CULTURAL DIFFERENCES IN SCHIZOPHRENIA

by

Nancy Jean Sunshine

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12/14/70
date

Leonard J. Simon
Chairman of Examining Committee

1/13/71
date

Walter Weiss
Executive Officer

Harold Wilensky

Barbara Dohrenwend

Supervisory Committee

The City University of New York

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Table of Contents

List of Tables

Introduction

The precise etiology of the diverse disorders diagnosed as schizophrenia is not yet known. Most workers in the field agree, however, that there are multiple determinants, and neither nature nor nurture is the sole determinant of this disorder. The hypothesis set forth for purposes of this research will be that there is a biological predisposition in some individuals to schizophrenia, that interpersonal stress triggers the symptoms, and that the form these symptoms take is learned, and follows cultural norms of accepted behavior toward difficulties. This is essentially the position taken by Bleuler (1930), Pasamanick & Knapp (1958), Meehl (1962), and many others.

Bleuler (1930) posited that schizophrenia has primary and secondary signs, and that most of the symptoms described by Kraepelin are secondary. The primary signs are disorders of affectivity, the tendency of the feelings to work independently of each other instead of together, and, according to Bleuler, such primary disorders are caused by lesions. A person's "complexes" are not enough to cause schizophrenia; the primary lesions must be present for schizophrenia to occur. Complexes only shape the morbid picture. The environment will influence the patient in his symptoms.

Pasamanick & Knapp (1958) supported this organismic etiology, and in their research based on case histories of acute and process schizophrenics suggested that there is a

continuum of neurologic deficit; some individuals are constitutionally more susceptible to schizophrenia than others, the more susceptible succumbing to the process earlier than others and more likely becoming chronic. The neurological deficit renders the person less capable of coping with interpersonal stress. Dohrenwend & Dohrenwend (1969) reviewed and summarized 11 twin studies (e.g., Luxenburger, 1928 and 1936; Rosanoff et al., 1934; Essen-Möller, 1941; Kallman, 1946; Slater & Shields, 1953; Inouye, 1961; Tienari, 1963; Kringlin, 1964 and 1967; Gottesman & Shields, 1966). Concordance rates for schizophrenia were consistently higher in monozygotic pairs than dizygotics, and, except for Tienari's low 6%, rates ranged from 25% to 68%. This points strongly to the existence of a genetic factor, although rates were not so high as to rule out environmental interaction. Meehl (1962) noted also that twin concordance rates were high for schizophrenia, and theorized that this genetic predisposition was an inherited integrative neural defect which he called "schizotaxia," and was a necessary condition for schizophrenia. All schizotaxic persons become "schizotypes" through social learning, according to Meehl, but most schizotypes remain compensated. However, given a poor interpersonal learning environment with inconsistent reinforcement (as might be engendered by a schizophrenogenic ambivalent mother, for example) the schizotype will

develop the symptoms of schizophrenia: thought disorder, conviction of his own unlovability, lack of pleasure capacity, and ambivalence. The content of schizophrenia is learned, but fundamentally it is a neurolic disease of genetic origin.

This research will focus on the content of schizophrenia. The general hypothesis may be stated as follows: If the content is learned, and if what is learned is a function of culture, then symptom differences will be found between two ethnic groups of different cultures when such factors as social strata are controlled. This study will compare Negro and Puerto Rican males hospitalized for schizophrenia. However, before examining these specific ethnic groups, early observations of cultural differences and such environmental factors as social class will be discussed in the sections to follow.

Section I Historical Perspectives

Differences in schizophrenia between cultures have been observed for a long time. Kraepelin noticed differences in the forms of schizophrenia occurring in such far-flung parts of the world as Java, Malaya, and elsewhere. Kraepelin believed these illnesses were due to physical and biological malfunctions of the brain, and that all symptoms had organic causes (Kraepelin, 1909). Within this framework he preferred to explain his observations in terms of metabolic disorders peculiar to the specific populations, races, and constitutions rather than in terms of environmental

differences.

Bleuler's observations were among people more closely situated geographically, such as the Irish and English, and he argued that differences between peoples as racially similar as these could not be explained by Kraepelin's metabolic interpretation. Bleuler's orientation was more psychological. He felt clusters of symptoms had a common underlying psychological process, and as such, were responsive to the impact of environment (Bleuler, 1950). This was a more optimistic point of view than Kraepelin's because it suggested that schizophrenia could be treated environmentally, and the key to treating these patients would be knowledge of their background and external circumstances.

Adolf Meyer's system, called "psychobiology," formed a combination of the psychological and the environmental points of view (Winters, 1950-1952). Like Bleuler, he differentiated several types of schizophrenia with different prognoses. Psychological and cultural factors entering into a patient's self concept influenced his responses to environment throughout the course and treatment of his illness.

The Freudian movement later de-emphasized the role of the social environment, turning instead to intrapsychic factors as determinants of schizophrenia. More recently, however, social psychiatry has been bridging the gap between pure biological causality and cultural influence. Schizophrenia is now seen as involving the entire personality,

both intrapsychically and interpersonally. Deviations from Freud began as early as 1912 with Adler and Jung, who believed that the interaction between parent and child had been neglected as a factor in personality formation. Later Sullivan (1947) wrote of the significance of emotional difficulties in the parent as affecting the growing child and developed the theory further. He saw man's problem as one of interpersonal relations. His theory of personality development is described in terms of the process of acculturation. Horney (1937) also interpreted neurosis culturally, and developed in detail a description of some of the effects of cultural pressures in producing emotional disturbance. Fromm (1941), who was trained in the social sciences as well as in psychoanalysis, kept a broad social perspective in studying psychological phenomena. He saw man as born with many more alternatives of behavior than other animals. Man has to learn how to live, and his nature, passions, thoughts, and behavior are a cultural product. Freud himself was a product of his own culture, and, since he had little experience with other cultures, assumed all cultures to be similar to his own. Much of what he believed to be biological has been later shown to be a reaction to a particular culture and not characteristic of universal human nature. Thus the influence of the Neo-Freudians (e. g., Sullivan, Fromm, Horney, etc.) have suggested that interpersonal relations and stresses implicit in various cultural backgrounds are basic to

different symptomatologies. In fact, the study of schizophrenia from different ethnic groups could highlight severely emotionalized conflicts rooted in culture.

Section II The Effects of Socioeconomic Class

Nearly every epidemiological study that has investigated mental disorders as a function of socioeconomic class has found schizophrenia more prevalent in the lower strata than in the middle and upper strata. Hollingshead and Redlich (1958) enumerated cases in New Haven who were under psychiatric treatment by private physician, clinic, or hospital, and found that the lowest class was overrepresented in the patient population. Lower class persons were more often diagnosed schizophrenic and sent to state hospitals. Mishler & Scotch (1965) summarized some studies (e. g., Nolan, 1917; Odegaard, 1932; Clark, 1948; Frunkin, 1952; Lapouse et al., 1956; Sin, 1953) dealing with sociocultural factors. On the basis of these studies reviewed, no firm conclusion could be drawn relating incidence of schizophrenia to migration and social mobility. However, a higher incidence of schizophrenia was definitely related to denser populated areas, and in eight out of nine studies was associated with the lowest social class groupings, Compared to state hospitals, private hospitals were more likely to have higher class patients and less likely to diagnose them as schizophrenic. According to Mishler & Scotch, private hospitals are reluctant to diagnose schizophrenia because of the social stigma attached to it.

Moreover, in higher class groups the illness is probably detected earlier so that treatment is shorter. Hospital admissions are not a representative sample of persons becoming schizophrenic, but rather of those who did not recover quickly.

Dohrenwend & Dohrenwend (1969) report an investigation of why schizophrenia is so much more prevalent in the lower class. They proposed that symptomatology may be perpetuated by the presence of secondary gain and absence of secondary loss, and that these factors operate in favor of elevating lower class prevalence rates. According to their survey which elicited attitudes toward mental illness from middle and lower class respondents, the less educated groups were more tolerant of mental disorder than the more educated groups, which would tend to perpetuate disorders or reports of disorders in the lower class group. Lower class respondents also tended more to reject ex-patients, which might explain why the lower class mental patient has to become dependent on the institution. Within the lower class, disadvantaged ethnic groups were more tolerant of symptoms than advantaged groups. Otherwise, social class was found to be a more potent predictor of attitudes than race. Since the present study seeks to compare two disadvantaged ethnic groups, it seems clear from the above that socioeconomic status will have to be held constant.

Section III Research on Ethnic Groups

As mentioned in Section I, the Neo-Freudians emphasized the role of interaction between parent and child as a significant factor in socialization and personality formation. During the formative years the child learns what are the cultural norms of acceptable and adaptive behavior through interacting with his parents. Faulty interaction in the family at this time can have pathological consequences, as Lidz et al (1965) found in their study of 17 families of schizophrenics. The following studies on specific ethnic groups illustrate how traditional family socialization styles affect the personalities of adults. Summary tables are given below.

TABLE I

Epidemiological Studies

Author(s)	Subjects and dependent variables	
Hyde & Chisolm, 1944	Army selectees and reasons for rejection from service.	
	Irish stock	Sociopathy, alcoholism
	Italian stock	Sociopathy
	Portugese stock	Neuroses
	Jewish stock	Neuroses
	Negroes	Sociopathy
	"Old" Americans	Neuroses

TABLE I, cont'd

Jaco, 1959 — Hospitalized psychotics in Texas; incidence rates per 100,000 population.

	Schizophrenia	Affective psychoses
Mexican males	20	3
Mexican females	26	7
American males	32	11
American females	43	19
Non-white males	30	2
Non-white females	32	2

Murphy et al, 1963 — Over 90 cultural samples from 27 countries; a 26 item questionnaire to representative psychiatrists eliciting most frequent symptoms.

Japan and Okinawa	Most likely hebephrenic, symptoms of withdrawal, flat affect.
Asia	Simple schizophrenia, delusions of jealousy.
South America	Flat affect; catatonic excitement, negativism,
India	Withdrawal; catatonic rigidity, negativism and stereotypy.
Africa and Near East	Visual and tactile hallucinations.
Rural areas	Catatonic stupor, delusions of grandeur.

TABLE I, cont'd

	Urban areas	Depersonalization, paranoid symptoms.
Wittkower, 1964	Hospitalized patients; field surveys, statistics, psychological tests, questionnaires and interviews to elicit symptoms.	
	Orient	Highest rate of simple schizophrenia.
	India	High rate of catatonic symptoms, less aggressive.
	Africa	Withdrawn and quiet, schizophrenia.
	Southern Italy	Most aggressive, least withdrawn.

Note: Depression was associated with tightly knit social groupings and higher socioeconomic status.

Lorr & Klett, 1968	Newly hospitalized patients and syndrome rating scales.	
	English	40% nonparanoid schizophrenia. 30% paranoid schizophrenia 22% anxious depression 8% manic
	French	Same distribution as above
	German	Same distribution as above

TABLE I, cont'd

Swedish	Same distribution as above, but a more hostile paranoia.
Italy	Predominately anxious depression. No % given.
Japan	Highest rate of schizophrenia, no % given.
U. S.	Most likely to have hyperactive motor disturbances and delusions of grandiosity as compared to other countries.

TABLE II

Controlled studies limited to two ethnic groups

Author(s)	Subjects and Dependent Variables		
Singer & Opler, 1956	Hospitalized males; projective tests and ratings.		
	Sex attitude	Impulse control	Emotionality
Irish:	Ambivalent to females	Use more fantasy, more inhibited, less aggressive.	Flat affect
Italian:	Conflict to father figure.	Acting out of aggression.	Labile
Opler, 1959	Hospitalized males, psychological tests and ratings.		
Irish	More characterized by latent homosexuality, sin and guilt preoccupations, good ward behavior, fixed delusions, alcoholism.		
Italian	More characterized by overt homosexuality, lack of sin and guilt preoccupations, more behavior disorder and somatic complaints.		
Meadow & Stoker, 1965	Hospital patients; symptom checklist and case files.		
Mexicans	Affective lability, weak superego, acting out behavior, more likely catatonic than American group.		
Americans	More likely paranoid with delusions of grandeur and persecution, guilt over sex, and less acting out behavior.		

TABLE II, cont'd

Stoker, 1965	Observations of males in child guidance clinic.
Spanish-Americans	Hostile aggressive and reactive symptoms
Anglo-Americans	Neurotic anger-in pattern with chronically disruptive symptoms.
Piedmont, 1966	Hospitalized males; extensive case studies.
German stock	Most characterized by paranoid hostility and a tight delusional system, flat affect, and no somatization of symptoms.
Polish	Characterized by anxiety, affective lability, more dependent than aggressive, more alcoholism, somatic complaints and more catatonic than paranoid.

The cross cultural studies summarized in Table I which deal with many diverse populations may reflect the sociocultural background of the psychiatrist rather than true symptomatology, according to Ihsan (1969). Cognitive abnormalities as withdrawal, auditory hallucinations, delusions and flat affect are considered universally deviant, as can be seen in the study by Murphy et al (1963). However, other social deviations may be considered normal to some cultures and not to others. Ihsan (1969) points out that paranoid delusions are said not to exist among illiterate peoples, but the fact may be they do exist-- only being manifested differently as in action rather than in verbal expression.

In each of these studies symptomatic differences have been interpreted either in terms of acceptance by the culture, in terms of class or urban versus rural differences, or in terms of appropriate paths of aggression, and these interpretations may overlap. The more carefully controlled studies reported in Table II can be interpreted in terms of specific differences in family constellation when sex and social status are held constant.

Murphy et al (1963) give an excellent example of the cultural acceptance interpretation. Social and emotional withdrawal was more frequently observed in cultures where this is deemed an acceptable mode of coping with stress. Delusions of grandeur and associated mannerisms were significantly more common in rural environments, while depersonalization was more common in urban areas. It was argued that since, in urban areas, a person's roles can be separated from one another, defensive isolation and suppression of other roles is possible. In other words, an individual can be one person at work without his clients or colleagues being aware that he is quite a different person in another setting. Pathology thus is limited to one role. Such compensation is not possible in rural life, where it is more likely that the individual sees the same person in all his roles. Pathology in one role pervades all roles, and thus decompensation is more complete. In such a predicament grandiose fantasies are more likely to be used as a last ditch effort to deny feelings of total helplessness. Another interesting finding was that religious delusions and delusions of destruction increased in step with the guilt evoking character of the religion. Christians scored highest and atheists scored lowest. In this case it is the religious institution which not only taboos impulsive behavior but also encourages repression of normal sexual and aggressive drives. Wittkower (1964)

also explains his results in terms of cultural acceptance. For example, the rigid and formal culture of the East is conducive to schizophrenia because introversion is valued highly. The importance of emotional control in India is related to the Indians' lack of aggression, and their propensity to catatonic symptoms is connected to their Sanyasi or Yogi rituals.

