partially supported. Social class differences found on the clusters are attributable to differences in expectations between Class 5 prepatients and others. The picture for the factors, however, is more complex. Responses to Factor IV, Diagnostic, do not show a pattern attributable to specific subgroup differences. Responses to Factor VII, Supportive-Optimistic, show significant differences attributable not only to differences between Class 5 and others, but also to differences in expectation between Class 1, 2 and 3 and others.

Ethnicity. The MANOVA results in Table 17 indicate significant ethnic differences in response to the clusters, but no significant ethnic differences in overall responses to the factors. Hypothesis 2A, predicting ethnic differences in expectations about mental health treatment is supported by one set of variables but is not confirmed by the other set.

Examination of the separate ANOVA for each cluster presented in Table 18 indicates that although the overall F is significant for the effect of ethnicity on cluster responses, no single cluster evidences a significant main effect for ethnicity. The Treatment Duration cluster, however, does show a significant two-way interaction between class and ethnicity and a significant three-way interaction between class ethnicity and form, as previously discussed.

On the other hand, while there is no significant overall effect for ethnicity on the factors, Factor V, Active Therapist, does show a significant main effect for ethnicity.

Inspection of the means shows Jewish prepatients with greatest expectation of therapist activity $\underline{M}$ = 1.42, "Other" prepatients with the lowest such expectation $\underline{M}$ - 1.06, and Hispanic prepatients intermediate between the two, $\underline{M}$ = 1.18.

In addition to the general hypothesis about ethnic differences, two specific hypotheses were proposed about ethnic differences. These hypotheses are tested in two ways. First, to provide consistency with the general data analysis approach, an analysis of variance was performed on the specified variables, with a multivariate analysis of variance for the remaining variables. These results are presented in Table 21.

A second analysis was performed on the data relevant to these particular hypotheses. Each hypothesis is directional, predicting higher psychological expectations for the Jewish respondents and higher medical expectations for the Hispanic respondents. In order to further examine these directional hypotheses, one-tailed $\underline{t}$ tests were performed on the designated variables. These results are presented after the analysis of variance results.

Hypothesis 2B predicts that there will be significant differences between Jewish and non-Jewish prepatients on those factors and clusters measuring expectations about psychiatric - psychological content in mental health treatment. ANOVA results, presented in Table 21, show no significant differences between Jewish and non-Jewish prepatients on the relevant cluster or factor. Multivariate comparisons between the groups on the remaining clusters and factors fo not show significant ethnic differences. Examination of the separate ANOVA results presented

Table 21

MANOVA and ANOVA Results for Ethnic Comparisons

Variable	F(df)	p
Jewish Prepatients Compared with All Others		
Psychiatric-Psychological, Cluster	F(1,305) = .92	.34
Psychiatric-Psychological, Factor	F(1,305) = 1.06	.30
Remaining Clusters - MANOVA	F(5,304) = .25	.94
Remaining Factors - MANOVA	F(6,304) = 1.03	.41
Hispanic Prepatients Compared with All Others		
Medical Cluster	F(1,305) = .82	.36
Medical Factor	F(1,305) = 1.59	.21
Remaining Clusters - MANOVA	F(5,304) = 1.20	.31
Remaining Factors - MANOVA	F(6,304) = .45	.84

in the Appendix indicates that the previously discussed ethnic difference obtained in the responses to the Active Therapist factor is attributable to the difference between Jewish respondents and all others, F (1,304) = 4.43, p .05, with greater Jewish expectation of therapist activity.

Hypothesis 2C proposes a significant difference between Hispanic and non-Hispanic respondents in response to those cluster and factor items reflecting medical expectations. Examination of the results presented in Table 21 indicates that the hypothesis is not confirmed. There are no differences between Hispanic prepatients and others in response to the medically related variables. There are also no significant differences in overall response to the remaining clusters and factors. Examination of the separate ANOVA results in the Appendix shows no significant difference, on any cluster or factor, between Hispanic respondents and any others.

Results of the one-tailed t tests also show no significant ethnic effects in the predicted directions. There is no significant difference between Jewish respondents and others in the predicted direction on the Psychiatric-Psychological cluster, t (322) = .70, p = .25, or on the corresponding factor, t (322) = 1.39, p = .09.

There are also no significant differences in the predicted direction between Hispanic prepatients and others on the Medical cluster, t (328) = .65, p = .26, or on the Medical factor, t (328) = -.32, p = .37

Other demographic characteristics. Multivariate analyses of variance were performed to examine the effects of prepatient age, sex, marital status and self-reported previous experience with mental health

treatment on responses to the factors and clusters. Data on the variables, including both overall MANOVA F ratios for clusters and factors as well as separate F ratios for each cluster and factor are presented in Table 22.

The MANOVA results yield significant differences for the effects of respondent self-reported previous treatment experience on overall responses to both the clusters and the factors. Examination of the separate ANOVA results indicates significant effects for previous experience on the Active Therapist cluster, on the Passive Therapist cluster, on the Psychiatric-Psychological cluster, and on the Treatment Duration cluster.

There are also significant effects on the Treatment Duration factor, and on Factor IV, Diagnostic.

Table 23 presents the cluster and factor means for prepatients with and without self-reported treatment experience. The data indicate that those respondents reporting previous experience expect less activity from the treatment staff than those without experience do.

The experienced prepatients also expect a longer period of treatment and expect more psychological content during the treatment than the other prepatients expect.

Although there are no overall significant effects attributable to the prepatients' age, there is a significant age effect on both the Supportive Therapist cluster and factor. Mean scores for age groups 18-30, 31-50, 51-65 and over 65 on the cluster are 2.87, 2.98, 3.29 and 4.30 respectively. Mean scores on the factor for these age groups are 1.34, 1.54, 1.57 and 2.50 respectively. It is clear that older

Table 22

MANOVA and ANOVA Results for Age, Sex, Marital Status and Previous Experience on Clusters and Factors

CLUSTER	Source	F (df)	p
Overall MANOVA	Age	F(30,1138) = .98	.50
	Sex	F(6,324) = 1.77	.11
	Marital Status	F(18,803) = .72	.80
	Previous Experience	F(6,324) = 4.55**	.0003
Active Therapist	Age[a]	.64	.67
	Sex[b]	.46	.50
	Marital Status[c]	.58	.63
	Previous Experience[d]	5.41*	.02
Medical	Age	1.69	.14
	Sex	.46	.55
	Marital Status	.58	.92
	Previous Experience	.37	.54
Supportive Therapist	Age	2.83*	.04
	Sex	1.13	.29
	Marital Status	.76	.52
	Previous Experience	.28	.59
Passive Therapist	Age	1.11	.36
	Sex	2.41	.12
	Marital Status	.55	.65
	Previous Experience	7.56**	.007
Psychiatric-Psychological	Age	.52	.76
	Sex	1.86	.17
	Marital Status	.53	.67
	Previous Experience	4.45*	.04
Treatment Duration	Age	.77	.58
	Sex	1.62	.20
	Marital Status	1.08	.36
	Previous Experience	10.20**	.002

Table 22 (continued)

FACTOR	Source	F (df)	p
Overall MANOVA	Age	F(35,1138) = 1.01	.47
	Sex	F(7,324) = .45	.87
	Marital Status	F(21,803) = .93	.55
	Previous Experience	F(7,324) = 2.99***	.006
Medical	Age[a]	1.60	.16
	Sex[b]	.21	.65
	Marital Status[c]	.41	.75
	Previous Experience[d]	.05	.83
Treatment Duration	Age	1.19	.32
	Sex	1.67	.20
	Marital Status	1.96	.12
	Previous Experience	12.56***	.0005
Supportive Therapist	Age	2.84*	.02
	Sex	1.14	.29
	Marital Status	1.78	.15
	Previous Experience	5.09*	.03
Active Therapist	Age	.84	.52
	Sex	.20	.65
	Marital Status	.56	.65
	Previous Experience	3.50	.06
Psychiatric-Psychological	Age	.36	.88
	Sex	.13	.72
	Marital Status	.15	.93
	Previous Experience	.34	.56
Supportive-Optimistic	Age	1.09	.37
	Sex	.53	.47
	Marital Status	.56	.64
	Previous Experience	.09	.77

[a] df Age = 5,326

[b] df Sex = 1,326

[c] df Marital Status = 3,326

[d] df Previous Experience = 1,326

*p .05

**p .01

***p .001

prepatients expect more supportive treatment than do their younger counterparts. There are no significant differences due to sex or marital status, either overall or on any cluster or factor.

Form. Hypothesis 4A predicts a difference in response patterns between those prepatients responding to the "mental health worker" lead and those responding to the "doctor" lead. MANOVA results presented in Table 17 indicate that there is a significant overall effect for form on the clusters, but no significant difference attributable to form in overall responses to the factors. The hypothesis therefore is confirmed for the clusters but not for the factors.

The separate cluster and factor ANOVAS in Table 18 indicate significant main effects for form only on the medical cluster. This is due to the expectation of a more medically oriented treatment associated with the "doctor" form, $\underline{M}$ = 7.87, than is associated with the "mental health worker," $\underline{M}$ = 7.18.

As previously stated, there is also a three-way interaction between class, ethnicity and form on the Treatment Duration factor, due to the expectation of a very short course of treatment among class 1, 2 and 3 Hispanics and eexpectation of a longer course of treatment among class 1, 2 and 3 Jews, but only in response to the "mental health worker" form.

Hypothesis 4B and 4C concern the possibility that significant social class differences will emerge in response to the "doctor" lead, as they did in the Williams study, but not in response to the "mental health worker" lead, repeating the Lorion findings. Although this possibility is considered by examining the class by form interactions,

Table 23

Mean Factor and Cluster Scores of Prepatients
With and Without Previous Experience

Variable	Previous Experience	No Previous Experience
Cluster		
Active Therapist*	5.63	6.60
Medical	7.42	7.49
Supportive Therapist	3.10	2.98
Passive Therapist*	3.11	2.74
Psychiatric-Psychological*	11.13	10.29
Treatment Duration*	3.05	2.47
Factor		
Medical	3.78	3.97
Treatment Duration*	2.37	1.84
Supportive Therapist	1.51	1.52
Diagnostic*	2.54	3.03
Active Therapist	1.08	1.34
Psychiatric-Psychological	2.59	2.49
Supportive-Optimistic	3.61	3.68

*Variable has significant previous experience differences.

none of which were significant, specific tests of these hypothesis were conducted.

Table 17 contains the overall MANOVA and separate ANOVA F ratios for factors and clusters, for the forms analyzed separately. All MANOVA F ratios are significant for social class on clusters and factors on both forms. The only differences from the complete analysis presented in Table 24 that emerge among the separate ANOVA F ratios here is that the Psychiatric-Psychological factor produces a significant social class difference on the "mental health worker" form, but not on the "doctor" form. This difference is due to the lower expectation for psychological content among Class 5 prepatients, M = 2.39, compared with M = 2.81 for Class 1, 2 and 3 and M = 2.86 for Class 4.

The results of this separate analysis of forms for social class differences do not support Hypothesis 4B and C, that social class differences will only emerge in response to the "doctor" lead.

Staff self-reported activity compared with prepatient expectations. Hypothesis 3 predicts that there will be social class linked differences between staff reports of their usual or "ordinary" form of treatment and the expectations that patients hold of this treatment. Specifically, the hypothesis states that there will be fewest differences between staff activity and the expectations of Class 1, 2 and 3 prepatients and greatest disparity between staff activity and the expectations of Class 5 prepatients.

