RESEARCH DESIGN IN THE STIRLING COUNTY STUDY

A Research Program in Social Factors Related to Psychiatric Health

By

Alexander H. Leighton, M.D.

A Report

To

The Departments of Health and Welfare, Ottawa and Halifax

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SUMMARY

1. Purpose of the Report.

The report is intended as a description of the research design and analytic methods of the Stirling County Study and is submitted in support of a request for a Dominion-Provincial Mental Health Grant.

2. Nature of this Summary.

This summary emphasizes the organizational and financial aspects of the work, and some of its practical outcomes. It touches only briefly on the research design. This is because the report itself is a summary of the research design and analytic methods.

3. Purpose of the Stirling County Study.

The central research aim of the Stirling County Study is to discover or verify meaningful relationships between the distribution of psychiatric illness and the distribution of stressful conditions in the social and cultural environment. Its practical aim is to increase the effectiveness of preventive psychiatry.

4. Location of the Study.

The Study is located in Digby County, Nova Scotia and the name "Stirling" is a pseudonym which we prefer to use in all memoranda and publications.

5. Administrative Organization.

The Study is financed jointly by the Carnegie Corporation of New York, the Dominion- Provincial Mental Health Grants of Canada and the Milbank Memorial Fund. It is administered by the Social Science Research Center of Cornell University, in cooperation with the Department of Health of the Province of Nova Scotia and in collaboration with Acadia and Dalhousie Universities.

The personnel of the Study is made up of both Canadians and United States citizens, but with the former

constituting more than half the total. The leadership in the project is also largely Canadian since all of the four major divisions of the Study are headed by Canadians (three English speaking and one French). The director of the total project is an American. He is responsible for having the Study located in Canada because of previous work in the area selected for research.

Since its inception, the Study has played a role in training people in fields related to mental health. Students have come to work in an apprenticeship fashion from Acadia, Dalhousie, University of Montreal, and Laval, as well as from Cincinnati, Cornell and Harvard.

6. Financial Support.

In 1950 a grant of $25,000.00 per year for three years was made by the Milbank Memorial Fund. This was followed shortly afterward by a grant of the same size and duration from the Carnegie Corporation of New York. The Canadian Government, through the Dominion - Provincial Health Grants committed itself to support the project at the rate of $18,000.00 per year for three years, to September 30th, 1953. Thus the total committed was $150,000.00 from the two foundations and $54,000.00 from the Canadian Government.

After the work had been underway for a year, the size of the grants were increased to meet the growing cost of living and to allow expansion of the work in order to take advantage of new opportunities. By the end of the three year period the total provided by the foundations came to $215,000.00 while that provided by the Canadian Government came to $66,000.00.

The funds granted by the Government pay something under half the cost of the strictly psychiatric aspects of the work. The rest of the expenses of the psychiatric unit have been met by the Milbank Memorial Fund. The social science aspects of the Study are supported by both Milbank and Carnegie. However, it is important to note that, while the Government funds are necessarily limited to specific operations in the psychiatric field, the foundation grants are applicable to any part of the total study.

In May, 1952, the two foundations made an additional joint grant to extend the project from 1953 to 1956. This amounts to $40,000.00 per year each, or $80,000.00 for both, making a grand total of $240,000.00 for three years.

The Government was asked to give $25,000.00 per year for three years, but actually granted $24,600.00 for

one year. The current request is for two and a half years at $30,000.00 per year. The half year is due to the fact that the Government funds began in the middle of its fiscal year. A two and a half year grant starting April 1, 1954, will make a total of six years since the inception of the project in October, 1950.

7. General Framework of the Research.

The research may be divided according to the following objectives.

1.) The development of concepts regarding the relationship of psychiatric disorder and social environment.

2.) The study of the social environment in a limited geographic area and its classification into sub-units that can be rated in terms of conditions promoting good and bad mental health.

3.) The study of the distribution of symptoms of psychiatric significance in the population.

4.) Testing for correlations between 2.) and 3.) above.

5.) Detailed qualitative study of selected psychiatric cases in order to get a high-magnification picture of cause and effect in the relationship of environment to disorder.

6.) The study of the functions of a rural clinic with emphasis on preventive psychiatry.

Items 3.), 5.), and 6.) demand the operation of a clinic in the study area.

Further information regarding research design may be found in the Report which is concerned with an elaboration of the points outlined above.

8. Some Practical Outcomes to Date.

To the end of October, 1953, the clinic has served 282 persons and we believe has rehabilitated some who would otherwise now be patients in a mental hospital.

The attitude of the local public has changed from one of skepticism and wariness to one of support and approval of the clinic.

The local physicians have been given every assistance in dealing with psychiatric cases and show a growing sophistication in dealing with psychiatric problems.

The schools have been given assistance, and referral methods developed which has brought therapeutic aid to a variety of disturbed children.

Advice and support have been given, through talks and consultations to Teachers' Institutes and Mental Health

Associations.

A detailed study of the functions of a rural psychiatric clinic is in preparation.

9. Plans for Future Research.

We expect to carry through to completion the various activities now underway in the study of social environment, distribution of psychiatric symptoms, correlations of the two, and the intensive qualitative analysis of clinic cases. The results will be published in a series of monographs, together with several additional monographs on method.

With the first round of analysis completed, it is planned that considerable additional field work and clinical investigation will be undertaken before the end of grants in 1956. This will be largely an extension of work already done, but there will be an effort to introduce some new lines of inquiry as outlined in the last section of the Report.

10. Some Practical Outcomes Hoped For in the Future.

We hope for practical outcomes in the future, derived both from our experiences in a rural mental health project and from our research.

We expect to have something to say about the functions of Mental Health Associations and we aim to prepare a proposal for an overall plan to provide mental health services for rural areas throughout the Province.

On the research side, if methods now under development prove successful, we hope to provide instruments for the rapid estimation of the concentration of carriers of psychiatric symptoms in any community, and also for assessing the types and seriousness of psychiatric illness. These latter are among the major practical outcomes for which we hope.

RESEARCH DESIGN IN THE STIRLING[1] COUNTY STUDY

by

Alexander H. Leighton, M. D.

Foreword

1. Some Explanatory Remarks:

i. Purpose of this Report:

The purpose of this report is to describe the research design and analytic methods of the Stirling County Study. It is intended as support to a request for a Dominion Provincial Mental Health Grant.

ii. Nature of the Study:

The study is concerned with some of the relationships between personality and culture. It is concerned with them as worthy of study in their own right but also because such relationships are believed important in the

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1. The reference here is to the Mental Health Study in Digby, Nova Scotia. "Stirling" is a pseudonym which we prefer to use in all memoranda and publications.

theory and practice of Psychiatry, particularly social psychiatry in its preventive aspects.

iii. Four Research Units:

Within itself the Stirling County Study has been divided into a social science unit, a mental health survey unit (formerly called "screening"), a psychiatric unit, a statistical unit and a director's office. All the professional members of the program hold appointments in the Department of Sociology and Anthropology at Cornell, while the psychiatrists are in addition members of the Department of Psychiatry.

iv. Personnel:

The social science unit has been headed by Robert N. Rapoport, an anthropologist. He has been assisted by a number of people on a part-time basis. These are listed below, together with an indication of their main contribution to our work. Their university affiliation at the time of participation is also shown, but it should be noted that departmental connection within the university is not necessarily the same as the name of the discipline used to indicate their contribution to our study.

Alphonse Deveau, sociology, (graduate

student, Laval); Gerald Fortin, sociology (graduate student, Laval); Therese Fortin, structured interviewing; Emile Gosselin, sociology, (faculty member, Laval); Charles Hughes, anthropology, (graduate student, Cornell); Jane Hughes, structured interviewing; Beatrice Landman, sociology, (research associate, Cornell); Dorothea Leighton, psychiatry, (research associate, Cornell); Edgar Lowell, psychology, (faculty member, Harvard); A. M. Macmillan, social psychology, (research associate, Cornell, formerly of Acadia); Elizabeth Marsh, social psychology, (faculty member, Cornell); Anne McCreary, structured interviewing; Hilda Parker, structured interviewing; Seymour Parker, anthropology, (graduate student, Cornell); M. A. Tremblay, sociology, (graduate student, Cornell, formerly of Laval); Caroline Winget, sociology; John Winget, sociology, (faculty member, University of Cincinnati).

The psychiatric unit has been headed by James S. Tyhurst, a psychiatrist from McGill. He has been assisted by the following persons who have had full-time appointments in Cornell: Charles Dumas, psychiatry, (University of Montreal); Audrey Roper, Administrative assistant; George Roper, social work and psychology; and W. H. D. Vernon,

psychology, (on leave from Acadia University). Part-time assistance has been given by Luce Jean, social work, (faculty member, Laval); Beatrice Landman, case-finding interviews (research associate, Cornell); A. H. Leighton, psychiatry, (faculty member, Cornell); Dorothea C. Leighton, psychiatry, (research associate, Cornell); Libuse Tyhurst, psychiatry, (research associate, Cornell). In addition there were three full-time and three part-time clerical assistants working on institutional records.

The mental health survey unit, (formerly called a "Screening Unit"), is under the direction of Allister Macmillan, a psychologist from Acadia. He has been assisted from time to time by the following Cornell psychiatrists: Temple Burling, Douglas Darling, Oskar Diethelm, Price Kirkpatrick, Guy La Rochelle, A. H. Leighton, Dorothea C. Leighton, William Longaker, and T. A. C. Rennie. He has also been assisted by Fraser Nicholson of the Department of Psychiatry of Dalhousie University. Statistical clerks, coders, and Hollerith machine operators have been employed, as needed, on a part-time basis.

The statistical unit has been headed by Garnet E. McCreary, formerly at the University of Manitoba, who has worked with the assistance of a number of clerks. In addition

to giving general advice in regard to statistics, he has been responsible for the selection and development of the statistical methods employed by the social science unit and the mental health survey unit.

The study as a whole has been directed by Alexander H. Leighton, who has been aided by D. C. Leighton, Psychiatrist, and Jane Hughes, administrative assistant.

A Psychiatric Clinic is maintained all year round in Stirling County and is the headquarters of the psychiatric unit. The central office for the rest of the work is at Cornell, but during the active phases of data gathering personnel reside in the county and a field office is established.

Currently, a number of changes in personnel are taking place. R. N. Rapoport is retiring from the social science unit in order to study in England, and will be replaced by M. A. Tremblay, formerly of Laval. The latter has been associated with the Stirling County Study since 1950. J. S. Tyhurst is retiring from the psychiatric unit in order to return to McGill and is being replaced by Eric Cleveland. The latter comes from the Department of Health of the Province of Nova Scotia, having received his psychiatric training at Dalhousie and Toronto.

Two new positions have been created: deputy director

of the Stirling County Study, and clinic administrator. A. M. Macmillan has been appointed to the first of these, and W. H. D. Vernon to the second.

v. Publications Board:

A Publications Board has been created to review and advise on articles and monographs prepared for publication. The Board consists of: Urie Bronfenbrenner, for psychology; Oskar Diethelm, for psychiatry; Jean Downes, for epidemiology, and Robin Williams, for sociology.

vi. Finances:

The work is jointly financed by the Carnegie Corporation of New York, the Dominion-Provincial Mental Health Grants of Canada, and the Milbank Memorial Fund. It is administered by the Social Science Research Center of Cornell University in cooperation with the Department of Health of the Province of Nova Scotia and in collaboration with Acadia and Dalhousie Universities.

2. The Aims of the Study.

The aims of the Stirling County Study are twofold, theoretical and practical.

i. The central aim of the study - theoretical:

Many claims have been made regarding the relationships between social environment and psychiatric disorder. The central research aim of the Stirling County Study is to discover, or verify, meaningful relationships between the distribution of psychiatric illness and the distribution of stressful conditions in the social environment.[2]

ii. The central aim of the study - practical:

The practical aim of the study is to increase the effectiveness of preventive psychiatry when applied to the individual and the community in which he lives.

3. Some Practical Outcomes achieved to date.

i. Contributions to the general public:

a.) Aid to the emotionally disturbed:

From the time of its opening until the end of October, 1953, the Clinic has served 282 persons. Some of these have been seriously ill, some have had only minor ailments. Some have been seen only once and some have received prolonged psychotherapy.

2. A broad outline of the research plan has been published and also a progress report. See A Proposal for Research in the Epidemiology of Psychiatric Disorder, Epidemiology of Mental Disorder, Milbank Memorial Fund, New York, 1950; and the Stirling County Study, Inter-relations between the Social Environment and Psychiatric Disorders, Milbank Memorial Fund, New York, 1952.

The Clinic staff have the impression that a number of patients have been helped, and that to some extent, a preventive role has been played by the Clinic. Persons, who, lacking early treatment would otherwise, we believe, have ended in a mental hospital, have been rehabilitated. We cannot of course prove this at the present stage of our research.

It is felt, too, that the presence of the Clinic has a stabilizing effect. In a sense our patients are never discharged. Persons who have received help know that the Clinic continues to be available to them should they need further assistance. This is reassuring, and therapeutic in itself, since there are so few agencies to which many people feel able to turn for support.

b.) Changes in Public Attitudes.