Jaco (1959) found his Mexican sample least likely to be psychotic and speculated that the pattern of living peculiar to the Spanish (extended family, present-orientation, non-competitiveness and Catholicism) contributed to their good mental health. However, this is also confounded by the fact that Mexicans were more likely to live in rural areas than urban, and urban rates for psychosis were higher than rural rates. The results found by Stoker (1965) and Meadow & Stoker (1965) on their Mexican and American samples indicate a definite pattern of acting out versus repression of affect, a pattern that could easily be class related. Anglo Americans are more likely to hold to the middle class values of repression of aggression.

Hyde & Chisolm (1944) interpreted their findings in terms of cultural acceptance, emphasizing suitable channels for aggression. It is assumed that the functional mental disorders are the result of stress and tension that comes from being subjected to severe deprivations. Psychopathy is one primitive outlet for such stress, and was found to be

highest in the lowest socioeconomic groups. Alcoholism is another outlet. Neuroses were higher in those cultures that deem alcoholism or psychopathy least acceptable. It seems plausible to conclude, then, that if a culture has a taboo against one outlet, for example aggressiveness or belligerence, other outlets, such as alcoholism, would act as a substitute for the one that is blocked.

Singer & Opler (1956) and Opler (1959) found that Irish and Italians differed in the sex at which anxiety or hostility was directed, the degree of impulse control or affective coloring, and the balance of defenses: fantasy and withdrawal patterns versus poor emotional and impulse control. This was seen as due to the contrast in family constellations. The development of delaying capacities and fantasy formation is based on early identification with significant family figures, and different cultures condition different modes of energy distribution which persist in psychosis. The Irish family constellation with its powerful mother figure emphasizes inhibition and delay of gratification. There is also ambivalence to female figures and difficulties in establishing identification with the father. Italian families, on the other hand, emphasize direct expression of emotions resulting from conflicts with the father figure.

Section IV Statement of Problem

The ethnic groups this study proposes to compare are Puerto Ricans and blacks of the New York City Harlem area. The fact that both groups are substantially within a poverty culture is expected to have a leveling influence on differences, but ethnic differences affecting the training, family pattern, expressive style and values will become manifest in different types of symptomatology in mental patients. The researcher is aware that entrance to a mental hospital is a highly selective process. The relation between social class and service from state institutions has been well documented. One cannot talk of "true" incidence of mental disturbance among races on the basis of those in treatment. Different rates of mental illness among different ethnic groups may be confounded by the likelihood that differential willingness to care for psychotics within the family other than within institutions may be responsible for some apparent differences in incidence, and this will have to be taken into consideration. However, blacks and Puerto Ricans from Harlem are of the lower class, and it is this class that is best represented in state hospitals like the one from which the sample is drawn. Also, the main focus of this thesis will be on how ethnic differences within the same social stratum affect the expression of mental disorder.

Section V Similarities in Black and Puerto Rican Class Circumstances

Glazer & Moynihan (1963), using census records in their extensive survey, suggested that both Puerto Rican and black cultures have something in common which separates them from other ethnic groups in the lower class. Other nationalities which have emigrated to New York have all gone through the initial stages of relative poverty, but have been able to rise in status with each generation to a greater degree. Blacks and Puerto Ricans are subjected, however, to special downward social pressure. Just at the time they are coming in, there is less demand for unskilled labor.

According to the case histories and clinical observations of Grier & Cobbs (1968), plus the extensive psychiatric interviews and migration records used by Mills et al (1950), the family is most often the extended clan for both blacks and Puerto Ricans of the lower class. Relatives, provided they are available, readily share the responsibilities of child rearing or come to the aid of a troubled member. Handlin (1959), in his monograph based on a demographic study by the Regional Plan Association, also noted that one aspect of the extended family is that all the people living under the same roof, whether related or not, are considered family. For the blacks, home is where "one's people" are; geography is part of the extended identity as is the extended family (Grier & Cobbs, 1968).

Similarly, for the Puerto Ricans, part of the extended family live in Puerto Rico and there is often travelling back and forth (Handlin, 1959). Lewis (1968) gives further evidence of this in his anthropological study of an extended Puerto Rican family, and is confirmed by census materials and historical data gathered by Senior (1961) as well as the personal observations of Wakefield (1959) who lived in Spanish Harlem for six months. This constant contact with the homeland tends to make the Puerto Rican way of life persist. For both groups one can also note the high incidence of early marriage, free unions, multiple spouses, and illegitimate children. Kardiner & Ovesy (1951) found much of this pattern evident in the case histories and psychiatric observations of blacks, as Lewis (1968) found with his Puerto Rican family study. Handlin (1959) posits that these phenomena are part of disorganized family relations that has resulted from the strain of migration and resettlement of any new immigrant group. A lax attitude toward sexual behavior is related to such chaotic family life that also troubled earlier immigrants. But in addition blacks must cope with the scars inherited from slavery and Puerto Ricans with the difficulty of transplanting the traditional Spanish Catholic courtship system or extended kinship patterns.

Section VI Differences between Puerto Rican and Black Cultures

A) Direct comparison between blacks and Puerto Ricans:

Incidental findings from a study done by Suchman (1965) give some clues to one aspect of difference between blacks and Puerto Ricans. He was attempting to determine the degree to which social cohesiveness, ethnic exclusivity, friendship solidarity and orientation to family tradition and authority influenced or was associated with such medical attitudes as knowledge about disease, skepticism of doctors, and acceptance of the sick role. A random sample of 1883 persons representing six different ethnic groups were drawn from Washington Heights. Data was gathered by extensive interviews and questionnaires. The finding in general was that the more homogeneous and cohesive the group, the more likely persons were to react to illness and medical care in terms of their own social group norms of medical behavior rather than be well informed and oriented to the objectives of modern medicine. Puerto Ricans were the most ignorant about disease. Blacks also lacked as much knowledge about medicine as the white ethnic groups, but were more oriented to the official medical care system. On the social side, Puerto Ricans were found to be a tightly knit group, scoring highest in friendship solidarity and social group cohesiveness. Blacks, on the other hand, were found to be a more loosely organized group than the average white group of the same class. Handlin (1959) states claims from actuarial evidence that the general incidence of disease and the mortality rate is lower in Puerto Ricans than blacks. It may

be that the cohesiveness of the Puerto Rican social milieu helps the individual define goals that make life worthwhile, a significant element in determining the degree to which he can maintain a healthy existance. However, the study by Dohrenwend & Dohrenwend (1969) questions this. Both blacks and Puerto Ricans, they claim, are equally disadvantaged. They are equally tolerant of the symptoms of schizophrenia, which would reduce the "secondary loss," and equally likely to benefit from systems of state aid which would act as a secondary gain, thus perpetuating disabling symptoms in both groups to the same degree.

B) The Black Culture

The black family structure and all its ramifications are rooted in slavery. The black man was brought to this country by force and completely cut off from his past, his language, his culture. Furthermore, he was exploited for his services, treated as subhuman, and put in a menial subservient status. In order to survive as a slave the black child had to be taught to feel inferior. The mother had to demand complete obedience from the child and never allow him to grow up expecting love and loving concern (Grier & Cobbs, 1968; Cleaver, 1968; Malcolm X, 1966).

Although there are many exceptions, the trend of the black family is matriarchal. The matriarchy is partly rooted in slavery, when the white master wielded more authority than the black father. However, some of the

same factors operating in slavery times still function today, perpetuating a sense of impotence in many black males. To say the black family is a matriarchy would be oversimplifying things. If a man is not allowed to be a consistent wage earner, or even protect his family members, the wife naturally must assume status as head of the household. She has to bear the culture and interpret society to the child as she knows it, and must shape their character to adapt to it. For the black it is a bleak, dismaying message to get across. The child must know the white world is dangerous and if he does not understand its rules it may kill him. He must learn independence early, and he must learn how to live with broken homes and inferior class status. The mother has been seen as contradictory and ambivalent, her discipline inconsistent. The mother has to blunt the male's masculine assertiveness and prepare him for his subordinate role in the world (Grier & Cobbs, 1968; Kardiner & Ovesy, 1951; Glazer & Moynihan, 1963; Moody, 1968). The black male, consequently, has had to base his self esteem on ways which seem either antisocial, escapist, or socially irresponsible. The pressure to find relief from this position seems quite directly related to the high incidence of broken homes and desertions, which Clark (1965) observed during his two years as chief project consultant and chairman of the board of directors of the planning stage of Haryou.

The sex roles in the black culture do not follow the

usual middle class norms. The role of the black male is hard. He is worse off economically, so is more often a burden than a support for the woman, not even adequately prepared for the father role. Often this is because he was brought up in a fatherless home himself (Kardiner & Ovesy, 1951). The black man has to struggle to feel manhood as his own and he has to overcome much opposition to assume a masculine posture (Grier & Cobbs, 1968). Even with education, girls are encouraged more than sons to remain in school. Thus a girl has higher aspirations and motivations than the male, and is more likely to make and finish plans (Grier & Cobbs, 1968; Glazer & Moynihan, 1963; Clark, 1965).

Consequently, the black men are sometimes seen by black women as weak, powerless, exploitive and irresponsible. Grier & Cobbs (1968) case history material revealed the contempt many black women have for their men . This antipathy is reciprocated by the male. According to Kardiner & Ovesy's findings (1951), which incorporated material gathered from Rorschach protocols, the black man sees the black woman as masculine and authoritarian. He views her with mistrust, hostility, and resentful dependency. This hostility to black women stems from their being also seen as inhibiting instruments of an oppressive system (Grier & Cobbs, 1968; Moody, 1968; Cleaver, 1968).

Both sexes suffer from low self esteem and a negative attitude toward their own group which can influence intel-

ligence and achievement performance adversely (Kardiner & Ovesy, 1951; Malcolm X, 1966; Fanon, 1967). The older blacks are, unlike the young, often too resigned to the status quo and feel quite hopeless that any changes can be made (Moody, 1968).

The defense mechanisms and expressive style of the black rise largely out of the effects of caste barriers. According to Poussaint (1967), lifelong frustration has generated extreme rage in the black, yet the society has tabooed the outlet of self assertion. This is an important factor behind the blacks' social and psychological problems, for the black has to repress this rage and find other outlets. Passivity became necessary for survival.

One way to deal with rage is by reaction formation, adopting the submissive role, being ingratiating around whites. The greater the suppressed rage, the more abject the pretense of love. Other ways the black deals with rage are going into sports, identifying with the oppressor ("Uncle Tomming"), identifying with another who is free to express rage directly to the oppressor, replacing rage with chronic resentment towards whites, or with psychosomatic symptoms, or escaping into drugs and alcohol (Kardiner & Ovesy, 1951; Poussaint, 1967). Kardiner & Ovesy's study perhaps applies more to older blacks. They found denial, lowered affectivity potential, and emotional detachment showing up quite consistently in the Rorschach protocols.

Other things that emerged were fear of relatedness, suspicion and mistrust, and a tendency to dissipate the tension of a provocative situation by reducing it to something simpler. Fanon (1967) states that this pattern is to be found in blacks all over the world when they come up against whites.

However, times are changing. The old passivity is fading and being replaced by assertive political and social action; aggressiveness is becoming more constructive (Poussaint, 1967). The rise in delinquency and riots, according to Clark (1965) are actually healthy in a way. The young have been promised many social reforms and the lifting of oppression, but the gap between the expectation and the true situation has been great enough to engender much frustration and hostility. The resulting aggression has become manifest in overt rebellion; a situation that could happen only in a stage intermediate between complete oppression and social justice. Clark states, "Delinquency statistics show that a group is in ferment, in the process of rejecting an earlier inferior status and moving to a higher level." (Page 88).

C) The Puerto Rican Culture

Berle's 1958 study was of particular interest in elucidating the Puerto Rican culture. His was an anthropological study of eighty slum families, and his observations as a family doctor situated in the area and having access to

the homes of these families is supplemented by anthropoligical information about norms of behavior and the meaning of health and disease to these families. Again, this section merely represents the areas of culture agreed on in most of the source material, and is not meant to convey the impression that exceptions do not exist.

The Puerto Rican family structure has its roots in the island culture, where kinship is still organized in the Spanish tradition. Old people are given respect and ritual kin are taken seriously (Mills et al, 1950; Glazer & Mounihan, 1963; Lewis, 1968; Wakefield, 1959; Rogler & Hollingshead, 1965).

The sexual roles are clearly dichotomized. The husband and father holds the power, supports the family, and in general wields the authority. In fact, the father takes resoponsibility for supporting all his children by former marriages, if any. The wife is expected to stay at home, take care of the daily routine, and keep her interests restricted to the home. Consequently the mothers may tend to overprotect their children (Mills et al, 1950; Lewis, 1968). Child rearing practices are clearly structured. Girls are carefully supervised and warned to keep their virginity. With such a restricted environment and its lack of personal freedom, the girl often escapes into early marriage and motherhood. In radical contrast, boys are given much more personal freedom. They are praised for

their manliness, taught their "proper" male role, and are required to show respect for their father. Otherwise they are left on their own (Glazer & Moynihan, 1963). From childhood on the boy becomes aware that a man's sexual capacity is of exceptional importance in demonstrating his masculinity and dominance. In the Puerto Rican culture this is called "machismo" (Lewis, 1968; Mills et al, 1950). While the burden of child rearing falls mainly on the mother, the father is not expected to have much to do with his children outside of demanding respect and obedience. To participate in housekeeping chores is "beneath his dignity" --he should feel free to come and go as he pleases (Glazer & Moynihan, 1963).

Within the lower class of the island culture, consensual marriages are common. A woman may have two or three husbands consecutively this way and still not feel promiscuous. However, many emotional difficulties can be traced to tensions and neglect in homes where children of former unions are rejected (Mills et al, 1950; Lewis, 1968; Rogler & Hollingshead, 1965).

There are many factors encouraging migration to the United States. In effect, there is a "stick and carrot." The stick is that education on the island is very poor and conditions are overcrowded. While technological development on the island created jobs, just as many were destroyed. Since many things necessary for daily living have to be

imported, the cost of living is high, but wages remain low (Glazer & Moynihan, 1963). The carrot is that regular air service between San Juan and New York is very inexpensive. The United States promises more economic opportunity, luring the Puerto Rican to New York where some of his kin may already be. Men migrate for economic reasons and women for family reasons (Wakefield, 1959; Handlin, 1959; Mills et al, 1950; Lewis, 1968).

