Status inconsistency in an 'artificial practice'*

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THE study of the 'artificial practice' was a logical development from an earlier study of people who required late calls (Jacob 1963). In that study, the evidence was that people who required non-urgent late calls were more likely to be in the middle intelligence range, to have high neuroticism and to have a high demand for medical attention in general. These results were not in strict agreement with the results of the 'artificial practice'.

In the 'artificial practice' I found that low intelligence, introversion and neuroticism are personal characteristics associated with a high demand for medical attention. Demand for medical attention and social class were not associated.

Part of the disagreement can be explained by the different method of assessing demand for medical attention between the two studies. In the earlier late call study this was done by an *ad hoc* classification choosing six items of service in the year as the criterion for high demand.

In the 'artificial practice' the criterion was nine items of service and people who had this number or less were called perimean because they fell within the mean figure observed in all the reports which I had been able to consult in the planning stage; those with ten or more items were called supramean because they were above this level. This difference in classification was not sufficient fully to explain the discrepancy between the two results.

Another important difference between the two studies was the method of assessing intelligence. In the late call study I used an index (Belson 1955) which made an assessment of intelligence by using the patient's age and occupation as criteria, whereas in the 'artificial practice' I used the Raven 'progressive matrices'. The Belson index was constructed from observations made in a study using the Vernon abstraction test, and since he found that there was a good correlation between occupation and intelligence score, I felt that the absence of an association between social class and the patient's demand–attendance pattern† in this study required closer investigation. My problem was to explain why there was an association between demand–attendance group and intelligence, but not social class.

Approach to the problem

I knew that I had demonstrated associations between demand–attendance group and age, sex, physique, neuroticism and introversion, and failure to make satisfactory sexual adjustment as well as intelligence. I guessed that failure to establish an expected association between occupation and intelligence would be explained by personality rather than physique, so only the last three associations were relevant to the problem. I found too few people with defective social adjustment to allow this to be used as a basis for comparison.

Similarly I found that as far as this study went neuroticism and introversion are

*'Artificial practice'—500 people whose medical records for a year have been detailed and studied in relation to their personal characteristics. This system is used to study the relation between people and their illnesses.

†Demand–attendance pattern or group—method of classifying patients in the artificial practice using the number of items of service and the number of episodes of illness as a criterion.

associated. I decided to investigate the three-cornered relationship, neuroticism, intelli-gence and occupation.

The approach I adopted is best set out in a series of numbered statements.

1. According to Belson's results and rule-of-thumb experience more intelligent people should be occupied in skilled work and by definition should be found in the higher social classes.

2. The 'artificial practice' is not a random sample of the population. No individual practice can be considered a random sample of the population.

3. The 'artificial practice' differs from a random sample of the population in that it contains too many supramean multiple patients.*

4. This group of patients have a high neuroticism score (Jacob 1968).

5. My failure to demonstrate an association between intelligence and social class may be attributed to (a) the disproportion of supramean multiple patients and (b) their high neuroticism.

6. This is equivalent to saying that occupation and intelligence are less likely to be associated in neurotic than in non-neurotic people.

7. This provides a hypothesis for investigation.

This problem has been tackled from a slightly different angle. For example it has been demonstrated that 'status inconsistency', that is, the lack of correspondence between educational level and occupation is associated with high symptom levels (Jackson 1962). Jackson concluded that all forms of status inconsistency are psychologically disturbing and that the disturbance is roughly proportional to the degree of inconsistency. Abram-son found in a later study that emotionality was associated with inconsistency whether the occupation grade was too high or too low for the educational level (Abramson 1966). Since educational achievement and intelligence are associated it seemed that my study would be more fundamental than those two.

Method

This type of investigation can only be done by indirect methods. I divided the 'artificial practice' into two groups; neurotics and non-neurotics. The next step was to tabulate the intelligence and social class of both groups separately. If the hypothesis that neurotic people are more likely to show status inconsistency than non-neurotic people is correct, there should be a demonstrable correlation between social class and intelligence in the non-neurotic group but a less evident correlation in the neurotic group.

One approach would be to examine all the records and introduce another grouping indicating whether the patient's status is consistent or not, the finances of the investiga-tion had run out, so I could not afford the additional punching. The second method, the one adopted, was to construct tables for the neurotic and non-neurotic groups in which intelligence and social class were compared and analysed by the χ^2 test. If the χ^2 is significant there is an association. As the distribution approaches to random, associations decrease. The figures are shown in tables I to IV.

The first table includes all patients whose Maudsley personality inventory 'n' score was 26 or less. This is the non-neurotic group. The dividing line was the mean 'n' score for the 'artificial practice'. The association between social class and intelligence in this group is significant at the 0.005 level. The second table is the equivalent table for people whose 'n' score is above the 'artificial practice' mean. In this case the associa-tion was not significant. The probability level was more than 0.1 which indicates chance distribution. Thus status inconsistency is commoner among those with a high 'n' score. The third table confirms an association between social class and intelligence in people with no frank history or neurotic breakdown under stress.