On a purely impressionistic basis we feel that there have been subtle changes in the attitude of the general public to the Clinic since its inception. From initial wariness and skepticism about what the clinic was "supposed" to do there seems to have developed a growing acceptance of its usefulness and an increasing awareness that others besides "crazy" people can be helped by psychiatric treatment. In fact, this change has been commented upon, on several occasions

in recent weeks by community leaders.

ii. Contributions to Professional Groups.

a). The local physician:

One of the most significant practical effects of the presence of the Clinic in the Stirling community has been the increasing interest in, and sophistication about, psychiatric problems, on the part of the local physicians, particularly in the town of Bristol.

From time to time the Clinic staff have held conferences on various types of mental disorders, to which members of the local medical association have been invited. The individual physician has been given every assistance in dealing with difficult cases. These have frequently been discussed with him in detail.

The effects of conferences and discussion are clearly noticeable, both in the types of case which are now being referred, and in the kind and amount of information available in the referral form.

b.) Teachers.

From the beginning of the project there has been a close relationship with the schools. One of the earliest contributions was made by the social science unit,

which conducted an opinion-attitude survey on behalf of the new Rural High School. The results of this survey strengthened the hand of the school administration and enabled it to add a number of courses to its adult education program which were felt to be needed by the members of its constituency.

In addition, the project staff has made a practice of meeting all requests for speakers at Teachers' Institutes, Home and School Associations, and the like. As an example, three members of the Clinic staff were on the program of a recent Teachers' Institute.

Teachers have visited the Clinic, to meet the staff and to learn about its work. The Clinic members have also attended staff meetings of the Rural High School.

Appropriate methods of referral have been developed whereby any school child needing therapeutic help, can obtain it at the Clinic. In addition, the School Board of the Rural High School has appointed the Clinic's Senior Psychologist as a consultant to the Guidance Department.

By these means, children with a variety of emotional problems, such as speech difficulties, retarded learning, reading difficulties, and vocational uncertainty, have been given assistance.

iii. Mental Health Associations.

No Mental Health Association exists in Stirling County and no direct attempt has been made to have one formed. It is our belief that such a development should come primarily by the action of members of the community itself, in reaction to a felt need.

However, we have given assistance to Mental Health Associations in adjoining and neighbouring counties. Speakers have been provided for meetings and we have been consulted on program, aims and methods. Only recently, at their request, three members of the executive of the Mental Health Association of an adjoining county, spent the larger part of a day at the Clinic in conference, discussing the mental health needs of their area, the objectives at which their association might aim, and the methods and programs they might adopt to reach these objectives.

iv. A study of the Problems and Functions of a Rural Clinic.

At a later point in this report (p. 69) the research done on this topic will be referred to.

4. Some Practical Outcomes hoped for in the future.

Two kinds of practical outcomes may be hoped for in the future one derived from the practical experience of working in the mental health field in a rural area, the other derived from our research.

i. Outcomes derived from experience:

With the continuing impact of the Clinic on the community we should hope to see the development of a Mental Health Association in Stirling County, and our experience with other associations of this sort should help to foster its rapid growth and adequate functioning. We should, therefore, hope to have something to say in the future about the value and functions of such associations.

Perhaps a more important result will be the outcome of experience in running a rural psychiatric clinic. From this experience we would hope to be able to prepare a proposal for an overall plan to provide mental health services for rural areas throughout the Province.

ii. Outcomes derived from research:

As will be shown later in the body of the report, a number of methods are under development which give promise of being able to discover in a community, the persons who are

"carriers" of symptoms which are of psychiatric significance. Some of these methods are rapid, and though giving evidence of reliability and accuracy, are superficial. Others are more time consuming but reach more deeply into the individual.

If our research efforts prove to be successful - and we cannot of course, at this time, be certain that they will be - it should be possible in the future to survey any community rapidly for an estimate of the concentration of symptom carriers in it. If a high concentration is found, time can then be taken to make a survey in greater depth to ascertain the types of illness, and their seriousness. Facilities can then be set up to deal with the problem. We are very hopeful that this kind of practical outcome will be one of the results of the Stirling County Study.

6.) The study of the functions of a rural clinic in preventive psychiatry. (p. 69)

Thus it may be seen that item 1.) shapes the questions to be asked and lays out the research operations. Items 2.), 3.), and 4.), attempt to provide partial answers to the question, "What patterns of relationship exist between social environment and psychiatric disorder?" Item 5.) is expected to yield partial answers to the question, "Why do these relationships exist?" Item 6.) is concerned with practical application.

Each of the above topics will be taken up in turn. The reader is requested to bear in mind that although they are of necessity presented serially here, in actual practice, work in all categories has gone on simultaneously. The different parts of the research are interdependent.

I. General Framework of Research

As noted in the foreword, our central research aim is the uncovering of meaningful relationships between social environment and psychiatric disorder. A practical aim is to explore the functions of a rural clinic in preventive psychiatry. With this in mind, the present report is divided into the following major categories:

1.) The development of theory whereby psychiatric disorder and social environment can be related in such a way as to permit data gathering and analysis. (p. 16)

2.) The study of the social environment in a given geographic area and its classification into sub-units that can be rated in terms of conditions promoting good and bad mental health. (pp. 17 - 38)

3.) The study of the numbers, typology and distribution of persons in the above areas who do and who do not, exhibit psychiatrically significant symptoms. (pp. 39 - 60)

4.) Testing for correlations between 2.) and 3.) above. (pp. 61 - 65)

5. Detailed, clinical, qualitative studies of selected cases to secure a descriptive dynamic picture of the relationship of environmental factors and psychiatric symptoms. (pp. 66-68)

II. Development of Theory and Operational Plan.

The main elements of the conceptual frame of reference, and a handbook of operations were prepared in the first year. Since then there have been additions as a result of findings and as a result of experience in doing the work. For example, both the finding that the number of of persons displaying psychiatrically significant symptoms was larger than expected, and the experience of interviewing people in the community led us to shift from an original plan of counting the total number of psychiatric cases to a second plan which called for the use of samples.

As a matter of logical procedure, it is our intention to publish on theory first, and most of that statement is now ready except for editorial polishing. Although a report on methods is equally advanced, we expect to withhold publication on this subject until after the preliminary findings have been presented.

III. Social Environment.

The study of the social environment, which has been primarily the responsibility of the social science unit, has the following four objectives:

1.) A general descriptive study of Stirling County in socio-economic and cultural terms.

2.) Plotting the distribution of selected sociological and cultural characteristics considered to be important in mental health.

3.) Intensive study of selected areas which show, to a minimum and maximum extent, the above sociological characteristics.

4.) Identification and description of social roles which appear to be maximally and minimally exposed to psychological conditions important in mental health.

These objectives will be taken up in order.

1. General Descriptive Study of Stirling County

The reasons for desiring a general descriptive study of Stirling County are probably obvious. It is a source of background data in terms of which subdivisions

of the county (such as communities, classes, and ethnic groups), may be understood and it affords a start in uncovering reasons for any unusual findings that may occur, as for instance a wholly unexpected distribution of psychiatric symptoms. It is, in essence, a systematic attempt to capture Pasteur's principle, "Chance favors the mind which is prepared".

The descriptive study, while summarized briefly in two reports, exists primarily as a file. It is arranged somewhat like an encyclopedia, but with the differnce that additions are continuously being made. The categories have been organized systematically to fit the topics of common interest in all socio-economic and cultural studies and also the particular characteristics of Stirling County. The headings consist in such items as "Family," "Religion", and "Ethnic Attitudes".[3] In addition, every community within the county on which we have data, is listed alphabetically. Thus, one can go to the file and pull out a set of cards on such different items as lobster fishing, child-raising, or the use of alcohol, and find therein virtually

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3. A full list of the categories is attached as Appendix A.

all the data we have on the subject. He can also select most of the communities in the county by name and pull out all our information on each.

The system of categories and the operational methods were evolved from a previous system developed in connection with wartime research.[4] It was also influenced by a similar file in the Raman Studies at the Department of Social Relations at Harvard, and by the Human Relations Area File at New Haven.[5]

In 1948 and 1949, before the current project opened, two summers of field work were devoted to the general study of the county. This data formed the basis of the original file. The system of categories was revised in 1950 and since that date the file has greatly expanded.

The file is up to date and many of its categories contain data which could be converted in a rather short time into articles and monographs on various sociological and cultural aspects of life in a rural maritime region. However, we do not plan to undertake such publication until the more central aims of our research have been achieved.

4. This is described in Human Relations in a Changing World by Alexander H. Leighton, E. P. Dutton, New York, 1949.
5. Outline of Cultural Materials, by George P. Murdock et al., Human Relations Area File, Inc., New Haven, Connecticut.

In addition to the file, the raw data from two questionnaire surveys is also available in the form of marginals (tabulations of the responses to the questions), and punch cards ready for use in testing correlations. One of these surveys was run in 1949 and covered only a part of the county, while the other, the Family Life Survey, was run in 1952, and extended over the entire area. Although both were carried out for particular purposes, both contain much data that pertains to general knowledge of the county.

Through the courtesy of the Dominion Bureau of Statistics, a duplicate set of punch cards of the Stirling County area was made from the 1951 census for our use. From these we have obtained census tables of much smaller sub-areas in the county than are usually available and more than this, numbers of correlation tables of a type that is not customarily made. Furthermore, the punch cards remain available for such correlations as we may in the future request from the Bureau -- subject, of course, to the limitations of the Census Act.

Finally, through the collaboration of the Canadian Library Association, microfilms have been made of a local newspaper going back approximately 90 years. This material has

not been analyzed or categorized, but is held as a resource, to be used when it becomes important to trace or confirm a particular historical trend that is relevant to our study of social factors significant in mental health. For example, the timing of many of the technological changes that have had a profound influence in the county could be established from this data.

2. Sociological Characteristics Important in Mental Health.

One of the main integrative ideas in our theoretical frame of reference is the proposition that social disorganization[6] creates psychological states which predispose to psychiatric disorder. This is not an all-inclusive notion; that is to say, we do not presume that all mental illness arises in this context. We do, however, propose to test the supposition that, by and large, more psychiatric symptoms

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6. For discussion of the meaning of the concept "social disorganization" see:
1.) Wineberg, Krison S., Society and Personality Disorders, Prentice-Hall, 1952.
2.) Wilson, L., and Kolb, W., Sociological Analysis, Harcourt Brace, 1949.
3.) Blumer, Herbert, "Social Disorganization and Individual Disorganization", Amer. J. Sociol. 42, 1939.
4.) Faris, Robert E. E., Social Disorganization, the Ronald Press Company, New York, 1948.
5.) Leighton, Alexander H., The Governing of Men, Princeton Press, 1945.

are found in disorganized groups than in those that are well organized.

Since the matter of the relationship of personal to social disorganization is central in our research scheme, an elaboration on the point is appropriate. Let us begin with a brief attempt to define social organization. For illustration, one may say it is that which distinguishes an army from a mob. In community terms it is the web of inter-related patterns whereby the biological and psychological needs of the constituent members of the group are satisfied; and whereby the identity, continuity and survival of the group is achieved. These are shared patterns and they include such items as leadership, communication, economic activity, and many others. The patterns not only have active perceivable aspects, but they also embrace ideas, values, sentiments and expectations by means of which the participation and co-ordination of the individuals in group activity is achieved.

This is the bridge between group organization and individual organization. Many of these sentiments and symbols have profound significance to the individuals of the group, significance which has to do with mental and emotional integration, (ego consistency, harmony in the self-system).

"Mother", for example, is a role in an institution, and family, which is part of the social organization of a group.

But "Mother" is also a symbol with great psychological influence, conscious and unconscious, relevant to the formation and maintenance of personality integration.

It is thus that social organization affects individual welfare, not only through the objectives of its patterns - that is the provision of food, clothing, shelter, mates, defence, and so on - , but also through the symbols, sentiments, and values which are a part of these patterns.

In contrast to social organization one may postulate over-organization or under-organization. The former is not relevant since it is not evident in the population we are studying.

Under-organization may be divided into two types:

a). Unorganization, that is lack of organization, like a freshman class or new recruits to the army,

b). Disorganization, that is deterioration of organization from a previously higher level.

Although theoretically distinct, these two are not always easily separated when it comes to observation. In our population, unorganization seems the less significant, which leaves disorganization as the point of emphasis.

Disorganization is a relative term by which we mean to indicate that one community is more fluid and uncertain than another in the occurrence of those patterns that have to do with the provision of food, shelter, clothing, mates, and defence, and also the values, sentiments, and expectations that are important in personality formation and the maintenance of personality integration.

Reverting for a moment to the earlier illustration, disorganization of the mother role not only weakens the family institution and its functions in pragmatic living, but it also, through distortion of the mother symbol and its implications, disturbs personality, either in its formation or in its later performance, or both.