The Puerto Ricans who migrate are more likely to be legally married than those that remain, and have more formal schooling. Compared to the islanders the migrants are more privileged, but they bring with them handicaps that make adapting to the more technological society difficult. Their schooling is still inadequate; if they are also black this counts against them; and they are largely unskilled. All enter a society where the opportunities for advancement have narrowed for the poor, the uneducated and foreign. While the men aspire to more highly skilled jobs, their lack of education makes them feel hopeless about attaining their goals.(Mills et al, 1950), so they place their hopes in their children.

But the island pattern of child rearing is not easy to maintain in New York (Glazer & Moynihan, 1963). In New York the comparative amount of freedom the children are lured into is frightening to the immigrant parent. Many parents feel inadequate at handling their children and give

up attempting to maintain control. Others (a pattern more typical) "tighten the screws" -- even on the boys -- and become overprotective. Another problem is that it is not as easy to arrange for a relative to relieve the mother from child care as it was in Puerto Rico. Mothers, without such help, begin to resent their children who have become such a strain on them.

The attitudes about sex roles and the family which the migrant has learned in the island culture are likely to be modified as life in New York effects changes in the actual roles. The woman may find it necessary to work and then discovers the freedom her traditional role denied her. At the same time the woman becomes more financially autonomous, the husband may feel the working wife is depriving him of an essential part of his masculine role, that of being sole support of the family (Mills et al, 1950; Lewis, 1968). This is indeed a conflict from the island culture. What is not affected by the migration is the feeling that the proof of manhood lies in his sexual capacity, and the conviction that he <u>should</u> be chief breadwinner. If a father falls ill in a nuclear family the mother's potential role as chief breadwinner is considered more threatening to family integrity and masculine self respect than acceptance of public assistance (Berle, 1958).

The lower class Puerto Ricans have a good capacity to relate to others. They seem to need sociability and inter-

action, are fun loving and have a zest for life, enjoying parties, dancing, and music. Their deepest need is love. Sex is an integral part of their daily lives. There is a constant need for excitement, new experiences and adventures (Berle, 1958; Glazer & Moynihan, 1963; Wakefield, 1959; Handlin, 1959; Senior, 1961; Mills et al, 1950; Rogler & Hollingshead, 1965). Lewis (1968), who also used Rorschach and TAT protocols in his study, describes the personality of the Puerto Rican as generally extratensive and unrepressed. There is much acting out, self expression, hedonism, and personal loyalty. The people are characterized less by depression and more by emotional lability. Because direct expression of feelings, even anger, are accepted rather than punished by the family, Puerto Ricans are not prone to internal conflict or a sense of guilt. Impulsivity, unrepressed rage, and violence are all part of the typical personality picture. They have a great capacity for religion (Wakefield, 1959) and many more believe in spiritualism and similar superstitions than will readily admit.

Puerto Ricans, therefore, have commonly attributed mental disorder to sorcery. Wakefield (1959), Glazer & Moynihan (1963), and Berle (1958) cite "ataques" as a most common expression of psychopathology. This is an epileptic type seizure. These attacks are also known as the "Puerto Rican syndrome" and seems to be a popular conventional reaction to any overwhelming catastrophe, a form of hysterical

syncope. Berle (1958) feels they are rage equivalents. Asthma attacks are also quite common, and felt by Berle to be related to conflicts. Dohrenwend & Dohrenwend's Washinton Heights study (1969) suggests a greater tendency for Puerto Ricans to somatize their symptoms: this group had a larger proportion with more than four such symptoms on the "22 Item Indicator of General Psychiatric Disorder" than their class counterparts in other groups.

D) Hypotheses

To summarize, the most salient differences between blacks and Puerto Ricans within the lower class appear to involve sex roles and expression of feelings. This will form the background for the hypotheses.

For the black, the female has been described as the dominant figure and for the Puerto Rican, the male has the authority. It is hypothesized that these sex role differences between the two groups will have certain consequences:

1. A primary consequence involves relations to authority figures. Where there is prejudice as there is toward blacks and Puerto Ricans and resultant segregation, the conflict engendered becomes manifest in resentment of and disrespect for authority. If authority is symbolized by different sexes in these two cultures, this phenomenon will be expressed by different attitudes toward the sexes between the cultures; i.e., blacks will show more resentment toward women and Puerto Ricans will show more resentment

toward men.

2. Another consequence would become evident in the manifestation of paranoia. The black family constellation, with its powerful mother figure, emphasizes inhibition and suppression of impulses, while Puerto Rican paternal dominance emphasizes acting out. These differences in mode of energy distribution, if they parallel the results found by Singer & Opler in their Irish and Italian patients (1956), should favor the formation of paranoid delusions more in the black than the Puerto Rican.

In the Puerto Rican culture greater sociablilty and capacity to relate to others has been noted, as well as the unrepressed expression of feelings. Four more hypotheses can be added at this point as possible consequences of cultural disparities in expressivity and sociability:

3. If the Puerto Ricans are more socially cohesive, their sociability would be reflected in their having more visitors, on the average, than blacks.

4. It is hypothesized that Puerto Ricans will exhibit more acting out, affective lability, and less emotional flatness than blacks.

5. Since the tendency to somatize symptoms is generally related to greater emotional responsiveness and impulsivity, it is not surprising that such symptoms were observed in the Puerto Rican culture. It is therefore hypothesized that Puerto Rican patients will show more bodily preoccupation and conversion reactions than blacks.

6. Both cultures, being in the lower socioeconomic group, are likely to experience more frustration of elemental physical needs, and the natural response to this is an increase in aggressiveness. The cultural taboo against direct expression of aggression in the black is not present for the Puerto Rican. It is hypothesized, therefore, that Puerto Rican patients will be more direct in their expression of hostility than black patients. Furthermore, an interaction is hypothesized here. Since the civil rights movement began, the younger generation is dropping the passivity of the older generation blacks. Therefore marked differences should be evident between the older and younger blacks, expressing itself in such symptomatic differences as greater incidence of alcoholism in the older blacks, and a greater incidence of violent behavior in the younger blacks. As a control, the Puerto Rican age groups should exhibit only differences due to aging alone. Such age related symptoms would include the greater floridity of psychoses in younger patients, and, with age, the greater likelihood of chronic alcoholism taking its toll.

Method

I. Subjects:

Male black and Puerto Rican subjects from the Harlem and Metropolitan units at Manhattan State Hospital were used. The study was done in two parts at two different times. Consequently, due to patient turnover, the Ss are not necessarily the same in both parts of the study.

The pilot study was essentially a ward census which determined age, education, chronicity and alcoholism of the patients. It was completed June, 1969. All records of patients who met the selection criteria were used. The second part of the study involved rating patients and was begun in October 1969. Rating was carried out over a six month period ending in spring of 1970. All of the patients in the two units who met the selection criteria were used. It was necessary to wait for new admissions to fill the equal sized groups required for this part of the study.

The survey of the hospital records from these units revealed that there were no differences between the two ethnic groups in years of education (mean years), percent of first admissions, nor mean age within age group.

The purpose of studying age was to see if any controls would be needed to equate the groups for age, and if so, what control would be needed. The data for age, which at first included subjects over 60 years of age (all of them blacks), were based on records of 38 blacks over 30 years

old, 24 blacks under 30 years old, 26 Puerto Ricans over 30 years old, and 27 Puerto Ricans less than 30 years old. Data describing age are presented in Table III.

Since the older groups differed significantly in mean age and range, Puerto Ricans ranging from 30 years to 60 and blacks ranging from 30 years to 70, the subjects over 60 were subsequently dropped to equate the age groups. Table III shows that this adjustment equated the age groups successfully. Since the variance of age in blacks over 30 was reduced by this procedure, an F max (Winer, 1962) test was done. The hypothesis for homogeneity of variance was regarded as tenable: F max = 1.81. Henceforth, all comparisons were done on the matched groups.

Variability in the 31-60 age groups was greater than that of the under-30 groups because the older groups span three decades while the younger groups span less than 15 years.

Means and SDs and distribution for education are shown on Table IV and include only those records where this information was available. Since, for the general population, the younger generation is more educated than the previous generation, the overall means of years of formal education are less for the older than for the younger groups. The older groups had a mean of 1.76 years less than the younger groups.

Multiple admissions as an index of chronicity was

studied to see if this variable was randomly distributed between the ethnic groups or if some control would be needed, since differences in chronicity could be a confounding variable. It is important to note that exact number of previous hospitalizations is extremely unreliable. The patient is generally the source of this information, and in his confused state may frequently misrepresent the facts. Keeping this in mind, our definition of chronicity must be conservative. First admissions are not defined as chronic, but multiple previous admissions are. A χ^2 of .36 ($p = .60$) indicated no significant differences in incidence of chronicity between races. Approximately 82% of the patients had had previous hospitalizations: 25 of 32 blacks over 30, 22 of 26 Puerto Ricans over 30, 18 of 24 Blacks under 30, and 24 of 27 Puerto Ricans under 30 years of age.

Occupational status was uniformly low, being either unemployed, unskilled, or semi skilled. Consequently, to control for socioeconomic status it was necessary to drop three college educated subjects. For Ss too young to have ever been employed, the occupation of the head of the household was considered. To control for ethnic differences only United States born blacks were selected. The Puerto Rican sample was limited to immigrants who had been in New York at least two years.

Since symptoms vary with age, age was controlled by

TABLE III

Distribution of age by decade taken during census

Age	Puerto Ricans	Blacks
Up to 19	4	1
20-29	23	23
30-39	13	8
40-49	9	16
50-59	2	8
60-69	2	5
70 and over		1
Absolute range	17-60	18-70*

*After those over 60 were dropped, range was 18-55.

Age means and SDs for groups including pts over 60

	Blacks		Puerto Ricans	
	Under 30	Over 30	Under 30	Over 30
n	24	38	27	26
Mean	24.42	48.84**	24.04	42.77
SD	3.76	9.63	4.26	9.07

**Blacks over 30 but under 60, n = 32. Mean age, 43.75, SD = 6.74.

TABLE III, Cont'd

Summary of Analysis of Variance for age in groups over 30

Source	df	MS	F
Race	1	255.97	6.24*
Error	62	88.58	

*$p < .05$

Summary of Analysis of Variance for age in groups over 30 after dropping Ss over 60

Source	df	MS	F
Race	1	13.91	< 1
Error	56	61.90	

TABLE IV

Distribution of years education taken from records in census

	Blacks		Puerto Ricans	
Grade	31-60	Under 30	31-60	Under 30
1				1
2	1	1	1	
3	2		1	
4		1	1	
5			3	
6	2	1	2	1
7	4	1	1	3
8	6	1	3	4
9	3	2	1	
10	1	3	1	1
11	3	4	1	5
12	4	8	2	4
Total years	214	215	121	173
Total persons	26	22	17	19

TABLE IV, Cont'd

Mean years of education for the two ethnic groups by age

	Blacks		Puerto Ricans	
	31-60	Under 30	31-60	Under 30
n	26	24	17	19
Mean	8.23	9.77	7.12	9.11
SD	2.79	2.81	3.02	2.85

Race means: blacks = 9.00, Puerto Ricans = 8.12

Age means: 31-60 = 7.68, under 30 = 9.44

Summary of Analysis of Variance for years of education, ethnic group by age group

Source	df	MS	F
Race	1	16.20	1.99
Age	1	63.99	7.85*
Race x Age	1	.62	< 1

*$p < .01$

TABLE V

Distribution of age by decade for patients who were rated

Age	Puerto Ricans	Blacks
Up to 19	7	3
20-29	11	14
30-39	13	8
40-49	3	8
50-60	6	4
Absolute range	16-60	17-58

establishing two age groups within each culture: a 30-and-under group, and a group 31-60. Twenty subjects met the criteria for each group. The breakdown of patients by unit appears below in Table VI.

TABLE VI

Distribution of patients by group in each unit

	Metropolitan	Harlem
Blacks 31-60	6	14
Blacks under 30	7	13
Puerto Ricans 31-60	14	6
Puerto Ricans under 30	17	3
Totals	44	36

As mentioned before, because of a certain amount of turnover, the patients who were rated are not necessarily the same patients who were involved in the record survey, but like the record survey, this list represents all of the patients in the two units who met the selection criteria.

II. Raters:

Eighteen attendants from the two units volunteered to help collect data by using two rating scales: the MACC II, which is a measure of ward adjustment, and the Wittenborn Psychiatric Rating Scale (1964), which measures symptomatology. These scales will be described in greater detail in the section to follow. Since race and sex may be confounding variables in this study, these rater characteristics were noted. The breakdown is: 8 black females,

6 black males, 2 white males, one white female and one Puerto Rican female.

As with any state hospital, getting initial cooperation from the attendants is a difficult task.[1] Instead of presenting the problem at staff meeting (which would implicitly identify the study with "the establishment"), the investigator approached the attendants individually and informally. The importance of their comparatively closer contact to the patients was stressed; that because of this daily contact they were in a position to judge ward behavior more accurately than the doctors, who were seldom on the ward. Second, in explaining what the study would entail, it was made quite clear that only a few patients would be rated each week. Third, the attendants were told they would be able to choose whom they wanted to rate, within the constraints of the design. This did not affect which patients were rated, for the supply of all available patients on each ward was exhausted. In effect they chose to rate those patients they were most familiar with first and it gave the attendants a sense of greater participation.

1. It is not recommended that any proposed study be introduced at a weekly staff meeting; this may appear to save time, but it opens the way for misunderstandings. The employees may pick up many false impressions; for example: that they are pressed for time, having to collect all data at once, that they might be forced to rate patients with whom they are not sufficiently familiar; and that this task will have to be done on their own time. In other words, the attendants may feel that participation in this research could only show up their inadequacies.

Next, the ward nurses gave permission for ratings to be done on hospital time as long as that rater was not being kept away from more immediate duties. E also offered to help on the ward. Finally, the rating scale items were clarified for the raters item by item. The language of the MACC II (Ellsworth, 1962) was simple enough to pose no problems, but that of the Wittenborn scale (1964) was too sophisticated for most of these attendants. The investigator and raters developed a simplified explication (see Appendix B) of the Wittenborn items which could be referred to for instructional purposes. After the first few ratings, the Wittenborn scale was familiar enough to the raters to be used without referring to the instruction sheet.

This following observation might prove helpful to others who intend doing research on the wards of state hospitals. The occupations of the raters are jobs that get filled, as a rule (at least in the New York area) by upwardly mobile blacks, and the majority of these raters were black. Occupational level ranged from the lower level aide or attendant to trained practical nurse and registered nurse. The white raters cannot be said to be typical of the white population in general. One was Puerto Rican, two had come from relatively disadvantaged backgrounds, and one was college educated. The latter was a conscientious objector who had elected to serve his two years working in a state hospital rather than fight in Vietnam. Although all

raters had been told when being trained that they, as attendants, were being used because they knew the patients better than anyone else, this statement was immediately accepted by only the non-black raters. Many of the black raters did not take the examiner's word for it, and a certain amount of suspicion prevailed at first. There was some feeling that it was they who were being studied rather than the patients, that their accuracy of rating was being checked by some superior criterion. One rater expressed this feeling by asking if their ratings were checking out close enough to the psychiatrist's "master file!"

