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ETHNIC SELF-HATRED IN BLACK PSYCHOTICS

by

SANDRA TAYLOR BAILEY

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

1976

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

ETHNIC SELF-HATRED IN BLACK PSYCHOTICS

by

Sandra Taylor Bailey

Advisor: Professor Harold Wilensky

The relationship between ethnic self-hatred and psychopathology among hospitalized black psychotics was explored in this study in an attempt to empirically clarify the nature and meaning of ethnic self-hatred in the symptom-complex of mentally ill blacks. A major question asked was whether or not ethnic self-hatred could be seen as an important variable in the psychopathology exhibited by black psychotics.

Subjects were 96 hospitalized black patients in two metropolitan New York State Hospitals, and 24 non-psychotic paraprofessionals who were used as a comparison group, in an analysis of the Ethnic Self-Image Inventory of Attitudes (ESII-A) which was used as one measure of ethnic self-hatred. Other measures of ethnic self-hatred were the Ethnic Self-Image Inventory of Behavior (ESII-B) and the Ethnic Figure Drawing Test (EFDT). The Ward Behavior Inventory (WBI) was used to measure psychopathology. The ESII-A, the EFDT, and five standard interview questions were administered to the

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psychotic subjects by the investigator. The ESII-B and the WBI were rated independently by staff on the wards from which patients were sampled. The ESII-A was verbally administered to psychotic subjects, but not to non-psychotic paraprofessionals who were instructed to complete the inventory and return it to the investigator.

Factor and item analyses of the ESII-A and the ESII-B were performed as statistical aids in test construction of these instruments developed by the author during the pilot-phase of the research.

The results of the study indicated that psychopathology and ethnic self-hatred as measured by the ESII-B factor scores were directly related ($\underline{r}$ = .49 and .45). There was no direct correlation between psychopathology and ethnic self-hatred as measured by the ESII-A factors. A test of whether the data were curvilinear revealed that in part the data were non-linear. Eta ratios of correlation revealed that three of the ESII-A factors and both ESII-B factors were significantly effective in predicting psychopathology (eta = .63, .50, .55, .83, .85).

A number of variables were significantly related to psychopathology. Among these were: place of birth (South); age; definition of the word black (positive and negative meanings); hair style (naturally straight), and diagnosis of paranoid schizophrenia.

Comparison of psychotics' and non-psychotics' responses

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on the ESII-A revealed highly significant differences between the two groups with psychotics exhibiting significantly higher degrees of ethnic self-hatred.

Results showed that ethnic self-hatred is an important variable in the psychopathology exhibited by black psychotics. Ethnic self-hatred was found among all patients, and findings demonstrated that ethnic self-hatred plays an important and central role in the emotional disturbance of black psychotics.

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INTRODUCTION

The Problem

For the past six decades, behavioral scientists have been cognizant of the existence of ethnic self-hatred including color delusions among mentally ill blacks. However, little systematic and/or empirical research has been conducted to clarify the nature and meaning of ethnic self-hatred in the psychopathology exhibited by mentally ill blacks. Further, the absence of any reported treatment program designed to diminish ethnic self-hatred reflects an historical attitude on the part of behavioral scientists in failing to consider it as an important independent factor in the symptomatology manifested by emotionally disturbed blacks.

The present study investigated some of the relationships between psychopathology and ethnic self-hatred among urban, hospitalized, black psychotics in an attempt to empirically clarify the role of ethnic self-hatred in the symptom-complex of this group. Also, the extent to which ethnic self-hatred could be viewed as a significant variable in the psychopathology of black psychotics was investigated in this study.

Review of the Literature

While the behavioral science literature on blacks is

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extensive and varied (Miller, 1970), only a limited amount of the available material pertains to ethnic self-hatred and its relationship to psychoses. The problem of reviewing the literature in this area is compounded by the paucity of studies of an empirical nature. In addition, the problems of measurement and methodology encountered by behavioral scientists in dealing with this subject, and the state of theory construction in the area, add further difficulty to an assessment of the literature. Proshansky and Newton (1968) in their evaluation of the literature pertaining to the nature and meaning of self-identity in blacks state:

> Our discussion of the nature and meaning of Negro self-identity is necessarily limited by the state of research and theory in the field. While there has been considerable genuine concern about Negro identity, there has been little actual research on Negro identity. The research findings can only be described as incomplete, fragmentary, and at times contradictory....
>
> In looking at the "quality" or value of the existing research on Negro self-concept, we find that social scientists have been severely hampered by methodological problems. Techniques for measuring self-concept have often seemed artificial; reports have frequently been highly subjective, and the number of subjects have typically been small. Researchers interested in Negro identity have also tended to think in "black-white terms," ignoring important social-class variables (p. 180).
>
> When there are variations and difficulties in method and technique in studying the individual, we can expect to find corresponding differences and difficulties in concept and theory (p. 181).

Those aspects of the literature most relevant to the present study included the following: (1) the development

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of ethnic awareness in black children; (2) ethnic identification and evaluation in blacks; (3) ethnic self-hatred in blacks, adolescents and adults; (4) ethnic self-hatred, personality, and mental disorder; and, (5) ethnic self-hatred, the independent variable.

Development of Ethnic Awareness in Black Children

The development of ethnic awareness in black children is an important etiological consideration in studying ethnic self-hatred in black psychotics. Its greatest significance is provided in terms of the formulation of theoretical propositions regarding the origin and role of ethnic self-hatred in relation to mental disorder. The question of when black children become aware of their ethnicity is fundamental to a theoretical stance which views ethnic self-hatred as an important variable in psychoses among blacks.

Ethnic awareness refers to how and when the child learns to conceptualize his blackness; while ethnic evaluation refers to how and when the child makes a judgment about his minority group status in relation to the dominant group, and other out-groups.

Several investigators have reported that black children are aware of ethnicity as early as age three. Most notable is the pioneering research of Clark and Clark (1947). The Clarks in a study of 253 black children found there was an increasing knowledge of ethnicity in black children from as early as age three, and reaching a peak at age seven.

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A number of other studies utilizing a variety of techniques of measurement have obtained similar results (Goodman, 1952; McDonald, 1970; Morland, 1958; Stevenson and Stevenson, 1960; Stevenson and Stewart, 1958).