Thus, to summarize, social disorganization affects personality adversely because: 1) it interferes with the psychological development and growth of the child; 2) it acts as a precipitating factor in adults by placing them under a variety of psychological stresses; 3) and it reduces opportunity for finding and utilizing compensations, that is psychological aids, that are generally available in societies with normal culture and organization.

It was decided that we should attempt to map the distribution of social organization and disorganization throughout the county, and by this means, select for further study a number of contrasting groups - that is, the least and most disorganized. Seven variables were selected and defined as being both indicators of social disorganization and detectable in Stirling County with the methods at our disposal. These may be summarized as follows:

1.) Poverty - This refers to a gradient from poverty through average economic resources to affluence.

2.) Secularization - Here reference is to a gradient that has at one end full participation and interest in religious life and at the other, little or no participation and interest.

3.) Acculturation - In Stirling County this has to do primarily with English-French relationships. At one end of the gradient is the person, English or French, who has minimal contact with the life and point of view of the other group. At the other end is the individual who is maximally engaged in changing from one way of life to the other.

4.) Rapid Social Change - This refers to the effects of technological, (e.g., lumbering and fishing) changes, and institutional (e.g., appearance of rural high schools and disappearance of large families) changes.

5.) Health - The gradient here is, obviously, prevalent poor health to prevalent good health.

How measured

6.) Migration - At one end of this gradient is the community made up of families who have been there for generations and to which there has been no migration. At the other is the community in which there is a high rate of turnover in membership.

7.) Disaster - This refers to the presence or absence of catastrophic events, such as fires, and to the prevalence of individual or family disasters, such as auto accidents, loss of family members in war, injuries, or even severe economic difficulties.

The above gives the merest sketch of the variables and does not attempt to describe them with the qualifications that have been necessary in the actual work. Nor, does it give any indication of the theoretical reasons for their choice. Such treatment would require a very

lengthy statement of concept and of operational methods, both of which are deemed to be beyond the scope of this report.[7]

Statements are now in preparation dealing with the patterning and intensity of each of these social disorganization variables throughout the county. This work is based on two primary sources of data: Interviewing of selected informed members of the county and interviews by means of a structured questionnaire administered to a systematic sample composed of 1,015 individuals. In addition, a number of secondary sources are also used, such as certain kinds of records, (e.g., church attendance, registration of vehicles showing year and make of car), and a survey by which each house in a county-wide sample was rated for objective signs of wealth or poverty it displayed.

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7. It is, however, important to emphasize, that, although we have estimated the variables in terms of high and low along a gradient, no straightforward gradient relationship is presumed to exist with regard to psychiatric symptoms. A theoretical relationship has been developed, but it is not in such simple terms as "the more poverty, the more psychological stress".

The reports on each variable are both qualitative and quantitative. In general, a descriptive and qualitative statement with rough quantitative estimates is prepared first, using the interviews with informed persons and also some of the secondary sources. To this the results of the systematic survey, (Family Life Survey) are later added and where discrepancies exist, an evaluative statement is made. Exceptions to this are migration, health and disaster, in which there is reliance almost entirely on the questionnaire survey.

For most of the variables, the first stage is completed and the social science unit with the help of the statistician is at present engaged in the analysis of the questionnaire responses. In the case of the first three variables, (poverty, secularization and acculturation), an attempt is being made to apply the Guttman scaling technique. For the others, indices have been constructed.

To sum up, then, the bulk of the work is nearing completion, including coding, punching and the construction of indices. What remains is the assembling and final evaluation of the results. As previously noted, the finished

product will be a qualitative and quantitative statement regarding the county-wide distribution of selected sociological variables thought to be important in mental health.

3. Intensive Study of Selected Areas.

In the original research design, the seven variables were to be used as a means for selecting a limited number of communities at the two extremes on the social organization-disorganization axis. In practice it was found necessary because of time pressures, to select these communities (hereafter called "focus areas") before all the data and the results of analysis were available. These areas consist in two comparatively well organized communities, three that are disorganized, and one town, Bristol, that contains both the extremes and the medium, and which may be called "complex".

A second set of seven variables (making a total of fourteen) was applied to the study of the focus areas. They may be described as follows:

1.) Leadership - This involves a definition of types and then a rating for presence or absence.

2.) Associations, both formal and informal - In this category we propose to compare communities in terms of

the presence or absence of associations for work, pleasure and other interests.

3.) Leisure - Reference here is to a rating for constructive as opposed to destructive types of leisure (e.g., handcrafts on the one hand and excessive drinking on the other).

4.) Broken homes - This has involved comparing communities in terms of numbers of both physically broken homes (one or both parents absent) and psychologically broken (both parents present, but with serious psychological difficulties between them).

5.) Crime and delinquency - The aim here is to compare the communities in terms of the numbers of incidents and to make absolute counts or estimates rather than use only the cases that come to the attention of the police.

6.) Communication - In this category a comparative rating is made of the patterning and frequency of communication between persons in the community and between the community and the outside world.

7.) Hostility - Here we attempt to compare the communities in regard to the amount of manifest hostility

expressed by members toward each other and toward persons, communities and institutions on the outside.

These second seven variables, like the first seven, are considered to be indicators of social disorganization, and the remarks made regarding theory and method relative to the first seven also apply to these.

Since the data concern much that is intimate, and not open to the more formal methods of the questionnaire, reliance has been placed primarily on prolonged personal contact with the focus areas. Both the interviewing of informed persons and participant observation were employed. This is not to imply that quantitative material is missing, but rather to say that it was gathered either through direct observation and counting, or through several key individuals in each community with whom it became possible to establish the necessary relationships of mutual understanding. It may also be noted that the questionnaire survey, (Family Life Survey, or "FLS") was administered in the focus areas and to a limited extent has played a part in depicting the distributions of the second seven variables. On the whole, however, the main sources have been, as indicated above, the interviewing of informed persons and participant observation.

We have in process here, as with the first seven variables, a set of reports detailing the distribution of social characteristics thought to be important in mental health. In this instance, however, the comparison will be limited to six contrasting sub-areas of the county, rather than the whole of Stirling. The reports are now in draft form and will be completed during the coming winter.

For illustrative purposes, the preliminary table below shows the probable distribution of the second set of

Interacting Social Units		Lei-sure	Hos-tility	Communi-cation	Associ-ation	Broken Homes	Crime & Delinquency	Leader-ship
#	I	1	1	1	1	1	1	1
Fairhaven	II	2	2	2	1	2	1	1
	III	3	2	3	3	3	2	3
	I	1	1	1	1	1	1	1
Lavallée	II	2	2	2	1	1	1	2
	III	3	2	2	2	1	2	3
	I	1	2	1	1	1	1	1
	II	2	2	1	1	2	1	1
Bristol	III	2	2	2	2	2	1	2
	IV	3	2	3	2	2	2	2
	V	4	3	3	3	3	3	3
The Bog		4	3	3	3	3	3	2
NorthWest Jonesville		4	3	3	3	3	3	3
MonkeyTown		3	2	3	3	3	2	3

Roman numerals refer to social classes.

seven disorganization variables in the focus areas. In this table, a social class is a series of "interacting social units" which are, to a great extent, internally cohesive. In our attempts to compare focus areas among themselves for the fourteen social disorganization variables and rate them accordingly, we found that there was no comparable homogeneity and that ratings were meaningless unless they were made along class lines. A rigid class analysis could not be undertaken since the three economically depressed areas (The Bog, Monkey Town, and Northwest Jonesville) were each characterized by being a lower class unit. Wherever the multiple class analysis is relevant (as in Bristol, Fairhaven, and Lavallee) it is used; wherever not, the single interacting social unit is the basic unit. For instance, the social interacting units number III of Lavallee, number III of Fairhaven, and number V of Bristol, (which represent the lower classes of these communities), have nearly the same socio-cultural characteristics and are comparable to groups of families living in the depressed communities.

Criteria for Evaluating Variables (according to class):

Leisure: The criteria which are used (always on an individual

basis for all variables analyzed) for rating community strata on leisure activities are: amount, type, orientation, and degree of organization and constructiveness.

Point 1 A great deal of leisure time taken at will (not imposed and usually socially oriented.) If it is individually oriented it is always constructive in nature.
Point 2 Smaller amount, same characteristics.
Point 3 Leisure imposed, a surplus of leisure activities which the individual does not know how to use, usually destructive in nature and not through formalized channels.
Point 4 Same characteristics as (3) except more intensity and more families.

Hostility Ratings:
Point 1 No outstanding gossip and no use of physical violence.
Point 2 Large amount of malicious gossip and occasional punishment through reprisals.
Point 3 Strikingly large amount of malicious gossip and frequent punishment through reprisals and manipulations of human beings.

Communication: The criteria are (1) travel, (2) use of mass media of communication, (3) visiting and get-togethers, (4) formal organization. Access and use of all these channels for communication.

Point 1 Access and use of many of these channels.
Point 2 Access and use of some.
Point 3 Access and use of little.

Association:
Point 1 A great many formal and informal organizations.
Point 2 Some formal and informal organizations.
Point 3 No formal and little informal organizations.

Broken Homes:
Point 1 Less than 10% of broken homes.
Point 2 Over 10% but less than 20%.
Point 3 Over 20% of broken homes.

Crime and Delinquency:
Point 1 Little crime and delinquency.
Point 2 Some crime and delinquency.
Point 3 A great deal of crime and delinquency.

Leadership:
Point 1 A surplus of leadership, and exercise of leadership all over the county.
Point 2 Some leaders which exercise leadership mainly in the community.
Point 3 No leadership and very little organized activity within the group.

While it is of interest to trace the distribution of the fourteen social disorganization variables in the county and in the focus areas, it is our belief that this is not sufficient for understanding their significance. The focus areas themselves, as the sociological hosts in which those variables operate, and as the social groups in which it is expected that greater and lesser numbers of people with psychiatric symptoms will be found, must also be understood.

They must be understood as communities, or sociological wholes, if this is what they are, or as fragments of larger social units if the latter is the case. Finally, they must be compared with each other in terms of some of the dimensions commonly used in describing human groups.

As can be readily seen, the above need poses a considerable problem in method. To meet this, a "model" for a community study was set up in 1950 and a systematic effort was made to gather the indicated data as soon as the identity of the focus areas was established. Recently this "model" has been redesigned and a community study following these specifications is being prepared on each of the focus areas.[8]

The sources of material for these community studies is that which has already been described: interviews with informed persons, a questionnaire survey administered to a systematic sample of 1,015 adults, participant observation and documentary sources including the 1951 census. In addition, a survey of child rearing practices consisting of 102 interviews with a sample of parents was carried out

8. The format is presented in Appendix B.

in 1952. The technique followed was that developed by Whiting and Sears at Harvard.[9]

Thus the studies of each community will be, like the report on the stress variables, a combination of qualitative and quantitative information. They should make clear the outstanding differences and similarities of the focus areas and show the social disorganization variables operating in terms of the total community context.

4. Social Roles

The study of social roles is the least well developed of our objectives in the study of social environment. Although a part of the theoretical framework from the beginning, it has not so far been put in shape for operational use. The matter is important because it may help to answer a question we have frequently raised, namely: even supposing that socially disorganized societies are more prone to psychological stress and distortion, may it not be

9. Some Child-Rearing Antecedents of Aggression and Dependency in Young Children, R.R. Sears, J.W.M. Whiting, V. Nolis, P.S. Sears, Genet. Psychol. Monogr., 1953, 46, 135-234. For a preliminary statement regarding this work in Stirling County see Appendix C.

that there are certain roles in the well organized societies which are highly stressful and hence likely to foster psychiatric disorder?

In our opinion, the answer to this is "yes" and we are consequently interested to develop methods whereby stress producing roles in average or well organized communities can be identified. We believe we have on hand considerable data relevant to this problem and we expect to give it attention when the studies of the social disorganization variables and the focus areas are sufficiently advanced. Additional field work will, however, be necessary and this is part of what we wish to accomplish in the next three years.

# # #

This section on the study of the social environment may be summarized and concluded by saying that we have in preparation a series of reports which will describe the distribution, patterning and intensity of selected sociological conditions that have bearing on mental health.

IV. Numbers, Typology and Distribution of Persons with Psychiatric Symptoms.

This section of the report may be divided into four parts:

1. Case-counting by means of identifying every case in the area, using all possible resources.
2. Case-counting by means of a survey questionnaire.
3. Case-counting on a sampling basis using all resources.
4. The development of a classification system suitable for epidemiological work.

Each of the above will be presented in turn.

1. Case-counting by Means of Identifying all Cases in Area.

Responsibility for this work has been in the hands of the psychiatric unit.[10] In accordance with the original plan an effort was made to identify and locate, geographically and sociologically, every individual with a condition of psychiatric interest living in Stirling County during the last 52 years. It was thought that this information could be obtained from institutional sources such as our own clinic, hospitals, almshouses, welfare agencies, correctional schools and penitentiaries, and from non-institutional sources such as local physicians, teachers, ministers, community leaders and police. After the psychiatric

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10. See footnote (2).

clinic was established it was found that patients treated there (and also the members of their families) were a source of many additional leads regarding the existence of other cases.