III. Dependent Variables:

In this section the measures used will be described and some data on their applicability to this study will be presented.

1. The Wittenborn Psychiatric Rating Scale (1964) is a scale of 72 items based on observations of ward behavior. It has the advantages of high construct validity with norms based on 1000 patients, is reliable, and can be used by regular aides (according to Wittenborn) since the items attempt to minimize the rater's judgemental involvement. A study (Wittenborn et al, 1952) using an earlier form of the same scale compared the judgements of two similar patient groups by two psychiatrists who differed radically in age, cultural background, theoretical bias and training (European versus American). The cluster patterns were

remarkably similar, implying that a cluster has the same kind of meaning from rater to rater, probably because the items on the 1964 revision fall into 12 clusters, but for purposes of this study only five clusters were measured, a total of 28 items. These were the clusters most relevant to the study. The actual rating scale used is given in Appendix A.

Because two units, each with their own attendants, were used, the same raters could not rate all the patients. Therefore special pains were taken to train these raters sufficiently so as to avoid errors due to ward differences. Besides briefing each rater on the scale to familiarize them with the concepts, the explanation of the WPRS items in simpler language developed in the Metropolitan unit was used as a standard instructional reference for both units. Each rater was instructed to select from each scale the statement which described the most extreme manifestation of the psychopathology they had observed while the patient was in the acute stage of his illness. The observation period had to be at least two weeks before any rating could be attempted. The behavioral data under scrutiny are the patterns of symptoms which would be clearly manifest before medication, therapy, and hospital environment obscured distinctions between patients. The investigator went over the first few ratings with the aides to insure that the ratings were reliable.

2. The MACC II Behavioral Adjustment Scale (Ellsworth, 1962) measures mood, cooperation, communication, and social contact, and gives an overall adjustment score. The first two clusters, mood and cooperation, reflect the degree of hostile attitudes exhibited by the patients in general. The scale is shown in Appendix C. The MACC II was used in an indirect fashion; to ascertain the extent to which patients direct their hostility differentially at males and females. If a patient reacted to one sex attendant with more animosity than the other sex, it was expected that this difference would show up in the ratings.

Attendants were told that in using this scale they must rate the patient as he is characteristically, not as he was at his sickest, as on the WPRS. Each patient was his own control in this measure, having a mean male score and a mean female score (each score based on two ratings) on mood and cooperation.

Examination of the raw data on the MACC ratings revealed several sources which confound the correlations between aides' ratings of the same patients. Each rater rated different numbers of patients, as well as different proportions of blacks and Puerto Ricans. A rater rating primarily blacks, for example, might have set up a different standard or anchor point of pathology based on his particular group of patients than a rater observing mainly Puerto Ricans. This caused the mean ratings to vary considerably

from rater to rater, as well as the range of scores used. The races were disproportionately rapresented in the two units, and examination of Tables VII, VIII, IX, X, XI, and XII, which used the raw scores, reveal how the analysis of variances for both mood and cooperation (sex by race, race by unit, unit by sex) were confounded by the potency of the unit variable.

On inspecting the tables of results for the cooperation cluster, it can be seen that on the Harlem unit females rated Puerto Ricans higher on cooperation than blacks, but in the Metro unit they rated Puerto Ricans lower than blacks. The sex differences are thus washed out and unit becomes the more potent variable. The Metro unit as a whole gave the lowest ratings on cooperation and the females gave the greatest variation (judging from the SDs) in ratings. On the mood ratings, the only sex difference in ratings appeared when the analysis was done on combined units, and here the race difference (blacks being rated better on mood than Puerto Ricans) was a much more significant result at the .001 level. When mood ratings were combined for sex and analysis was done between races and units, all the Fs were significant. Each unit rated blacks about the same, but Puerto Ricans were rated higher on the Harlem unit than the Metro unit. When the races were combined, and comparisons were done between units and male vs. female raters, the unit variable was the most potent at $p < .01$, and there were no overall sex differences.

TABLE VII

MACC cooperation cluster: means and SDs of male and female raters for black and Puerto Rican subjects for combined units

Subjects:	Blacks		Puerto Ricans	
Raters:	Male	Female	Male	Female
n	80	80	80	80
Mean	14.08	14.44	13.05	11.71
SD	3.47	3.14	3.47	5.86

Summary of ANOVAR

Source	df	MS	F
Race	1	283.20	17.73*
Sex	1	19.20	1.28
Race x Sex	1	56.80	3.56**

*$p < .01$

**$p < .10$

TABLE VIII

MACC cooperation cluster: means and SDs of black and Puerto Rican subjects on each unit, combined ratings.

Subjects:	Blacks		Puerto Ricans	
Unit:	Metro	Harlem	Metro	Harlem
n	52	108	124	36
Mean	13.85	14.46	11.66	14.91
SD	3.04	3.43	4.86	3.91

Summary of ANOVAR

Source	df	MS	F
Race	1	40.00	2.44*
Unit	1	196.31	11.99**
Race x Unit	1	91.58	5.59***

*$p < .25$ (Although this F is noted, it is not to be considered significant.)

**$p < .01$

***$p < .05$

TABLE IX

MACC cooperation cluster: means and SDs of male and female raters for combined races from the Metro and Harlem units

Unit:	Harlem		Metro	
Raters:	Male	Female	Male	Female
n	72	72	88	88
Mean	14.13	15.02	13.11	11.48
SD	3.86	3.16	3.12	5.46

Summary of ANOVAR

Source	df	MS	F
Unit	1	416.00	25.26**
Sex	1	11.20	< 1
Unit x sex	1	126.40	7.82*

*$p < .01$

**$p < .001$

TABLE X

MACC mood cluster: means and SDs of male and female raters for black and Puerto Rican subjects for combined units

Subjects:	Blacks		Puerto Ricans	
Raters:	Male	Female	Male	Female
n	80	80	80	80
Mean	15.56	15.02	14.17	13.94
SD	2.91	2.97	3.02	4.46

Summary of ANOVAR

Source	df	MS	F
Sex	1	44.25	3.82*
Race	1	371.95	32.09**
Sex x Race	1	6.90	< 1

*$p < .05$

**$p < .001$

TABLE XI

MACC mood cluster: means and SDs of black and Puerto Rican subjects on each unit, combined ratings

Subjects:	Blacks		Puerto Ricans	
Unit:	Metro	Harlem	Metro	Harlem
n	52	108	124	36
Mean	15.14	15.44	12.47	15.62
SD	2.93	2.87	3.80	2.83

Summary of ANOVAR

Source	df	MS	F
Unit	1	156.84	14.63*
Race	1	81.58	7.61*
Unit x Race	1	106.31	9.91*

*$p < .01$

TABLE XII

MACC mood cluster: means and SDs of male and female raters for combined races from the Metro and Harlem units

Unit:	Harlem		Metro	
Raters:	Male	Female	Male	Female
n	72	72	88	88
Mean	15.30	15.76	14.43	13.18
SD	3.00	2.84	3.03	4.26

Summary of ANOVAR

Source	df	MS	F
Sex	1	12.00	< 1
Unit	1	238.40	20.89*
Sex x Unit	1	58.40	5.12**

*$p < .01$

**$p < .05$

Because this data is too confounded to be meaningful, the raw scores had to be transformed such that "anchoring points" and ranges were equivalent from rater to rater. The patient ratings for each individual aide were therefore ranked and transformed into deciles (Underwood et al, 1954). The highest score was given the value of 10, and scores below the tenth percentile given the value of .5.

Since the "mood" cluster picks up irritability, sullenness, bitterness and anger, it lent itself as a supplementary measure of overt hostility. Because the number of white attendants was so small, no attempt was made to compare their ratings with those of the black attendants.

3. Hospital records include information on date of admission, number of previous hospitalizations, marital status, education, occupation, country of birth, plus diagnosis and psychiatric examinations from the city hospital. The state hospital examinations are conducted by resident psychiatrists under staff supervision. Records (from the pilot study) were referred to for incidence of alcoholism.

Hospital records invariably raise a number of questions. Since some patients reveal very little during these interviews, some descriptions are less complete than others. However, the objective signs of alcoholism are typically noted by more than one doctor when they are present. It is assumed that the variable of chronic alco-

holism can be derived from records even if different residents are examining. If there was mention of alcoholic brain syndrome, alcoholic deterioration, psychosis due to alcohol, Korsakov syndrome, alcoholic hallucinosis, D. T.s, cirrhosis of the liver; this was counted as "alcoholism." Simple intemperance was considered below the cutoff point and not counted.

The hospital also keeps records of visitors and number of visits, and a count of number of visitors in the first six visiting days of hospitalization was taken as a measure of social cohesiveness. Six visiting days is an arbitrary figure, but it is probable that in the first days after commitment there is a tendency for visitors to be more willing to come, and the records more likely to be accurate for each patient.

4. Foulds, Caine, & Creasy (1960) devised a hostility scale using 52 items from the abridged MMPI. This scale was standardized on a variety of mental patients diagnosed as "hysteroid hysterics, obsessive hysterics, hysteroid dysthymics, obsessional dysthymics, melancholics, paranoids, and psychopaths." (Some of these terms are used only in British psychiatry. The modifier denotes the personality type as rated by psychiatrists while the object refers to the diagnostic category. For example, an "obsessive hysteric" would be a patient of basically obsessional personality, who is manifesting hysterical symptoms.) Factor

analysis found all correlations to be positive, suggesting that a general hostility factor was being measured. But there were correlations suggesting that the "extrapunitive" clusters were measuring something quite different than the "intropunitive" clusters. In administering the scale, patients are asked to pick which statements apply to them and which statements do not apply. Clusters are: acting out, criticism of others, projected delusional hostility, self criticism, and delusional guilt. Taking the total, psychopaths scored the highest on hostility and hysterics scored the lowest. The Foulds data also disclosed that paranoids tended to score highest on projected delusional hostility and criticism of others. Psychopaths scored highest on acting out hostility, criticism of others, and delusional guilt. Hysteroid hysterics generally scored low on all the scales, most notably on delusional guilt.

This scale was used as a supplementary measure of amount and direction of hostility. Statements were printed on cards which the patient was asked to sort into "true" and "false" piles. A set of cards was also available in Spanish (taken from a standardized Spanish translation of the MMPI and shown in Appendix E). Because of poor eyesight or blurring of vision due to medication, as well as some illiteracy, E read the statements to some 40 patients, which included 9 Puerto Ricans under 30, 12 Puerto Ricans over 30, 9 blacks under 30 and 10 blacks over 30.

Results

I. Alcoholism

The data on alcoholism was derived from the hospital records during the preliminary census. The main finding was the greater incidence of alcoholism in the black patients.

Number of alcoholics within each group is given in Table XIII. Before dropping the six blacks who were over 60 years old, 34% of the blacks were found to be alcoholic. When these Ss were omitted, 27% of the blacks were alcoholic. All the subjects who were dropped had been black alcoholics. In contrast, only 11% of the Puerto Ricans were found to be alcoholic according to the criterion used in this study.

In comparing the two age groups, 36% of the group over 30 including those over 60 were alcoholic, and when the Ss over 60 were dropped, 29% were alcoholic. Only 8% of the patients in the under-30 group were alcoholic. Evidently age differences are a most potent factor in alcoholism, although there is a race difference too. Since the objective signs of alcoholism used as the criteria for this study are symptoms that take years of abuse to develop, it is understandable that alcoholics are more widely represented in the older population.

The measurements, taken during the pilot study, are not necessarily on the same patients who were measured by rating scales. As was mentioned earlier, the second part of the study was begun three months later, and there was some turnover in patients by then.

TABLE XIII

Incidence of Alcoholism*

	Blacks		Puerto Ricans		Age
	Alcoholics	Non-alcohol	Alcoholics	Non-alcohol	Total
Under 30	3	21	1	26	51
31-60	12	20	5	21	58
Over 60	6	0	0	0	6
Race total	21	41	6	47	

*χ^2 values: blacks vs. Puerto Ricans including over-60 years is 6.33, $p < .02$; omitting over-60 years $\chi^2 = 3.47$, $p < .10$.

Comparing age groups before dropping over-60 years, $\chi^2 = 9.75$, $p < .10$, and omitting over-60 years, $\chi^2 = 6.60$, $p < .02$. Comparing the black and Puerto Rican over-30 groups, $\chi^2 = 4.53$, $p < .05$; when over-60s are omitted, $\chi^2 = 1.66$, $p < .20$.

II. Rating Scales and Hostility Measures

A) Cultural differences in sex role:

The MACC ratings, which were transformed for each attendant into deciles, were used to compare male and female aide's ratings. Analyses on sex by unit averaged over race are shown on Tables XIV and XV and demonstrate that the transformation described in Dependent Variables was effective in controlling the anchor points. Averaging over races, neither the sex nor the unit variable yielded any differences, and knowing these were controlled for statistically, testing could then reveal any possible race by sex interaction.. Scores represent the sum of two ratings for the same patient by the same sex raters.

Comparisons of male and female ratings used the sum of the two same sexed raters' transformed ratings as a "score" for each patient. The means, SDs are shown on Tables XVI and XVII for mood and cooperation, respectively.