Ethnic Identification and Evaluation in Blacks

While many researchers are in accord on the issue of when the black child begins to evaluate his ethnicity, there is considerable disagreement regarding the theoretical stance taken to explain the issue of how such an evaluation takes place.

Clark (1955, p. 50) is one investigator who takes the position that the black child learns to evaluate his ethnicity through learning the value the society places on his blackness. Essentially, Clark conceptualizes the evaluation of ethnicity as stemming from many sources of communication available to the child as he becomes better able to utilize secondary process thinking. Clark's conceptualization is basically social-psychological in nature with emphasis given particularly to a sociological frame of reference regarding the effects of prejudice and discrimination as being the primary factors in how the black child evaluates his ethnicity in relation to others.

Clark and Clark (1947) in a study of 253 black children, a study which used a Dolls Test to measure racial identification and preference, found that approximately two thirds of the children showed a preference for the white

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doll and a rejection of the brown doll, in response to a series of questions designed to elicit racial identification and preference.

Clark and Clark (1950) in a related study, using a Dolls Test, a line drawing technique, and a coloring test to measure ethnic evaluation and its emotional component in 160 black children, ranging in age from five to seven, found that children spontaneously commented upon their choices, and rejections of white and brown dolls, in response to specific requests. These qualitative data demonstrated an acceptance of the white doll as positive, and a rejection of the brown doll as negative and devalued. Some of the explanations of rejection of the brown doll were:

> Because him foot ugly; looks bad all over; looks bad cause it don't look pretty; cause it's brown--I would like to be brown; cause him black--cause his cheeks are colored--it's ugly; cause he is a nigger; I don't like brown; cause it looks like a Negro; I look brown cause I got a suntan; cause it hasn't got any eyelashes (p. 60).

Some of the explanations of these children for acceptance of the white doll were:

> Cause he's not colored like these--they are the best looking cause they're white; cause it's the prettiest one; cause she's got red on her cheek; cause it got pretty hands, eyes, and eyebrows; cause it's got blue eyes--cause its got pretty eyes; cause it's white--my mother is white too; cause that the good one; cause his feet, hands, ears, elbows, knees, and hair are clean (p. 61).

Clark and Clark concluded that the evaluation of ethnicity occurs simultaneously with the development of

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racial awareness in black children, and that black children evaluate themselves negatively and accept the values given them by the dominant culture:

> It appears from the data that coincident with the awareness of racial differences and racial identity there is also the awareness and acceptance of the existing cultural attitudes and values attached to race. It is clear that the Negro child, by the age of five is aware of the fact that to be colored in contemporary American society is a mark of inferior status (p. 62).

Other studies that lend support to Clark and Clark (1950) are (Goodman, 1952; Morland, 1958; and, Stevenson and Stewart, 1958).

McDonald (1970) in a study of children in an integrated therapeutic nursery reported that the evaluation of ethnicity of black children stemmed from skin color anxiety, which was the result of normal conflicts children encounter as they move through the psychosexual stages of development. She views skin color anxiety as the normal occurence for black children, and, indeed <u>all</u> children, in terms of associations made during the anal phase of development when the child equates skin color with bowel movements and dirtiness. McDonald further views the attitudes of parents regarding their own color as determining factors in compounding the child's skin color anxiety and self-esteem with respect to ethnicity.

Several investigators have used figure drawing tests to assess how black children evaluate themselves. Coles (1964) reported that black children when drawing a black

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person drew less complete faces and limbs than when drawing white persons. He concluded that the inadequate drawings of black persons reflected black children's feelings of helplessness and negative identity.

Similarly, Hammer (1968) concluded that the social environment in which some black children are reared creates an impoverished psychological atmosphere which consequently creates inadequate self-images. Hammer reported that black children displayed a sense of social helplessness when drawing human figures, as was exemplified by the production of less complete figures, or fewer faces, arms and hands than white children produced.

In a similar study of black adolescent students, Frisch and Handler (1967) found that blacks tended to grossly overemphasize and distort hair on a figure drawing test. The hair-face ratio was significantly greater for drawings done by the 122 black subjects than for those done by the 103 white subjects. The researchers presented a cultural interpretation of this finding. The anlaysis of the drawings and the cultural interpretation asserted were based on a content analysis compiled by the authors in which a comparison was made between monthly issues of a black and a white magazine. The investigators found that the photographic advertisements in the white magazine, which were hair-related totaled 1%, while the corresponding value of hair-related advertisements in the black magazine totaled

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17%. Other findings were that black children characteristically did not draw persons with Negroid features. Further data were collected using a figure drawing test, and instructing subjects to draw Negroid figures. Eighty-eight percent of the black subjects were able to draw distinctive Negroid features. The authors concluded that the performance of these black children on the test suggests a cultural reflection of their desire for assimilation and integration.

Ethnic Self-Hatred in Adolescents and Adults

Studies have examined the question of whether ethnic self-hatred continues from childhood to adolescence to adulthood. Johnson (1967) studied the ethnic attitudes of black youth between the ages of 12 and 20, who resided in the rural South. Subjects were given a list of six possible racial categories or colors of people, asked to choose adjectives from a list, and to describe people in 30 value-judgments. He found there was a definite tendency to classify as black a greater number of negative judgments. Comments made during interviews with subjects added qualitatively to the nature of the negative judgments made, suggesting that judgments stemmed from existent ethnic attitudes with respect to self and in-group members.

Dennis (1963) examined some drawings made by black college students and black children. He observed that blacks, when asked to draw a man, almost invariably drew

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a white rather than a black figure. He concluded that black children and adults, in drawing a man, drew the type of person whose appearance they admired, and preferred a white appearance.

In a related study, Dennis (1968) tested the hypothesis that the Black Pride or Black Power Movement has had an effect on the ethnic images of black college students. He compared a set of drawings made by black students at Howard University in 1957 with a set of drawings obtained from students at the same University in 1967. Comparison of the sets of drawings showed that in the 1957 set, no drawing decidedly represented a black; while in the 1967 set, 18% of the drawings clearly represented blacks.