Table 25 presents the data relevant to this hypothesis. The results of the MANOVA test for comparisons between the staff self-reports and the prepatient expectations by social class indicate

Table 24

MANOVA and ANOVA F Ratios for Social Class Differences on Clusters and Factors, by Form

Variable	Form 1 F	Form 1 p	Form 2 F	Form 2 p
CLUSTERS				
Overall MANOVA	F(12,298) = 2.55**	.003	F(12,298) = 2.77**	.01
Active Therapist[a]	4.27*	.02	4.56*	.02
Medical	2.39	.10	2.87	.07
Supportive Therapist	5.08**	.01	3.29*	.04
Passive Therapist	.70	.50	.67	.51
Psychiatric-Psychological	2.49	.09	.46	.63
Treatment Duration	1.36	.26	.74	.48
FACTORS				
Overall MANOVA	F(14,302) = 2.61***	.001	F(14,302) = 2.70***	.001
Medical[b]	2.08	.13	2.83	.07
Treatment Duration	1.12	.30	.81	.45
Supportive Therapist	5.07**	.01	4.55*	.02
Diagnostic	3.89*	.03	3.35*	.04
Active Therapist	1.35	.26	.84	.43
Psychiatric-Psychological	3.41*	.04	.22	.80
Supportive-Optimistic	6.26**	.002	5.43**	.005

[a] df = 2,324

*p .05

**p .01

***p .001

Table 25

MANOVA and ANOVA F Ratios for Differences Between Staff & Prepatients by Prepatient Social Class

Variable	Staff & Class 123 F^a	p	Staff & Class 4 F^b	p	Staff & Class 5 F^c	p
Clusters						
MANOVA	F(6,125)= 4.30	.001	F(6,141)= 8.04	.001	F(6,199) = 8.71	.001
Active Therapist	8.89**	.01	21.63***	.001	29.44***	.001
Medical	.06	.81	.01	.91	4.78*	.03
Supportive Therapist	9.95**	.002	18.00***	.001	29.46***	.001
Passive Therapist	.56	.45	.05	.83	.22	.64
Psychiatric-Psychological	.10	.75	.82	.37	].]5	.28
Treatment Duration	15.00***	.001	19.75***	.001	14.08***	.001

[a] df = 1,143
[b] df = 1,146
[c] df = 1,154

* p .05
** p .01
*** p .001

Table 25 (continued)

Variable	Staff & Class 123 F[a]	p	Staff & Class 4 F[b]	p	Staff & Class 5 F[c]	p
Factors						
MANOVA	F(7,)= 7.77	p .001	F(7,148)= 14.20	p .001	F(7,138)= 16.59	p .001
Medical	2.94	.01	.06	.81	2.82	.10
Treatment Duration	14.87***	.001	14.08***	.001	13.82***	.001
Supportive Therapist	.22	.64	1.26	.26	11.29***	.001
Diagnostic	3.98*	.05	6.70**	.01	16.27***	.001
Active Therapist	8.43**	.004	7.54**	.007	10.68**	.002
Psychiatry-Psychological	.06	.81	.91	.34	.62	.43
Supportive-Optim.	25.96***	.001	64.62***	.001	86.89***	.001

[a] df = 1,143
[b] df = 1,146
[c] df = 1,154

* p .05
** p .01
*** p .001

overall significant differences for all comparisons on both clusters and factors. These results do not support the hypothesis of class differences in correspondence between prepatient expectations and staff practices.

Examination of individual factors and cluster F ratios for the comparisons separately by social class indicates general similarity between social classes in the pattern of differences from the staff, with some distinctions.

The staff reports a set of activities significantly different from the expectations of prepatients from all social classes in response to the Active Therapist, Supportive Therapist and Treatment Duration clusters, the same clusters which produced social class differences. In addition there is a significant difference between staff self-reports and prepatient expectations in response to the Medical cluster items, but only for Class 5 respondents.

In response to the factors, significant staff-patient differences for all three social class groups emerge for the Treament Duration, Active Therapist and Supportive-Optimistic factors, also those factors which were sensitive to subgroup differences in previous analyses. There is also a significant difference between staff and prepatient responses for Class 5 prepatients on the Supportive Therapist factor. Mean scores for staff self-reports and prepatient expectations are presented in Table 26. These scores indicate that for the Active Therapist cluster and the associated Diagnostic and Active Therapist factors, the staff reports providing a significantly less directive form of treatment, with less diagnostic activity, than any of the

prepatient groups expect.

Response to the Supportive Therapist cluster and to the associated Supportive-Optimistic factor indicate that the prepatients expect a more supportive form of treatment than the staff reports itself as ordinarily providing, however the staff-reports are not discrepant from the expectations of Class 1, 2 and 3 or Class 4 prepatients on the Supportive Therapist factor. It is only when the staff reports are compared with the expectations of Class 5 respondents on this factor that the difference becomes significant.

The Treatment Duration cluster and factor are the remaining variables which produce significant differences between prepatient expectations and staff activity. Examination of the mean scores in Table 26 indicates that the staff reports itself as ordinarily providing a treatment that is longer lasting than any of the prepatient groups expect.

In summary, the variables which produce significant staff-prepatient differences are those which produce main or interaction effects for social class, with the inclusion here of a difference for Class 5 prepatients on the Medical cluster.

All social class groups produce a response pattern which is, overall, significantly different from that of the staff. The Class 1, 2 and 3 groups does not produce fewer differences than the Class 4 group does. The Class 5 groups does produce two differences, including one in Medical expectations, in addition to those found between the staff reports and treatment expectations of other social class groups.

Table 26

Mean Factor and Cluster Scores of Staff and Prepatients

Variable	Staff Self-Report	Prepatients Class 1,2,&3	Class 4	Class 5
Clusters				
Active Therapist	3.89	5.59**	5.94***	6.57***
Medical	6.68	7.31	6.79	7.85*
Supportive Therapist	1.80	2.63**	2.89***	3.52***
Passive Therapist	2.97	2.90	2.97	3.00
Psychiatric-Psychological	11.24	10.79	10.77	10.96
Treatment Duration	3.69	2.79***	2.75***	2.92***
Factors				
Medical	3.35	4.10	3.47	4.11
Treatment Duration	2.75	2.11**	2.14***	2.23***
Supportive Therapist	1.25	1.15	1.14	1.92***
Diagnostic	2.00	2.57*	2.65**	3.20***
Active Therapist	.68	1.25**	1.07**	1.24**
Psychiatric-Psychological	2.57	2.52	2.68	2.50
Supportive-Optimistic	1.51	3.10***	3.72***	4.08***

* difference between staff and prepatient group, p .05
** difference between staff and prepatient group, p .01
*** difference between staff and prepatient group, p .001

Method of Administration (Student Data)

Hypothesis 5 predicts that responses to the clusters and factors will vary with the method of administration of the questionnaire. The hypothesis specifically predicts that administering the questionnaire by interview, as Williams did, will produce significant social class differences, while asking the respondents to self-administer the questionnaire, as Lorion did, will produce no social class differences in responses.

The data used to test this hypothesis were collected from college students asked to role play a first visit to the community mental health center. Before proceeding to the results relevant to testing for differences due to method of administration it is necessary to compare the student role-playing data with that derived from actual prepatient interviews.

Student - Prepatient Comparisons: Interview. MANOVA results for the comparison, social class by social class and form by form, of interviewed students with prepatients is presented in Table 27. Only one comparison, that between Class 4 students and prepatients for the factors in response to the mental health worker form, produces a statistically significant difference between groups.

Separate ANOVA results, presented in the Appendix, indicates a significant difference between the Class 4 groups on the Supportive Therapist factor, F (1,63) = 9.37; p .01. There is an expectation of more therapist support among the prepatients, M = 4.11, than there is among the students, M = 2.60.

Although overall MANOVA F ratios for other comparisons between

Table 27

MANOVA F Ratios for Differences Between Prepatients and Students by Form and Method of Administration

Group	Interviewer F(df)	p	Self Administration F(df)	p
Class 1, 2 and 3				
Form 1 (mental health worker)				
Clusters	F(6,86) = 1.60,	.16	F(6,108) = 2.61*	.03
Factors	F(7,85) = 1.34,	.26	F(7,106) = 1.43	.21
Form 2 (doctor)				
Clusters	F(6,74) = 1.38,	.24	F(6,99) = 3.36**	.007
Factors	F(7,74) = 1.05,	.42	F(7,97) = 3.20**	.006
Class 4				
Form 1				
Clusters	F(6,68) = 1.03,	.42	F(6,76) = 4.44***	.001
Factors	F(7,66) = 2.55*	.03	F(7,73) = 5.24***	.001
Form 2				
Clusters	F(6,63) = .71	.64	F(6,74) = 1.56	.18
Factors	F(7,63) = .28	.95	F(7,72) = 1.22	.32
Class 5				
Form 1				
Clusters	F(6,48) = .17	.98	F(6,52) = 3.51*	.02
Factors	F(7,49) = 137	.91	F(6,53) = 11.43***	.001
Form 2				
Clusters	F(6,53) = 1.94	.09	F(6,56) = 1.02	.44
Factors	F(7,53) = 1.23	.33	F(7,54) = 1.53	.21

interviewed students and prepatients did not reach significance, there were other significant differences in individual ANOVA results. Class 1, 2 and 3 students were different from their prepatient counterparts in response to the Supportive-Optimistic factor on the mental health worker form. As in the case of the Class 4 comparison, this was due to a greater expectation of support among the prepatients than among the students. Although there are also significant differences between the two students scored as having Class 5 origin and their prepatient counterparts, both of these differences in response to the "doctor" form, this result is unreliable , due to sample size. There was a significant difference between the groups in response to the Active cluster, attributable to a greater expectation of therapist activity among the prepatients, $\underline{M}$ = 6.59, than among the students, $\underline{M}$ = 3.00. The final difference was in response to the activity related Diagnostic factor. The Class 5 prepatients expected more diagnostic activity than the two students did.

Student - Prepatient Comparisons: Self-Administration. Examination of the multivariate $\underline{F}$ ratios presented in Table 27 indicates that the majority of comparisons between students who self-administered the questionnaire and their prepatient social class and form counterparts produce significant differences. Three of the four possible comparisons for Class 1, 2 and 3 produce significant differences, while for Class 4 and for Class 5 respondents there are significant differences in overall cluster and factor responses to the "doctor" form, but not in response to the "mental health worker" form.

To summarize the results of the student-prepatient comparisons,

while there are some significant differences between student role-playing responses to the interview and those obtained from actual prepatients, only in the case of Class 4 responses to the factors on the "mental health worker" form do the differences reach overall significance. Responses the students make to the self-administered version of the questionnaire, however, are sharply different from those of their prepatient counterparts.

Method of Administration

Complete results of the MANOVA tests for method of administration, form, class and the two- and three-way interactions, using student role-playing data, are presented in Table 28. The ANOVA results for the separate factors and clusters are presented in the Appendix.

No overall significant MANOVA F ratios for the effects of method of administration, form or class, or for the effects of any interaction were obtained from the students, nor were there any significant main effects for class or form on any cluster or factor examined separately.

The separate ANOVA results do indicate significant main effects for method of administration in response to the Supportive Therapist cluster, F (1,199) = 4.84, p .05, to the Supportive Therapist factor, F (1,203) = 3.90, p .05 and to the Treatment Duration factor, F (1,203) = 4.62, p .05. Examination of the means for these groups indicates a greater expectation of support on the cluster for those interviewed, M = 2.75, compared with those who self-administered the form, M = 2.40. The same relationship holds true for responses to the factor, with interview and self-administration means of 1.55 and

Table 28

Student Data

MANOVA Tests on Clusters and Factors for Effects of Method of Administration, Form and Social Class

Source	F (df)	p
Clusters		
Administration	F(6,194) = 1.36	.23
Form	F(6,194) = .96	.45
Class	F(12,388)= .34	.98
Administration X Form	F(6,194) = 1.41	.21
Administration X Class	F(12,388)= .55	.88
Form X Class	F(12,388)= .67	.78
Administration X Class X Form	F(12,388)= 1.64	.08
Factors		
Administration	F(7,197) = 1.60	.14
Form	F(7,197) = 1.75	.10
Class	F(14,394)= .53	.92
Administration X Form	F(7,197) = 1.57	.15
Administration X Class	F(14,394)= .74	.73
Form X Class	F(14,394)= 1.21	.28
Administration X Form X Class	F(14,394)= 1.55	.09

1.23 respectively. Responses to the Treatment Duration factor indicated an expectation of longer treatment in the interview condition, $\underline{M}$ = 2.09, compared with self-administration of the questionnaire, $\underline{M}$ = 1.58.