On the Metro unit blacks were rated higher than Puerto Ricans on mood (over 13 vs. around 9) but differences due to sex rater were not as readily apparant. On the Harlem unit blacks and Puerto Ricans were rated almost equally, about 11, but males tended to rate the blacks higher (11.48 vs. 10.20) and Puerto Ricans lower (10.67 vs. 11.50). Cooperation followed a similar pattern on the Metro unit: blacks were rated 11.84 and 13.15 by males and females respectively, and Puerto Ricans were rated 9.55 and 9.73 by males and

Table XIV

MACC cooperation cluster: means and SDs of male and female raters for combined races from the Metro and Harlem units

Unit:	Metro		Harlem	
Raters:	Male	Female	Male	Female
n	44	44	36	36
Mean	10.23	10.74	10.42	10.39
SD	5.65	5.77	5.14	5.57

Summary of ANOVAR

Source	df	MS	F
Unit	1	.40	< 1
Sex	1	2.40	<1
Unit x sex	1	2.80	<1
Within	156	30.87	

TABLE XV

MACC Mood cluster: means and SDs of male and female raters for combined races from the Metro and Harlem units

Unit:	Metro		Harlem	
Raters:	Male	Female	Male	Female
n	44	44	36	36
Mean	10.37	10.74	11.28	10.53
SD	5.61	5.52	5.24	5.71

Summary of ANOVAR

Source	df	MS	F
Unit	1	8.80	<1
Sex	1	1.60	<1
Unit x Sex	1	8.40	<1
Within	156	30.54	

TABLE XVI

MACC Mood cluster: means and SDs of male and female raters for black and Puerto Rican subjects on the Metro and Harlem units

	Metro Unit			
	Blacks		Puerto Ricans	
Raters:	Males	Females	Males	Females
n	13	13	31	31
Mean	13.92	13.62	8.89	9.53
SD	4.24	3.30	5.35	5.72
	Harlem Unit			
n	27	27	9	9
Mean	11.48	10.20	10.67	11.50
SD	5.14	5.80	5.20	5.02

TABLE XVII

MACC Cooperation cluster: means and SDs of male and female raters for black and Puerto Rican subjects on the Metro and Harlem units

	Metro Unit			
	Blacks		Puerto Ricans	
Raters:	Males	Females	Males	Females
n	13	13	31	31
Mean	11.84	13.15	9.55	9.73
SD	4.93	5.28	5.71	5.96
	Harlem Unit			
n	27	27	9	9
Mean	10.07	10.07	11.44	11.33
SD	5.17	5.34	4.75	5.84

respectively. On the Harlem unit there were even less sex differences: both rated blacks 10.07 and males rated Puerto Ricans 11.44, while females rated them 11.33.

The cooperation cluster results were only chance, and comparisons of male and female ratings of the mood clusters yielded no t values greater than one. Looking at the Metro and Harlem units respectively, blacks were rated 13.92 and 11.48 by the males, and 13.63 and 10.20 by the females. Puerto Ricans were rated 8.89 and 10.67 by male raters and 9.53 and 11.50 by female raters.

B) Paranoia:

1. Projected Hostility

The results and analysis of what the patients admitted to on this cluster of the Foulds Hostility scale are given in Table XVIII. The cluster contains nine items relevant to feelings of persecution (see Appendix E). There were no significant differences between ethnic or age groups. All groups admitted to a mean of about half the items.

TABLE XVIII

Projected hostility scale: means and SDs

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	4.4	4.1	4.5	4.9
SD	2.63	2.22	2.22	2.08

Age means: over 30 = 4.45, under 30 = 4.5

Race means: Black = 4.25, Puerto Rican = 4.7

Summary of ANOVAR

Source	df	MS	F
Age	1	0	
Race	1	4.13	<1
Race x age	1	12.37	2.18*

*$p < .25$, not considered significant.

2. WPRS paranoia ratings

The means, SDs and ANOVAR summary on paranoia as rated by the aides on the WPRS are given in Table XIX. Items on this cluster assess how much the patient believes everybody hates him, feelings of persecution, ideas of influence, and delusional misinterpretations. No significant differences were found due to either race or age. All group means fell fairly close to 5, the halfway mark on this 10 point scale.

TABLE XIX

WPRS paranoia ratings: means and SDs

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	4.1	5.3	5.1	5.2
SD	2.69	2.76	3.22	3.09

Age means: over 30 = 4.6, Under 30 = 5.2

Race means: Black = 4.7, Puerto Rican = 5.2

Summary of ANOVAR

Source	df	MS	F
Race	1	4.49	< 1
Age	1	9.11	<1
Race x Age	1	6.62	<1

Figure 1 summarizes the WPRS means for each group and the relative importance of a particular cluster in the group symptom pattern. Paranoia was relatively important in the younger blacks, tying in second place with total psychotic belligerence, but in the older blacks it ranked only sixth in importance.

Figure 1

Summary of WPRS cluster means for each group, with ranks

	Blacks				Puerto Ricans			
	Under-30	Rank	Over-30	Rank	Under-30	Rank	Over-30	Rank
Paranoia	5.3	2.5	4.1	6	5.2	5.5	5.1	4
Affective flatness	4.7	5	4.6	4	5.2	5.5	5.4	3
Total schizophrenic excitement	5.5	1	6.1	1	7.1	1	6.6	1
Verbal schizophrenia	4.9	4	5.4	2	6.3	3	6.3	2
Motoric schizophrenia	4.4	6.5	5.1	3	6.1	4	4.9	5
Hysterical conversion	2.8	9	3.0	8	4.4	9	4.6	7
Total psychotic belligerence	5.3	2.5	4.2	5	6.4	2	4.8	6
Attention demanding	4.4	6.5	3.6	7	4.9	8	4.0	8
Assaultive	3.5	8	2.8	9	5.0	7	3.6	9

C) Social Cohesion:

The measure of social cohesion used in this study was the number of visitors in the first six visiting days, and Puerto Ricans had significantly more visitors than blacks. Results are shown on Table XX. The range was quite wide, varying from no visitors to 18 visitors for one young Puerto Rican. More than half (12) of the blacks over 30 had no visitors at all, 5 young blacks had none, 3 Puerto Ricans over 30 and 4 young Puerto Ricans had no visitors. Visiting rate for the blacks was half that of the Puerto Ricans. χ^2 for race was 29.67 and for age, 13.04. Both statistics are significant at $p < .001$.

TABLE XX

Mean visitors per patient over the first 6 visiting days

	Blacks	Puerto Ricans	Age mean
Over 30	1.1	4.1	2.6
Under 30	3.4	4.4	4.1
Race mean	2.2	4.5	

D) Nature of Symptomatic Differences:

1. Affective flatness, schizophrenic excitement, verbal schizophrenia, and motoric schizophrenia

Puerto Ricans and blacks were not different in emotional flatness as measured by the WPRS affective flatness cluster. According to the scale items, this cluster is defined by a lack of interest in others' problems, unawareness of others' feelings, and little affective involvement. Puerto

Ricans did score higher in schizophrenic excitement, especially verbal schizophrenia. The Wittenborn scale divides the schizophrenic excitement total into two parts. Verbal schizophrenia is manifested by words not being relevant, mumbling and shouting, unintelligibility, and speaking to hallucinations. Motoric schizophrenia is evidenced by behavior which has no function, restlessness and distractibility, stereotypic movements, and tics or grimaces. Results showing means and SDs appear in Tables XXI, XXII, XXIII, and XXIV. Probability levels of .25 are noted but are not to be considered significant.

TABLE XXI

WPRS affective flatness: means and SDs

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	4.6	4.7	5.4	5.2
SD	2.74	2.10	2.65	2.59

Race means: black = 4.6, Puerto Rican = 5.3

Age means: over 30 = 5.0, under 30 = 5.0

Summary of ANOVAR

Source	df	MS	F
Race	1	9.12	1.35*
Age	1	.11	<1
Race x Age	1	.32	<1
Within	76	6.75	

*p <.25

TABLE XXII

WPRS Schizophrenic excitement total: means and SDs

	Blacks		Puerto Ricans	
	Under 30	Over 30	Over 30	Under 30
Mean	5.5	6.1	6.6	7.1*
SD	2.42	2.33	2.01	1.88

Race means: black = 5.8, Puerto Rican = 7.0

Age means: over 30 = 6.3, under 30 = 6.3

Summary of ANOVAR

Source	df	MS	F
Race	1	23.12	4.65**
Age	1	.12	<1
Race x Age	1	5.50	1.10
Within	76	4.97	

*Any two treatment means not underscored by the same line are significantly different at $p < .05$ level, according to Duncan's New Multiple Range Test (Edwards, 1965).

**$p < .05$

TABLE XXIII

WPRS Verbal schizophrenia: means and SDs

	Blacks		Puerto Ricans	
	Under 30	Over 30	Under 30	Over 30
Mean	4.9	5.4	6.3	6.3*
SD	2.76	2.76	2.45	2.26

Race means: black = 5.1, Puerto Rican = 6.3

Age means: over 30 = 5.8, under 30 = 5.6

Summary of ANOVAR

Source	df	MS	F
Race	1	27.62	3.99**
Age	1	1.02	<1
Race x Age	1	1.52	<1
Within	76	6.93	

*Any two treatment means not underscored by the same line are significant at $p < .10$ level.

**$p < .05$

TABLE XXIV

WPRS Motoric schizophrenia: means and SDs

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	5.1	4.4	4.9	6.1
SD	2.74	2.48	2.55	2.50

Race means: black = 4.8, Puerto Rican = 5.5.

Age means: over 30 = 5, under 30 = 5.2

Summary of ANOVAR

Source	df	MS	F
Race	1	10.52	1.52*
Age	1	1.02	<1
Race x Age	1	17.10	2.46*
Within	76	6.94	

*$p < .25$

Schizophrenic excitement encompasses both verbal and motoric symptoms. Puerto Ricans as a whole were significantly higher on "schizophrenic excitement total," and "verbal schizophrenia." On the total, they were rated 7.0 as compared to the black's 5.8. Age means did not differ: both were 6.3. But in ranking the ratings, it is interesting to note that blacks under 30 scored the lowest, 5.5, followed by blacks over 30 with 6.1, then Puerto Ricans over 30 with 6.6, and finally Puerto Ricans under 30 with 7.1. The greatest difference was between the two younger groups.

On verbal schizophrenia, the racial differences were evidently due to the exceptionally low rating received by the blacks under 30 (4.9), for the blacks over 30, rated 5.4, were not significantly lower than the two Puerto Rican groups, both of which rated 6.3. An example of what is reflected on verbal schizophrenia could be observed when the experimenter was administering the Foulds Hostility scale. For half of the patients the cards had to be read to them because they were illiterate or needed glasses. Of those patients who could read, blacks typically read silently, while Puerto Ricans taking the Spanish version invariably read aloud, slowing the testing process considerably. Puerto Ricans reading the English version also read aloud, and in about 3 or 4 cases mis-read the card to conform to their delusions. When this happened the cards were removed and read to them. Blacks did not exhibit such overtly delusional activity when taking the hostility scale: if one can judge by their behavior in the interview prior to administration, they tended to keep their "craziness" out of the testing situation.

The affective flatness cluster in the WPRS measures appropriateness of affect, not the sort of lability that was observed here. According to the mean ratings, Puerto Ricans tended to rate higher on affective flatness, being rated at 5.3 as compared to the blacks' 4.6. This difference was insignificant, however. Like the Italians in Opler's (1959) study, the Puerto Ricans' impulses were poorly

controlled, they were more assaultive (see Table XXXII) and showed more schizo-affective features.

Analysis of motoric schizophrenia found that no differences existed as a function of race or age. Each group received a wide variation of ratings, and means ranged from 4.4 for the blacks under 30 to 6.1 for Puerto Ricans under 30. But the large variance rendered these differences insignificant.

2. Floridity

Looking at the WPRS as a whole, Puerto Ricans scored higher on every scale, reflecting greater floridity of symptoms. Thus it would be expected that analysis of WPRS totals would bring significant results. Since blacks and Puerto Ricans were disproportionately represented on the two units, Harlem having many blacks and few Puerto Ricans, and Metropolitan having few blacks and mostly Puerto Ricans, it is possible that the Harlem unit raters might be influenced by an "anchor point" of pathology level based on their black majority, while the Metropilitan unit might have a different "anchor point" based on their Puerto Rican majority. This could affect the accuracy of ratings in spite of careful instruction. Therefore an unweighted means analysis of variance (Winer, 1962) was computed for culture by unit using the sum of the five cluster standard scores as a patient's "pathology score." The results are presented in Table XXV.

TABLE XXV

Total WPRS, Race x Unit; means, SDs, and summary of ANOVAR

	Blacks		Puerto Ricans	
	Metro	Harlem	Metro	Harlem
n	13	27	31	9
Mean	38.85	39.48	50.35	39.33
SD	16.9	16.6	16.2	8.1

Summary of ANOVAR

Source	df	MS	F
Race	1	500.87	2.00*
Unit	1	419.69	1.63*
Race x Unit	1	527.46	2.10*

*$p < .25$, not considered significant.

As could be seen, results were not significant. The difference between the Metro unit and the Harlem unit was the same as the difference between the Puerto Ricans and blacks, which explains the interaction, since most Puerto Ricans are on the Metro unit. In the Harlem unit the 9 Puerto Ricans were rated the same total level as the blacks. The finding that Puerto Ricans in the Harlem unit are notably less florid raised some questions which required closer inspection of the data. Puerto Ricans over 30 years in age, being in larger number (6) than those less than 30 (3), lowered the scores on symptoms related to older age. Furthermore, the Puerto Ricans were rated lower on "flat affect" and it was

stated by attendants that most of them were depressed in the initial stages of illness. This may account for their apparent lack of floridity.

Because of the marked difference in ethnic composition between the two units, another analysis was done on WPRS totals, age by race. Results are shown on Table XXVI. As expected, the analysis of these totals brought significant results, the Puerto Ricans being rated more severely in their pathology than blacks. There were no significant age differences.

TABLE XXVI

Total WPRS, age by race: means, SDs, and summary of ANOVAR

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	38.10	40.45*	45.60	50.15
SD	15.39	17.90	15.81	16.68

Summary of ANOVAR

Source	df	MS	F
Race	1	1429.20	5.44**
Age	1	238.05	<1
Race x Age	1	24.20	<1

* Using Duncan's New Multiple Range test (Edwards, 1965), blacks over 30 and under 30 did not differ from one another significantly. Within the Puerto Ricans, age did make a sizeable difference, and both were significantly more florid than the black groups at $p < .01$

**$p < .025$

E) Somatization:

Comparisons shown on the hysterical conversion scale (Table XXVII) revealed a very significant race difference at $p < .01$. No age or interaction effects appear. Puerto Ricans (mean = 4.5) tended more than blacks (mean = 2.9) to somatize symptoms and have hysterical conversion reactions. Physical symptoms were often used to gain attention in this group. According to raters' comments and the observations of the examiner, Puerto Ricans were commonly asking for treatment such as ointments, etc., and were more prone to seizures, or "ataques."