Johnson (1958) in an exhaustive questionnaire study of black and white attitudes found that ethnic self-hatred was present in a substantial percentage of the blacks studied. He found that 59% of the black youth agreed with the statement, "if Negroes would prepare themselves, the white man would give them good jobs"; 50% agreed that "Negroes blame whites for their position, but it is really their own fault"; 47% agreed, "Negroes in this country need a lot more education before the white man gives them equal rights"; 41% agreed that, "Negroes will never get ahead because when one is succeeding, the others pull him down"; 31% agreed, "the white man is always trying to help the Negro but the Negroes won't try and help themselves";

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28% agreed, "Negroes are always shouting about their rights and have nothing to offer"; and, 20% agreed, "Negroes would be better off if they acted more like white people" (p. 205).

Parker and Kleiner (1964) studied the ethnic identification of blacks and attempted to test the hypothesis advanced by Frazier (1957) that there exists a "Black Bourgeosie" (Frazier, 1957) that emmulates the white dominant group, and has internalized many of the negative and/or patronizing white middle-class attitudes and stereotypes about the black masses; and, that such behaviors are representative of ethnic self-hatred. Parker and Kleiner utilized a questionnaire to measure the ethnic attitudes of blacks and its relationship to status position and mobility. Their findings supported Frazier's concept of the "Black Bourgeosie." They found that blacks in the higher status positions generally had values more similar to those of the white middle class, greater desires to associate with whites, more internatlization of negative attitudes toward other blacks, and weaker ethnic identifications than individuals in the lower status positions. They noted also that ambivalence and weak identification patterns increased with status, while consistant positive identification decreased.

Maliver (1963) attempted to measure ethnic self-hatred and its relationship to personality, in regard to the identification with the aggressor hypothesis in 160

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black male southern and northern college students. He hypothesized that blacks scoring high on a scale of anti-Negro bias would show a concomitantly higher incidence of negative attitudes toward parents, negative attitudes towards the self, and would be more prone to react passively in the face of hostile interpersonal attack. On the other hand, blacks scoring low in anti-Negro bias were expected to show a high incidence of positive attitudes towards parents and self, and to be more likely to retaliate when attacked. Results of the study did not support the hypothesis that general personality differences could be predicted on the basis of the degrees of anti-Negro prejudice held by blacks.

Ethnic Self-Hatred, Personality and Mental Disorder

Though investigators have concerned themselves with the general nature of psychoses in blacks, the available research reveals that there are few studies which pertain specifically to the relationship between ethnic self-hatred and psychoses. The quality of much that has been reported is often diminished by the biased analyses and conclusions of the data. The problem in reviewing the literature in this area is further compounded by the paucity of empirical research.

Lind (1914) in discussing ethnic self-hatred and color delusions in blacks remarked: "...no exhaustive study of psychoses in Negroes is necessary to show that it

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exists in very many of these and often molds largely the topography of the delusional field" (p. 404).

Many investigators have attempted to examine ethnic self-hatred and its relationship to psychoses in a more objective manner. Vitols et. al. (1963) point out that culture plays an important role in the characterization of specific hallucinations and delusions:

> ...Hallucinations and delusions are very much a part of the fabric of the society in which they occur. The patient through the highly condensed symbol--hallucinations and/or delusions--not only expresses his feelings but also gives form and substance to his feelings by identifying with some cultural value (p. 474).

Vitols et. al. (1963) in a study of delusions and hallucinations in white and black schizophrenics found that the incidence of hallucinations was significantly higher among black schizophrenics than among white schizophrenics, hospitalized for the first admission in a state hospital system. The investigators also found that 15 of the 128 black schizophrenics had whole or partial delusions of being white, and that none of the 110 white schizophrenics had delusions of being black, or anything other than white.

In a similar investigation of black psychotics, Myers and Yochelson (1948) found that color delusions were not uncommon in a hospital service of approximately 1000 males. The researchers presented several case histories to illustrate ethnic self-hatred in these patients. They concluded that the insecurity involved in being a member

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of the black ethnic group led to chronic anxiety; and, that security mechanisms become important and are reflected in the need for increased self-esteem and self-expression. These protective mechanisms, the investigators concluded, are characterized by the use of skin bleachers and hair straighteners, in the dreams and fantasies of blacks, in the phenomenon of passing and in the psychotic reactions of black patients. Another major conclusion was that the psychotic reaction often included characteristics which demonstrated a need to solve the problem of color and the difficulties in living related to being black.

Goldenberg (1953) in a study of black schizophrenics and non-schizophrenics, a study which used a psychological test battery to investigate the identification with the aggressor hypothesis, found that black schizophrencis manifested a greater amount of hostility toward blacks, and a greater tendency to identify with whites than the non-schizophrenics, who were used as controls. Non-schizophrenics showed a greater tendency to accept their minority group status. Also, the non-schizophrenics had more fantasized retaliation against whites, more covert white identifications, and a closer approximation to a black ego ideal.

Brody (1961) in an explanatory study of the prominent social factors in the breakdown of a group of young adult black patients in a segregated state hospital con-

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cluded that it appears as though a vast majority of American blacks suffered from multiple problems of identification, problems inherent in culture conflict, caste restrictions, and minority group membership. He also concluded that these multiple problems were in part transmitted through the family structure. Brody further concluded:

> Ultimately their developing unification around common aspirations may determine certain changes in the forms of psychiatric illness which are exhibited. At present, the Negro's problem in defining his existence is reflected in a "normal" character structure incorporating his various attempts at conflict solution and tension discharge.
>
> It is not clear that the methods of acting out difficulties and other tension-discharging or essentially narcotizing techniques...act as effective defenses against the final development of a psychotic response--that is make it less necessary for the purposes of conflict resolution and tension reduction (p. 340).

The case history materials presented by Brody suggested that minority group status and ethnic self-hatred were common problems among the patients studied.

Volkan (1963) reported five poems written by black male juvenile delinquents, who were unprepared for a sudden school desegregation. The poems indicated the subjects' wishes to be white.