The Medical cluster and factor as well as the Active Therapist cluster and the associated Diagnostic factor produced two-way interactions between method of administration and form, and three-way interactions between method of administration, form and social class. The Medical cluster and factor produced a pattern of highest medical expectations among those interviewed with the "doctor " form with means of 7.39 for the cluster and 3.71 for the factor, and lowest medical expectations expressed by those who self-administered the "mental health worker" form, whose means for the cluster and factor were 5.47 and 2.57 respectively. The other conditions were intermediate.

Interpretation of the three-way interaction among method of administration, form and class is complicated by the extreme scores produced by Class 5 respondents. On the Medical cluster, the two highest mean scores are produced by the Class 5 respondents, as is the lowest score. The highest mean, 9.00, is produced by six students of Class 5 origin in response to self-administration of the "doctor" form. The lowest mean score of 4.75 is produced by four Class 5 students in response to self-administration of the "mental health worker " form. The Medical factor produces a similar pattern of extreme high and low scoring by the few students categorized as Class 5 in origin.

The Active Therapist cluster and the associated Diagnostic factor

also produce two-way interactions between form and method of administration. Highest mean scores, indicating greatest expectation of active, diagnostic treatment, are obtained in response to the "doctor" form administered by interview. These mean scores are 5.39 and 2.29 for the cluster and factor respectively. Lowest mean scores, 4.24 and 1.51 for the cluster and factor, are obtained in response to the self-administered "mental health worker" form. This is the same pattern produced by the interaction of form with administration technique on the medical variables. As in that case, interpretation of the interaction with class is difficult due to the association of all extreme high and low scores with the very few students of Class 5 background.

A final examination of the responses to the treatment expectation questionnaire for social class differences was made, using the student data divided into two sets. One set, repeating the combination of form and method of administration used by Williams, was composed of those students interviewed and responding to the "doctor" lead (Form 2). The other group, repeating the combination of form and method used by Lorion, was composed of those students who self-administered the "mental health worker form" (Form 1). Results for these comparisons are presented in Table 29. Neither group produces significant social class differences.

The above results do not confirm Hypothesis 5. There are no overall differences between responses to the questionnaire obtained by interview compared with those obtained by self-administration, at least when using students role-playing the patient condition. There are, however, differences between the two methods of administration

when the separate results are examined for each ANOVA. Social class does not interact with method of administration among the students, and three way interaction effects between social class, form and administration are difficult to evaluate due to the extreme scoring pattern of the very few students classified as Class 5.

Table 29

MANOVA and ANOVA F Ratios for Social Class Differences on Form 2, Interview and Form 1, Self-Administration (Student Data)

Variable	Form 2 Interview F	p	Form 1 Self Administration F	p
CLUSTERS				
MANOVA df(12,38)	.67	.75	df(12,130) .36	.97
Active Therapist	1.21[a]	.31	.22[b]	.85
Medical	1.85	.18	.17	.85
Supportive Therapist	.53	.60	.73	.48
Passive Therapist	.08	.93	.22	.80
Psychiatric-Psychological	1.21	.31	.87	.42
Treatment Duration	.40	.68	.53	.59
FACTORS				
MANOVA df(14,40)	1.08	.40	df(14,130) .61	.85
Medical	2.01	.15	.14	.87
Treatment Duration	.05	.95	.09	.91
Supportive Therapist	.12	.88	.45	.64
Diagnostic	2.85	.07	.03	.98
Active Therapist	.73	.49	.49	.61
Psychiatric-Psychological	.12	.88	.46	.63
Supportive Optimistic	.01	.99	2.13	.13

[a] df = 2,32
[b] df = 2,78

CHAPTER VI

CONCLUSION

This research was stimulated by the assertion that class-linked differences in expectations about mental health treatment was an explanation for the consistent finding that Class 4 and Class 5 persons were less likely to be found in psychotherapeutic forms of treatment than their higher social status counterparts were. It was secondarily stimulated by the presence of contradictory findings about class linked treatment expectations and the association of these contradictions with methodological and procedural differences between studies. The conclusion will be presented in the same order, with discussion of social class and other subgroup differences first, followed by discussion of the methodological issues.

Treatment Expectation Differences Among Prepatients

Social class differences. The argument that prepatient expectations are causally significant in producing the relationship between social class and treatment modality rests on three assertions. The first assertion is that there are social class differences in treatment expectations among those seeking services. The second assertion is that these differences produce class linked discrepancies between patient expectations and staff treatment activity. The final assertion is that these class linked discrepancies produce the negative relationship between social class and psychotherapeutic treatment.

The results of the present study are relevant to the first and second assertion of the argument.

The results support the first assertion. There are significant social class differences in expectations about mental health treatment among the applicants for services at the Maimonides Community Mental Health Center. There were significant overall multivariate effects for social class in responses to both sets of variables, clusters and factors. These overall findings confirm those reported by Overall and Aronson and those reported by Williams. The findings differ from those reported by Lorion.

These overall social differences are primarily attributable to differences in expectations about the active, directive content of treatment and about the degree of support the therapist is expected to provide. There are also complex interaction effects among social class, ethnicity and question wording in response to items about the duration of treatment.

The Active-Directive items were designed to reveal an expectation that the therapist will tell the patient what is "wrong," and will identify the cause of the problem. Affirmative responses also indicate that the therapist is expected to give active instruction and direction about how to get along with people and how to solve problems, and is expected to provide a definite set of rules to follow. The data indicate a greater expectation of such therapist activity among Class 5 prepatients than among other applicants for service. There are no differences between Class 4 and Class 1, 2 and 3 prepatients in response to these items.

The items called "supportive" represent an expectation the therapist will comfort and cheer the patient, while avoiding upsetting material. Social class differences are due to greater expectations for support among the Class 5 prepatients, with greatest difference between Class 5 and Class 1, 2 and 3 respondents.

Findings about social class differences in expectations about treatment duration are complex, producing interaction effects with ethnicity and with form. Class 1, 2 and 3 prepatients from Hispanic backgrounds expect a treatment of shortest duration, while Jewish prepatients of the same social class expect the longest treatment duration. The difference is more extreme in response to the "mental health worker" form.

Responses to the other dimensions of treatment expectations examined showed no evidence of social class differences. There are no differences among the prepatients in expectations about a focus on organic or physical problems or for a medical form of treatment, nor were there social class differences in expectations that emotionally charged material with psychodynamic content would be introduced during treatment. Social class differences along these dimensions were asserted by Hollingshead and Redlich and were reported by Williams. There were also no social class differences in response to variables indicating expectations that the therapist would remain passive, leaving the direction of communication to the patient, a difference asserted by Hollingshead and Redlich, but not found by Williams.

Those differences that were found do not support the assertion of a simple distinction between "middle class" and "lower class"

prepatients. Differences are not between the Class 1, 2 and 3 group usually called middle class on one hand, and the blue collar workers of Class 4 coupled with the low occupational status and poorly educated Class 5 applicants on the other. Rather, the differences are between Class 5 respondents and all others.

Ethnic differences. The study sought to explore ethnic differences in mental health treatment expectations, while attempting to clarify the role of ethnic differences in producing contradictions among previous findings. Hypotheses concerning ethnic differences in treatment expectations are only partially supported by these findings. There are overall differences attributable to ethnic group membership in response to the clusters, but not in response to the factors. Examination of the variables separately indicates only one particular ethnic difference; Jewish prepatients evidenced an expectation for greater therapist activity than the other groups did. In addition, only the treatment duration variables produce a class-ethnicity interaction. These data, therefore, do not support Lorion's speculation that the Williams findings of social class differences are in part due to the presence of Jewish respondents only in the Class 1, 2 and 3 group.

Previous experience. There are significant overall effects on both factors and clusters for previous experience. Applicants who report previous experience with mental health treatment expect less therapist activity and more therapist passivity, as well as more psychological content and longer treatment duration than their inexperienced counterparts do. In all cases the experienced prepatient mean score is closer to staff reports of treatment activity than the

inexperienced mean score is.

There were no other overall significant prepatient subgroup differences. The only other difference found was a greater expectation of therapist support among older applicants for treatment. In contrast to other reports, no significant differences due to prepatient sex or marital status were found.

Staff - Prepatient Differences

The results of this study do not support the second assertion of the argument that class linked prepatient expectations are an important reason for findings that assignment to treatment modality is class biased. Overall multivariate comparisons of the expectations of prepatients divided by social class with staff self-reported treatment activity indicates significant differences between the staff reports and each social class group. Furthermore, examination of staff-prepatient comparisons for the variables separately indicates a similar pattern of differences between expectations and treatment reports for each social class group. Prepatients from Class 1, 2 and 3 differ from the staff on the same dimensions that the Class 4 prepatients do. Class 5 prepatients shared differences with the other groups but showed an additional disparity between their expectations and the staff self-reports.

In all comparisons prepatients expect significantly more therapist activity and support than the staff reports itself as ordinarily providing, as well a shorter period of treatment than the staff describes as ordinary. In addition to these differences, Class 5 respondents expect significantly more medical interest and treatment than the staff reports itself as providing.

The dimensions along which the prepatients and the treatment staff differ, those of therapist activity and support, and the duration of treatment, are the same ones along which there are social class differences. The differences in treatment expectations between social classes, however, are not great enough for any social class group to be similar to the staff. While there are differences in expectations between patient social class groups, all groups are inaccurate, if agreement with staff reports is taken to represent accuracy. Class 5 prepatients are inaccurate on an additional dimension. The results therefore indicate that prepatients from all social class groups have misconceptions about the nature of mental health treatment, as the staff describes it.

For those concerned with the delivery of treatment, the issue becomes one of correction of these misconceptions. In this light, the data concerning differences between those applicants for service who report previous experience compared with those who report no experience take on particular significance. In each comparison, the experienced is closer in its expectations to staff self reports than the inexperienced group is; that is to say, more accurate. It is clear that patients become more accurate in their expectations with experience.

Methodological Issues

The secondary focus of this research was to clarify the role played by methodological differences in research techniques in the production of contradictory findings. Three differences between the procedures used by Williams and those used by Lorion were identified

as potential sources of disparity. First, the researchers used somewhat different items grouped into somewhat different factors as dependent variables. A second difference was introduced with the change in wording of the lead. The third difference was in the method by which the questionnaire was administered. The particular grouping of items to form dependent variables proved to be the most serious difference.

Factor analysis and the selection of variables. The results of the factor analysis carried out in this study, coupled with the results of the replications of previous analyses, point to a major difficulty in the interpretation of empirical studies of subgroup differences in prepatient expectations about mental health treatment.

The present factor analysis produced seven factors, three of which are similar to factors derived by both Williams and Lorion (Medical, Diagnostic and Supportive-Optimistic), and one of which is similar to a Lorion factor (Treatment Duration). The three remaining factors have no strong correlation with any factor previously reported.

Of even greater importance is the finding that the presence or absence of significant social class differences, both overall and in response to apparently similar expectation dimensions, is specific to the particular items grouped to form particular dependent variables. Grouping the appropriate items into the Williams factors produces results which correspond with their findings of social class differences in treatment expectations. There are significant social class differences, both overall and in response to two of their five factors. On the other hand, the items grouped into Lorion's six factors produce no overall significant social class differences, and a significant

difference only on that single factor for which he had reported a significant social class-sex interaction effect. These findings confirm his report of no social class differences in treatment expectations, at least for his factors.

A new study, published after the collection of the data presented here further points up the nature of both problems - the particularity of factors produced in each study, and the specificity of findings about social class differences to the factors used. Balch, McWilliams, Lewis and Ireland (1978), using 13 items from the Overall and Aronson scale along with seven new items, collected self-administered expectations from 317 first admission applicants for treatment at the Tucson East Community Mental Health Center in Arizona. A factor analysis, which produced four factors, was performed on the results. Of course, none of the factors produced (labeled Directive/Advice, Medical Orientation, Psychological Orientation and Supportive) are identical to any of those previously reported. Correlations with previous factors are not reported. The authors found sex differences in response to the "Directive/Advice" factor, marital status differences in response to the "Medical Orientation" factor, and no differences, on any factor, due to social class. These results are probably specific to the particular variables used.