TABLE XXVII

WPRS Hysterical conversion: means and SDs

	Blacks		Puerto Ricans	
	Under 30	Over 30	Under 30	Over 30
Mean	2.8	3.0	4.4	4.6*
SD	1.81	1.95	2.15	2.01

Race means: blacks = 2.9, Puerto Ricans = 4.5

Age means: over 30 = 3.8, under 30 = 3.6

Summary of ANOVAR

Source	df	MS	F
Race	1	49.62	11.33**
Age	1	1.01	< 1
Race x Age	1	.01	< 1

* Any two treatment means not underscored by the same line are significant at $p < .05$.
**$p < .01$

F) Expression of Aggression:

1. Foulds Hostility scale results

This scale, which E administered to each subject, measures the amount of hostility the patient admits to and the manner in which he expresses aggression. To encourage honesty, each subject was told that the answers he gave would be confidential and not shown to the doctor, nor would they in any way influence his privileges or delay his discharge. Results appear in Table XXVIII. The only finding to approach significance at the $p < .10$ level was an age difference: older patients were more likely to criticize others. The subjects of most groups, judging from the means, tended to put themselves in a good light by rejecting more and accepting less items which would make them appear as destructive, paranoid, incompetent, or having delusions of guilt, but admitting to more items on the "criticism of others" scale. Although not a significant finding, yound puerto Ricans accepted the highest number of the "acting out" items, suggesting that they may take some pride in using direct expression of aggression. Visual inspection of the race means is suggestive of the Puerto Rican's greater tendancy to act out, project hostility, and have delusions of guilt while blacks tend more to criticize others, but these impressions are not statistically significant.

TABLE XXVIII

Means and standard deviations on separate Foulds scales

Acting out: 13 items

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	5.50	5.25	6.00	6.60
SD	3.15	3.18	3.27	2.65

Race means: blacks = 5.38, Puerto Ricans = 6.30

Age means: over 30 = 5.75, under 30 = 5.93

Summary of ANOVAR

Source	df	MS	F
Age	1	.62	< 1
Race	1	17.12	1.72**
Race x age	1	3.60	< 1

Criticism of others: 12 items

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	7.90	6.80	7.50	6.30
SD	2.66	2.20	1.76	2.93

Race means: blacks = 7.35, PuertoRicans = 6.90

Age means: over 30 = 7.70, under 30 = 6.55

Summary of ANOVAR

Source	df	MS	F
Age	1	25.32	3.95*
Race	1	4.52	< 1
Race x Age	1	.02	< 1

TABLE XXVIII, Cont'd

Projected hostility: 9 items. See Table XVIII, p. 67

Self criticism: 11 items

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	5.1.	4.6	4.2	5.4
SD	1.79	2.61	2.67	2.00

Race means: blacks = 4.85, Puerto Ricans = 4.8

Age means: over 30 = 4.6, under 30 = 5.2

Summary of ANOVAR

Source	df	MS	F
Age	1	2.10	< 1
Race	1	.10	< 1
Race x Age	1	15.32	2.58**

Delusions of guilt: 7 items

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	2.7	3.3	3.1	3.7
SD	1.96	2.33	2.29	1.98

Race means: blacks = 3.00, Puerto Ricans = 3.40

Age means: over 30 = 2.9, under 30 = 3.5

Summary of ANOVAR

Source	df	MS	F
Age	1	8.46	1.69**
Race	1	3.22	< 1
Race x Age	1	0	

*p < .10
**p < .25 (not significant)

2. Psychotic belligerence

Results derived from the "psychotic belligerence" scale of the WPRS, shown on Tables XXIX, XXX, XXXI, indicated age differences which were significant in the total belligerence and assaultive scale, which is subsumed under total belligerence. The over 30 group obtained a mean score of 4.5 as compared to 5.9 of the under 30 group on total belligerence, and no race by age interaction was evident. On the assaultive scale the over 30 groups obtained a mean score of 3.2 while the under 30 groups obtained a mean score of 4.2. The Puerto Ricans under 30 were rated the most assaultive, 5.0. "Attention demanding" was the other subscale, which showed up more age than race differences, but at only a low level of significance. Within each age group the Puerto Ricans were more attention demanding than the blacks, but not significantly so, and the age means (3.8 for over 30 vs. 4.7 for under 30) were not different enough to reach more than the .10 level of significance. This sort of acting out and unmanageability is a symptom of youth; older patients have evidently settled down. The only cultural difference was in the assaultive scale where Puerto Ricans, and especially the younger ones, obtained the highest scores. Young blacks were no more assaultive than the older Puerto Ricans; the interaction hypothesis thus far is not supported.

TABLE XXIX

WPRS Total psychotic belligerence, means and SDs

	Over 30		Under 30	
	Blacks	Puerto Ricans	Blacks	Puerto Ricans
Mean	4.2	4.8	5.3	6.4***
SD	2.31	2.45	2.59	2.57

Race means: blacks = 4.7, Puerto Ricans = 5.6

Age means: over 30 = 4.5, under 30 = 5.9

Summary of ANOVAR

Source	df	MS	F
Race	1	14.45	2.23
Age	1	36.45	5.63**
Race x Age	1	1.25	<1

***Any two means not underscored by the same line differ significantly at $p < .05$.

**$p < .05$. F should be 3.96 to be significant at .05 level.

TABLE XXX

WPRS Attention demanding, means and SDs

	Over 30		Under 30	
	Blacks	Puerto Ricans	Blacks	Puerto Ricans
Mean	3.6	4.0	4.4	4.9*
SD	2.31	2.79	2.86	2.74

Race means: blacks = 4.0, Puerto Ricans = 4.5

Age means: over 30 = 3.8, under 30 = 4.7

Summary of ANOVAR

Source	df	MS	F
Race	1	1.52	< 1
Age	1	23.12	3.05**
Race x Age	1	.30	< 1

* Any two means not underscored by the same line differ significantly at $p < .10$.

**$p < .10$. F should be 3.96 to be significant at .05 level.

TABLE XXXI

WPRS Assaultive, means and SDs

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	2.8	3.5	3.6*	5.0
SD	2.04	2.09	2.09	2.37

Race means: blacks = 3.2, Puerto Ricans = 4.3

Age means: over 30 = 3.2, under 30 = 4.2

Summary of ANOVAR

Source	df	MS	F
Race	1	28.45	5.85**
Age	1	22.05	4.54**
Race x Age	1	1.20	< 1

* Any two means not underscored by the same line differ significantly at $p < .05$.

**$p < .05$. F should be 3.96 to be significant at .05 level.

3. Mood and cooperation

Hostility may be expressed in a bitter and unpleasant mood or by negativism and lack of cooperation. In computing the means and SDs shown in Tables XXXII and XXXIII, the transformed ratings of each attendant rating a particular patient were totaled and comprised that patient's "score."

TABLE XXXII

MACC mood: means and SDs for race and age

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	23.05	24.13	19.88	19.40
SD	9.75	8.25	8.17	9.46

Race means: blacks = 23.59, Puerto Ricans = 19.64

Age means: over 30 = 21.46, under 30 = 21.76

Summary of ANOVAR

Source	df	MS	F
Race	1	312.05	3.74*
Age	1	1.80	< 1
Race x Age	1	12.02	< 1
Within	76	83.97	

*$p < .10$. This F just misses being significant at $p < .05$. A figure equal to or greater than 3.96 would have made it significant at $p < .05$.

TABLE XXXIII

MACC cooperation: means and SDs for race and age

	Blacks		Puerto Ricans	
	Over 30	Under 30	Over 30	Under 30
Mean	30.50	22.70	21.50	18.68
SD	10.99	8.59	10.59	10.05

Race means: blacks = 21.60, Puerto Ricans = 20.09

Age means: over 30 = 20.00, under 30 = 20.69

Summary of ANOVAR

Source	df	MS	F
Race	1	53.63	<1
Age	1	3.83	<1
Race x Age	1	114.01	1.11
Within	76	102.09	

Although cooperation showed only chance differences, on mood Puerto Ricans over all were rated as more "unpleasant" than blacks at $p < .10$, scoring 19.64 vs. 23.59. Since transforming the ratings into deciles may have served to over-control and minimize any possible differences between means, this finding on mood could be considered a notable difference. For one thing, an inherent factor in such a transformation is that 10% of a particular rater's scores fall into each stated decile, thus precluding a normal distribution within any one aide's ratings and inflating the variance of scores in the group of raters. Any differences would have to result from one ethnic group

clustering mostly above the 50th percentile and the comparison group clustering mostly in the lower half of the distribution.

The interaction hypothesis for age and ethnic group again was rejected by this measure.

IV. Conclusions

The results of this study are remarkably parallel to the Singer & Opler findings describing Irish and Italians. Thus this study provides further evidence of the role of culture in transmitting symptom styles.

Although the hypothesis concerning cultural differences in sex of resented authority figures was given only weak support, and no significant differences were found between the two groups on paranoia, other significant differences marked off the two ethnic groups more sharply. Blacks were characterized by a pattern of withdrawal. They had fewer visitors and were more likely to be diagnosed alcoholic. They were considerably less florid in their symptomatology than Puerto Ricans and thus considered less of a management problem by attendants. Puerto Ricans, by contrast, were less withdrawn and more florid in symptomatology, more likely to exhibit schizo-affective features, and used somatization to a significantly greater degree than blacks. Since they were more prone to acting out and assaultiveness, attendants found them to be more of a management problem and rated them lower in mood, except in

a few cases where the initial stages of illness were distinguished by depressive features. They had more visitors than blacks, and were reported by attendants to come out of their initial psychotic state more rapidly and become sociable, while blacks were withdrawn rather than florid in their initial stages and tended to remain that way.

Discussion and Implications

I. Sex Role

The hypothesis that resented authority figures would be reflected in less respect for females by the blacks, and for males by the Puerto Ricans was not upheld statistically by the measurements used in this study. However, on mood the trend was in favor of the hypothesis, and since the transformed scores used in the comparisons may minimize true differences by inflating the variance as described in the results, this tendency should be noted. The MACC scale was used in an indirect way. The rationale behind the method of measuring is based on common observation, which Heider (1958) comceptualized in his psychology of interpersonal relations. He stated that in interpersonal relations a balanced state is striven for: if a person (p) likes another person, (o), and o likes p, this is balanced; a state of harmony exists. If p does not like o, but o likes p, disharmony esists and one of the dyad changes his sentiments to achieve a state of balance. In the MACC ratings, it was expected that if a patient resents authority figures and if one sex is more likely to represent authority to him than the other sex, then that patient would be inclined to dislike the attendants whose sex symbolized authority than those whose sex did not symbolize authority. According to the rule of balance stated by Heider, the rater's sentiments would reciprocate, or mirror, those of

the patient, and thus influence his rating in a positive or negative direction.

The lack of support for this hypothesis could imply the following:

1. Because patients depend on attendants for issuing privileges, their resentment is less likely to be expressed by lack of behavioral cooperation.

2. The transformation inflated the variance of the ratings too much to detect any real differences.

3. The hypothesis may be incorrect.

II. Paranoia

Although within the black under-30 group, paranoia ranked fairly high in their symptom pattern on the WPRS there were no statistically significant differences in paranoia between the groups on any of the paranoia measurements. The implications of this finding are important. Many studies and other source material take for granted that the black must be more paranoid than other minority groups because of his need for adaptive awareness and assume thus that paranoid symptoms among blacks must be regarded differently from those in the general population. Perhaps this formulation has been overstated, and should be re-examined. While cultural factors could influence type of delusion and relative tightness or looseness of the delusional system (variables which were not differentiated in this study), the finding was that blacks were no more paranoid

than Puerto Ricans. Unless the measurements used in this study were not precise enough, or the population was atypical, this finding questions the automatic assumption of a paranoid-prone black culture, though perhaps Puerto Ricans also have reason to be paranoid-prone.

III. Implications of social cohesiveness

The finding, based on their more frequent visits, that Puerto Ricans are more socially cohesive was an expected result. The study by Suchman (1965) found that the more parochial, closely knit groups had a rather low level of health knowledge and were less likely to "give in" to illness. Blacks, on the other hand, being loosely organized, were also more informed on the popular health orientation and more likely to use public health facilities. Puerto Ricans, being skeptical of doctors, according to Suchman, would evidently be more willing to care for psychotics within the family and try to "cure" them by spiritual means. For them the state hospital is a last resort; the mental illness tolerance threshold is higher in these families than in black families. This may be why the Puerto Rican sample had more florid symptoms than blacks. A differential willingness to care for schizophrenics within the family as shown would result in a greater number of mild schizophrenics within the sample of blacks, but a Puerto Rican sample which included only persons with the most unmanageable symptoms.

IV. Conversion reactions

The hypothesis that Puerto Ricans would tend to somatize symptoms and have hysterical conversion reactions was overwhelmingly supported. It is interesting to note that this finding parallels the findings in Opler's study (1959). Somatic (hypochondriacal) complaints were present in 13 out of 30 Irish patients and in 21 of the 30 Italian patients measured in this study. Both Puerto Ricans and Italians are of Latin cultures, and it is probable that some element in the Latin cultures predisposes their people to somatize symptoms, have somatic delusions or hysterical conversion reactions.

In the Puerto Rican culture the traditional Spanish courtship system which places value on virginity in the female and sexual dominance in the male is not unlike the Victorian era when hysteria was so common. Males thus view females as either "good girls" (marriage prospects) or as sexual objects. These values are also present in the Italian culture.

Conversion reactions are commonly developed in a culture of superstition and scientific ignorance. If hysterical symptoms are reinforced by attention and "sudden visitation" and miraculous cures are taken seriously, then one can speak of hypersuggestibility within a culture. Puerto Rican culture is replete with many of these elements: spiritualism, magic, witchcraft, and so on.

V. Alcoholism

Another finding in this study was the greater incidence of alcoholism in blacks compared to a relatively low incidence in the Puerto Rican patients.

Many theories have been proposed to explain the origin of alcoholism. Dynamic theory assumes alcoholics are persons fixated at the oral level with unconscious homosexual impulses, and give a developmental picture which unfortunately is not specific for alcoholics (Fenichel, 2945). Learning theories are also too inclusive. However, the culture has been found to be a powerful variable. Alcoholism originates because of cultural variables acting in conjunction with learning variables. Culture gives the socially acceptable tool to use in avoiding tension. Alcohol, as such, is used as one defense mechanism in reducing one's self perception as an inadequate person. If the psychological defense system fails, as it easily does in the alcoholic, the tool of alcohol becomes chronic drunkenness and eventual deterioration (McCord et al, 1959).

Again, the finding in this study was similar to Opler's 1959 study. Only one of his Italian patients had ever been chronically addicted to alcohol, while almost two thirds of the Irish sought escape from problems through alcohol addiction. Escaping into alcohol appears to be one way that the black culture uses to cope with their particular anxiety. The black male has been described as having

incomplete masculine identification. Growing up in a matrifocal household -- in which the man is a powerless and scorned figure -- encourages ambivalence as to male functions and masculinity. Likewise Opler's Irish alcoholics were described as viewing themselves "forever boys and burdens," lacking possibilities of a firm male identification based on fear of female figures early in life, and as having a shattered self esteem. As the Irish culture accepts the use of alcohol for dealing with resultant feelings of depression, futility, inadequacy, and inferiority, so does the black culture use alcohol to escape from these same feelings. With the availability of alcohol and the lack of other outlets, alcoholism becomes quite common in the black culture as in the Irish-American culture.