Volkan (1966) in a later study of the psychodynamic processes of two blacks with Leukoderma (white patches of skin) concluded that "the fact that the ancestry of the American Negro is mixed is the 'historical kernal'...which has been distorted into delusion by many Negro patients" (p.35). Volkan reports that black schizophrenics often justify their

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delusions of being white in a variety of ways:

> To justify the misjudgement of reality, schizophrenic Negro patients who have the delusion of being white usually show the lighter skin of their palms or the matrix of the fingernail as proof of their whiteness. One Negro schizophrenic at the University of Virginia Hospital who developed the habit of taking many showers everyday reported that he wanted to wash away the sunburn, and that, in fact, his skin was white (p.35).

> During the transitional period between holding onto reality, which is being a Negro, and developing a delusion of being white, Negro patients may relate themselves to the peoples of India or China or to the American Indian.... On many occasions the schizophrenic Negro considers himself an Egyptian or Spaniard before he believes that he is a white American. This may be due to the fact that geographically Egypt and Spain are close to the so-called "Dark Continent" and psychologically may represent a bridge between whiteness and blackness (pp.35-36).

Before presenting Volkan's descriptive findings of the psychodynamics of two blacks with Leukoderma it is first necessary to comment on the latter part of his above statement. Volkan states that the fact that geographically, Egypt and Spain are close to Africa, the "Dark Continent" is important in understanding the process of developing a delusion that one is white, and that believing oneself to be an Egyptian, psychologically may be understood as a bridge between whiteness and blackness. It is important to note that <u>Egypt is in the "Dark Continent."</u> Hence, the black patient who believes himself to be Egyptian is in addition to being deluded, suffering from ignorance

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and a white-wash of history. Similarly, Volkan's analysis suffers in this context, in that he, too, was not cognizant of the geographic location of Egypt. Egypt is in Africa, and Africa historically has been referred to by some as the "Dark Continent."

Volkan found in his study of two blacks with Leukoderma that the patches of white skin possessed by these patients played an important part in the emotional disturbances they exhibited. He concluded that the fact that these patients had something which most blacks do not possess (white skin) led to the manifestation of problems in racial identity, which were reflected in the symptom-complex. The racial identity, Volkan concluded, was projected onto and condensed with the problem of bisexuality.

Prange and Vitols (1963) utilized black jokes as a means of studying conflict in blacks. They collected 18 jokes derived from black male paraprofessionals at a mental hospital for blacks. They found that the jokes were preoccupied with relationships to whites and the stateof being intimidated because of blackness. They conceptualized within the context of a frame of reference espoused by Zwerling (1955) that jokes can reveal unconscious conflicts which are otherwise revealed in indirect and disguised form. The study concluded that the southern black is greatly preoc-

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ocupied with the fact of being black, and that this concern may be the major consideration of the everyday life of blacks.

Parker and Kleiner (1966) attempted to investigate the relationship between racial identification and mental illness. Subjects were black hospitalized mental patients and normal blacks from a black community. These investigators utilized an item on a questionnaire that asked subjects how they would feel about a friend who tried to pass as a measure of racial identification and conflict with respect to minority group status. They found that blacks in the mental hospitals were inclined to be strongly identified with blacks, or not identified with blacks; while subjects from the community tended to be ambivalent about their racial identification. Based on this finding, the investigators concluded that ambivalence may be realistic and adaptive conditions for blacks, but that the polarization of racial identification was indicative of pyschopathology:

> ...the psychiatrically healthy Negro is an individual with conflicts about his racial identification. It is the mentally ill person who tends to remove this constant conflict from conscious awareness (p. 160).

The above conclusions reached by Parker and Kleiner have been criticized by Proshansky and Newton (1968, p. 196), who state that implicit in the logic of the Parker and Kleiner conclusions is the notion that

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the more unbearable the conflict about racial identification becomes, the more the individual may deny the conflict altogether (either strongly identifying with or rejecting his racial group), and becoming mentally disturbed. The essential criticism of the Parker and Kleiner research is while denial of conflict regarding identification is apparently unhealthy, one cannot assume that ambivalence and conflict are healthy. Furthermore, the operational definition of mental health in the Parker and Kleiner study is erroneous in that it was based on the assumption that individuals in the communtiy are void of psychopathology. "... a judgment of mental health, based soley on whether or not an individual is in a psychiatric hospital, is open to serious question" (Proshansky and Newton, 1968, p.196).

Problem Oriented Interventions

While there is an extensive body of literature on the nature of ethnic self-hatred in blacks, few studies deal with the issue of how to alter ethnic self-hatred. While there have been reports stating that techniques should be devised and utilized to alter ethnic self-hatred among blacks, little actual empirical research has been reported. Though educators have often devised and implemented programs to enhance the ethnic self-esteem of black children,

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psychotherapists, in this respect, appear to have reached an impasse. As of the writing of the present study, a review of the literature contained no reference to a study designed to diminish psychopathology by diminishing ethnic self-hatred in mentally ill blacks. Therefore, this section will basically present some of the reports of educators regarding educational approaches to enhancing ethnic self-esteem.

Chethik, et. al. (1967) are one group of clinicians who have noted the problem of enhancing the ethnic self-esteem of emotionally disturbed black children. They suggest that it is possible to present a healthy black image to the black child in lieu of Erikson's three black identities (Erikson, 1950, p.214). Erikson postulates three black identities: (1) "Mammy's oral sensual 'honey child' tender, expressive, rhythmical"; (2) "the evil identity of the dirty, anal, sadistic, phallic-rapist 'nigger'"; and, (3) "the clean anal compulsive, restrained, friendly but always sad 'white man's Negro'" (p.214).

Chetik, et. al. suggest the following two ways of providing alternative positive images to the negative ethnic images found among emotionally disturbed black children:

> (1) Identification with strong, successful, kind, but goal-oriented and civic-minded Negro men and women; (2) use of the positive images

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> emanating from the Negro figures in the present civil rights struggle. This identification with these figures will limit the self-hatred and enhance the search for identity of the emotionally disturbed Negro child. (p.77).

Newton (1969) suggests that bibliotherapy may be used as a method of enhancing the self-esteem of minority group children. She maintains that it is possible to increase the achievement motivation and the learning potential of minority group children by providing them learning materials specifically designed to enhance the ethnic self-image. She defines bibliotherapy as directive, purposive readings, which can be used to aid in altering the attitudes and behaviors of children and adolescents. She also suggests that audio and visual materials may be used in conjunction with bibliotherapy in attempting to enhance the ethnic self-esteem of minority group children.