However, as the work progressed it became evident that it would be desirable to introduce a number of modifications in the original plan.

First, it was found that the total number of people with conditions of psychiatric interest as reflected in the institutional records was larger than anticipated. This should not be taken to mean that Stirling County is a region with an unusually high proportion of psychiatric cases. No data exists as a basis for drawing such a conclusion; rather, the indications that are available lead us to the tentative conclusion that the area is in the normal range, but that symptoms of psychiatric significance are more widespread than we at first supposed. To this must also be added the fact that, as we have gained experience, we have broadened our definition of "a case" and so included more symptoms and patterns than originally planned, and certainly many more than the average person has in mind when he thinks of a "mental case" or a "neurosis." These points will be amplified later in the discussion of the classification system for epidemiological work.

From the point of view of research design and procedure, the larger numbers opened up the possibility of using sampling methods with all the implications for more efficient procedure which this entails.

Second, there were marked variations between the different institutional sources in their manner of reporting, the types of cases they attracted, and in other matters. Moreover, any one institution tended to vary markedly through time in the course of fifty years. Similar differences of greater magnitude existed between the non-institutional sources with the result that major problems of comparability were posed.

Third, the data on each case from every source were as a rule incomplete, if one took into account that we had to have not only a report on symptoms, but also basic sociological data so each individual could be placed geographically and in terms of the sociological variables. In the material derived from institutional sources, the minimal data required were complete in not more than one out of fourteen cases. The ratio was worse in those cases derived from non-institutional sources.

In order to meet these problems a number of steps were taken. First, the scope of the case counting was limited and more rigorously defined. We took as our universe, all those

persons who were alive and resident[11] in Stirling County as of May 1, 1952, instead of all the people in the area over a fifty-year period.

A second step was the selection of Bristol town and environs as an area in which to push the case-counting effort through to completion in order to discover more thoroughly the nature of our problems and to test our methods for solving them.

Third, all our records of cases derived from the four metropolitan hospitals serving the area were examined and a compilation made of those coming from the Bristol town region. These in turn were analyzed by means of the diagnoses and symptoms reported and were arranged in four categories:

A. Almost certainly a psychiatric case.

B. Probably a psychiatric case.

C. Possibly a psychiatric case.

D. No evidence of being a psychiatric case.

Fourth, by the use of key informants a census was made of the Bristol area resulting in a map that showed every house and its assigned number, and a file that contained a card on each adult resident in the area as of May 1, 1952. Cases A., B., and

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11. Persons in mental hospitals and other institutions are included if their residence is given as some point in Stirling County, even though they may have been in the hospital many years.

C., were checked against the cards and all those not found in the census were eliminated from further consideration.

The fifth step consisted in interviewing the remaining individuals (approximately eighty) who were in the A., B., and C. categories. This was done in order to get additional medical information (including psychiatric) and the necessary sociological data. The map and the assigned house numbers made locating the people relatively easy and the interviewing was carried out by a team of five. Three of this group were women who had had experience as interviewers, but who were not trained in psychiatry or clinical psychology. The other two were psychiatrists (A. H. and Dorothea Leighton), and we participated not only as interviewers, but also in supervising the other three.

Refusals were negligible and the course of the work made it clear that it was possible to complete the data on cases found by means of hospital records, but at a cost of approximately two man-hours of work per interview, including travel time and recording. A similar follow up study in a French speaking area gave essentially the same results.

The sixth step was an attempt to answer two questions: How many similar types of cases are there in the population who have never been to one of the metropolitan hospitals? How can we

systematize the case-finding work when utilizing non-institutional sources? To meet these problems it was decided we should adopt a sampling procedure. A twenty percent sample of the adults of the Bristol town area was drawn and checked against data on hand from all sources, both institutional and non-institutional. In addition, all individuals in the sample were interviewed and a further check was made by systematically interviewing two physicians and a local leader about each of these people. Further details regarding this sample and the results will be presented a little later, but we may note here that it demonstrated that, of the people in the community with symptoms of psychiatric interest, relatively few had been to one of the hospitals. In other words, the "cases" found by searching the institutional records were a small part of the total in the community. It was therefore decided that, instead of trying to identify and count every individual case, it would be more efficient to rely on sampling, since this promised to give both a more accurate picture of the total numbers and more details for analysis. The sampling procedure will be described later.

However, since the survey of institutions did yield some valuable information on the sociology of medical treatment

for psychiatric disorders, (that is to say, what kind of people get treatment and of what type), and since it provided data for use in samples, the survey of institutional records was carried to completion on the metropolitan hospitals, all the correctional institutions in the Province, twelve almshouses, the one general hospital in Stirling County, and the files of the Welfare Department. In order that this material might be handled in terms of a uniform date for the entire county, a census as of May 1, 1952, for all of Stirling is being compiled, together with maps showing every house and its assigned number.

In addition to the above, we also have on hand the results of a pilot study in case-finding through the medium of the rural schools.

The only field work remaining, (aside from completing the census), is a review of the Stirling County cases in one general hospital in an adjacent county. For the time being, such additional field work in total case counting, like further analysis and reporting, has been postponed in favor of completing work more centrally related to our main epidemiological interest. Nevertheless, we expect during the course of the next three years, to return to the institutional data and prepare a statement saying something about what sociological categories of people get treatment for what kinds of symptoms.

2. Case-counting by Means of a Survey Questionnaire.[12]

At the very beginning of the study it was decided that explorations should be conducted regarding the feasibility of case-finding by means of a psychological screening device. The development of this work has been in the hands of the mental health survey unit.

The instrument evolved, (hereafter called the Health Opinion Survey or HOS), was derived from a large range of tests available in the field of mental health screening, but had as its core the N.S.A. psychosomatic inventory.[13] It was so constructed as to have the advantages of shortness, relative independence of the respondent's level of education, inoffensiveness, and susceptibility to rapid scoring.

For trying out the test, we took as our subjects, patients who had been diagnosed by psychiatrists as having some form of psychiatric illness and a random sample of a community population in two counties similar to the English speaking part of Stirling, but some hundred miles away. The results of the community testing were recorded sequentially in groups of 50.

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12. The subject matter of this section is of necessity largely in statistical terms. To attempt to express it otherwise would render the section much too voluminous.

13. See Measurement and Prediction by Stouffer, et al., The American Soldier, Princeton University Press, 1950, pp. 535-538.

The criterion groups were limited in age to those between 20 and 59 and a stratified cluster sampling was used to spread the HOS over a wide range of social conditions. When the first 300 interviews in the community and the first 50 of the psychiatrically ill group had been completed, a preliminary item analysis showed that certain of the questions were answered very differently by these two groups. There was also evident a stability of marginals between the groups of 50 in the community interviews. Additional interviews were therefore obtained in order to increase the accuracy and flexibility of the analysis. A total of 117 interviews with psychoneurotic cases and 612 with community members were ultimately secured.

A 10% sample of the original sample of community people was interviewed by a psychiatrist who rated each on an ill-well scale and gave a diagnostic classification when he felt this possible. This recheck sample was drawn disproportionately, so as to contain more persons who gave neurotic type answers to the questions than it did people who gave answers characteristic of the majority of the population in the community. The purpose in the recheck was to have the psychiatrist's estimates as a further means of examining the effectiveness of the test. At the time he interviewed the respondents, he did not know how they had been scored on the test questions.

After the field work was completed in the fall of 1951, the analysis proper began. An item analysis was first run to test the discriminating power of each of the 75 HOS test items. Forty were found to work at the 1% level of confidence in discriminating between the community and the psychoneurotic group. At the same time an effort was made to see if the items would form Guttman scales or quasi-scales, but this was unsuccessful. Next followed a discriminant analysis which we adapted to the trichotomous nature of our data (each question had three possible choices in response). Twenty of the forty highly discriminating items were chosen on the basis of their having maximum capacity to distinguish consistently between the psychoneurotic and various community groups living in a variety of social conditions.

The general basis of discriminant analysis is to find (using inter-correlations among the items) the weight for each item that will give a score that separates the mean score for each group as far as possible while keeping the score variance within each group as small as possible. This results in minimum overlap of the frequency distribution of scores of one group (in our case the ill) with the scores of the other group (in this case the community population). In finding the weights, one subgroup of the community population was used on the assumption that it contained the least proportion of people with neurotic illness.

(This estimate was based on a general appraisal of the group). It turned out that the discriminant function had high agreement with the psychiatrist's rating of people as ill or well in his sample.

Discriminant analysis has in general one basic drawback when applied to trichotomous data; one has to assume an underlying measure. Our particular discriminant analysis had the further drawback that the community group probably contained a relatively small but unknown percentage of people with psychoneurotic difficulties.

Since the amount of computation involved in discriminant analysis is considerable if one does not have electronic equipment available, we plan in future work to use approximations.[14] Although it is not believed that these seriously impair the discrimination, the efficiency of these shortcuts as applied to our data remains to be investigated.

In addition to discriminant analysis, we have also carried out latent structure analysis. Five psychiatrists (three of them not otherwise connected with the research) rated the questions in the HOS in terms of their significance in contributing information on a number of components of psychoneurotic illness,

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14. See Approximate Methods in Calculating Discriminant Functions by Geoffrey Beall, Psychometrika, 1945, 10, 205-217; and The Discrimination of Two Racial Samples by Paul Horst and Stevenson Smith, Psychometrika, 1950, 15, 271-289.

such as anxiety, depression, overconcern with the body, etc. Using this material, the latent dichotomy model chosen was a close approximation to the phenomena with which we dealt. The fundamental concept of latent dichotomy is that the response patterns are divided into two underlying classes such that correlations between the items within a unit are entirely explained by these latent classes. That is, within each latent class, the items in the scale are entirely independent of each other (i.e., pairwise, tripletwise, etc.).

Using the above method, seventeen latent structures have been found in units involving five questions each. Some of these have a very high capacity for distinguishing between the ill population and the community. For example, one set of five questions is by itself able to discriminate 90% of all the psychoneurotically ill group. More important is the possibility that by this means the HOS will be able to go beyond a crude separation of ill and well and say something about the type of illness.

In Stirling some of the screening questions were included in the Family Life Survey and hence have been administered to 1,015 individuals on a county-wide scale. The selection of questions for this inclusion was not necessarily the best possible since it had to be done before the analysis of the HOS had advanced to the point outlined above. Nevertheless,

we expect that the responses to these questions will give important indications of the distribution of psychiatric illness in the whole of Stirling.

In the case of the random sample in Bristol town area, the HOS questions were also used and by this means they afford us an opportunity for comparing them with other methods of case finding. Analysis of this material has not yet begun, but will be carried out as soon as the steps indicated in the next paragraph have been achieved.

As noted earlier, one of the difficulties with our discriminant analysis is that the community population contains an unknown number of psychiatrically ill people. In order to achieve the best capabilities of the test, it should be calibrated using a population that is entirely well instead of a random selection from a community. This has heretofore been impossible, but the emergence of the random sample of the Bristol town area and the total push to gather all relevant psychiatric data on the people in that sample has provided us with a group which, if not absolutely free of psychiatric symptoms, certainly approaches it. Five psychiatrists working collaboratively in a complicated system of cross-checking each other have reviewed all the information on each individual in the random sample and have separated out a group of people as free of symptoms of psychiatric

significance. These are now being used as a criterion group and their responses to the test questions are being compared with those of the group known to be psychiatrically ill. From this we expect to derive a new calibration of the HOS that can be applied both to the total random sample of the Bristol town area and to the county sample embodied in the Family Life Survey.

Looking further ahead in the future, we hope during the next three years to develop and refine the HOS instrument. This has particular reference to checking its reliability and validity when used with a French cultural group and to examining its capacity to discriminate between psychiatric types of illness and a variety of more organic diseases. We are also anxious to employ it more extensively in Stirling County in order to secure a larger sample of people with psychiatric difficulties so that we may increase the number of correlations we are able to test.

As far as reporting is concerned, a monograph on the HOS is in preparation, all the basic points have been described, and what remains is largely a matter of editorial work. An article on the latent structure analysis has been written and presented by Garnet McCreary, the statistician, to the Summer Statistical Seminar, University of Connecticut.

3. Case-Counting on a Sampling Basis.

Brief mention has been made of two samples that have been drawn in Stirling, the Family Life Survey covering the whole county and the random sample in Bristol town area. Both of these have bearing on case-counting and must now be described in more detail.

The Family Life Survey (hereafter called the FLS) was carried out in the summer of 1952 by the Social Science Unit and the Statistician working together. It consisted in a questionnaire that gathered data bearing primarily on the sociological variables related to social disorganization, but it also sought general information about the county and contained selected HOS questions. The sample was composed of 1,015 adult respondents from the county as a whole, but the sample rate was adjusted in different areas in accordance with our division of the county into twenty-two strata. This system was designed to present the maximum of homogeneity within a single stratum and maximum of heterogeneity between strata as determined by pre-existing general knowledge of the county. The sampling rate for any particular stratum was determined by the size of that stratum, its importance, (e.g. focus areas), and the relative amount of homogeneity within it. By this means it was possible, among other things, to sample the focus areas

more heavily than other regions. Within each stratum respondents were chosen by a systematic random method.