Clearly, if there is to be any comparability among empirical studies of client expectations about treatment, there must be agreement among researchers about the measuring instrument used, and the variables to be used in tests for differences. The tendency for each researcher to perform a new factor analysis - producing factors only

more or less similar to those of other researchers - and then to test for differences on this idiosyncratic set of variables cannot produce realistic policy for the provision of services to a highly diverse group of clients.

The use of two sets of dependent variables in this study provides interesting information. Differences in results on the two sets of variables cannot be attributed to sampling differences in subjects, setting or time. On the same subjects, findings for the items grouped into factors are sometimes different from those for the items grouped into clusters.

Multivariate results on prepatient data differed in important ways for the two sets of variables. Although both clusters and factors produced significant overall multivariate F ratios for social class effects, only the clusters were associated with overall differences for ethnicity and for form. For overall comparisons between Class 5 respondents and those from other social classes, the factors produced overall significant differences, but the clusters did not. In other comparisons the two sets of variables produced similar overall results.

When the results for the variables considered separately are examined, the correspondence between clusters and factors is almost perfect. Social class differences are found in response to the Supportive cluster and factor and for the Active cluster and its associated Diagnostic factor. The significant results for the effects of form are confined to the Medical cluster and factor. The significant interaction effects between class and ethnicity are confined to the Treatment Duration cluster and factor. Comparisons between staff

reports and patient expectations produce significant differences in response to the Active cluster and the associated Active and Diagnostic factor, the Supportive cluster and the associated Supportive-Optimistic factor and to the Treatment Duration cluster and factor. Only for the ethnic comparison is there a difference in results, with the Active factor alone associated with ethnic group differences.

The comparison of the results for the two sets of variables indicates that the original clusters are preferable for research purposes to the factors. The multivariate results for form and for ethnicity indicate that the clusters are more sensitive to these differences, and are equally sensitive to social class differences. The results for the variables considered separately indicate that no advantage is derived from the factor analysis procedure. Those factors which produce significant differences also produce significance in the clusters with which they are highly correlated.

There is also no advantage derived from the factor analysis procedure in producing groupings of items that are associated with one another on an empirical basis. The generally high Alpha coefficients associated with the original clusters indicate that they possess internal consistency and reliability.

Finally, the clusters are more easily interpretable than the factors are. They have a straight forward content validity which some of the factors do not possess.

Form and the wording of the questionnaire lead. Other procedural and methodological differences between previous studies proved to be less potent in their ability to determine the presence or absence of

social class differences. The change in wording of the lead from "doctor" to "mental health worker," while it did produce an overall difference on the clusters attributable to a greater expectation of medical treatment in response to the "doctor" form, did not interact with social class in the predicted fashion. Separate analysis of the responses to each form failed to reproduce previous findings. Each form was associated with overall social class differences and with almost exactly similar patterns of response to individual variables. There was no apparent medical "set" produced by the "doctor" form that accounts for social class differences in the Williams study.

Method of administration. The third procedural variation, which compared responses collected by interview with those collected by respondent self-administration of the questionnaire, also failed to produce different social class comparison results for each technique. There were no overall significant main effects due to method of administration, although there were effects on individual variables.

There were also no significant overall interaction effects between method of administration, form and social class. It is not possible, at least on the basis of the data from the student sample, to attribute the differences between Williams' findings and those of Lorion to such interactions.

CHAPTER VII

SUGGESTIONS FOR FURTHER RESEARCH

Some questions about the presence or absence of significant differences among the subgroups of people applying for mental health treatment remain. There are also possibilities for further explorations of the contribution of methodological differences to differences between results reported by different researchers.

Additonal Social Class Differences

The present study, following the practice of previous studies, combined prepatients from Class 1, Class 2 and Class 3 into one group. This grouping is in part dictated by the hypothesized contrast between "middle class" prepatients and others. It is also necessitated by the small numbers of applicants for treatment from Class 1 and from Class 2 who are included in the sample.

Class 1 and 2 persons make up a only a small percentage of the population to begin with. Hollingshead and Redlich, in their study, assigned 3% of their sample to Class 1, and 10% to Class 2. In the present study there were 12 Class 2 prepatients, making up 4% of the total sample, and five prepatients assigned Class 1 status, making up 1.5% of the sample, indicating some underrepresentation of these groups. A sample which included larger numbers of respondents from these social classes would permit interesting contrasts not only among prepatient groups, but also between the expectations of these prepatients and

staff treatment activity reports.

Additonal Ethnic Group Differences

The sample from which the data were derived includes members of three major New York ethnic groups. It does not contain respondents from other important groups. The most significant omission is the lack of Black respondents, due to the absence of a Black community in the Maimonides Mental Health Center catchment area. The Anglo-American community which forms the nationwide majority is also not included here. The restricted range of ethnic groups included leaves questions open about ethnic differences other than those explored here.

Even among the groups which are represented in the sample, the failure to find group differences may be in part due to the inclusion of the most acculturated members of these communities. Interivews were conducted only at the main buildings of the Mental Health Center. Pre-patients who seek help here may differ from their less assimilated counterparts who seek help at the "satelite" centers maintained in the communities. A further study which included those who seek treatment at the satelite centers would provide interesting data.

Methodological Issues

The present study did not find significant differences due to method of administration, or significant interaction effects among method of administration, form and social class.

Interpretation of the data concerning method of administration is complicated by the fact that these data were collected from role-playing students, who did not show significant social class differences on

those comparisons which did produce social class differences among the prepatients. The possibility of an effect due to method of administration, or to an interaction between method of administration and form remains an intriguing possibility. The recent study by Balch and his colleagues, in addition to using their own factors, had the respondents self-administer a form using the term "therapist" in the lead to identify the service provider. These procedures, which are similar to those used by Lorion, also produce no social class differences. Collection of data in which prepatients self-administered the questionnaires would clarify this issue finally.

LIST OF APPENDIXES

TREATMENT EXPECTATIONS SURVEY

INTERVIEW

S # ____ ____ ____ 01-03/

1. Sex

Male . . . 1 05/
Female . . 2

2. Please look at this card and tell me the number of the age group you are in.

HAND CARD # 1

Younger than 20 . . 1 07/
21 - 30 2
31 - 40 3
41 - 50 4
51 - 65 5
66 or older 6

3. Are you married now?

Yes . . . 1 09/

IF NO

Were you ever married?

No 2

IF YES

Are you divorced, separated or widowed?

Divorced or separated 3
Widowed 4

4. Please look at this card and tell me in what religion you were raised.

HAND CARD # 2

Protestant	1	11/
Catholic	2	
Jewish	3	
Other	4	

5. Where were you born?

U.S.A.	1	13/
Puerto Rico or other Spanish-speaking country . .	2	
Other	3	

Where were your parents born?

U.S.A.	1	14/
Puerto Rico or other Spanish-speaking country . .	2	
Other	3	

6. What was the highest grade you finished in school?

Graduate Professional Training	1	16/
College Graduate (4 years)	2	
Partial College (and 2 yr. programs) . .	3	
High School Graduate	4	
Partial High School	5	
Jr. High School (7th - 9th grade) . . .	6	
Less than 7th grade	7	

7. I would like to ask you some questions about working.

By working I mean working for pay at a job, or running your own business or profession, or working in your family's business with or without pay.

How many of the things on this card describe what you are doing now - which ones fit what you are doing now?

HAND CARD # 3	Housewife/unpaid housekeeper 1
	Full time work for pay 2
	Part time work for pay 3
	Full time student 4
IF ON PAID VACATION or PAID SICK LEAVE FROM JOB, CODE FOR WORKING	Part time student 5
	Unemployed, looking for work 6
	Unemployed, not looking for work 7
	Retired 8
	Other (SPECIFY) 9

IF HOUSEWIFE/UNPAID HOUSEKEEPER - USE LEAD B

IF FULL TIME STUDENT - USE LEAD C

ALL OTHERS - USE LEAD A

A. What kind of work (do/did) you mostly do? - What do/did you actually do on your main job? (IF MORE THAN ONE JOB CONCURRENTLY, ASK ABOUT JOB AT WHICH R SPENDS MOST TIME)

HOUSEWIFE/UNPAID HOUSEKEEPER (MARRIED

B. What kind of work (does/did) your spouse mostly do? What (does/did) your spouse actually do on his/her main job?

FULL TIME STUDENT

C. What kind of work does the person who supports you do? - What do they do on their main job?

FOR ALL R'S

In what kind of busines is that - what do they make or do?

On this job (are/were) (you/they) self-employed or an employee?

Self-employed . . . 1
Employee 2

On this job (do/did) (you/they) supervise other people?

Yes . . . 1
No 2

IF YES

How many people (do/did) (you/they) supervise?

_____

==========

FOR OFFICE USE ONLY

Occupation 1 18/
2
3
4
5
6
7

Occupation ___ X 7 = ___
Education ___ X 4 = ___
Index of Social Position ___ 20-21/

Social Class 11 - 17 . . . . . 1 23/
18 - 27 2
28 - 43 3
44 - 60 4
61 - 77 5

FROM INDEX OF SOCIAL POSITION

---

8. In the last year, in which of these groups did your income fall? Please include the income of all the members of your family you live with.

Under $2,000	1	24/
$2,000 - $2,999	2	
$3,000 - $4,999	3	
$5,000 - $6,999	4	
$7,000 - $8,999	5	
$9,000 - $10,999	6	
$11,000 - $12,999	7	
$13,000 - $14,999	8	
$15,000 - $16,999	9	
$17,000 and over	0	

---

9. Interviewer

DR	1	25/
MH	2	
AL	3	
SD	4	
RM	5	
IT	6	
SL	7	
DG	8	
WS	9	
Other	0	

TREATMENT EXPECTATION SURVEY

Now I am going to read you some statements. They describe a number of possible ways in which the mental health worker you will be seeing might attempt to treat you.

Please listen to each statement, and then tell me if you expect the mental health worker to do what is described.

Say "yes" if you think the mental health worker will do what the statement describes.

Say "no if you think the mental health worker will not do what the statement describes.

	FORM A 1	29/

Do you think the mental health worker will:

1.	expect you to come in even when you don't feel a need to see him?	Yes . . . 1 No 2	31/
2.	give you a physical exam?	Yes . . . 1 No 2	32/
3.	expect you to do most of the talking?	Yes . . . 1 No 2	33/
4.	ask you a lot of questions?	Yes . . . 1 No 2	34/
5.	still be seeing you one year from now?	Yes . . . 1 No 2	35/
6.	ask questions about any operations you have had?	Yes . . . 1 No 2	36/
7.	give you medication?	Yes . . . 1 No 2	37/

Do you think the mental health worker will...

8. try to get your mind off your troubles?	Yes . . . 1 No 2	38/
9. want you to talk about people who upset you?	Yes . . . 1 No 2	39/
10. tell you how to get along with people?	Yes . . . 1 No 2	40/
11. tell you what is wrong with you?	Yes . . . 1 No 2	41/
12. still be treating you three months from now?	Yes . . . 1 No 2	42/
13. be particularly interested in your aches and pains?	Yes . . . 1 No 2	43/
14. take your pulse and blood pressure?	Yes . . . 1 No 2	44/
15. be interested in what happened to you as a child?	Yes . . . 1 No 2	45/
16. tell you what kinds of food you should eat?	Yes . . . 1 No 2	46/
17. still be treating you one month from now?	Yes . . . 1 No 2	47/
18. avoid subjects which might upset you?	Yes . . . 1 No 2	48/
19. want you to decide when you no longer need to come in to see him?	Yes . . . 1 No 2	49/
20. tell you ways to solve your problem?	Yes . . . 1 No 2	50/

Do you think the mental health worker will...