A similar stance is taken by Arnez (1972) who advocates the utilization of revolutionary black literature as a method of enhancing the black self-concept. Revolutionary black literature generally refers to literary materials written by black authors which focuses solely on the experience of being black to the exclusion of other themes. Like Newton (1969), Arnez advocates the use of music, drama, and dance in conjunction with literature, as vehicles which

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can be used to enhance the self-esteem of minority group children.

Smith (1967) suggests that the ethnic self-image of black adolescents can be enhanced through a speaker models approach. Thus, once a month, he used black speakers, who had become successful, in spite of the hardships they incurred during their childhood and adolescence to talk with his students. Among the speakers were a teacher who was also a civil right activist, an engineer, an anthropologist, a journalist, an attorney, a poetress, the secretary of a United States Congressman, a doctoral divinity student, and a psychologist. Based on the achievements of the 24 students at the end of the school year, findings which Smith admits are open to question, he concluded that the speaker models approach was successful and instrumental in instilling positive ethnic images in the students observed.

Ethnic Self-Hatred: The Independent Variable

The problems involved in formulating hypotheses, explicating theories, and defining important independent variables may be viewed as one reason why there is a paucity of theory in the area of psychological consequences of ethnic self-hatred.

Schermerhorn (1956) deals with the issue of designating the independent variable in psychological and psychiatric research pertaining to blacks and mental

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disorder. He maintains that theoretical propositions which are not cognizant of the special factors in the background of the black personality run the risk of misjudging and falsely assessing the etiological factors in mental disorder among blacks; as well as misunderstanding the therapeutic process.

He further contends that "mistakes in diagnosis could result from uncritical use of case history materials in a Negro patient, if given the same weight that they are given for a white patient" (p.881).

Schermerhorn proposes that sociological considerations make it possible to questionthe value of propositions about the specification of the independent variable in psychiatric research that seeks to analyze and conceptualize the etiology of mental disorder in blacks. He maintains that consideration of a unique group of factors may furnish proper clues to etiology within the context of mental disturbance among blacks. He maintains further that researchers who rely on analytic reasoning and theory construction which do not take into consideration the cultural context of a particular pheomenon are subject to formulate imperfect conclusions and explicate misguided theories:

> ... it is the pitfall of neglecting the Gestalt in favor of the summation of behavior units analytically established. The method is self-corrective insofar as the imperfect research

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> results force the investigator to adopt new hypotheses for testing, and in the long run, he will probably formulate a more sophisticated notion of unity-in-variety (p.879).
>
> Close examination of the Negro community reveals a number of interpenetrative or mutually implicative factors that may be separable for analytic purposes and yet have a total impact of a unique sort in the subculture, i.e., have no analogy in the daily experiences of otherwise comparable white persons (p.880).

Fanon (1967) contends that the development of psychopathology in blacks stems directly from the effects of prejudice and discrimination. Fanon, in discussing the development of abnormality among blacks, asserts that the effects of racism are so pervasive as to render the individual mentally ill, even where there has been an absence of direct contact with white racism. He states further that mental illness observed in whites can be viewed as an outgrowth of the disturbances in the family environment, while the opposite is the case for the black:

> ... this is the most important point--we observe the opposite in the man of color. A normal Negro child, having grown up within a normal family, will become abnormal on the slightest contact with the white world (p.143).

Fanon elaborates his above contention and theorizes a Collective Catharsis to explain the occurence of abnormality in blacks who have never been in direct contact with whites, but who nevertheless manifest psychopathology, Essentially, Fanon contends that the black child acquires a sense of how he is perceived by

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whites, not only from direct contact with whites, but from exposure to secondary process materials (books, cartoons, radio), and language. The consequent result, according to Fanon, is an identification with that which is white and valued and a devaluation of blackness:

> Very often the Negro who becomes abnormal has never had any relations with whites... we have to fall back on the idea of Collective Catharsis. In every society, in every collectivity, exists--must exist a channel, an outlet through which the forces accumulated in the form of aggression can be released. This is the purpose of games in children's institutions, of psychodramas in group therapy, and, in a more general way of illustrated magazines for children... (pp.145-146).
>
> The magazines are put together by white men for little white men. This is the heart of the problem. In the magazines the Wolf, the Devil, the Evil Spirit, the Bad Men, the Savage are always symbolized by Negroes or Indians; since there is always identification with the victor, the little Negro, quite as easily as the little white boy, becomes an explorer, an adventurer, a missionary "who faces the danger of being eaten by the wicked Negroes" (p.146).
>
> With the exception of a few misfits within the closed environment, we can say that every neurosis, every abnormal manifestation, every erethism in an Antillean is the product of his cultural situation. In other words, there is a constellation of postulates, a series of propositions that slowly and subtly--with the help of books... schools... films... radio--work their way into one's mind and shape one's view of the world of the group to which one belongs (p.152).

Fanon's theoretical view regarding the proposition that there is a causal relationship between

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ethnic self-hatred and mental disorder in blacks is in part convergent with the views of several clinicians who have conceptualized the role of ethnic self-hatred in mental disorder among blacks.

Kennedy (1952) in a study of two black female neurotics found that there appeared to be a causal relationship between ethnic self-hatred and emotional disturbance:

> The cause of the neuroses of these two patients appeared to be the conflicts arising from a hostile, white ego ideal. The self-hatred, generated by the fact of not being white, started with the earliest infancy (p.218).

Kennedy concluded that the most adaptive solution to the color conflict in blacks would be a resistance of the white ego ideal and the development of a healthy black ideal in its place, within the context of the black culture. She views the institution of a healthy black ego ideal as resulting in an increase in ethnic self-esteem. Finally, Kennedy states that additional research is necessary to determine the most effective form of reconstructive therapy for the black patient.

Clark's conceptualization of the role of ethnic self-hatred in emotional disorder is similar to the positions of Fanon (1967) and Kennedy (1952). Clark (1955), however, is more cautious in asserting a causal relationship between the effects of racism and mental disorder among blacks. He maintains that as black

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children develop an awareness of their ethnicity, they also learn and accept the prevailing social attitudes and values attached to ethnicity and skin color by the larger society. The acceptance of negative values with respect to oneself and one's in group are seen by Clark as indicative of emotional disorder.