The last table was not completely satisfactory because some of the calculated expec-

*Supramean multiple patient—a patient who required 10 or more items of service in the observation year and three or more separate episodes of illness.

TABLE I

ASSOCIATION BETWEEN INTELLIGENCE GRADE AND SOCIAL CLASS IN PATIENTS WITH 'N' SCORE IN THE RANGE 0–26

Intelligence grade	Social class			
	I, II, III	IV	V	Total
I, II+, II	41	15	7	63
III+, III	21	22	15	58
III—	17	14	18	49
IV, IV—, V	23	22	19	64
TOTAL	102	73	59	234

$\chi^2 = 19.49$ degrees of freedom = 6   P < 0.005

TABLE II

ASSOCIATION BETWEEN INTELLIGENCE GRADE AND SOCIAL CLASS IN PATIENTS WITH 'N' SCORE 27–48

Intelligence grade	Social class			
	I, II, III	IV	V	Total
I, II+, II	20	13	5	38
III+, III	13	14	9	36
III—	27	22	26	75
IV, IV—, V	40	23	18	81
TOTAL	100	72	58	230

$\chi^2 = 9.02$ degrees of freedom = 6   0.25 > P > 0.10

TABLE III

ASSOCIATION BETWEEN INTELLIGENCE GRADE AND SOCIAL CLASS IN PATIENTS WITH NO HISTORY OF FRANK NEUROSIS

Intelligence grade	Social class			
	I, II, III	IV	V	Total
I, II+, II	52	22	12	86
III+, III	30	33	21	84
III—	37	31	38	106
IV, IV—, V	49	37	29	115
TOTAL	168	123	100	391

$\chi^2 = 20.50$ degrees of freedom = 6   P < 0.005

TABLE IV

ASSOCIATION BETWEEN INTELLIGENCE GRADE AND SOCIAL CLASS IN PATIENTS WITH HISTORY OF FRANK NEUROTIC BREAKDOWN

Intelligence grade	Social class			
	I, II, III	IV	V	Total
I, II+, II	7	6	2	15
III+, III, III—	10	8	10	28
IV, IV—, V	17	8	5	30
TOTAL	34	22	17	73

χ^2 not applicable but gives a provisional probability greater than 0.25.

ted figures fell below 5. This table examines the association between intelligence and social class among the patients with a frank history of neurotic breakdown. The distribution of the patients is closer to a random distribution and suggests that a larger number of people would have confirmed this.

These figures sustain the hypothesis that status inconsistency as measured by intelligence test score and social class is associated with neurosis and neuroticism.

There was no point in examining the association between intelligence and social class in the four demand–attendance categories separately because this would have led to a circular argument. The supramean multiple group has a higher neuroticism score than either perimean group so that status inconsistency is automatically a feature of this group.

Discussion

In the studies mentioned above, status inconsistency, that is failure in correspondence between social class and educational status, is shown to be associated with neurosis. My study shows that this proposition can be stated in more general terms; neuroticism, that is emotional instability, is associated with the situation in which intelligence—as distinct from education—does not correspond to social class.

The inconsistencies observed in this study (table II) involve a two-way displacement. Patients in the lower intelligence group are found in class III and people in higher intelligence groups are found in class IV. The redistribution is not big enough to produce a complete reversal of the expected trend. If it were, the figures would have become statistically significant in the direction opposite to table I.

The extent to which this type of observation follows a cause and effect relationship is open to debate. It could be that the apparent confirmation of the hypothesis is a chance finding, but if this is so, coincidence must have played a remarkably large part.

Downward displacement may be a natural concomitant of neuroticism either because personality factors make difficulties in accurate assessment when these people look for jobs or because emotional instability and a high sickness rate lead to a bad work record and difficulty in obtaining stable employment. This would not explain the upward displacement shown by others.

It could also be explained by an alternative hypothesis. Many skilled workers in my practice are doing semi-skilled work because this is financially more rewarding. They find such work monotonous and become dissatisfied. In this situation neuroticism could be the end result of tension.

The community in which the people in the artificial practice live is highly industrialized and there may be a shortage of completely-unskilled work for the less intelligent. This would produce an upward displacement. This additional responsibility could produce tension and neuroticism in the less intelligent. It is equally feasible that a neurotic drive to improve one's social status may lead people into seeking work beyond their capabilities. In others a neurotic desire to avoid responsibility may lead to down grading. Any one or all of these possibilities may be at work to produce the observed association between status inconsistency and neuroticism. It has already been shown that neuroticism is associated with a high demand for medical attention (Jacob 1968) and that in the main this demand is characterized by physical breakdown (Jacob 1967). Although the cause and effect relationships among these various findings are open to debate, within the practical practice of medicine and health service planning it seems clear from these figures that where one finds status inconsistency one can also expect to find neuroticism and high morbidity.

Summary
Status inconsistency is the situation in which someone's educational status does not

correspond to his social status. This definition has been expanded to mean the situation in which someone's intellectual capacity as measured by his intelligence test performance does not correspond to his social status.

The evidence in the 'artificial practice' indicates that status inconsistency according to this definition is associated with neuroticism.

The interpretation of this finding is discussed.

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