21. want you to look at the bright side of things?	Yes . . . 1 No 2	51/
22. listen more than he talks?	Yes . . . 1 No 2	52/
23. speak to those people who make you upset?	Yes . . . 1 No 2	53/
24. give you definite rules to follow?	Yes . . . 1 No 2	54/
25. be interested in your digestion?	Yes . . . 1 No 2	55/
26. try to cheer you up?	Yes . . . 1 No 2	56/
27. sympathize with your problems?	Yes . . . 1 No 2	57/
28. tell you what is wrong with what you do?	Yes . . . 1 No 2	58/
29. be silent even when you have nothing to say?	Yes . . . 1 No 2	59/
30. ask questions about your personal life?	Yes . . . 1 No 2	60/
31. want your opinions?	Yes . . . 1 No 2	61/
32. ask what medicines you have been taking?	Yes . . . 1 No 2	62/

Do you think the mental health worker will...

33. want to know what kinds of things make you unhappy?	Yes . . . 1 No 2	63/
34. tell you what is causing your trouble?	Yes . . . 1 No 2	64/
35. ask what physical illnesses have been in your family?	Yes . . . 1 No 2	65/
36. want to know about your thoughts and feelings?	Yes . . . 1 No 2	66/
37. want to know what other doctors you have seen lately?	Yes . . . 1 No 2	67/
38. have a list of things he will want to check over?	Yes . . . 1 No 2	68/
39. want to know how happy you are?	Yes . . . 1 No 2	69/
40. be interested in hearing any personal problems you have?	Yes . . . 1 No 2	70/
41. ask you to describe the physical illnesses you have had?	Yes . . . 1 No 2	71/
42. want to know what your friends are like?	Yes . . . 1 No 2	72/
43. listen to your troubles?	Yes . . . 1 No 2	73/
44. be interested in knowing if some things make you nervous?	Yes . . . 1 No 2	74/
45. ask about how well you get along with your family?	Yes . . . 1 No 2	75/
46. ask about how well you sleep?	Yes . . . 1 No 2	76/
47. ask about your sex life?	Yes . . . 1 No 2	77/

8. Now I would like to ask you some questions about any treatment you may have had here at the Mental Health Center or at other services like it.

Have you been treated here at Maimonodes Community Mental Health Center before?

Yes . . . 1
No 2

IF YES

When was that - how long ago were you treated?

Within last 12 months . . . 1
1 to 2 years ago 2
2 to 5 years ago 3
More than 5 years ago . . . 4

What kind of treatment did you have?

Therapy, Psychotherapy 1
Medicine, Medication, Drugs 2
Hospitalization 3
Other (SPECIFY) 4

Have you been treated at any other Community Mental Health Center?

Yes . . . 1
No 2

IF YES

When was that - how long ago were you treated?

Within last 12 months . . . 1
1 to 2 years ago 2
2 to 5 years ago 3
More than 5 years ago . . . 4

What kind of treatment did you have?

Therapy, Psychotherapy 1
Medicine, Medication, Drugs 2
Hospitalization 3
Other (SPECIFY) 4

Have you ever been treated at a Mental Health Clinic?

Yes . . . 1

No 2

IF YES

When was that - how long ago were you treated?

Within last 12 months . . . 1

1 to 2 years ago 2

2 to 5 years ago 3

More than 5 years ago . . . 4

What kind of treatment did you have?

Therapy, Psychotherapy 1

Medicine, Medication, Drugs 2

Hospitalization 3

Other (SPECIFY) 4

Have you ever been treated at a Psychiatric Hospital?

Yes . . . 1

No 2

IF YES

When was that - how long ago were you treated?

Within last 12 months . . . 1

1 to 2 years ago 2

2 to 5 years ago 3

More than 5 years ago . . . 4

What kind of treatment did you have?

Therapy, Psychotherapy 1

Medicine, Medication, Drugs 2

Hospitalization 3

Other (SPECIFY) 4

Have you ever been treated by a private Therapist or Psychiatrist?

Yes . . . 1

No 2

IF YES

When was that - how long ago were you treated?

Within last 12 months . . . 1

1 to 2 years ago 2

2 to 5 years ago 3

More than 5 years ago . . . 4

What kind of treatment did you have?

Therapy, Psychotherapy 1

Medicine, Medication, Drugs 2

Hospitalization 3

Other (SPECIFY) 4

==========

FOR OFFICE USE ONLY

Previous Experience

Maimonides CMHC 1 78/

Other CMHC 2

Mental Health Clinic 3

Psychiatric Hospital 4

Private Therapist 5

MCMHC plus other service 6

More than one service(not incl.MCMHC) . 7

No previous experience 0

When was that - how long ago were you treated?

CODE FOR MOST RECENT

Within last 12 months . . . 1 79/

1 to 2 years ago 2

2 to 5 years ago 3

More than 5 years ago . . . 4

No previous experience . . . 0

Type of treatment

Therapy, Psychotherapy	1	80/
Medication	2	
Hospitalization	3	
Other	4	
Therapy and Medication	5	
Therapy and Hospitalization	6	
Medic. and Hosp.	7	
Medic., Hosp., and Therapy	8	
Some treatment, plus other	9	
No previous experience	0	

==========

TREATMENT EXPECTATION SURVEY

Listed below are a number of possible ways in which the doctor you are about to see might attempt to treat you.

Please read each statement carefully and circle whether or not you expect the person who will treat you to do what is described in the statement. It is important that you answer all of the questions.

FORM B 1 29/

Do you think the doctor will:

1.	expect you to come in even when you don't feel a need to see him?	Yes . . . 1 No 2	31/
2.	give you a physical exam?	Yes . . . 1 No 2	32/
3.	expect you to do most of the talking?	Yes . . . 1 No 2	33/
4.	ask you a lot of questions?	Yes . . . 1 No 2	34/
5.	still be seeing you one year from now?	Yes . . . 1 No 2	35/
6.	ask questions about any operations you have had?	Yes . . . 1 No 2	36/
7.	give you medication?	Yes . . . 1 No 2	37/
8.	try to get your mind off your troubles?	Yes . . . 1 No 2	38/

STAFF TREATMENT ACTIVITY SURVEY

INTERVIEW

S # _____ _____ _____ 01-03/

1. Sex

Male . . . 1 05/
Female . . 2

2. Age

Younger than 20 . . 1 07/
21 - 30 2
31 - 40 3
41 - 50 4
51 - 65 5
66 or older 6

3. Ethnicity

Hispanic 1 10/
Jewish 2
Other 3

4. Highest Degree

B.A. . . . 1 12/
R.N. . . . 2
M.S.W. . . 3
Ed.D. . . 4
Ph.D. . . 5
M.D. . . . 6

Patient Load

	Hispanic	Jewish	Other	
Middle Class				
Working Class				
Poor				

STAFF SURVEY

Now I am going to read you some statements. They describe a number of possible ways in which you might attempt to treat the patients you see.

Please listen to each statement, and then tell me if, in the ordinary course of treatment, you do what the statement describes.

Say "yes" if you do ordinarily do what the statement describes.

Say "no" if you do not ordinarily do what the statement describes.

Do you ordinarily:

1.	expect your patients to come in even when they don't feel a need to see you?	Yes . . . 1 No 2	31/
2.	give your patients, or have them get, a physical examination?	Yes . . . 1 No 2	32/
3.	expect the patient to do most of the talking?	Yes . . . 1 No 2	33/
4.	ask your patients a lot of questions?	Yes . . . 1 No 2	34/
5.	expect to still be seeing your patients one year from now?	Yes . . . 1 No 2	35/
6.	ask questions about any operations your patients have had?	Yes . . . 1 No 2	36/
7.	give your patients medication, or recommend medication for your patients?	Yes . . . 1 No 2	37/

8. try to get your patients' minds off their troubles?	Yes . . . 1 No 2	38/
9. want your patients to talk about people who upset them?	Yes . . . 1 No 2	39/
10. tell your patients how to get along with people	Yes . . . 1 No 2	40/
11. tell your patients what is wrong with them?	Yes . . . 1 No 2	41/
12. expect to still be treating your patients three months from now?	Yes . . . No 2	42/
13. show particular interest in your patients' aches and pains?	Yes . . . 1 No 2	43/
14. have your patients' pulse and blood pressure taken?	Yes . . . 1 No 2	44/
15. show interest in what happened to your patients as children?	Yes . . . 1 No 2	45/
16. tell your patients what kinds of food they should eat?	Yes . . . 1 No 2	46/
17. still be treating your patients one month from now?	Yes . . . 1 No 2	47/
18. avoid subjects which might upset the patient?	Yes . . . 1 No 2	48/
19. want your patients to decide when they no longer need to come in to see you?	Yes . . . 1 No 2	49/
20. tell your patients ways to solve their problem?	Yes . . . 1 No 2	50/

21. want your patients to look at the bright side of things?	Yes . . . 1 No 2	51/
22. listen more than you talk?	Yes . . . 1 No 2	52/
23. speak to those people who make your patients upset?	Yes . . . 1 No 2	53/
24. give your patients definite rules to follow?	Yes . . . 1 No 2	54/
25. show interest in your patients' digestion?	Yes . . . 1 No 2	55/
26. try to cheer your patients up?	Yes . . . 1 No 2	56/
27. sympathize with your patients' problems?	Yes . . . 1 No 2	57/
28. tell your patients what is wrong with what they do?	Yes . . . 1 No 2	58/
29. be silent even when your patients have nothing to say?	Yes . . . 1 No 2	59/
30. ask questions about your patients' personal life?	Yes . . . 1 No 2	60/
31. want your patients' opinion?	Yes . . . 1 No 2	61/
32. ask what medicines your patients have been taking?	Yes . . . 1 No 2	62/
33. want to know what kinds of things make your patients unhappy?	Yes . . . 1 No 2	63/
34. tell your patients what is causing their trouble?	Yes . . . 1 No 2	64/

35. ask what physical illnesses have been in your patient's family?	Yes . . . 1 No 2	65/
36. want to know about your patients' thoughts and feelings?	Yes . . . 1 No 2	66/
37. want to know what (other) doctors your patients have seen lately?	Yes . . . 1 No 2	67/
38. have a list of things you will want to check over?	Yes . . . 1 No 2	68/
39. want to know how happy your patients are?	Yes . . . 1 No 2	69/
40. be interested in hearing any personal problems your patients have?	Yes . . . 1 No 2	70/
41. ask your patients to describe the physical illnesses they have had?	Yes . . . 1 No 2	71/
42. want to know what your patients' friends are like?	Yes . . . 1 No 2	72/
43. listen to your patients' troubles?	Yes . . . 1 No 2	73/
44. be interested in knowing if some things make them afraid or nervous?	Yes . . . 1 No 2	74/
45. ask about how well your patients get along with their family?	Yes . . . 1 No 2	75/
46. ask about how well your patients sleep?	Yes . . . 1 No 2	76/
47. ask about your patients' sex life?	Yes . . . 1 No 2	77/

ORIGINAL QUESTIONNAIRE - OVERALL AND ARONSON (1963)

Do you think the doctor will . . .

1. give you medicine?
2. not ask questions about your personal life?
3. tell what is wrong with you?
4. try and cheer you up?
5. not want your opinion?
6. listen more than he talks?
7. give you definite rules to follow?
8. avoid aubjects which might upset you?
9. ask what medicines you have been taking?
10. want to know what your childhood was like?
11. want to know what kinds of things make you unhappy?
12. tell you what is causing your trouble?
13. ask what physical illnesses have been in your family?
14. want you to look at the bright side of things?
15. want to know about your thoughts and feelings?
16. want to know what other doctors you have seen lately?
17. ask you a lot of questions?
18. be interested in your digestion?
19. want to know how you get along with people?
20. tell you ways to solve your problems?
21. have a list of things he will want to check over?
22. want to know how happy you are?
23. expect you to do most of the talking?
24. be particularly interested in your aches and pains?
25. try to get your mind off your troubles?
26. ask questions about any operations you have had?
27. be interested in hearing any personal problems you have?
28. tell you what is wrong with what you do?
29. not give you a physical examination?
30. ask you to describe the physical illnesses you have had?

31. want to know what your friends are like?
32. take your pulse and blood pressure?
33. listen to your troubles?
34. tell you what kinds of food you should eat?
35. be interested in knowing if some things make you afraid or nervous?

QUESTIONNAIRE - WILLIAMS et al. (1967)

Do you think your treating doctor will . . .