Clark contends further that ethnicity is an important underlying factor in the personality structure of minority individuals. While the symptoms of personality distortion in adolescents and adults appear unrelated to ethnicity, that which is directly observable in black adolescents and adults may represent a disguise of the major problem of ethnic self-esteem, which began in childhood:

> The discovery that very young children develop techniques for protecting themselves against negative racial status must be balanced by the observation that it takes time before these children learn all of the many subtle and complex ways of disguising the symptoms of personality damage. In studying this problem among adolescent and adult members of a minority group, therefore, one must not only look for the direct signs and symptoms of personality distortion such as are clearly observable in children, but also realize that these symptoms at the older age may express themselves in forms apparently unrelated to the racial problem. The consequences of prejudice and segregation for the personality continue with increasing complexity from childhood through adolescence as part of the development of the total personality (p.47).

Clark, while not explicitly asserting a causal relationship between ethnic self-hatred and mental dis-

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order, neverthless implies such a possibility:

> Students of personality are forced to recognize that the complexity of personality and society make it difficult to isolate any single factor upon the whole personality of the individual. Nevertheless, the evidence from social science research, from general observations from clinical material, and from theoretical analyses consistently indicates that the personality of minority group individuals is influenced by the fact of their minority-group status (p.47).

Grier and Cobbs (1968) maintained that mental disorder in blacks can be estimated only after one extrapolates what they refer to as the black norm from the total symptom-picture. Like Fanon, they view the effects of discrimination and prejudice as important factors in the development of emotional illness in blacks, resulting in "cultural paranoia, cultural depression, cultural masochism and cultural anti-socialism" (pp.149-150). These authors conclude that these concepts are adaptive defense mechanisms of coping with anxiety and conflict due to one's minority group status and view these mechanisms as normal in the psychological makeup of blacks.

Similarly, Kardiner and Ovesey (1962) concluded that caste is the dominant factor in neuroses among blacks:

> There is the question whether caste or class is the dominant Negro source of conflict, and whether the conflicts about caste are so prominent they should submerge differences that would otherwise arise from class distinctions, as is

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> likely to be the case with whites. ...we cannot avoid the conclusion that the dominant conflicts of the Negro are created by the caste situation, and that those of class are secondary. This is due to the fact that the adaptation of the Negro is qualified primarily by the color of his skin--an arbitrary but effective line of demarcation (pp.301-302).

Kardiner and Ovesey concluded that mental disorder in blacks must be judged against the cultural adaptive norm, particularly in relation to paranoid tendencies.

Bailey (1973) conducted an exploratory pilot study, which investigated the relationship between psychoses and ethnic self-hatred among 35 urban, black psychotics, hospitalized at a state hospital in New York City. The research was three-fold in purpose: (1) the development and pretesting of instruments to measure ethnic self-hatred in psychotic blacks; (2) the initiation and testing of The Second Chance Black Family treatment approach (Bailey, 1973), designed to diminish psychopathology by diminishing ethnic self-hatred; (3) the pretesting of procedures and methods for the present empirical study of the relationship between psychopathology and ethnic self-hatred, as well as for a proposed treatment study.

Three instruments were developed and pretested by Bailey (1973): The Ethnic Self-Image Inventory of Attitudes (ESII-A), The Ethnic Self-Image Inventory of Behavior (ESII-B), and The Ethnic Figure Drawing

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Test (EFDT). Bailey (1973) reported that the ESII-A:

> ... consists of 66 Likert type items pertaining to six general classifications of attitudes about blackness: (1) The wish to be something other than black; (2) The incoporation of white beauty standards; (3) There is something inherently negative about blacks; (4) Stereotyped attitudes about whites and black-white relationships; (5) Stereotyped solutions to discrimination; (6) Positive ethnic attributes (pp. 68-69).

The ESII-B consists of 23 items pertaining to behaviors observed to occur in black psychotics who exhibited ethnic self-hatred; while the EFDT consists of five requests. Basically, the EFDT is a modified Draw-A-Person test, altered to include the use of colored pencils, and requests for ethnic drawings:

> ... (1) "Draw a person"; (2) "Draw yourself exactly as you look"; (3) "Draw yourself as you would like to look, if you could change your appearance"; (4) "Draw a white person"; (5) "Draw a Negro person" (p.69).

Bailey found that patients exhibited varying degrees of ethnic self-hatred, including color delusions. Some of the color delusions found were delusions of being "mixican, French, Cherokee Indian, and white" (p.70). Other ethnic delusions found included delusions of being related to well known whites, owning slaves and plantations, and having non-existent naturally straight hair.

Other major findings were that the ESII-A, the ESII-B, and the EFDT were useful in eliciting

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patients' attitudes, thought processes, and defensive functioning with respect to ethnicity. The Second Chance Black Family therapy group, as a mode of gathering data was invaluable. Bailey found that patients continually initiated discussions about ethnicity, often recalling traumatic childhood events pertaining to their ethnicity. The combination music, listening, and dance therapy technique developed was particularly useful in helping patients to reassess their attitudes about blackness. Further, some changes were noted in various patients' delusional systems, in terms of previously fixed color delusions becoming fluid.

Bailey's major conclusion was that the data demonstrated that the patients studied exhibited hostile white ego ideals, and that:

> The color delusions, behaviors, attitudes, rationalizations, and projections of the patients studied can be seen as attempts to minimize conflict and anxiety stemming from the fact of their ethnicity. Whatever the protective devices used, it seems clear that the individual is seeking only to insure that no further harm, no additional pain or hurt, will result from his blackness (p.75).

Finally, Bailey concluded that additional empirical research was needed to clarify the role of ethnic self-hatred among psychotic blacks.

Statement of the Hypothesis

The basic conceptual problem was to investigate the relationship between ethnic self-hatred and psycho-

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pathology, in terms of whether or not ethnic self-hatred could be identified as a significant factor. The central question asked was to what extent could psychopathology be accounted for by the ethnic self-hatred manifested by black psychotics. The working hypothesis was formulated as follows: There would be a positive correlation between degree of psychopathology and degree of ethnic self-hatred. The Ward Behavior Inventory (WBI) was used as the measure of psychopathology (Burdock et. al., 1968), and scores on the ESII-A, the ESII-B, and the EFDT (see appendices A,B,C,D) were used as the measures of ethnic self-hatred.