VI. The role of culture

Qualitative differences which this study revealed between the two cultures was the proclivity of blacks to use alcohol to excess and the Puerto Ricans' tendency to have psychosomatic symptoms and conversion hysteria. The close resemblance to the findings of Singer & Opler (1956) and Opler (1959) is also notable. Blacks were not unlike the Irish in their tendency to use alcohol to excess and their easier management on the ward, while Puerto Ricans were similar to the Italians in their symptomatology and tendency to act out and be harder to handle. "Latin culture" is a possible common denominator that relates the Puerto

Ricans and Italians, and the representative life style that is inherent in the Latin culture gives both Italians and Puerto Ricans a similar design for living. Blacks and Irish have no such common heritage, but their family roles and values, plus means of coping with stress, are similar enough to generate symptoms which differentiate them from the Latin culture.

In the Puerto Rican culture the great emphasis on love and sex has been described, as well as the blacks' feelings of inadequacy and blunted aggression. Puerto Rican culture is built around love, sex, sociability. Machismo is the measure of the man, what makes him feel worthwhile. Blacks have to cope with feelings of impotency in trying to get ahead in a hostile society. To express rage openly has not been condoned in the culture very long. Feelings of frustration, futility, depression, have been a common anxiety with which to cope. Each culture offers a tool to cope with each of these stresses: conversion hysteria symptoms for the Puerto Rican and drinking to excess for the black. In general, whatever the culture, each reinforces its own mode of energy distribution, as well as those coping mechanisms which are sanctioned by society.

VII. Expression of aggression

Both cultures in this study are presumed to have aggressive impulses originating from frustrations of their impoverished environment. The measurements revealed that Puerto Ricans were more assaultive than blacks. Young

patients rated higher on "total psychotic belligerence" and "assaultiveness," which presumably represents the higher energy level of youth. Puerto Ricans were rated more unpleasant on mood than blacks. Thus far it is evident that Puerto Ricans do express their hostility more openly than blacks. But the expected interaction that young blacks would be most assaultive appeared on none of the measures. Young blacks in this sample use the same cultural passivity that the older generation laid down. This may be due to one of two alternatives:

1. Perhaps it is too soon for attitudes engendered by modern civil rights consciousness to change this passivity. Cultures have a way of changing slowly, and the impact of any change that will reach the core of the personality must come during the formative years of early childhood. Even the youngest patient in this sample had completed his formative years by the time the black revolution began in earnest. It may well be that cultural differences in schizophrenia between generations of blacks will not show up until their children born after 1965 become old enough to join a population of adult schizophrenics.

2. A second alternative is that the blacks who do not express the rage are the ones that become schizophrenic. If frustration is too intense and the problem insurmountable, apathy and withdrawal may appear instead of aggression. Rage which is unexpressed and overcontrolled too long can

break through at some point, flooding the defenses and becoming manifest as psychotic symptoms.

VIII. Summary statement

The general hypothesis that the pattern of symptoms in schizophrenia would follow cultural norms of behavior toward difficulties was accepted. Whether acting out and somatizing or withdrawal and repression is the behavioral style of the normal population in that culture, habits of coping with difficulties which are learned within this framework are used in an exaggerated fashion, shaping the psychopathological symptoms that are exhibited in the patient population. This may be one illustration or manifestation of a basic psychological law: that in stressful situations which increase arousal in an organism the response most likely to occur will be the one with the greatest habit strength. These habits, or patterns of coping, are rooted in any particular culture and are perpetuated by custom. They interact with whatever is valued by that culture.

Puerto Ricans place a high value on love and interpersonal relationships. Being a close knit and parochial type of people, they prefer to care for their sick within the family, and they tolerate more unmanageable behavior before giving in and placing the patient in a state hospital. After commitment they typically continue social support by frequent visits. The Puerto Rican

expressive style is unrepressed and emotional. They stress more forcefully than the blacks the importance of machismo for the male and virginity and femininity for the female. At the same time they emphasize the expression of sexuality as well as other passions. The culture seems to have all the elements to make for hysterical, conversion, or bodily symptoms. When one is threatened with loss of love and support, the somatization of emotional stress is the Puerto Rican way of coping. The cultural expressive style of acting out and unrepression is exaggerated under stress, such that the patient population with its affective lability, violence, and floridity of symptoms, becomes a real ward management problem.

Blacks place less importance on love and interpersonal relations. Since they lack the clear cut cultural framework which the Puerto Ricans possess, they have little to draw them together except their common inferior status. Being relatively non-cohesive, they lack the security of deeper interpersonal involvements and are cautious about expressing their emotions. Because of less interpersonal closeness and a more public oriented notion of medicine, blacks are less likely to care for the sick within the family, and this may be one reason why the pathology level in the study sample was lower than that of the Puerto Ricans in this research.

Conditioned to years of subservience and persecution,

blacks have had to clamp down on their emotions and assume an attitude of adaptive awareness and passivity to survive. In the kind of stress that would produce mental symptoms, passivity and withdrawal could become intensified. This may be one reason why the black patients were found to be more compliant and less of a ward management problem.

As for the use of alcohol as a tool to cope with anxiety, the blacks use it much like the Irish, as a means to escape dysphoric feelings of impotence and alienation. Since they have few other outlets, this favors the use of alcohol to excess as a way of dealing, or not dealing, with insurmountable problems.

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Appendix

Appendix A

WITTENBORN PSYCHIATRIC RATING SCALES (REVISED)

J. Richard Wittenborn

INSTRUCTIONS TO RATER

1. The statements in the Rating Scales are arranged in steps from 0 (no pathology) through 3 (extreme pathology).

2. For each scale, select the one statement which best describes the most extreme manifestation during the observation period.

3. If the behavior is doubtful or variable, select the alternative which is nearer to 3.

4. Rate every item, but base the rating on the specified period of observation only.

5. Record your rating by encircling the number at the right of the selected statement.

Scale		Factor		
		II	IVd	V
20. Does not use words in an obscure or irrelevant manner.	0			
Words not always clearly relevant to recognizable ideas	1			
Words used in such a manner that ideas seem unclear and confused	2			
Words not relevant to any recognizable, logical idea.	3			x
21. Shows no particular interest in or curiosity about the problems or difficulties of others	0			
Shows some interest or curiosity about the problems and difficulties of others.	1			
Will talk freely about the problems and difficulties of others.	2			

			II	IVd	V
	Shows an avid and persisting interest in or curiosity about the problems and difficulties of others.	3		-x	
22.	Appears ot be reasonably appreciative of the feelings of others.	0			
	Indicates that he is aware of the moods or feelings of others, but shows little personal concern; behavior is not influenced in any discernible, helpful or sympatgetic way.	1			
	No evidence that he is aware of the feelings of others.	2		x	
23.	Does not talk to himself.	0			
	Comments to self are not obviously unusual or bizarre.	1			
	Speaks or mutters to self in a bizarre or unusual manner.	2			
	Mumbles, shouts, or grunts in an unintelligible and seemingly unprovoked manner.	3			x
24.	Reveals interest in others and emotional resonance during interview.	0			
	Expresses feelings only about self during interview.	1			
	Expresses concern about self, but with only shallow display of feeling.	2			
	Does not participate in interview or participates with no evidence of affective involvement.	3		x	
25.	Does not offer words which are unclear or unidentifiable.	0			
	Some words are mouthed, slurred, or muffled, but are identifiable.	1			
	Some words are unidentifiable.	2			
	Frequently utters strange grunts, shouts, barks, or makes other unintelligible sounds.	3			x

			II	IVd	V
26.	Realizes his difficulty is a long standing difficulty of personality.	0			
	Acknowledges that his problem may be a current difficulty of personality.	1			
	Does not believe he <u>now</u> has a <u>psychological</u> problem, may minimize any present personality basis for his difficulties by emphasizing past traumatic episodes or past emotional difficulties.	2			
	No evidence that he believes that he has or has had psychological problems, may blame current symptome on specific reverses, illness, or injury.	3		x	
27.	Any speech is clearly relevant to the context.	0			
	May speak in a way which is not clearly relevant to the context.	1			
	Speech appears to be based on delusional thinking.	2			
	Speech may be in response to hallucinations.	3			x
28.	No discernible psychological use made of physical disease symptoms.	0			
	Use is made of physical disease symptoms to gain attention or to dramatize self.	1			
	Use is made of physical disease symptoms for evading responsibilities, justifying failures, etc.	2	x		
Subtotals (P. 1)			II	IVd	Ve

Scale			Factor	
29.	Practically all of his behavior has an understandable function or serves an apparent purpose.	0		V
	Some behavior appears to have no function or to serve no purpose.	1		
	Much of his behavior has no obvious function or serves no practical purpose.	2		
	All behavioral manifestations are without function or purpose.	3		x
32.	Usually calm and deliberate.	0		
	Restless when the situation is obviously boring.	1		
	May be restless without apparent cause.	2		
	Restless and distractible in all situations.	3		x
34.	No characteristic movements of limbs and body.	0		
	Has certain characteristic movements.	1		
	Stereotyped movement, including gestures, may be manifested regardless of circumstances.	2		
	Stereotyped movements interfere with appropriate and adaptive responses.	3		x
36.	Face never reveals tics, grimaces, or stereotyped expressive changes.	0		
	Face may show minor involuntary twitches or other movements.	1		
	Unmistakable tics, grimaces, or other seemingly involuntary changes in facial expression.	2		
	Tics or grimaces, fluttering eyelids, etc. are usually characteristid of the patient and are interrupted for			

	short intervals only.	3			x
Subtotals					Vf
			Factor		
Scale			II	VIg	VII
48.	No evidence that he believes that others may dislike him.	0			
	Indicates an awareness that some people may not like him.	1			
	Expresses a belief that most people could turn against him.	2			
	Believes that almost everybody hates him.	3			x
50.	Seeks help or advice when absolutely necessary <u>if at all</u>.	0			
	Requests for help or advice, although reasonable, may be unnecessary.	1			
	Requests for help and advice are clearly unnecessary.	2			
	Demands continuous help, direction, or reassurance.	3		x	
52.	Does not express any feeling that he has been misused in any way.	0			
	Feels that there may be people who would like to see him fail or be unhappy.	1			
	Feels that people may conspire to keep him from getting what is justly his.	2			
	Feels that he is systematically persecuted by individuals or groups who desire to deprive, defame or punish him.	3			x
53.	Needs are expressed in a mild and considerate manner, if at all.	0			
	Needs are <u>asserted clearly</u> but with some consideration for the situation and others.	1			

			II	VIg	VII
53.	Cont'd				
	Needs are asserted without consideration for the situation or for others.	2			
	Needs are asserted with unreasoning urgency.	3		x	
56.	Is not unusual in his demands or requests.	0			
	Has a characteristic tendency to make requests of various hospital personnel.	1			
	Is something of a ward pest in his demands on the personnel.	2			
	Always wants to see the doctor or Chaplain--demands attention from high level personnel.	3		x	
57.	No complaints or symptoms of physical disease or disability.	0			
	Complaints or symptoms of physical disease or disability are due primarily to organic factors.	1			
	Complaints or symptoms of physical disease or disability are due indirectly or secondarily to organic factors.	2			
	Organic basis for complaints or symptoms of physical disease or disability no longer present if ever present.	3	x		
58.	No evidence that patient feels that others seek to spy upon or control his behavior or thought.	0			
	Wonders if others have a particular interest in his thoughts or personal behavior.	1			
	Wonders if others attempt to influence his behavior in some unknown manner or attempt to control his thoughts.	2			

			II	VIg	VII
58.	Cont'd				
	Believes that others influence his behavior in some strange manner or control his thoughts.	3			x
59.	Does not appear to be attention demanding.	0			
	In conversation, usually brings attention of others to his own role.	1			
	Engages insistently in description of his own role or difficulties.	2			
	Dramatically attention-demanding.	3		x	
	Subtotals (p. 2)		II	VIg	VII

Scale			Factor		
			II	VIh	VII
61.	Patient is not belligerent.	0			
	Is observed to be belligerent on provocation.	1			
	Belligerent or combative on slight or imagined provocation.	2			
	Spontaneously initiates physical assaults.	3		x	
63.	Presents no complaint or symptoms of organic pathology or malfunctioning which was not caused by emotional factors.	1			
	Presents organic pathology or malfunctioning which was caused in part or greatly aggravated by emotional factors.	2			
	Presents organic pathology or malfunctioning which was probably caused by emotional factors.	3	x		
64.	Not assaultive.	0			
	Makes physical counterattack when strongly provoked.	1			
	Makes physical attack on slight provocation.	2			

			II	VIh	VII
64, Cont'd					
	Attacks without apparent provocation.	3		x	
66.	Never criricizes others.	0			
	Criticizes others when clearly provoked.	1			
	May criticize others without obvious provocation.	2			
	Spontaneously and continually critical of others.	3		x	
67.	No evidence that he misconstrues the intentions of others.	0			
	May exaggerate the intentions of others.	1			
	May seriously misinterpret the intention of others.	2			
	Spontaneously and continually critical of others.	3			x
69.	Does not appear to be impudent or cocky.	0			
	Noticeably impudent.	1			
	Aggressively impudent--almost invariably impolite.	2			
	Deliberately disrupts routines, demoralizes situations.	3		x	
72.	Does not swear.	0			
	Upon obvious provocation, may use a <u>few</u> profane words.	1			
	<u>When provoked</u>, language is conspicuously profane or obscene.	2			
	Language is <u>characteristically</u> profane or obscene.	3		x	
Subtotals (P. 3)			II	VIh	VII

Grand Total Raw Cluster Scores: II, IVd, V, Ve, Vf, VI, VIg, VIh, and VII.