*1. sympathize with your problems?
*2. ask about how well you get along with your family?
*3. ask about how well you sleep?
*4. tell you how to get along better with people?
*5. ask about your sex life?
6. tell you what is wrong with what you do?
7. tell you what kinds of food you should eat?
8. have a list of things he would want to check over?
9. tell you ways to solve your problems?
10. give you definite rules to follow?
11. tell you what is causing your trouble?
12. tell you what is wrong with you?
13. give you medication?
14. take your pulse and blood pressure?
15. ask you to describe the physical illnesses you have had?
**16. give you a physical examination?
17. ask questions about any operations you have had?
18. be particularly interested in your aches and pains?
19. be interested in your digestion?
20. want to know what other doctors you have seen lately?
21. ask what physical illnesses have been in your family?
22. avoid aubjects which might upset you?
23. want to know what your friends are like?
24. try to get your mind off your troubles?
25. want you to look at the bright side of things?
26. want to know what your childhood was like?
27. ask what medicines you have been taking?
28. try to cheer you up?
**29. ask you questions about your personal life?
30. want your opinions?

31. Listen more than he talks?
32. want to know what kinds of things make you unhappy?
33. want to know about your thoughts and feelings?
34. ask you a lot of questions?
35. want to know how you get along with people?
36. want to know how happy you are?
37. expect you to do most of the talking?
38. be interested in hearing any personal problems you have?
39. listen to your troubles?
40. be interested in knowing if some things make you afraid or nervous?

* Added by Williams et al.

** Changed from negative form in original. Word "not" dropped.

QUESTIONNAIRE - LORION (1974)

(This questionnaire was self-administered. The instructions are included.)

Listed below are a number of possible ways in which the mental health worker you are about to see might attempt to treat you.

Please read each statement carefully and circle whether or not you expect the person who will treat you to do what is described in the statement. It is important that you answer all of the items.

Do you think the mental health worker will . . .

*1. expect you to come in even when you don't feel a need to see him?
2. give you a physical exam?
3. expect you to do most of the talking?
4. ask you a lot of questions?
*5. still be seeing you one year from now?
6. ask you questions about any operations you have had?
7. give you medication?
8. try to get your mind off your troubles?
*9. want you to talk about people who upset you?
10. tell you how to get along with people?
11. tell you what is wrong with you?
*12. still be treating you three months from now?
13. be particularly interested in your aches and pains?
14. take your pulse and blood pressure?
15. be interested in what happened to you as a child?
16. tell you what kinds of food you should eat?
17. still be treating you one month from now?
18. avoid subjects which might upset you?
*19. want you to decide when you no longer need to come to see him?
20. tell you ways to solve your problem?
21. want you to look at the bright side of things?
22. listen more than he talks?
23. speak to those people who make you upset?

24. give you definite rules to follow?
25. be interested in your digestion?
26. try to cheer you up?
27. sympathize with your problems?
28. tell you what is wrong with what you do?
*29. be silent even when you have nothing to say?

* Added by Lorion.

Table 30

ANOVA Tables: Replication-Social Class Differences on Williams Factors

Factor	Source	SS	MS	F	p
Diagnostic	Class[a]	.37	.19	.25	.78
	Error[b]	116.85	.76		
	Total[c]	117.22			
History of Somatic Illness	Class	9.37	4.68	1.34	.26
	Error	537.80	3.49		
	Total	547.17			
Active Medical	Class	11.51	5.76	2.38	.09
	Error	373.18	2.42		
	Total	384.69			
Supportive Optimistic	Class	7.52	3.76	3.34*	.04
	Error	172.48	1.12		
	Total	180.00			
Advice Guidance	Class	11.53	5.77	6.49**	.01
	Error	136.82	.89		
	Total	148.35			

[a] df Class = 2

[b] df Error = 333

[c] df Total = 335

* p .05

** p .01

Table 31

ANOVA Tables: Replication-Social Class Differences on Lorion Factors

Factor	Source	SS	MS	F	p
Dynamic Orientation	Class[a]	3.41	1.71	2.69	.07
	Error[b]	97.76	.63		
	Total[c]	101.17			
Medical Diagnosis	Class	4.66	2.33	1.43	.24
	Error	251.04	1.63		
	Total	255.70			
Medical Support	Class	6.10	3.05	1.27	.28
	Error	368.92	2.40		
	Total	375.02			
Supportive Direction	Class	28.00	14.00	3.16*	.05
	Error	262.49	4.43		
	Total	290.49			
Treatment Duration	Class	2.41	1.21	1.51	.22
	Error	123.33	.80		
	Total	125.74			
Passive Therapist	Class	2.45	1.22	1.37	.26
	Error	137.52	.89		
	Total	139.97			

[a]df Class = 2

[b]df Error = 154

[c]df Total = 156

*p .05

Table 32

Subgroup Mean Scores for each Factor and Cluster

Variable	Ethnicity	Social Class 1,2,3	4	5	Total	1,2,3	Social Class 4	5	Total
		Form 1 (mental health worker)				Form 2 (doctor)			
Active Therapist Cluster	Hispanic	6.02	5.80	7.40	6.50	5.50	5.80	7.00	6.40
	Jewish	4.67	7.30	6.17	6.27	5.71	5.50	8.00	6.05
	Others	5.50	5.86	6.38	5.95	6.14	5.29	6.13	5.81
	Total	5.25	6.24	6.54	6.13	5.83	5.43	6.59	6.00
Medical Cluster	Hispanic	9.00	7.80	9.00	8.50	4.00	6.20	9.00	7.40
	Jewish	7.50	7.40	7.40	7.43	9.00	3.00	7.00	8.05
	Others	6.75	6.90	7.38	7.02	8.43	7.00	7.28	7.38
	Total	7.31	7.14	7.74	7.37	8.39	6.45	7.72	7.55
Supportive Therapist Cluster	Hispanic	2.00	2.40	4.20	3.08	3.02	2.80	3.43	4.14
	Jewish	3.00	3.80	4.00	3.64	2.57	2.50	4.00	2.79
	Others	2.63	3.36	3.38	3.23	2.43	2.29	3.18	2.71
	Total	2.69	3.35	3.71	3.32	2.57	2.43	3.33	2.82

Table 32 (Cont.)

Subgroup Mean Scores for each Cluster and Factor

Variable	Ethnicity	Social Class 1,2,3	4	5	Total	Social Class 1,2,3	4	5	Total
		Form 1 (mental health worker)				Form 2 (doctor)			
Passive Therapist Cluster	Hispanic	3.50	2.75	2.80	2.91	3.00	2.60	2.50	2.60
	Jewish	2.83	3.40	3.00	3.14	2.64	2.50	3.33	2.74
	Others	3.25	2.91	3.23	3.07	2.86	3.00	3.05	3.00
	Total	3.13	3.03	3.08	3.07	2.74	2.86	2.93	2.85
Psychiatric-Psychological Cluster	Hispanic	11.80	11.40	11.46	11.50	11.02	9.40	11.38	10.80
	Jewish	11.67	11.50	9.83	11.09	10.17	9.50	9.00	10.00
	Others	11.25	11.00	11.25	11.12	10.00	10.40	10.95	10.60
	Total	11.50	11.19	10.91	11.17	10.30	10.09	11.00	10.51
Treatment Duration Cluster	Hispanic	1.30	3.20	3.50	2.82	3.00	2.06	3.13	2.73
	Jewish	3.86	2.60	2.33	2.91	3.31	2.00	2.62	3.06
	Others	2.25	2.86	3.00	2.79	2.00	3.00	2.89	2.79
	Total	2.69	2.84	2.91	2.83	2.90	2.67	2.93	2.85

Table 32 (Cont.)

Subgroup Mean Scores for each Cluster and Factor

Variable	Ethnicity	Social Class 1,2,3	4	5	Total	Social Class 1,2,3	4	5	Total
		Form 1 (mental health worker)				Form 2 (doctor)			
Factor I Medical	Hispanic	5.50	4.60	4.80	4.83	1.50	3.00	5.00	3.87
	Jewish	4.00	3.40	3.80	3.67	4.64	.05	3.00	3.95
	Others	3.20	3.48	4.00	3.57	4.71	3.60	3.83	3.90
	Total	3.69	3.64	4.13	3.80	4.39	3.18	4.07	3.91
Factor II Treatment Duration	Hispanic	1.88	2.60	2.80	2.33	2.00	1.40	2.25	1.93
	Jewish	2.89	2.06	2.00	2.27	2.54	1.09	2.03	2.28
	Others	1.75	2.33	2. 15	2.17	1.43	2.21	2.22	2.08
	Total	2.06	2.28	2.25	2.22	2.14	1.90	2.21	2.10
Factor III Supportive Therapist	Hispanic	.50	1.00	2.20	1.42	1.00	1.40	2.06	1.68
	Jewish	1.56	1.84	2.10	1.83	1.14	1.00	2.33	1.32
	Others	1.13	1.59	1.92	1.60	1.19	1.03	1.68	1.33
	Total	1.19	1.59	2.00	1.64	1.13	1.09	1.86	1.40

Table 32 (Cont.)

Subgroup Mean Scores for each Cluster and Factor

Variable	Ethnicity	Social Class 1,2,3	4	5	Total	Social Class 1,2,3	4	5	Total
		Form 1 (mental health worker)				Form 2 (doctor)			
Factor IV Diagnostic	Hispanic	3.50	2.40	3.20	2.92	2.00	2.40	3.25	2.80
	Jewish	1.67	3.33	2.67	2.68	2.86	2.00	3.67	2.89
	Others	2.13	2.82	3.15	2.78	3.14	2.21	2.79	2.65
	Total	2.13	2.89	3.04	2.78	2.87	2.24	3.00	2.74
Factor V Active Therapist	Hispanic	1.00	1.20	1.76	1.33	1.08	1.02	1.13	1.08
	Jewish	1.67	1.20	1.17	1.32	1.36	1.50	2.33	1.53
	Others	.88	.32	1.00	.83	1.29	1.33	1.16	1.24
	Total	1.19	.95	1.21	1.08	1.30	1.27	1.27	1.28
Factor VI Psychiatric - Psychological	Hispanic	2.94	2.88	2.80	2.92	3.00	2.40	2.63	2.60
	Jewish	2.83	2.80	2.17	2.64	2.38	2.50	2.50	2.41
	Others	2.75	2.86	2.33	2.69	2.00	2.33	2.58	2.39
	Total	2.81	2.86	2.39	2.71	2.32	2.36	2.59	2.44

Table 32 (Cont.)

Subgroup Mean Scores for each Cluster and Factor

Variable	Ethnicity	Social Class 1,2,3	4	5	Total	Social Class 1,2,3	4	5	Total
		Form 1 (mental health worker)				Form 2 (doctor)			
Factor VII Supportive Optimistic	Hispanic	2.50	3.20	4.40	3.58	4.00	3.40	4.29	3.93
	Jewish	3.17	4.70	4.67	4.27	2.93	3.50	4.33	3.21
	Others	3.63	4.05	3.77	3.83	2.71	2.86	3.87	3.25
	Total	3.31	4.11	4.13	3.95	2.96	3.05	4.04	3.38

Table 33
Analysis of Variance Tables
Social Class Comparisons on Those Variables With
No Significant Social Class Differences in the
Three-Way Analysis of Variance

Class Comparison	Source	df	SS	MS	F	p
Medical Cluster						
5 with All Others	Class	1	20.14	20.14	2.34	.13
	Error	312	2686.32	8.61		
5 with 4	Class	1	38.74	38.74	4.43*	.04
	Error	213	1863.73	8.75		
5 with 1,2,3	Class	1	1.59	1.59	.20	.65
	Error	196	1546.44	7.89		
4 with All Others	Class	1	41.60	41.60	4.94*	.03
	Error	312	2630.16	8.43		
4 with 1,2,3	Class	1	19.69	19.69	2.26	.14
	Error	215	1784.31	8.72		
1,2,3 with All Others	Class	1	3.85	3.35	.44	.51
	Error	312	2701.92	8.66		

Social Class Comparisons (Cont.)