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METHOD

<u>Subjects</u>

A total of 96 hospitalized, black psychotics were interviewed and tested between January, 1973 and July, 1975 by the investigator who was employed at Bronx State Hospital (B.S.H.).

In June, 1975, the available and suitable patient population at Bronx State Hospital had been exhausted, and Manhattan State Hospital (M.S.H.) patients were sampled. Of the total number of patients, 56 were from Bronx State Hospital, while 40 were from Manhattan State Hospital.

In all cases, the patients sampled met the criteria of being black (Negro, Afro-American, colored). This concept operationally referred to persons known to have had African ancestry, regardless of place of birth and exclusive of those who were Hispanic. This concept was defined in terms of the ethnic identity noted in hospital case records as affirmed by relatives, friends, and staff. All patients were diagnosed as psychotic. The Bronx State Hospital patients demonstrated more ward pathology ($\bar{X}$=31.6) than the Manhattan State Hospital patients ($\bar{X}$=22.7).

At Bronx State Hospital, the sample was drawn from the Lincoln, Lincoln Community Mental Health, Crotona,

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Highbridge, and Williamsbridge-Fordham Units. Manhattan State Hospital patients were sampled from the Meyer-Manhattan State Hospital Harlem Unit.

The data collection was purposive in that the investigator attempted to obtain a total sample of available and cooperative patients who met the operational criteria of black and psychotic. As the population of patients on a particular ward in a given Unit was exhausted, the examiner moved on to another ward and/or Unit. In all cases, subjects were systematically sampled in that upon arrival on a ward, the investigator gathered the names of all patients meeting the criteria and subsequently alphabetized them, beginning sampling by the alphabetical order of names.

A small sample of normal paraprofessional black staff were drawn from Bronx State Hospital (N=24). In most instances, these staff worked on the same wards from which the patient sample was obtained.

Characteristics of patients according to hospital, sex, age, marital status, education and place of birth are presented in Table 1. Characteristics of the non-psychotic staff according to sex, age, and education are presented in Table 2.

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TABLE 1

Characteristics of Patients According to Hospital, Sex, Age, Marital Status, Education, and Place of Birth

Characteristics	Hospital B.S.H. (N=56)	Hospital M.S.H. (N=40)	Total All Cases (N=96)
Sex			
Male	23(41%)	22(55%)	45(47%)
Female	33(59%)	18(45%)	51(53%)
Age Range			
16-19	3(5%)	1(2%)	4(4%)
20-29	21(38%)	7(18%)	28(29%)
30-39	12(21%)	14(35%)	26(27%)
40-49	12(21%)	6(15%)	18(19%)
50-59	7(13%)	8(20%)	15(16%)
60-63	1(2%)	4(10%)	5(5%)
Marital Status			
Single	31(55%)	24(60%)	55(57%)
Married	9(16%)	10(25%)	19(20%)
Separated	7(13%)	3(8%)	10(10%)
Divorced	4(7%)	0(0%)	4(4%)
Widowed	4(7%)	2(5%)	6(6%)
Unknown	1(2%)	1(2%)	2(2%)
Education Range			
2-6 yrs.	5(9%)	4(10%)	9(9%)
7-9 yrs.	11(20%)	14(35%)	25(26%)
10-12 yrs.	34(60%)	21(53%)	55(57%)
1-3 yrs. college	6(11%)	1(2%)	7(7%)
Place of Birth			
North	26(46%)	15(38%)	41(43%)
South	22(39%)	20(50%)	42(44%)
Other U.S.	4(7%)	2(5%)	6(6%)
Canada	1(2%)	1(2%)	2(2%)
West Indies	3(5%)	2(5%)	5(5%)

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TABLE 2

Characteristics of Paraprofessional Staff According to Sex, Age, and Education

Characteristics	Number	Percent
Sex		
Male	9	38
Female	15	62
Total	24	100
Age Range		
23-29	4	21
30-39	11	58
40-48	4	21
Total	19[a]	100
Education Range		
High School	12	50
1 year College	2	8
2 years College	5	21
3 years College	2	8
4 years College	3	13
Total	24	100

[a]Five staff members did not give their ages. Sample $\bar{X}$ age = 35.0

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The X age for psychotics was 37.7, S.D.=12.7. The median age was 34.

Instruments

The ESII-A, the ESII-B, and the EFDT were used to measure ethnic self-hatred, while the WBI was used to assess psychopathology.

A review of the literature revealed multiple techniques for the measurement of black ethnic attitudes toward self and in-group members, but virtually little which had been used for the measurement of ethnic self-hatred in psychotic blacks. The Semantic Differential (Osgood, 1957) was pretested during the pilot study with little success, due to the apparent inability of subjects to understand instructions, even when modified for simplicity; also, some patients were unable to read. Therefore, the ESII-A, the ESII-B, and the EFDT were constructed (Bailey, 1973).

The ESII-A consists of 66 items scored on a five point Likert (1932) scale scoring system (see Appendix A).

Items were derived from four sources (Bailey, 1973; Johnson, 1958; Maliver, 1963; Steckler, 1957). The possible range of scores is from 0 to 264 (maximum ethnic self-hatred).

The ESII-B consists of 23 items scored for presence and items are then summed. Each item marked present receives a one point, and items are summed. Total possible score (maximum ethnic self-hatred) is 23. (See Appendix B.)

The EFDT consists of the request for five drawings,

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and essentially is a modified Draw-A-Person test, modified to include the use of colored pencils and the request for ethnic drawings (see Appendix C).

Due to the inability of 49% of the patients to complete the test as instructed, and the refusal of 35% of the psychotics to take the test, the EFDT (see Appendix C) was reviewed qualitatively.

The WBI (Burdock et. al., 1968) consists of 138 items scored for presence or absence, and was used to assess psychopathology. Scores range from zero (no pathology) to 138 (maximum pathology). According to Burdock and Hardesty (1968), the WBI items were constructed so as to reflect overt characteristics of psychopathology in terms of "observable units of behavior....(Characteristics) such as facial expression, grooming, eating, toileting, physical status, habits, cooperativeness, communicativeness, vocalization and speech patterns, interpersonal relations, hostility or aggressiveness, mannerisms, and affect" (p.1). (See Appendix D.)