Symptom Cluster	Cluster	Raw Score Equivalents for Standard Score Profile										Raw Cluster	Raw Scores
		1	2	3	4	5	6	7	8	9	10		
Hysterical Conversion	II	0	1	2	3	4	5	6	7	8	9	II	
Affective Flatness	IV (d)	-3-0	1	2	3	4	5	6	7		8	(d)	
Schizophrenic Excitement Total	V	0	1	2	3-4	5-6	7-8	9-11	12-15	16-19	20-24	V	
Verbal	(e)	0	1	2	3	4	5	6	7-8	9-10	11-12	(e)	
Motoric	(f)	0	1	2	3	4	5	6	7-8	9-10	11-12	(f)	
Psychotic Belligerence Total	VI	0	1	2	3-4	5-6	7-8	9-11	12-15	16-20	21-27	VI	
Attention Demanding	(g)	0	1	2	3	4	5	6	7-8	9-10	11-12	(g)	
Assaultive	(h)	0	1	2	3	4-5	6-7	8-9	10-11	12-13	14-15	(h)	
Paranoia	VII	0	1	2	3	4	5	6	7-8	9-10	11-12	VII	

Appendix B

Wittenborn Psychiatric Rating Scale: Psychologese to English

Instruction sheet

		Rate
20.	Makes sense when he talks.	0
	Sometimes gets onto "crazy" topics.	1
	Confuses ideas, not clear.	2
	He finds it impossible to get across his ideas in words.	3
21.	Minds his own business.	0
	Is curious about other people's problems.	1
	Gossips freely about other people's problems.	2
	Is always poking his nose into other people's business	3
22.	Is considerate of other people's feelings.	0
	Knows other people have feelings, but doesn't give a damn.	1
	Seems not to be aware of the feelings of others.	2
23.	Doesn't talk to himself.	0
	May "think out loud" and talk to himself, but it doesn't sound crazy.	1
	Mutters to himself in a crazy or queer way.	2
	Mumbles, shouts, grunts loudly to himself or to his "voices."	3
24.	In a conversation shows the right amount of feeling.	0
	Talks only about feelings about himself in conversation.	1
	Will talk about his feelings but voice is flat and monotonous.	2
	Refuses to speak at all or get into a conversation.	3
25.	Speaks normally and clearly.	0
	Slurs his speech, otherwise normal.	1
	Makes up some of his words.	2
	Often grunts, shouts, barks, talks gibberish.	3
26.	Knows clearly why he is in the hospital.	0
	Will only admit his problem is temporary.	1
	Admits he had emotional problems in the past, but won't admit to any now.	2
	Denies that he is mentally ill in spite of the evidence of his behavior, blames other factors.	3
27.	When he talks he sticks to the subject.	0
	Sometimes goes off the subject being talked about.	1
	Talks mainly about his delusions.	2
	Talks mostly to his "voices."	3
28.	If he gets a cold or sprained ankle, etc., he does not use it to get his own way.	0
	Complaints of aches and pains to gain sympathy and contact.	1
	Uses physical symptoms to get out of work, ward chores	2

29. All his behavior serves some purpose. 0
Some of his actions are useless, for example he bites his nails. 1
Much of his behavior serves no purpose--maybe he washes his hands all the time, etc. 2
None of his actions seem to serve any purpose. 3

32. Usually calm. 0
Restless when things get boring. 1
Restless without apparent cause. 2
Constantly restless, can't sit still, paces about. 3

34. Has no characteristic movements of arms, legs, body. 0
Has certain mannerisms, for example, you could recognize him because of the funny way he walks. 1
These mannerisms and gesturing are hard for him to control in most situations. 2
These mannerisms are such a habit he couldn't stop even if there were a fire. 3

36. Face has a normal expression. 0
Sometimes his face twitches. 1
He has tics, "makes faces," without being too able to control himself. 2
Tics, faces, fluttering eyelashes and/or screwing up his face are a serious problem with him. 3

48. Doesn't seem to think anybody dislikes him. 0
Thinks <u>some</u> people may not like him. 1
Thinks <u>most</u> people could turn against him. 2
Thinks everybody hates him. 3

50. Seeks help or advice when necessary if at all. 0
May seek help <u>sometimes</u> when he could really do it himself. 1
Asks for help and advice most of the time when we all know he could do it himself. 2
Demands help and reassurance continuously. 3

52. Doesn't seem to feel misused. 0
Thinks some people would like to see him fail or be unhappy. 1
Thinks some people are plotting to keep him from getting what is justly his. 2
Feels persecuted by people or groups that want to get back at him or punish him. 3

53. Asks for things politely if at all. 0
Clearly tells you what he needs, but has the sense to wait until the situation is right. 1
Will interrupt someone to tell you what he needs. 2
He will bust into a private conference just to tell you he needs something, as if it couldn't wait. 3

56. Does not ask for much. 0
Often asks things of attendants and nurses. 1
Is a ward pest in his demands on ward personnel. 2
Keeps asking to see the doctor, demands attention from VIPs and/ or takes out writs frequently. 3

57. Never gets physically ill. 0
Any aches or pains are physical rather than mental. 1
Physical symptoms may be partly due to emotions, like an upset stomach when nervous, or headaches. 2
Complains of aches and pains when everyone knows there is nothing physically wrong with him. It's all in his head. 3

58. Patient does not think he's being spied on or anything 0
Wonders if others are especially interested in his thoughts or behavior. 1
Wonders if he's being controlled by unusual forces. 2
He really believes people control his thoughts in some strange way. 3

59. Does not demand attention. 0
At group meetings he usually wants to talk about his problems. 1
Always bitches about his own problems. 2
Demands attention dramatically, for example by standing on tables, showing off, cutting or hurting self to get attention. 3

61. Patient does not get into arguments. 0
Can be provoked into an argument. 1
Will pick a fight for small reasons, like if you look at him funny. 2
Is usually the one to pick fights. 3

63. Rarely gets physically ill. 0
Any physical complaints he has are just physical, like a broken toe or common cold. 1
Physical complaints are made worse or caused by emotional upset, like chronic stomach trouble. 2
Physical ailments caused by emotional factors, like fainting, hysterical seizures, etc. 3

64. Doesn't pick fights. 0
Hits people only in self defense. 1
Doesn't take much to make him take a poke at someone. 2
Is always starting fights. 3

66. Never criticizes others. 0
Criticizes others if there is good reason. 1
Criticizes others for no reason. 2
Continually critical of others. 3

67. Never takes anything the wrong way. 0
May exaggerate the intentions of others, like thinking a woman wants to make love to him when she's only being helpful and friendly. 1
May seriously take things the wrong way--you have to be careful the way you tell him something. 2
No matter what anyone does, he fits it into his delusional beliefs. 3

69.	Is not rude or cocky.	0
	Noticeably rude at times.	1
	Almost always impolite.	2
	Spoils things for everybody, like at a ward party he'll make it so everyone has an awful time.	3
72.	Doesn't swear.	0
	Uses a few 4 letter words if provoked.	1
	Swears like a sailor when provoked.	2
	Uses filthy language constantly.	3

Appendix C

THE MACC BEHAVIORAL ADJUSTMENT SCALE FORM II

Robert B. Ellsworth

12031 Wilshire Boulevard

Los Angeles, California, 90025

Mood scale (numbers refer to score)

Is he pleasant, never seems to be irritable or grouchy?

1. Usually very grouchy
2. Most often irritable
3. Sometimes pleasant
4. Most frequent pleasant
5. Always pleasant

Is he sullen?

1. Always sullen
2. Most often sullen
3. Sometimes sullen
4. Rarely sullen
5. Always pleasant

Is he bitter:

1. Always bitter
2. Usually bitter
3. Sometimes bitter
4. Rarely bitter
5. Never bitter

Is he angry and hostile?

1. Always angry
2. Usually angry
3. Sometime friendly
4. Usually friendly
5. Almost always friendly

Cooperation scale

Does he generally cooperate, "go along" with things asked of him?

1. Almost never cooperates
2. Most frequently resistive
3. Resistive rather often
4. Goes along with requests most of the time
5. Always does what is asked

Does he seem resistive?

1. Very resistive
2. Most often resistive
3. Sometimes resistive
4. Rarely resistive
5. Never resistive

In the things that are expected of him to do, does he go ahead and do them on his own without having to be told how and when to do it, or must he be directed and encouraged to do them?

1. No initiative
2. Occasionally acts "on his own."

3. Fairly often goes ahead "on his own"

4. Usually shows initiative

5. Almost always goes ahead "on his own"

In tasks assigned to him, can he "stay with" the task without frequent redirection, without becoming preoccupied and "lost"?

1. Almost always becomes preoccupied quickly

2. Rarely "stays with" tasks

3. Continues tasks fairly long

4. Usually "stays with" it

5. Almost always completes tasks

Appendix D

Acting out scale

D30 In school I was sometimes sent to the principal for "cutting up."

E7 I don't blame anyone for trying to grab everything he can get in this world.

F31 I easily become impatient with people.

G29 I get mad easily and then get over it soon.

G31 At times I feel like smashing things.

G32 At times I feel like picking a fist fight with someone.

G47 At times I have a strong urge to do something harmful or shocking.

G48 Sometimes I feel as if I must injure either myself or someone else.

I1 I can easily make other people afraid of me, and sometimes do for the fun of it.

I2 Sometimes I enjoy hurting persons I love.

I4 I sometimes tease animals.

I26 I am easily downed in an argument

I43 I like adventure stories better than romantic stories.*

---

* denotes items in which <u>disagreement</u> places it in the cluster.

Criticism of others

B55 I have very few quarrels with members of my family.*

C3 Some of my family have habits that bother and annoy me very much.

C31 I have, at times, stood in the way of people who are trying to do something, not because it amounted to much, but because of the principle of the thing.

D47 Most people make friends because friends are likely to be useful to them.

D49 I do not blame a person for taking advantage of someone who lays himself open to it.

D50 Most people are honest chiefly through fear of being caught.

D52 I think most people would lie to get ahead.

D53 I think nearly anyone would tell a lie to keep out of trouble.

E9 When someone does me a wrong, I feel I should pay him back if I can, just for the principle of the thing.

E53 It is safer to trust nobody.

F30 I have often found people jealous of my good ideas just because they have not thought of them first.

G50 Some people are so bossy that I feel like doing the opposite of what they request, even though I know they are right.

Projected hostility

G52 I have no enemies who really wish to harm me.*

G53 If people had not had it in for me, I would have been much more successful.

G54 Someone has it in for me.

G55 I am sure I get a raw deal from life.

H4 I believe I am being followed.

H10 I commonly wonder what hidden reason another person may have for doing something nice for me.

H11 I believe I am being plotted against.

H15 Someone has been trying to rob me.

H26 I know who is responsible for most of my troubles.

Self Criticism

A23 I seem to be about as capable and smart as most others around me.*

C25 I have often lost out on things because I couldn't make up my mind soon enough.

C29 I usually expect to succeed in things I do.*

F33 Often I can't understand why I have been so cross and grouchy.

I13 My hardest battles are with myself.

I25 I have several times given up doing a thing because I thought too little of my ability.

I26 I am easily downed in an argument.

I31 I have sometimes felt that difficulties were piling up so high that I could not overcome them.

I39 I am certainly lacking in self confidence.

I40 I am entirely self confident.*

I41 I shrink from facing a crisis or difficulty.

Delusions of guilt

F50 Much of the time I feel as if I have done something wrong or evil.

G3 I believe my sins are unpardonable.

G4 I have not lived the right kind of life.

G9 I believe I am a condemned person.

I17 I wish I could get over worrying about things I have said that may have injured other people's feelings.

I36 At times I think I am no good at all.

I37 I certainly feel useless at times.

Appendix E

Foulds, Caine, & Creasy Hostility scale

From Spanish MMPI standardized by A. Torres, Wells College, N. Y.

Actuaciones fuera de lugar

D30 En la escuela me llevaron ante el director algunas veces por hacer travesuras.

E7 No culpo a nadie que trate de apoderarse de todo lo que pueda en este mundo.

F31 Pierdo fácilmente la paciencia con la gente.

G29 Me molesto con facilidad, pero se me pasa pronto.

G31 A veces siento deseos de destruir cosas.

G32 A veces siento el deseo de empezar una pelea a puñetazos con alguien.

G47 A veces siento un fuerte impulso de hacer algo dañino o escandaloso.

G48 Algunas veces siento el impulso de herirme of de herir a otros.

I1 Con facilidad puedo infundirle miedo a otros y a veces lo hago por diversión.

I2 Algunas veces me gusta herir a las personal que quiero.

I4 De vez en cuando mortifico a los animales.

I26 Soy vencido facilmente en una discusión.

I43 Me gustan más las historias de aventuras que las de amor.

Críticas de otros

B55 Tengo muy pocos disgustos con miembros de mi familia.

C3 Algunos de mis familiares tienen hábitos que me molestan y perturban mucho.

C31 Algunas veces he sido un obstáculo a personas que querían hacer algo, no porque eso fuera de mucha importancia, sino por cuestión de principio.

D47 La mayoría de la gente se hace de amigos por conveniencia propia.

D49 No culpo a la persona que se aproveche de alguien que se expone a que le ocurra tal cosa.

D50 La mayoría de la gente es honrada principalmente por temor a ser descubierta.

D52 Creo que la majoría de la gente mentiría para ir adelante.

D53 Creo que casi todo el mundo mentiría por evitarse un problema.

E9 Cuando alguien me hace un mal siento que debiera pagarle con la misma moneda, si es que puedo, como cuestión de principio.

E53 Es más seguro no confiar en nadie.

F30 A menudo he encontrado personas envidiosas de mis buenas ideas precisamente porque a ellas no se les habían ocurrido antes.

G50 Algunas personas son tan dominantes que siento el deseo de hacer lo contrario de lo que me piden, aunque sepa que tienen razón.

Proyectada hostilidad

G52 No tengo enemigos que realmente quieran hacerme daño.

G53 Si la gente no la hubiera cogido conmigo yo hubiera tenido mucho más éxito.

G54 Alguien me tiene mala voluntad.

G55 Estoy seguro que la vida es cruel conmigo.

H4 Creo que me estan siguiendo.

H10 Generalmente pienso qué segunda intención queda tener otra persona cuando me hace un favor.

H11 Creo que estan conspirando contra mi.

H15 Alguien ha estado tratando de robarme.

H26 Yo sé quién es el responsable de la mayoría de mis problemas.

Auto crítica

A23 Me parece que soy tan capacitado e inteligente como la mayor parte de los que me rodean.

C25 Muchas veces he perdido una oportunidad porque no he podido decidirme a tiempo.

C29 Por lo general espero tener éxito en las cosas que hago.

F33 A menudo no puedo comprender por qué he estado tan irritable y malhumorado.

I13 Mis luchas más difíciles son conmigo mismo.

I25 Varias veces he dejado de hacer algo porque he dudado de mi habilidad.

I26 Soy vencido fácilmente en una discusión.

I31 Algunas veces he sentido que las dificultades se acumulaban de tal modo que no podía vencerlas.

I39 Decididamente no tengo confianza en mí mismo.

I40 Tengo entera confianza en mí mismo.

I41 Me acobardo ante las crisis, dificultades o problemas.

Falsos conceptos de culpa

F50 Muchas veces me siento como si hubiera hecho algo malo o diabólico.

G3 Creo que mis pecados son imperdonables.

G4 No he vivido la vida con rectitud.

G9 Creo que estoy condenado o que no tengo salvación.

I17 Quisiera poder olvidarme de cosas que he dicho y que quizás hayan herido los sentimientos de otras personas.

I36 A veces pienso que no sirvo para nada.

I37 Decididamente a veces siento que no sirvo para nada.