From a case counting point of view, the FLS provided the following data on every individual in the sample:

1.) A health inventory,

2,) Responses to selected HOS questions,

3.) Appraisal by the interviewer,

4.) Complete coverage of the major sociological items.

By checking the names of the respondents against the files gathered from institutional sources, (hospital reports, etc.), certain medical and psychiatric data can be added to many of the FLS protocols. Finally, each one of the thousand and fifteen names can be checked against all possible non-institutional sources of information about cases, thus providing us with a sample in which case-counting from all sources has been carried through to completion. Since the characteristics of the sample are known, the scope and limits of statistical manipulations are relatively clear and many of the problems are eliminated that are inherent in trying to identify, describe and count every case in the area.

However, the above steps for using the FLS as a sample in a total case-counting operation have not as yet been put into effect since there is some question as to whether or not they are

all necessary. In order to make the operation as efficient as possible, two other aspects of our work need to be brought to the point where their results can be used. The first of these is the recalibration of the HOS and the completion of the latent structure analysis so that we shall be clear as to what kind of reliance can be placed on this screening device. The second is to finish a preliminary analysis of the random sample of the Bristol town area so that the benefits of this experience can be incorporated in the attempt to cover the whole county. The Bristol sample will be described below, but we may anticipate here by saying that it looks at present as if the only non-institutional source really worth attention, given the time and cost required, is the local physician.

Thus, in short, it seems likely that in order to use the FLS sample for a case-counting effort, it will be necessary to do the following:

1.) Add all data from our institutional files.

2.) Check the list of 1,015 names against the records of the one hospital (in an adjacent county) that is not in our institutional file.

3.) Interview all the doctors in Stirling County on the 1,015 individuals in the sample.

Turning now to the 20% random sample drawn in the Bristol town area, we may note that it is in reality two samples that are capable of being adjusted to each other. One is that portion of the FLS which fell in the area, and the other is a 10% sample drawn by random methods from our census file for the area. The FLS questionnaire was much longer than that used with the sample drawn from the census, but both surveys have essentially identical sections covering the following topics:

1.) A health inventory.

2.) Responses to selected HOS questions.

3.) Appraisal by the interviewer.

4.) Coverage of enough sociological items so that the respondent can be placed geographically and sociologically.

5.) The results of interviewing two local physicians in regard to the health status and history of the respondent (this includes psychiatric symptoms).

6.) The results of cross-checking with our files derived from institutional sources.

7.) The results of cross-checking with our files derived from non-institutional sources (excluding, of course, the two physicians mentioned under 5.) above).

As previously noted, the data available in this sample (except the HOS responses) has been studied in its entirety by

three psychiatrists and in part by two others, and a group of respondents has been identified as being free from any evidence of psychiatric symptoms. This was done primarily in order to provide a criterion group for the recalibration of the HOS. However, the group can also be used to run a number of correlations with social environment within the Bristol area and to make a preliminary test as to whether or not they constitute a group relatively little exposed to the forces of social disorganization. This analysis will be mentioned again in a succeeding section.

The chief analytic problem in the random sample has been the development of a system of classification and rating of those respondents who do show symptoms of psychiatric interest. This has been accomplished through the collaborative effort of eight psychiatrists and is considered in the section that follows.

4. Classification of Cases for Epidemiological Analysis.

As a starting point, let us restate our main purpose as being the discovery of how people who exhibit symptoms of psychiatric interest are distributed in the Bristol town area. This is regarded as a pilot study for a later analysis of a sample (FLS) drawn from the whole of Stirling. The nature of the data being used has already been described (items 1 to 7 on page 56)

A preliminary in determining the distribution of symptoms is the evaluation of the information on each individual in the sample and by this means his classification into logical and medically significant categories.

The nomenclature which we have selected for use is a portion of that given in The American Psychiatric Association's "Diagnostic and Statistical Manual, Mental Disorders." The manner in which these terms are employed, however, is different from that suggested in the book. We do not use them as diagnoses. Instead, they are a shorthand way of referring to symptom patterns. We cannot use them as diagnoses because most of the Manual headings and diagnoses involve decisions as to etiology. In our data there is not, as a rule, enough information to permit adequate judgements regarding etiology, and hence diagnosis is impossible. However, there is, for the most part, sufficient information so that the symptoms can be grouped according to the "disorders" and "reactions" of the Manual.

Many other methods of grouping symptoms, beside the American Psychiatric Association method, could have been used, and we might have invented our own. Indeed, considerable experimentation along the latter line has been done. In the end, however, we concluded that the Manual System was simple and workable, readily lending itself to coding and opening opportunities

for comparison with other studies - provided the modifications in our use are taken into account. Within the framework of the Stirling County study it promises to be a bridge between different types of data, such as the case studies in the Clinic and material collected by searching the records of hospitals.

Starting, then, with the idea that the terms apply to constellations of symptoms, but are not necessarily commitments regarding etiology, we are employing the following disorders (and the reactions classified) under each:

(a) Disorders Associated with Brain Tissue Function.

(b) Mental Deficiency.

(c) Psychotic Disorders.

(d) Psychophysiologic,Autonomic and Visceral Disorders

(e) Psychoneurotic Disorders.

(f) Personality Disorders.

In addition to the above disorders and their subdivisions being employed as a means of describing symptoms and symptom patterns, ratings are also made as to the time, duration and degree of confidence in the psychiatric significance of the symptoms. This is a four point scale, arranged as shown below:

A - Almost certainly of psychiatric significance.

B - Probably of psychiatric significance.

C - Possibly of psychiatric significance.

D - No indication of there being anything of psychiatric significance.

An evaluation sheet, containing the classification of symptoms and the ratings, is prepared on every individual in the sample. Four psychiatrists scan all the data on each respondent and one other makes sampling checks to be sure that adequate criteria are maintained in terms of a consensus of psychiatric judgement.[15]

Ultimately, the symptom patterns and the ratings will be put on punch cards, after which it will be possible to begin running correlations with the social environmental factors. It is expected that it will be midwinter before the evaluation of the Bristol town area is completed.

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15. See Appendix D for further detail.

V. Correlations Between Prevalence of Psychiatric Symptoms and Various Types of Social Environment.

One of the major steps in our ultimate analysis will be to see if there are more people with symptoms in the most disorganized focus areas than in the well organized focus areas. The carrying out of this step will not, obviously, be as simple as may be implied in the above statement, since neither the human beings in the sample nor the focus areas vary along a unidimensional line from absence of symptoms to the presence of frank psychiatric disorder, nor from organization to disorganization. However, by means of the classifications made possible on the evaluation sheets and by means of the "model" statements regarding the focus areas, it should be possible to try out several different sets of symptom patterns against several patterns of disorganization and organization. At the very least we should be able to see whether or not the marked differences that have been found between focus areas are reflected in any way in the distribution of people with symptoms. We know the focus areas present sharp sociological contrasts and it remains to see if this means anything in terms of psychiatric illness.

If correlations are found, then, depending on their

characteristics, various other consequent tests for correlations will be indicated, new hypotheses will be generated and ultimately new questions will be formed to be asked in additional field work.

A second major step in the ultimate analysis will be an attempt to find out whether or not individuals with symptoms have been more exposed to difficult environmental situations than have those who do not show these symptoms.

This will constitute analysis in terms of individuals and the sociological variables, rather than communities and the sociological variables. The populations to be compared will be the symptomatic and the asymptomatic and the comparison will be in terms of exposure to a number of the most important sociological variables which we have postulated as being significant in social disorganization. Here again no simple linear relationship can be anticipated, but rather a number of different types of symptom patterns will have to be considered in relation to several different sociological variables in varying combinations and intensities.[16] It is expected, however, that the scales and indices that have been

16. See, for example, Differential Fertility in Ontario. An Application of Factorial Design to a Demographic Problem, N. Keyfitz, Population Studies, 1953, 123-134.

developed for rating the communities can, in a large measure, also be applied to these ratings of individual experience.

The question may be raised as to why we bother with the correlations between communities and variables; will not the correlations between individuals and variables be sufficient? Our answer to this is that we have theoretical reasons for suspecting that the community versus variable correlations may in some aspects be more significant than the individual versus variable correlations. We are, of course, not sure of this, but have thought the possibility sufficiently serious to spend a great deal of time in gathering the necessary data for exploring it. The reasoning runs something like this: communities are quasi-organisms in a condition of inter-dependence that has some resemblance to a system in a state of equilibrium. As a result, the way in which a particular factor bears on a particular individual is not only a product of the factor and the individual, but is also profoundly influenced by the total patterning of the community. Consequently, the same factor and the same individual could interact differently in one community as compared to another.

To take an illustration, poverty, if severe enough, is always something of a hazard, but the same level of poverty

may be differently felt in two different communities. It may be one thing to be a poor man in a rich community, and something else to be a poor man in a poor community.

Another way of putting this matter is to say that if a community is a system in equilibrium then the point at which a pressure is applied is not necessarily the point in the group where the resultant stress is maximally felt and consequently is not necessarily where the psychological break is most likely to occur. To make this sound less mysterious we may take as a crude example the case of a fishing village that is exposed to the danger of having its livelihood swept away by the establishment of Otter trawlers operating out of city ports. The semi-organismic concept of a community suggests that the resultant stress may not be most keenly felt by the fishermen, but might appear with more force, and hence with more psychological difficulties, among their wives, their children or among the farm families in the area who supply the fishermen, or among the merchants. Predicting these kinds of chain reactions is an exceedingly difficult business, although post facto analysis has often pointed strongly to them. However, to the extent that prediction can be achieved at all, it must be done on the basis of a knowledge of the

cultural and social patterns.

Having thus attempted to explain the reason for our emphasis on community-variable studies, we must also say that we have not felt that such studies by themselves would be adequate, for there is a strong probability that some kinds of correlation will be most clearly and consistently evident at the individual-variable level. A possible example of this is in broken homes. In Stirling County, at any rate, being the child of a broken home is prone to be psychologically troublesome no matter what community one comes from or lives in and hence if there is any significant relationship between being the product of a broken home and having psychiatric symptoms, it is likely to be most readily evident in the individual-variable type of analysis.

As already mentioned, new hypotheses are expected to arise from the correlations (both positive and negative) in an effort to explain them. These in turn will lead to new research. However, the current phase of our work is limited to the establishment of the correlations for our population and does not envision at the present time definitive results in terms of distinguishing cause and effect.

VI. Qualitative Analysis of Case Records.

Although we do not, as just mentioned in the last section, expect to establish the reasons for correlations, we are extremely interested in developing theoretical propositions of an explanatory nature. It is only by this means that we can hope to make the most of whatever correlations we find. Without this they will remain isolated facts lacking in significant dynamic implications and devoid of capacity to lead into new fields of scientific endeavor.

The most important source of such theory is the ongoing work with patients currently under study in the clinic together with the assembly of case records already completed. It is here more than anywhere else that we can find leads regarding what correlations to test and regarding explanations for those found to exist. Without this, our interpretations of the epidemiological findings are very likely to be static and academic rather than realistically geared to clinical experience.

In the first two years of the clinic's existence, our emphasis, (aside from case finding and case counting), has been on securing a wide variety of case histories recorded in sufficient detail to make possible the realization of the objectives outlined above. These records include not only

psychiatric study, but also psychological tests and social workers' reports on home visits. During the past year considerable time was given to the discussion of the content of the case histories and to the further development of criteria for uniformity of investigation and reporting concerning the role of environmental factors in the dynamics of psychopathology and personality formation.

Recently we have begun the actual analysis of case histories with a view to producing a descriptive account of the psychopathological and related intra-psychic and interpersonal patterns which appear to be significant in Stirling County - as judged from the individuals attending our Clinic. For example, one section of this study will be concerned with ways in which personality formation can be affected by growing up on isolated farms, another with the effects of shifting from one culture to another, as from French to English, or from Europe to life in Canada.

It should be noted that these two examples illustrate a general aim in the clinic research - to examine by means of intensive individual studies the same kinds of problems that are treated statistically and sociologically in the non-clinical part of the work. The individual studies will, however, do what the other studies do not, namely show in

individual cases how various events are related sequentially and causally in the lives of patients and by this means provide leads for general theory bearing on mental health. This qualitative clinical investigation is regarded by us as a keystone in the total research design.

The qualitative study is being carried out jointly by psychiatrist, psychologist and social worker at the clinic and it is expected that it will be ready for publication by next summer.

A second objective for the winter and spring is a review of all cases in order to determine what kind of a sample, both psychiatric and sociological, the clinic cases constitute. On this basis we expect to fill any important gaps that remain and thus render the clinic material open to some kinds of statistical treatment.

VII. Operational Study of a Rural Psychiatric Clinic.

A very detailed study has been made of the functioning of the clinic in relation to every case attending it for the first two years. Each case is looked at from the point of view of such problems as those of referral situation, complaint, diagnosis, types of treatment, types of psychotherapy, contacts with the family, types of interview in addition to psychotherapy, outside consultations, termination of attendance at the clinic, evaluation of progress, and usefulness of the clinic. J. S. Tyhurst is preparing a report based on this study which will describe the operations of the clinic, the problems met and the recommendations which arise out of this experience with a psychiatric clinic in a rural setting.