Class Comparison	Source	df	SS	MS	F	p
Passive Therapist Cluster						
5 with All Others	Class	1	.02	.02	.02	.88
	Error	312	243.36	.78		
5 with 4	Class	1	.01	.01	.01	.94
	Error	213	164.31	.77		
5 with 1,2,3	Class	1	.01	.01	.01	.92
	Error	196	150.92	.77		
4 with All Others	Class	1	.36	.36	.45	.72
	Error	312	243.36	.78		
4 with 1,2,3	Class	1	.00	.00	.00	.97
	Error	215	178.45	.83		
1,2,3 with All Others	Class	1	.01	.01	.00	.96
	Error	312	243.36	.78		
Psychiatric - Psychological Cluster						
5 with All Others	Class	1	.33	.33	.08	.78
	Error	312	1316.64	4.22		
5 with 4	Class	1	.46	.46	.13	.71
	Error	213	726.33	3.41		
5 with 1,2,3	Class	1	.00	.00	.00	.98
	Error	196	866.31	4.42		
4 with All Others	Class	1	.49	.49	.12	.73
	Error	312	1332.24	4.27		
4 with 1,2,3	Class	1	.31	.31	.06	.80
	Error	215	1098.65	5.11		
1,2,3 with All Others	Class	1	.02	.02	.00	.95
	Error	312	1325.04	4.25		

Social Class Comparisons (Cont.)

Class Comparison	Source	df	SS	MS	F	p
Treatment Duration Cluster						
5 with All Others	Class	1	2.06	2.06	1.55	.21
	Error	312	444.96	1.33		
5 with 4	Class	1	1.82	1.82	1.70	.19
	Error	213	227.92	1.07		
5 with 1,2,3	Class	1	1.52	1.52	1.03	.31
	Error	196	288.12	1.47		
4 with All Others	Class	1	.74	.74	.56	.46
	Error	312	413.08	1.34		
4 with 1,2,3	Class	1	.00	.00	.00	.98
	Error	215	331.14	1.54		
1,2,3 with All Others	Class	1	.49	.49	.37	.54
	Error	312	413.09	1.35		
Factor I - Medical						
5 with All Others	Class	1	10.57	10.57	2.15	.14
	Error	312	1531.92	4.91		
5 with 4	Class	1	21.83	21.83	4.58*	.03
	Error	213	1013.88	4.76		
5 with 1,2,3	Class	1	.96	.96	.20	.65
	Error	196	938.37	4.78		
4 with All Others	Class	1	23.51	23.51	4.91*	.03
	Error	312	1491.36	4.78		
4 with 1,2,3	Class	1	10.94	10.94	2.23	.14
	Error	215	1057.78	4.92		
1,2,3 with All Others	Class	1	1.88	1.88	.38	.54
	Error	312	1535.04	4.92		

Social Class Comparisons (Cont.)

Class Comparisons	Source	df	SS	MS	F	p
Factor II - Treatment Duration						
5 with All Others	Class	1	1.14	1.14	1.28	.26
	Error	312	277.68	.89		
5 with 4	Class	1	.91	.91	1.15	.28
	Error	213	166.14	.78		
5 with 1,2,3	Class	1	1.14	1.14	1.27	.26
	Error	196	176.42	.90		
4 with All Others	Class	1	.25	.25	.29	.59
	Error	312	277.68	.89		
4 with 1,2,3	Class	1	.05	.05	.05	.83
	Error	215	217.15	1.01		
1,2,3 with All Others	Class	1	.55	.55	.62	.43
	Error	312	279.06	.90		
Factor III - Supportive Therapist						
5 with All Others	Class	1	9.30	9.30	9.19**	.003
	Error	312	318.24	1.02		
5 with 4	Class	1	5.85	5.85	5.62*	.02
	Error	213	221.52	1.04		
5 with 1,2,3	Class	1	9.87	9.87	10.41**	.002
	Error	196	186.23	.95		
4 with All Others	Class	1	1.06	1.06	.99	.32
	Error	312	333.84	1.07		
4 with 1,2,3	Class	1	1.00	1.00	.96	.33
	Error	215	225.77	1.05		
1,2,3 with All Others	Class	1	5.38	5.38	5.14*	.02
	Error	312	327.61	1.05		

Social Class Comparisons (Cont.)

Class Comparison	Source	df	SS	MS	F	p
Factor V - Active Therapist						
5 with All Others	Class	1	.22	.22	.31	.58
	Error	312	215.28	.69		
5 with 4	Class	1	.47	.47	.70	.40
	Error	213	144.84	.68		
5 with 1,2,3	Class	1	.01	.01	.00	.94
	Error	196	152.88	.78		
4 with All Others	Class	1	.65	.65	.95	.33
	Error	312	215.28	.69		
4 with 1,2,3	Class	1	.46	.46	.71	.40
	Error	215	139.75	.65		
1,2,3 with All Others	Class	1	.20	.20	.29	.59
	Error	312	215.28	.69		
Factor VI - Psychaitric - Psychological						
5 with All Others	Class	1	1.23	1.23	2.15	.14
	Error	312	117.84	.57		
5 with 4	Class	1	1.55	1.55	3.00	.09
	Error	213	110.76	.52		
5 with 1,2,3	Class	1	.38	.38	.49	.48
	Error	196	150.92	.77		
4 with All Others	Class	1	1.27	1.27	2.15	.14
	Error	312	184.08	.59		
4 with 1,2,3	Class	1	.27	.27	.55	.46
	Error	215	103.23	.48		
1,2,3 with All Others	Class	1	.01	.01	.02	.90
	Error	312	184.08	.59		

Table 34
Analysis of Variance Tables
Jewish Prepatients Compared with Others on
Variables with No Specific Hypothesized
Differences

Variable	Source	SS	MS	F	p
Clusters					
Active Therapist	Ethnicity[a]	.26	.26	.06	.80
	Error[b]	1316.32	4.33		
Medical	Ethnicity	3.51	3.51	.40	.53
	Error	2687.36	8.84		
Supportive Therapist	Ethnicity	.23	.23	.11	.74
	Error	632.32	2.08		
Passive Therapist	Ethnicity	.05	.05	.06	.80
	Error	243.19	.80		
Treatment Duration	Ethnicity	1.32	1.32	.97	.32
	Error	413.44	1.36		

[a] df Ethnicity = 1

[b] df Error = 304

Table 34 (Cont.)

Analysis of Variance Tables
Jewish Prepatients Compared with All Others
on Variables with No Specific Hypothesized
Differences

Variable	Source	SS	MS	F	p
Factors					
I - Medical	Ethnicity[a]	.18	.18	.04	.84
	Error[b]	1504.77	4.95		
II - Treatment Duration	Ethnicity	.84	.84	.94	.33
	Error	270.56	.89		
III - Supportive Therapist	Ethnicity	.01	.01	.01	.93
	Error	352.27	1.07		
IV - Diagnostic	Ethnicity	.04	.04	.03	.86
	Error	452.96	1.49		
V - Active Therapist	Ethnicity	2.97	2.97	4.43*	.04
	Error	203.68	.67		
VII - Supportive-Optimistic	Ethnicity	.03	.03	.01	.90
	Error	586.72	1.93		

[a] df Ethnicity = 1

[b] df Error = 304

Table 34 (Cont.)

Analysis of Variance Tables

Hispanic Prepatients Compared With Others on Variables with No Specific Hypothesized Differences

Variable	Source	SS	MS	*F*	*p*
Clusters					
Active Therapist	Ethnicity[a]	6.23	6.23	1.49	.22
	Error[b]	1270.72	4.18		
Supportive Therapist	Ethnicity	.12	.12	.06	.81
	Error	623.32	2.08		
Passive Therapist	Ethnicity	1.15	1.15	1.48	.23
	Error	243.08	.77		
Psychiatric-Psychological	Ethnicity	1.76	1.76	.41	.52
	Error	1292.03	4.25		
Treatment Duration	Ethnicity	.61	.61	.44	.51
	Error	422.56	1.39		

[a] df Ethnicity = 1

[b] df Error = 304

Table 34 (Cont.)

Analysis of Variance Tables
Hispanic Prepatients Compared with All Others
on Variables with No Specific Hypothesized
Differences

Variable	Source	SS	MS	F	p
Factors					
II- Treatment Duration	Ethnicity	.23	.23	.26	.61
	Error	270.56	.89		
III- Supportive Therapist	Ethnicity	.10	.01	.01	.92
	Error	322.24	1.06		
IV - Diagnostic	Ethnicity	.60	.60	.40	.52
	Error	449.91	1.48		
V - Active Therapist	Ethnicity	.03	.03	.04	.83
	Error	206.72	.68		
VI - Psychiatric-Psychological	Ethnicity	.86	.86	1.59	.21
	Error	164.16	.54		
VII - Supportive-Optimistic	Ethnicity	.22	.22	.12	.73
	Error	574.56	1.89		

[a] df Ethnicity = 1
[b] df Error = 304

THE TWO FACTOR INDEX OF SOCIAL POSITION

Introduction.

The Two Factor Index of Social Position was developed to meet the need for an objective, easily applicable procedure to estimate the positions individuals occupy in the status structure of our society. Its development was dependent both upon detailed knowledge of the social structure, and procedures social scientists have used to delineate class position. It is premised upon three assumptions: (1) the existence of a status structure in the society; (2) positions in this structure are determined mainly by a few commonly accepted symbolic characteristics; and (3) the characteristics symbolic of status may be scaled and combined by the use of statistical procedures so that a researcher can quickly, reliably, and meaningfully stratify the population under study.

Occupation and education are the two factors utilized to determine social position. Occupation is presumed to reflect the skill and power individuals possess as they perform the many maintenance functions in the society. Education is believed to reflect not only knowledge, but also cultural tastes. The proper combination of these factors by the use of statistical techniques enable a researcher to determine within approximate limits the social position an individual occupies in the status structure of our society.

The Scale Scores.

To determine the social position of an individual or of a household two items are essential: (1) the precise occupational role the head of the household performs in the economy; and (2) the amount of

formal schooling he has received. Each of these factors are then scaled according to the following system of scores.

A. The Occupational Scale.

1. Higher Executives, Proprietors of Large Concerns, and Major Professionals.

a. Higher Executives

Bank Presidents; Vice-Presidents
Judges (Superior Courts)
Large Business, e.g., Directors, Presidents, Vice-Presidents, Assistant Vice-Presidents, Executive Secretary, Treasurer.
Military, Commissioned Officers, Major and above, Officials of the Executive Branch of Government, Federal, State, Local, e.g., Mayor, City Manager, City Plan Director, Internal Revenue Directors.
Research Directors, Large Firms

b. Large Proprietors (Value over $100,000[1]).

Brokers
Contractors
Dairy Owners
Lumber Dealers

c. Major Professionals

Accountants (C.P.A.)
Actuaries
Agronomists
Architects
Artists, Portrait
Astronomers
Auditors
Bacteriologists
Chemical Engineers
Chemists
Clergyman (Professionally Trained)
Dentists
Economists
Engineers (College Grad.)
Foresters
Geologists
Lawyers
Metallurgists
Physicians
Physicists, Research
Psychologists, Practicing
Symphony Conductor
Teachers, University, College
Veterinarians (Veterinary Surgeons)

2. Business Managers, Proprietors of Medium Sized Businesses, and Lesser Professionals.

a. Business Managers in Large Concerns.