In addition to this, within the next two years we expect that, out of our practical and our research experience, certain concrete proposals for developments in rural psychiatry will emerge. We aim, for example, to prepare for the consideration of the Department of Health of the Province of Nova Scotia a number of concrete proposals for service in preventive psychiatry on a province-wide basis.

VIII. Plans for the Future.

Under this heading is assembled an outline of what we intend to accomplish by 1956 when our present grants expire. Some of this has already been mentioned in the course of the previous sections, but it is restated here, together with certain new points, for the sake of clarity.

A major consideration - indeed, it is the one that integrates all aspects of the work - is the development of theory. Just as one of the first products of the work will be a statement of a theoretical framework, so we hope at the end of six years to make a second theoretical statement based on the intervening experience.

In regard to the research operations, we expect to carry through to completion the various activities now under way in the study of the social environment, the distribution of psychiatric symptoms, the correlations of the two, and the qualitative analysis of clinic cases. Specifically this means finishing the analysis of the sociological variables and the focus areas, plotting on a sociological map the distribution of symptoms by means of the Bristol sample and the FLS, testing for correlations, using the analysis of the clinic cases as a means of deriving tentative explanations and as a source of suggestion regarding what additional correlations

to select for testing.

On the methodological side it means <u>further developmental testing of the HOS</u> and extensive reporting on this and on other new methods that have had to be evolved in order to make it possible to relate psychiatric disorder and social environment and to bring into cooperation such different disciplines as anthropology, psychiatry, psychology, sociology and statistics. With statistics in particular there has been the adaptation of models to this research and new advances in the field of latent structure analysis.

From the practical point of view of preventive psychiatry, there is a report to be finished on the potentialities and functions of a rural clinic and suggestions for a Province-wide service.

In addition to all of the above, we intend to initiate and complete some new field work. The exact nature of this is hard to predict at this point since it will be determined by the analysis which is now underway and which will bear fruit in the course of the current winter. Some of the opportunities that are apparent are as follows:

1.) The study of additional focus areas to increase the range of possible comparison. For example, we are particularly anxious to investigate the negro population of Stirling.

2.) The study of additional sociological variables which may emerge as a result of work in the clinic.

3.) The study of those roles that are significant from a psychiatric point of view, their classification and rating in terms of the psychological difficulties they present to those who occupy them. (See p. 37).

4.) Increasing the size of the sample used in assessing the prevalence of psychiatric symptoms in order to permit more refined statistical treatment.

5.) Extensive surveying of large populations using the HOS alone. This would probably yield results at a high level of statistical confidence as far as statements of the relative mental health of various subgroups of the county is concerned. It would probably be lacking, (as compared to 4.) above), in affording a means of defining what types of symptom patterns are involved. However, even in this, it would not be altogether deficient if the current work on latent structure analysis lives up to its promise.

6.) Clinical investigation of asymptomatic individuals. The aim here would be to compare, in terms of personality study, the cases that have been examined in the clinic with a population of individuals who do not display symptoms of psychiatric significance. This would require,

obviously, considerable cooperation, much more than has been asked of the respondents in the surveys, and it is by no means certain that this could be obtained. However, if we are to expand our research in psychological depth, this would be the direction in which to go. One of the major problems in the whole field of psychiatric knowledge is that so much is built on the investigation of pathology without a comparable knowledge of the "normal".

7.) Analysis and reporting on the sociological characteristics of treatment for psychiatric illness in Stirling County. This would be based on the institutional files and could include some indications of the changes that have occurred over the last 50 years. Possibly a little additional field work would be necessary, but for the most part if would be a matter of using material already collected and subjected to preliminary sorting.

8.) The study of migrants. The current work is designed to give us some information regarding migration, particularly the history of individuals who are now in the county. In the future we should like to conduct a follow-up study of a sample of individuals who have left Stirling. There are two reasons for this: a.) to see if migration acts selectively to bias a sample of individuals based on those left behind in

the county; and, b.) to see if, as some other studies have indicated, migrating populations have a higher rate of mental illness than do similar groups of people who stay at home.

9.) Exploration of the possibility of using the clinic as an educational medium whereby our findings can be fed back to the community and incorporated in action aimed at improving the mental health of people.

10.) The study of family patterns and the process whereby a child is made a member of society. For theoretical reasons, this process if considered of major importance in the development of psychiatric symptoms, or in the avoidance of them. Rather than rely solely on retrospective accounts, we wish to push further the studies already begun regarding the values and methods of families in a variety of contrasting social environments.

It is evident that not all of the above can be accomplished in the next three years. In general, first priority will be given to those activities which are most centrally related to our main purposes.

IX Financial Considerations.

The Stirling County Study began in 1950 on the basis of financial support for three years from the Carnegie Corporation of New York, the Milbank Memorial Fund and the Dominion Provincial Mental Health Grants. After the work had been underway for a year, the size of the grants were increased to meet the growing cost of living and to allow expansion of the work because of new opportunities. The grant from the foundations was increased from $150,000 to $215,000, while the Dominion Provincial Grant was increased from $54,000 to approximately $66,000.

In the spring of 1952 when the Study was about a year and a half old, it was necessary to decide whether or not application should be made for a three year extension, that is until 1956. The extension was indicated primarily because of opportunities for development that had become evident after the work had got under way. It seemed that while reasonably satisfactory results could be secured within the original three year plan, much more significance would be achieved if the time for the study were increased.

As far as reporting concisely on progress is concerned, it would have been better to have delayed the request until 1953. This was precluded by two considerations: first,

commitments to personnel could not wait until the end of the first three year period without our running the risk of being unable to obtain the most desirable people for the second three year period; second, the research plan had to be changed at once to fit the demands and opportunities of a six year rather than a three year program. This meant, in essence, that the studies would be prolonged and deepened, rather than terminated and reported.

These matters were drawn to the attention of the officers and trustees of the Carnegie Corporation of New York and of the Milbank Memorial Fund and an application was filed for an additional $240,000.00 to carry the project from July 1, 1953 to June 30, 1956. This was granted in May, 1952.

This placed us in the position of having to make up our minds as to whether or not we would re-adjust the research to a six year basis right away, or proceed on the three year basis until after we had heard from the Canadian Government. The decision was made in favor of shifting immediately to the six year plan for the following reasons: since the bulk of the money was already available, since the community and the Province were cooperative and since Dalhousie and Acadia Universities were well disposed toward collaboration, it was certain that the work would go on for the entire period; the

best advice we could get suggested that it would be autumn at the earliest before a decision could be obtained in regard to the Dominion Provincial Grants; and with our research forces already deployed and active in the field, it would be expensive and inefficient, if not impossible, to close down and then attempt to reopen at a later date.

As soon as possible work was begun on preparing a request for an additional Dominion Provincial Grant. In July, I spent several days in discussion with members of the Provincial Department of Health and in August attempted to arrange a visit to the Department of Health and Welfare in Ottawa, but was advised to delay this until September. On making the visit, I was questioned by members of the Department about progress, research design (with particular emphasis on statistical methods), and about the proportion of help being provided by the foundations. There was at that time a thirty page progress report on our work available, which I offered to send to the Department, but I was advised that something shorter, of five to ten pages, would be more appropriate. Such a statement was transmitted via the Province on my return to Nova Scotia. It contained a recapitulation of the financial arrangements that have been outlined above.

No final word was received regarding the status of our request until April 1953. This was after the Government fiscal year had closed and the existing grant had expired. Consequently, months before, in order to keep research going and in order to be able to fulfill obligations to personnel, arrangements had to be made to carry the entire project on foundation money in case the Government grants were not allowed. This hampered full utilization of research opportunity in the current year since some work, particularly in analysis, had to be reduced, in view of the possible emergency. For example, we did not hire as many statistical clerks, or contract for as much time of tabulating machines as we wished, in case this money would be needed to pay salaries in the Psychiatric Clinic.

The word received in April regarding the status of our request was to the effect that an extension of six months would be provided, (until October 1953), and it was suggested that for a further grant we make a new submission with more detailed explanation of research design and results.

We were faced with a dilemma: we could either close the clinic and step up our rate of analysis, or we could keep the clinic open and continue at the current rate. If we closed the clinic, the purpose for which the grant was being

requested would be largely defeated since public service, public relations and the composition of our staff would be so altered as to make reopening the clinic impossible. If we kept the clinic open, and maintained our present schedule and distribution of work, there was no chance of having ready a statement that would even approach meeting the requirements of the Department of Health and Welfare.

In consequence a request for a year's extension was made and was immediately granted. As a result, we are able to work in the current year with considerable freedom and security, except for one hazard: the expenditure of foundation monies is still limited by the necessity of maintaining reserves to cover cost of the succeeding two years in case the Dominion Provincial Grants are not made.

It is our hope now that on the basis of the present report we shall be able to receive support from the Dominion Provincial Mental Health Grants for the next two and a half years - April 1, 1954 to September 30, 1956 - making a total of six years since the beginning of the grant in October, 1950. The request is for $30,000.00 per year for two and a half years.

APPENDIX A

List of Categories

1. Economic Affairs (Poverty-Affluence)

   a. Income
      1. Wages and salary
      2. Profits and losses
      3. Loans, mortgages, and liens
      4. Other

   b. Income disposition (Patterns of spending)
      1. Insurance
      2. Savings and debts
      3. Prices
      4. Taxes
      5. Other spendings and investments

   c. Property
      1. Buildings and immovable property
      2. Inheritance and movable property

   d. Food

   e. Dress and adornment

   f. Tertiary industries and exchanges
      1. Markets
      2. Banking
      3. Corporations
      4. Monopolies
      5. Public utilities
      6. Business cycles

2. Diseases and health

   a. Morbidity (illness)
      1. Medical facilities

   b. Mortality

   c. Good health

3. Disaster

4. Social change

   a. Technological

   b. Demographic (Migration and othe population changes)

   c. Institutional

   d. Economic
      1. Prosperity and slump, or fluctuations
      2. Conservation measures toward the natural environment

   e. History

   f. Rapid change

5. Inter-ethnic relations

   a. French-English

   b. Negro-French

   c. English-Negro

   d. Other

6. Religious Role and secularization

   a. Religion and the supernatural
      1. Denominations (named)

   b. Superstitious practices and beliefs

   c. Secularization

7. Leadership-Followership

8. (Broken homes) Family life

   a. Family

   b. Marriage

   c. Divorce

   d. Other

9. Associations

   a. Government and political
      1. Town
      2. Municipal
      3. County
      4. Provincial and federal

   b. Church

   c. Professional

   d. Formal social (e.g., Masons)

   e. Cooperatives

   f. Working groups

   g. Visiting groups

   h. Cliques, gangs, etc.

   i. Armed forces

10. Law and Social Control (Crime and delinquency)

   a. Law and social control
      1. Formal
      2. Informal

   b. Crime and delinquency

11. Communications

   a. Education
      1. Government school system
      2. Other government education
      3. Religious schools
      4. Other religious education
      5. Other education

   b. Language

   c. Rapport

   d. Transportation
      1. Tourists

   e. Mass media of communication

   f. Inter-personal relations

g. Humor

h. Other (e.g., telephone, postal)

i. Isolation

12. Leisure

a. Fine art

b. Travel (for pleasure)

c. Drink and indulgence

d. Recreation (play, etc.)

13. Inter- and intra-group conflict and cooperation

a.	Inter-generational (and intra-)	1. conflict	2.	cooperation
b.	Inter-class	" "	1. "	2. "
c.	Inter-social clique	" "	1. "	2. "
d.	Inter-religious group	" "	1. "	2. "
e.	Generalized	1. Hostility	2. Good will and cooperativeness	

14. Age

a. Infancy

b. Childhood

c. Adolescence

d. Adulthood

e. Old age

15. Sex

a. Male role

b. Female role

c. Inter-sex relationships (love, etc.)

16. Occupation

    a. Primary industries
        1. Farming and farmers
        2. Fishing and fishermen
        3. Lumbering and lumbermen
        4. Other

    b. Secondary occupations
        1. Owner
        2. Supervisor
        3. Worker-laborer
        4. Independent craftsman

    c. Tertiary occupations
        1. Services
        2. Professions and semi-professions
        3. Trade and traders

    d. Job stability

17. Social class

    a. Social stratification

    b. Social class mobility

18. Ethnic

    a. French

    b. Negro

    C. English

    d. Other

19. Annual Cycle

    a. Subsistence

    b. Social (e.g., festivals, etc.)

20. Daily routine

21. Natural environment

22. International situation (wars, etc.)

23. Named communities (to be selected from the paragraph and filled in by processor)

24. Named persons (to be selected from the paragraph and filled in by processor)

25. Bibliography

Note 26. Total interview recorded under _____, _____, _____, etc.

APPENDIX B

Outline of community model

1. Geography

   a. Community definition
   b. Description of the physical setting
   c. Distribution of industries
   d. Human occupance and land settlement patterns

2. Population

   a. Population statistics: age, sex, etc.
   b. Migration data: age, sex, motivation, destination, contact with emigrants, history of general migration patterns.
   c. Social stratification: description of class structure if this is present.#

3. Industrial Enterprises

   a. Primary industries: types and distribution (e.g., fishing, farming) Relative importance of various industries; number of people engaged
   b. Secondary and tertiary industries: types and distributions (e.g., fish processing, carpentry); relative importance of each; number of people engaged.
   c. List of occupations; distribution of types of multiple occupations
   d. Annual cycle of economic activities for the various industries and occupations; seasonal types of work
   e. Poverty-affluence: How does this community rank in the county? What is the pattern within the community?
   f. Sentiments (attitudes and values) connected with various forms of economic activities; which activities have the most prestige? which provide the most leisure? What are the ideal sentiments toward work and leisure?
   g. What are the major changes that have taken place over the last 50 years in the industrial enterprises of this community?

4. Communication

   a. Intra-community communications:

      1. Channels for communication (telephone, visiting, etc.)
      2. Amount of use of the different channels

#In the cases in which a focus area has class stratification (i.e., the two well organized and the complex areas), then each class is treated as if it were a focus area, and all the categories of this format are utilized in its description. Thus, the focus area as a whole is described as a functioning unit and in addition the major sub-units which it contains are also delineated with particular reference to similarities and contrasts in the distribution of social disorganization variables.

3. Ideal content of these communications and ideal channels
4. Actual content in terms of expression of hostility

b. Communication outside the community:

1. Channels (roads, newspaper, telephone, radio, etc.)
2. Amount of use
3. Ideal content and ideal channels
4. Actual content in terms of expression of hostility
5. Changes in the last 50 years.

5. Social differentiation (non-rank)

a. Age grading

1. Ideal pattern of behavior at various age levels: infancy, childhood, adolescence, adulthood, and old age
2. Actual patterns of above
3. Child rearing practices
4. Changes over the last 50 years

b. Sex differentiation in roles

1. Ideal patterns: sentiments about the roles of men and women
2. Actual patterns as per above
3. Changes noted in sex-roles in the last 50 years

c. Inter-sex relations

1. Ideal patterns: sentiments about sexual relations, courtship and marriage
2. Actual patterns as per above
3. Changes in the last 50 years

6. The family

a. Composition of the households in the community
b. Ideal roles of family members: father, mother, child, and other common and important family members
c. Actual roles of family members
d. Discussion of the forces for cohesion and stability versus disintegration of the family patterns
e. Changes noted in the last 50 years.

7. Associations

(In each of the following, list and describe, giving as much data as possible on aims, composition, rules, norms, effectiveness, etc.)

a. Formal Associations: religious, professional-business-occupational, social, political-governmental
b. Informal associations, cliques, visiting groups, loafing groups, etc.

8. Leadership

a. Ideal sentiments about qualities of good leadership
b. Actual patterns of formal leadership; types of activities, sources of leaders, range of influence outside the community, bases for the exercise of power and leadership
c. Actual patterns of informal leadership: give particular attention to people who form opinion without title of leader
d. Changes over the last 50 years

9. Leisure patterns

a. Ideal sentiments about how leisure time should be spent
b. Actual patterns of constructive leisure and recreation: are they social or individual? What are the social consequences?
c. Actual patterns of non-constructive leisure (that is, patterns that have socially disruptive consequences such as excessive drinking,) gambling, sexual promiscuity, etc.) Discussion as in B above.
d. Seasonal variations in leisure activities
e. Changes over the last 50 years

10. Law and social control

a. Formal agencies for enforcing the legal system. How do they function locally? How effective?
b. Informal agencies for social control. Same discussion as above.
c. Social bases for the informal control: fear of police, shame and guilt sanctions, etc.

11. Health

a. Nutrition and general hygiene knowledge: theories of disease, ideas about food, etc.
b. Medical services; how readily available? How used? Other cures and practitioners?
c. Illnesses, their types and prevalence

12. Disasters

    a. Major community disasters (e.g., sweeping fires)
    b. Minor disasters, that is, disasters to families and individuals
    c. Perceived threats of disasters in the local environment; evaluation of these perceptions

13. Sacred values--Religious systems of beliefs

    a. Sentiment systems and practices of organized religions present. Give the outstanding characteristics.
    b. Moral values derived from these sentiments
    c. Secularization trends over the last 50 years. Any revivalistic trends? How does this community compare with others in the county? What variations are there within the community?

14. Sentiments connected with ethnic descent

    a. What ethnic groups are present? Do they represent the characteristics of the larger ethnic patterns in the county as a whole? (in language, religious values, etc.)
    b. Nationalistic attitudes
    c. Relations between ethnic groups
    d. Changes in the last 50 years

15. Rapid social change

    a. Summarize the principal changes noted in the last 50 years in technology and in human institutions (e.g., change in fishing methods and in the school system)

16. Stressful roles

    a. Describe those roles in the community which by their nature seem particularly likely to expose an individual occupying them to p psychological and emotional difficulties (e.g., a backwoods school teacher with a permissive license).

APPENDIX C

Preliminary Report on Child-Rearing Survey

by
Edgar Lowell

During the early fall of 1952 (August and September), a survey of child rearing practices was made in selected communities in Stirling County, Nova Scotia. Information was gathered by interviewing 102 mothers who had children between the ages of three and seven years. In three focus communities all available children in the age range were covered, and in the fourth, all available children in the age range whose parents had been interviewed in the Family Life Survey were covered.

There were 30 interviews in a predominantly English community, 21 in a predominantly French community, 25 in rural slum areas and 26 from Bristol town (all of these were focus areas).

The interview consisted of approximately 75 open-ended questions designed to gather information on the way these mothers raised their children. The questions dealt with such matters as time of initiation and completion, apecial techniques used, and general details of the weaning, toilet training, agression training and independence of the children. They were also designed to reveal general caretaking practices and an estimate of the affective relations within the household. Each area of socialization was examined for the level of demands or standards set by the parents, and the pressures and techniques they used to gain compliance with these standards.

The questions were open-ended, but were designed to obtain sufficient information to permit reliable scale judgements in some 200 scales. Enough of the mother's responses were recorded on the interview form to enable the interviewer to reconstruct the interview immediately afterwards in the presence of another rater. Initially both the interviewer and the rater would rate the account of the interview on the 200 scales independently.

After sufficient reliability was demonstrated by this method, pooled judgments were utilized. In no case was the interviewer the only person rating the interview.

In addition to the interview, each informant also completed a check-list of common verbal threats used by mothers. She merely recorded the frequency of use of some 18 common verbal threats.

The coded material was transferred to IBM punch cards and at this time, marginals (straight frequency tabulations) have been made on all of the interviews. Analysis, now under way, will include a comparison of Stirling County child rearing practices with a sample of 400 mothers in the metropolitan Boston area who were interviewed on the same variables. The analysis will also include a characterization of the practices in each community and a comparison of the differences between them. An hypothesis concerning the influence of child rearing practices on the formation of level of aspiration, and in turn the relation of level of aspiration to social disorganization variables will also be tested.

Although it is premature to attempt to summarize the findins, several striking patterns may be noted.

The average mother in the disorganized focus areas, as compared with mothers in the other communities was more likely to have had her baby at home (84%), she was more likely to have breast fed her child (44%), started her change of mode (sucking to sipping) weaning latest (11-16 mos.), and completed the weaning in the shortest time (1-6 days). She reports the highest percent of complete self-demand feeding schedule (76%), and the fewest (33%) and the least severe feeding problems.

She was not the latest to begin toilet training, but completed it in the shortest time and reported the most severe reaction on the part of the child.

She made the least demands upon the child, reporting the lowest demands concerning table manners, bed-time, making noise, neatness and orderliness, restriction on use of house and furniture, continuation in school, and having regular chores around the house.

She exerted the least overall pressure to meet these demands, and had the lowest standards for obedience. Her husband has the highest standards for obedience. She was most likely to use spanking as a punishment, but was most convinced that it did no good. If she threatened to punish she was most likely to follow through with her threat.

She used the least praise, and was most apt to ignore good behavior. She also made the least sex-role differentiation.

Two areas in which she evidenced concern were aggression to other children, where she showed the least permissiveness; and she also kept the closest track of where the child was during the day.

She was the youngest when married (19.4 years), was most likely to have been born in the same community (60%), most likely to have done all of caring for the infant. She was separated from the infant the least, while her husband was most likely to have been away. He also did the least caretaking of the infant. After the child was two years or older, she was most likely to have had a job for at least a short time.

The child shows the most dependency, wanting to cling to her or be near her both now and at an earlier age. She makes the most positive response to these dependency supplications, and is most openly demonstrative in her display of affection. She reports the least enjoyment in caring for the baby and both she and her husband were rated as having the least warm affectional relations with the child now.

She reports the highest dissatisfaction with her current situation and the lowest valuation of the mother role.

In addition to their value as normative child rearing data, these differences, many of which are statistically significant, can be used to supplement the picture of community life gathered by other field workers.

APPENDIX D

Classification of Cases for Epidemiological Analysis

Using the A.P.A. diagnostic manual, the following disorders and the reactions listed under them are employed:

(a) Disorders Associated with Brain Tissue Functions

Acute

Chronic

If the symptoms clearly indicate classification under one of the reactions, (page 2 - 4 of the A.P.A. book), such as senile brain disease 009-79X, the appropriate reaction is specified.

(b) Mental Deficiency

Mild

Moderate

Severe

We follow the instructions in the A.P.A. manual given on page 23. Since we must be noncommital about etiology, we use the Y- series rather than the X- series of code numbers, (see page 5). The rating of mild, moderate and severe gives some trouble since it is rare that any I.Q. figures are available. In general there are three sources of evidence regarding retardation: the interviewer's estimate, the doctor's estimate, and the number of years the respondent has been in school compared to the number of grades completed.

(c) Psychotic Disorders

We do not use the involutional category because of its etiological implications.

All the other categories of reaction listed on page 5 and explained on pages 24-29 are used when they seem to fit the pattern revealed. Attention is called to the last of the reaction categories (000-xy0) as being useful when there is evidence of psychosis, but little descriptive data.

Because our data are incomplete, some individuals whom a fuller history would reveal as manic depressive will inevitably be classified as 000-x14 Psychotic Depressive Reaction. This category is used when there is clear indication of depression, but no information regarding cycles, or elations. The involutional depressions also turn up here. These peculiarities will be taken into account at the time of analysis.

The number of psychotics in our sample is small so that in practice, very few of the reaction categories are used. While the judgement by the evaluator that a psychosis is or has been present is of maximal importance, effort toward refined differential diagnosis within this category is not worthwhile, due to both the small numbers and the limitations of our data.

(d) Psychophysiologic Autonomic and Visceral Disorders

Our use of this category, (pages 29-31), involves considerable modification of the A.P.A. manual's orientation. We deal only in the symptomatic aspects and usually without enough

data to tell whether or not the symptoms are accompanied by anxiety. We can, however, give emphasis to the point that organs and viscera are concerned which are not under voluntary control or perception. Nevertheless, even at best, we cannot make a hard and fast distinction between this and the next disorder group, the psychoneurotic. Instead, we have, frequently, to give the same individual reaction labels that occur in both sets of disorders.

All the reaction categories are applicable as ways of grouping symptoms, but with omission under every one of the phrase, "in which emotional factors play a causative role", since we cannot, as a rule, tell about this.

As many of the reaction categories (e.g. skin, musculoskeletal, respiratory) may be applied to one individual as the symptoms warrant.

Convulsive disorders do not appear here at all, but under brain disease, psychosis or psychoneurotic. Ordinarily, unless there is evidence to the contrary, they are under brain disease.

There is one notable defect in the system for our purpose: there is no place to put headaches without specifying some causal relationship such as to the cardiovascular system. This we usually cannot tell and we have therefore established an additional category, "00y-580, Headaches." All headaches are placed here, even when labelled migraine, and the latter word is

crossed out of 004-580 in the manual. If there is hypertension as well as headache, then 004-580 is used as well as 00y-580.

(e) Psychoneurotic Disorders.

The instructions in the A.P.A. manual, (pages 31-34) are followed with the usual modification where etiological factors enter the orientation of that book. This applies particularly to 000-x06 Depressive Reaction where one of the considerations is the existence of immediate environmental stress. This category is to be used by us for those individuals who show some signs of depression, but of a mild or chronic type, more akin to a psychoneurotic disorder than the sweeping psychotic depressions. In other words, it is a matter of degree of mood disturbance, rather than the presence or absence of environmental precipitating events. Thus, a "reactive depression" if severe, appears under psychotic Depressive Reaction, while if mild appears under psychoneurotic Depressive Reaction.

Again, contrary to the instructions in the A.P.A. manual, several of the reactions under psychoneurotic disorders are used simultaneously if this helps to describe the case more adequately. Since only the reactions listed get on the punch cards for tabulation, it is important to do this, rather than leave major symptoms out.