Advertising Directors
Branch Managers
Brokerage Salesmen
District Managers
Executive Assistants
Executive Managers, Govt. Officials, minor, e.g., Internal Revenue Agents
Farm Managers
Office Managers
Personnel Managers
Police Chief; Sheriff
Postmaster
Production Managers
Sales Engineers
Sales Managers, National Concerns
Sales Managers (Over $100,000)

1. The value of businesses is based upon the rating of financial strength in Dun and Bradstreet's Manual.

b. Proprietors of Medium Businesses (Value $35,000-$100,000)

Advertising Owners (-$100,000)
Clothing Store Owners (-$100,000)
Contractors (-$100,000)
Express Company Owners (-$100,000)
Fruits, Wholesale (-$100,000)
Furniture Business (-$100,000)
Jewelers (-$100,000)
Labor Relations Consultants
Manufacturer's Representatives
Poultry Business (-$100,000)
Purchasing Managers
Real Estate Brokers (-$100,000)
Rug Business (-$100,000)
Store Owners (-$100,000)
Theater Owners (-$100,000)

c. Lesser Professionals

Accountants (Not C.P.A.)
Chiropodists
Chiropractors
Correction Officers
Director of Community House
Engineers (Not College Grad.)
Finance Writers
Health Educators
Librarians
Military, Commissioned Officers, Lts., Captains
Musicians (Symphony Orchestra)
Nurses
Opticians
Pharmacists
Public Health Officers (M.P.H.)
Research Assistants, University (Full-time)
Social Workers
Teachers (Elementary and High)

3. Administrative Personnel, Small Independent Businesses, and Minor Professionals.

a. Administrative Personnel

Adjusters, Insurance
Advertising Agents
Chief Clerks
Credit Managers
Insurance Agents
Managers, Department Stores
Passenger Agents--R.R.
Private Secretaries
Purchasing Agents
Sales Representatives
Section Heads, Federal, State, and Local Government Offices
Section Heads, Large Businesses and Industries
Service Managers
Shop Managers
Store Managers (Chain)
Traffic Managers

b. Small Business Owners ($6,000-$35,000)

Art Gallery
Auto Accessories
Awnings
Bakery
Beauty Shop
Boatyard
Brokerage, Insurance
Car Dealers
Cattle Dealers
Cigarette Machines
Cleaning Shops
Clothing
Coal Businesses
Convalescent Homes
Decorating
Dog Supplies
Dry Goods
Electrical Contractors
Engraving Business

Feed
Finance Co., Local
Fire Extinguishers
5 & 10
Florist
Food Equipment
Food Products
Foundry
Funeral Directors
Furniture
Garage
Gas Station
Glassware
Grocery-General
Hotel Proprietors
Inst. of Music
Jewelry
Machinery Brokers
Manufacturing
Monuments
Package Store (Liquor)
Painting Contracting
Plumbing
Poultry Producers
Publicity & Public Relations
Real Estate
Records and Radios
Restaurant
Roofing Contractor
Shoe
Shoe Repairs
Signs
Tavern
Taxi Company
Tire Shop
Trucking
Trucks and Tractors
Upholstery
Wholesale Outlets
Window Shades

c. Semi-Professionals

Actors and Showmen
Army M/Sgt; Navy C.P.O.
Artists, Commercial
Appraisers (Estimators)
Clergymen (Not professionally trained)
Concern Managers
Deputy Sheriffs
Dispatchers, R.R. Train
I.B.M. Programmers
Interior Decorators
Interpreters, Court
Laboratory Assistants
Landscape Planners
Morticians
Oral Hygienists
Photographers
Physio-therapists
Piano Teachers
Radio, T.V. Announcers
Reporters, Court
Reporters, Newspaper
Surveyors
Title Searchers
Tool Designers
Travel Agents
Yard Masters, R.R.

d. Farmers

Farm Owners ($25,000-35,000)

4. Clerical and Sales Workers, Technicians, and Owners of Little Businesses. (Value under $6,000)

a. Clerical and Sales Workers

Bank Clerks and Tellers
Bill Collectors
Bookkeepers
Business Machine Operators, Offices
Claims Examiners
Clerical or Stenographic
Factory Storekeeper
Factory Supervisor
Post Office Clerks
Route Managers (Salesmen)
Sales Clerks
Shipping Clerks
Supervisors, Utilities, Factories

b. Technicians

Camp Counselors
Dental Technicians
Draftsmen
Driving Teachers
Expeditor, Factory
Experimental Tester
Instructors, Telephone Co., Factory
Inspectors, Weights, Sanitary
Inspectors, R.R., Factory
Investigators
Laboratory Technicians
Locomotive Engineers
Operators, P.B.X.
Proofreaders
Safety Supervisors
Supervisors of Maintenance
Technical Assistants
Telephone Co. Supervisors
Timekeepers
Tower Operators, R.R.
Truck Dispatchers
Window Trimmers (Store)

c. Owners of Little Businesses.

Flower Shop ($3,000-$6,000)
Newsstand ($3,000-$6,000)
Tailor Shop ($3,000-$6,000)

d. Farmers.

Owners ($10,000-$20,000)

5. Skilled Manual Employees.

Adjusters, Typewriter
Auto Body Repairers
Bakers
Barbers
Blacksmiths
Bookbinders
Boilermakers
Brakemen, R.R.
Brewers
Bulldozer Operators
Butchers
Cabinet Makers
Carpenters
Casters (Founders)
Cement Finishers
Cheese Makers
Chefs
Compositors
Diemakers
Diesel Engine Repair & Maintenance (Trained)
Diesel Shovel Operators
Electricians
Electrotypists
Engravers
Exterminators
Fitters, Gas, Steam
Firemen, City
Firemen, R.R.
Glassblowers
Glaziers
Gunsmiths
Gauge Makers
Hair Stylists
Heat Treaters
Horticulturists
Lineman, Utility
Linoleum Layers (Trained)
Linotype Operators
Lithographers
Locksmiths
Loom Fixers
Lumberjacks
Machinists (Trained)
Maintenance Foremen
Installers, Electrical Appliances
Masons
Masseurs
Mechanics (Trained)
Millwrights
Moulders (Trained)
Painters
Paperhangers
Patrolmen, R.R.
Pattern and Model Makers
Piano Builders
Piano Tuners
Plumbers

5. Skilled Manual Employees (Continued)

Printers
Radio, T.V., Maintenance
Repairmen, Home Appliances
Riggers
Rope Splicers
Sheetmetal Workers (Trained)
Shipsmiths
Shoe Repairmen (Trained)
Stationary Engineers (Licensed)
Stewards, Club
Switchmen, R.R.
Tailors (Trained)
Teletype Operators
Toolmakers
Track Supervisors, R.R.
Tractor-Trailer Trans.
Typographers
Upholsterers (Trained)
Watchmakers
Weavers
Welders
Yard Supervisors, R.R.

Small Farmers

Owners (under $10,000)
Tenants who own farm equipment

6. Machine Operators and Semi-Skilled Employees

Aides, Hospital
Apprentices, Electricians, Printers
Steamfitters, Toolmakers
Assembly Line Workers
Bartenders
Bingo Tenders
Building Superintendents (Cust.)
Bus Drivers
Checkers
Clay Cutters
Coin Machine Fillers
Cooks, Short Order
Delivery Men
Dressmakers, Machine
Drill Press Operators
Duplicator Machine Operators
Elevator Operators
Enlisted Men, Military Services
Filers, Benders, Buffers,
Foundry Workers
Garage and Gas Station Assistants
Greenhouse Workers
Guards, Doorkeepers, Watchmen
Hairdressers
Housekeepers
Meat Cutters and Packers
Meter Readers
Operators, Factory Machines
Oiler, R.R.
Paper Rolling Machine Operators
Photostat Machine Operators
Practical Nurses
Pressers, Clothing
Pump Operators
Receivers and Checkers
Roofers
Set-up Men, Factories
Shapers
Signalmen, R.R.
Solderers, Factory
Sprayers, Paint
Steelworkers (Not Skilled)
Stranders, Wire Machines
Strippers, Rubber Factory
Taxi Drivers
Testers
Timers
Tire Moulders
Trainmen, R.R.
Truck Drivers, General
Waiters-Waitresses ("Better Places")
Weighers
Welders, Spot
Winders, Machine
Wiredrawers, Machine
Wine Bottlers
Wood Workers, Machine
Wrappers, Stores and Factories

7. Unskilled Employees.

Amusement Park Workers (Bowling Alleys, Pool Rooms)
Ash Removers
Attendants, Parking Lots
Cafeteria Workers
Car Cleaners, R.R.
Car Helpers, R.R.
Carriers, Coal
Countermen
Dairy Workers
Deck Hands
Domestics
Farm Helpers
Fishermen (Clam Diggers)
Freight Handlers
Garbage Collectors
Grave Diggers
Hod Carriers
Hog Killers
Hospital Workers, Unspecified
Hostlers, R.R.
Janitors, Sweepers
Laborers, Construction
Laborers, Unspecified
Laundry Workers
Messengers
Platform Men, R.R.
Peddlers
Porters
Roofer's Helpers
Shirt Folders
Shoe Shiners
Sorters, Rag and Salvage
Stagehands
Stevedores
Stock Handlers
Street Cleaners
Unskilled Factory Workers
Truckmen, R.R.
Waitresses--"Hash Houses"
Washers, Cars
Window Cleaners
Woodchoppers

Relief, Public, Private

Unemployed (No Occupation)

Farmers

Share Croppers

This scale is premised upon the assumption that occupations have different values attached to them by the members of our society. The hierarchy ranges from the low evaluation of unskilled physical labor toward the more prestigeful use of skill, through the creative talents of ideas, and the manipulation of men. The ranking of occupational functions implies that some men exercise control over the occupational pursuits of other men. Normally, a person who possesses highly trained skills has control over several other people. This is exemplified in a highly developed form by an executive in a large business enterprise who may be responsible for decisions affecting thousands of employees.

B. The Educational Scale

The educational scale is premised upon the assumption that men and women who posses similar educations will tend to have similar tastes and similar attitudes, and they will also tend to exhibit similar behavior patterns. The educational scale is divided into seven positions: (1) Graduate Professional Training. (Persons who complete a recognized professional course leading to a graduate degree are given scores of 1). (2) Standard College or University Graduation. (All individuals who complete a four-year college or university course leading to a recognized college degree are assigned the same scores. No differentiation is made between state universities, or private colleges.) (3) Partial College Training. (Individuals who complete at least one year but not a full college course are assigned this position. Most individuals in this category complete from one to three years of college.) (4) High School Graduates. (All secondary school graduates whether from a private preparatory school, a public high school, a trade school, or a parochial high school, are assigned the same scale value.) (5) Partial High School. (Individuals who complete the tenth or the eleventh grades, but do not complete high school are given this score.) (6) Junior High School. (Individuals who complete the seventh grade through the ninth grade are given this position.) (7) Less Than Seven Years of School. (Individuals who do not complete the seventh grade are given the same scores irrespective of the amount of education they receive.)

Integration of Two Factors

The factors of Occupation and Education are combined by weighing the individual scores obtained from the scale positions. The weights for each factor were determined by multiple correlation techniques.

To calculate the Index of Social Position score for an individual the scale value for Occupation is multiplied by the factor weight for Occupation, and the scale value for Education is multiplied by the factor weight for Education. For example, John Smith is the manager of a chain supermarket. He completed high school and one year of business college. His Index of Social Position score is computed as follows:

Factor	Scale Score	Factor Weight	Score X Weight
Occupation	3	7	21
Education	3	4	12
	Index of Social Position Score		33

Index of Social Position Scores.

The Two Factor Index of Social Position Scores may be arranged on a continuum, or divided into groups of scores. The range of scores on a continuum is from a low of 11 to a high of 77. For some purposes a researcher may desire to work with a continuum of scores. For other purposes he may desire to break the continuum into a hierarchy of score groups.

I have found the most meaningful breaks for the purpose of predicting the social class position of an individual or of a nuclear family is as follows:

Social Class	Range of Computed Scores
I	11-17
II	18-27
III	28-43
IV	44-60
V	61-77

When the Two Factor Index of Social Position is relied upon to determine class status, differences in individual scores within a specified range are ignored, and the scores within the range are treated as a unit. This procedure assumes there are meaningful differences between

the score groups. Individuals and nuclear families with scores that fall into a given segment of the range of scores assigned to a particular class are presumed to belong to the class the Two Factor Index of Social Position score predicts for it.

The assumption of a meaningful correspondence between an estimated class position of individuals and their social behavior has been validated by the use of factor analysis.[2] The validation study demonstrated the existence of classes when mass communication data are used as criteria of social behavior.

[2] See August B. Hollingshead and Frederick C. Redlich, Social Class and Mental Illness, John Wiley and Sons, New York, 1958, pp. 398-407.

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