Attention is called to the last category 000-x0y, "psychoneurotic reaction other," as very useful where there is

not sufficient data for subclassification.

As already noted, this group of reactions may be listed for an individual who also carries labels from the group of psychophysiologic reactions.

(f) Personality Disorders.

The instructions and reactions given under this category, (pages 34-39), are taken essentially as given. Attention is called particularly to 000-x70, "special symptom reactions."

This ends the categories used by us. We do not use the Transient Personality Disorders given in the Manual, (pages 41-42), since these all involve making some assumption about a relationship with the environment. All the symptoms mentioned under these headings may be classified under one or another of the categories already listed.

On page 47 there is reference to:

(a) External precipitating stress

(b) Premorbid personality

(c) Degree of psychiatric impairment.

For reasons already noted, we do not take (a) into account in the evaluation. (b) must also be disregarded because of lack of data.

In the case of (c) however, it is often possible to make some sort of estimate and consequently we make it a practice to note this, following the criteria set up on page 49. This is

applied to each of the main symptom patterns that are listed and to the total effect of all the symptom patterns taken together. As far as the time of the impairment is concerned, this is assumed to deal with the period during which the symptoms existed. Thus, the word "current" must be deleted from the last line of the first paragraph under 5. on page 49 of the manual. A similar modification needs to be introduced regarding the content of the next paragraph.

The definitions of the five ratings of impairment are acceptable for the purpose of the evaluation.

Having discussed the criteria upon which the evaluation is based, it is appropriate now to give an outline of organization.

An actual demonstration is probably the best way of presenting the matter, followed with notes of explanation where indicated.

Evaluation Sheet

Mrs. S. G. Age 50 #93-II

1). Findings

Positive	Negative
R.	R.
a.) Hay fever as a child, not serious.	a.) Health has never affected the amount of work she does.
b.) Severely upset stomach 8 years ago.	
c.) Rheumatism at 15, serious.	
d.) "Used" to be bothered a lot by nervousness, could not stand noise.	Dr. X.
e.) Has felt once or twice that she was going to have a nervous breakdown.	a.) She only has minor ills.
f.) Had a nervous breakdown at 18 after her marriage.	Dr. Y.
g.) Sometimes tired in the morning.	a.) Her health is good.
h.) Had dizzy spells when younger.	
i.) Had cold sweats formerly, but not now.	
j.) Often troubled by sick headaches, but better now.	
k.) Sometimes has loss of appetite.	
l.) Sometimes worries a lot, especially about financial matters.	

2.) Comment.
Item c.) above probably refers to rheumatic fever.
The Interviewer and the Respondent had trouble in communicating because each had an accent unfamiliar to the other.

3.) Symptom Pattern

I. Psychophysiological
(1) Respiratory 003-580; Hay fever.
Time: as a child.
Duration: childhood or less.
Impairment: None.

(2) Gastrointestinal 006-580: Frequent sick headaches, history of severe gastrointestinal upset, loss of appetite.

Time: current
Duration: at least 8 years
Impairment: minimal

(3) Headaches 00y-580:
Time: current
Duration: unknown
Impairment: minimal

Total Psychophysiological Impairment: Minimal

II. Psychoneurosis
(1) Other 000-x0y. History of nervous breakdown at 18, also general nervousness, fear of nervous breakdown, dizzy spells, cold sweats, and worry about finances.
Time: current
Duration: since youth
Impairment: minimal

4.) Rating as a Symptom Carrier - - - - - - - - - - - A

5.) Total Impairment - - - - - - - - - - - - - - - - - Minimal

6.) Confidence in Symptom Pattern - - - - - - - - - - A

7.) Nature of Rating - - - - - - - - - - - - - - - - - Does not apply

Evaluation Sheet.

Mrs. A. M. Age 27 #711

1.) Findings

	Positive	Negative
R.		
a.)	Backache since first child 3½ years ago.	
b.)	Headaches lately, feels sick.	
c.)	Bowel trouble (presumably constipation) takes pills.	
d.)	"Tipped uterus."	
e.)	Bothered by nervousness which her husband says is her imagination.	
f.)	Since first pregnancy, cannot scrub "and do things like that". (due to back).	
g.)	Rates her health in the last year as only fair.	
h.)	Worries an awful lot, about whether husband will have enough work or not, etc.	
i.)	Sometimes feels tired in the morning.	
j.)	Dizzy spells a few times with headaches.	
k.)	Bothered a little with sick stomach.	
l.)	Has had nightmares a few times.	
m.)	Shortness of breath attributed to sinus.	
Dr. B.		
a.)	She has backache which appears only when her husband is not making money. Vomited the whole 9 months of her last pregnancy, not sure of the basis.	

2.) Comment

The main point seems to be backache since first pregnancy 3½ years ago, plus some general nervousness and a few somatic complaints. Comments on worry and nightmares suggest some diffuse anxiety.

3.) Symptom Patterns.

I. Psychophysiological

(1) Musculoskeletal 002-580: Backache, headache and dizziness

Time: Current
Duration: 3½ years
Impairment: Mild

(2) Gastrointestinal 006-580: Constipation, sick stomach with headaches.

Time: current
Duration: 3½ years
Impairment: Minimal

(3) Headaches 00y-580:

Time: current
Duration: Unknown
Impairment: Minimal

Total neurophysiological impairment: Mild

II Psychoneurotic

(1) Anxiety Reaction 000-x01: Bothered by general nervousness, worries "an awful lot", has had a few nightmares, some shortness of breath (which may be due to sinus.)

Time: current
Duration: unknown
Impairment: mild

4.) Rating as Symptom Carrier - - - - - - - - A

5.) Total Impairment - - - - - - - - - - - - - Mild

6.) Confidence in Symptom Patterns - - - - - A

7.) Nature of Rating - - - - - - - - - - - - Does not apply

Evaluation Sheet.

Mr. R. S. Age 40 #323

1. Findings

Positive	Negative
R. a.) "Low blood pressure" at 35 of medium seriousness. b.) Health in the last year given as "good" rather then the usual "excellent".	R. a.) Feels in good spirits most of the time. Dr. M. a.) His health is o.k. and he is an honest and steady worker.

2.) Comment

He gives a short list of somatic complaints and all these of some time ago and without seriousness. Yet he complains of low blood pressure at one time and gives his health as good, rather than excellent, which arouses a suspicion of psychoneurosis.

3.) Symptom Pattern

I Psychoneurosis

(1) Other 000-x0y: complaint of low blood pressure.

Time: 5 years ago
Duration: unknown
Impairment: None

4.) Rating as Symptom Carrier - - - - - - - - - C

5.) Total Impairment - - - - - - - - - - - - - None

6.) Confidence in Symptom Pattern - - - - - - C

7.) Nature of Rating - - - - - - - - - - - - - V

Evaluation Sheet.

Mrs. B. W. Aged 31 #89-II

1.) Findings

Positive	Negative
R.	I.
a.) "Kidney trouble" for 3 years. This was due to lack of relaxation of the bladder and cleared up without treatment.	a.) Did not appear worried about health problems.
b.) For the last two years, that is since her marriage, the amount of work she can do has been affected by the above condition.	b.) Seemed at ease during the interview.
c.) She sometimes worries about her family.	
d.) Hands damp all the time.	
e.) Feet cold.	
f.) She dreams about awful things every night.	
I.	
a.) Does not look robust.	
Dr. M.	
a.) Very quiet and seclusive.	
b.) Will not move to Ontario where her husband could have much better job.	
Dr. B.	
a.) Nervous and high strung and worries more than usual.	
Metropolitan Hospital	
a.) Uretral spasam 1950	

2.) Comment

None

3.) Symptom Pattern

I Psychophysiologic

(1) Genitourinary 007-580: Uretral spasam.
Time: Current
Duration: 2-3 years
Impairment: Moderate

II Psychoneurotic

(1) Anxiety 000-x01: worries, damp extremeties, nightmares
Time: Current
Duration: Unknown
Impairment: Mild

III Personality Disorder

(1) Schizoid Personality 000-x42: Seclusive tendencies
Time: current
Duration: Lifelong
Impairment: Mild

4.) Rating as Symptom Carrier - - - - - - - - - - A

5.) Total Impairment - - - - - - - - - - - - - - Moderate

6.) Confidence in Symptom Pattern - - - - - - A for I and II
C for III

7.) Confidence in Rating as SC - - - - - - - - - A

Evaluation Sheet

Miss E. R. Aged 54 #263

1.) Findings

Positive	Negative
R.	R.
a.) Coronary thrombosis last year.	a.) In good spirits most of the time.
b.) High blood pressure for 14 years of medium seriousness.	
c.) Work has been affected for last 6 months.	
d.) Sometimes bothered by damp extremeties.	
e.) Sometimes has palpitations.	
f.) Sometimes troubled by sick headaches.	

Dr. M.

a.) Confirms coronary and high blood pressure. The latter was very high and resistant to treatment.
b.) She has a bit of a temper.

2.) Comment.

The coronary and the high BP are obvious. It is hard to know whether there is also a psychoneurotic picture of anxiety, or whether palpitations, headaches, and damp extremeties are a direct product of the hypertension and the heart condition.

3.) Symptom Pattern

I Psychophysiologic

(1) Cardiovascular 004-580: High blood pressure and Coronary.

Time: current
Duration: 14 years
Impairment: moderate

4.) Rating as a Symptom Carrier - - - - - - - - B

5.) Total Impairment - - - - - - - - - - - - - Moderate

6.) Confidence in Symptom Pattern - - - - - A

7.) Confidence in Rating as SC - - - - - - - - A

Notes on evaluation form.

1.) Findings: under this heading are listed the items that pertain to symptoms. On the "Positive" side are those reports which suggest psychopathological symptoms, while under "Negative" go reports indicating good health.

All that has been obtained directly from the Respondent is put under R, followed by Interviewer's comments under I. (Not pertinent in this case), then data from doctors under Dr. X. or Y (in the negative column only in this case) and finally, data from other sources such as hospital records.

2.) Comment: under this heading is placed any remarks which the evaluator wishes to make as a clue to his thinking, or points which do not fit under the previous heading but which are to be kept in mind in making the judgements which follow.

3.) Symptom Pattern: under this heading the A.P.A. groupings are used as we have outlined them. We use "symptom pattern" rather than "diagnosis", in order to keep in mind what it is that we are doing. The heading time, refers to the date of occurrence of the symptom pattern. (Current, if still in existence, otherwise number of months or years ago.) Duration refers to the length of time it has lasted, and Impairment follows the guide given in the A.P.A. book on page 49. Under all three of these headings it is our practice to put, "Unknown", or "Cannot say", when it is felt that an appraisal

cannot be made.

Total Psychophysiologic Impairment is rated because there are several entries under the general heading. Whenever there is more than one set of reaction patterns listed under a given disorder pattern, a total estimate of impairment for the disorder should be made. Where there is only one entry under a disorder (as under II, Psychoneurosis, in this instance), there is no need for any additional statement.

4.) Rating as a Symptom Carrier: This is the overall rating as to whether the person has or has not psychiatrically significant symptoms. The possible ratings are as follows:

A. Almost certainly is a Symptom Carrier.

B. Probably is a Symptom Carrier.

C. Might possibly be a Symptom Carrier.

D. No evidence that R is a Symptom Carrier.

It is to be noted that under B. and C. above, there are two rather different types of doubt which may be the basis for these ratings. The report on symptoms may be vague so that one cannot be sure that psychiatrically significant patterns are present, or, the pattern may be clear enough, but there may be reason to doubt whether there are psychogenic factors involved in the particular case. As an example of the latter, we have made it a routine to consider asthma, hypertension and peptic ulcer as rating B if they are not accompanied by any clearly

psychoneurotic disturbance. This is done on the general theoretical expectation that a high proportion of people exhibiting these symptoms do have psychopathology playing a part in their etiology, but that one cannot be certain this is so in a given case. Rheumatism that appears to be of the rheumatoid type has been routinely classified as C, because in our opinion it may also have a significant psychogenic component, but the probability here is less well accepted by psychiatrists.

5.) Total Impairment. is based again on page 49 of the manual, but refers to the total symptomatology, that is all the disorders taken together. The time referent is the duration of the symptom patterns.

6.) Confidence in Symptom Pattern. refers to level of confidence in the classification of the symptoms. As noted earlier, the classification should be made so as to maximize this rating, choosing if necessary a large category, such as "psychoneurotic other", rather than a more precise grouping such as "anxiety reaction" if the latter means a low level of confidence. The scale is as follows:

A. - High confidence.

B. - Some doubt, but on the whole fairly confident (Probable)

C. - Very doubtful but feel there is some chance that the classification is right.

D. - No confidence at all.

7.) Nature of Rating.

This is to be used only when "Rating as a Symptom Carrier" is marked B, or C. As noted under 4.) (on the previous page of this report) there are two different bases for doubt. If the doubt is due to vagueness of data regarding symptom "V". is marked. If doubt is due to nature of the symptom pattern (e.g. asthma), "N". is marked.