Procedure

Patients were first asked whether they wished to be called by their first or last names, and given the option of calling the investigator by her first name. Subjects were told by the examiner that she was interested in their "attitudes and ideas about Negro people." Patients were informed at the point of introduction that their participation was optional, and in no way would effect their status in the hospital. Patients were also informed by

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the investigator that their rights to confidentiality would be maintained, and that the examiner would not discuss their responses with staff assigned to them if they chose to have their responses kept confidential.

Data pertaining to demographic characteristics were collected first, and the investigator noted the patients' skin tone, and hair style.

Second, the ESII-A was administered verbally by the investigator, who recorded patients' responses. Patients were given the following instruction: "I am interested in some of your ideas about Negro people. I will read some statements to you. For each statement, tell me how much you agree or disagree with the statement. In other words, tell me whether you strongly agree, agree, are undecided, disagree, or strongly disagree." Those patients verbalizing the desire to read items for themselves were provided a blank ESII-A form. Also, patients were told that if the investigator was reading "too fast" they should "feel free to tell me, 'slow down, you're going too fast'," and that the investigator would re-read any statement they wished. During the instructions for the test, patients were also told that if they didn't understand a particular statement, "it's okay, nobody understands everything." In instances where patients verbalized inability to comprehend a statement, the item was scored as undecided, the neutral point in the scoring system. Finally, at the instruction phase of the interview, patients were also asked whether

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they would be "bothered" if the investigator smoked, and told that if they were smokers, they should "feel free to help yourself to my cigarettes if you like."

Third, the EFDT was administered, and followed by five standard interview questions (Bailey, 1973 p. 69): "What race are you?; What color are you?; What does the word black mean to you?; How would you define Negro? (or, what does the word Negro mean to you?; When and how did you first discover you were a Negro?" (Patients with ethnic and color delusions revealed during the course of the interview were asked this question based upon the ethnic label the patient applied to himself.)

Finally, the investigator asked each patient at the end of the interview if he or she had any questions they wished to ask her: "I don't have any more questions. Is there anything you want to ask me?" Patients asking questions were given answers to any questions asked with the exception of questions concerning their hospitalization, therapist, and other personal information regarding themselves, and/or their condition. All personal questions asked of the investigator about herself, or the research were answered truthfully in language the patient could understand. Upon the conclusion of an interview, the investigator thanked each patient.

Following the conclusion of the actual patient interview, the investigator requested of the staff that they select someone familiar with patients interviewed to rate

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the ESII-B and the WBI. Questions staff had about the researcher and the nature of her research were answered.

The ESII-A was not verbally administered to paraprofessional staff due to the expression by some staff of anxiety and their desire to keep confidential from the investigator some of their attitudes, and personal data (e.g. age). Therefore, each staff member was given an ESII-A form to complete, instructed to provide only their initials, their age, sex, and education (highest grade completed), and to return the form to the examiner either in person, through the Hospital mail, or to place it under her office door.

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RESULTS

All data were coded and keypunched for computer analyses except the *F* tests of significance for eta, which were calculated by hand. Various computer programs were selected from the PSTAT Statistical package. The data were analyzed through the use of factor analyses for the ESII-A, and the ESII-B. Following the factor analyses, an item analyses of these instruments was performed using a program written[1] for the investigator for this purpose, since the PSTAT Statistical package did not contain an item analysis program. The program written for the item analyses was based upon the Borhstedt (1969) method of computing the reliability and validity of multiple item scales.

Interval level variables were analyzed by the use of Pearson Product-Moment correlations, and eta coefficients of correlation where the data were curvilinear. Bi-serial correlations were calculated to analyze nominal level data. Originally, a multiple regression analysis was planned; however, the fact that the data were in part curvilinear precluded such an analysis.

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[1]The item analysis program was written by Mr. George Banks, B.S., Instructor, Department of Computer Science, The City College of the City University of New York.

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The EFDT could not be scored quantitatively for ethnic self-hatred since a substantial number of patients either refused to take the test, and/or to follow instructions. Therefore, these data were reported descriptively in terms of patients' productions and their corresponding spontaneous comments about the test.

The sample of normal paraprofessional black staff were compared to the psychotics through an item by item analysis of responses to the ESII-A, in addition to comparison of the total score for each group on this instrument. Also, the comparison of psychotics and non-psychotics was analyzed for the dimensions of ethnic self-hatred obtained from the factor analysis of the ESII-A for the psychotics. Due to the small sample of normals (N=24), a factor analysis of their responses to the ESII-A could not be computed. These data were analyzed through the use of an analysis of variance of the difference between means.

Qualitative data regarding ethnic self-hatred were obtained and analyzed descriptively from patients' verbatim responses to the ESII-A, the EFDT, the five standard interview questions, and subjects' responses to the interview and the investigator. Also, staff comments regarding the ESII-A and the present study were descriptively analyzed.

Factor Analyses

The ESII-A. The 66 items comprising the ESII-A were intercorrelated and the factor matrix analyzed. The PSTAT

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program selected for the factor analysis was Varimax wherein independence between factors is assumed.

The factor analysis revealed 30 positive roots of which 15 had factor loadings of 0.70 or higher. The computer was instructed to determine the number of significant factors. Six significant factors were found in the final rotation of the matrix. Items loading less than 0.40 were deleted. One item with 0.40 loadings on more than one factor was deleted to maintain independence of factors.

The six significant factors obtained for the ESII-A, their labels, number of items, and reliability coefficients are presented in Table 3. Factor six on the ESII-A was omitted from the correlation analyses since further analyses revealed it to have a relatively low reliability, and it consisted of only two items.

The Items, factors, and their respective factor loadings are presented in Table 4.

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TABLE 3

The ESII-A: Factors, Their Labels, Number of Items, and Reliability Coefficients

Factor	Label	#Items	Reliability Coefficient
I	Physiognomy	13	.90
II	Negative social characteristics	10	.84
III	Blacks are source of prejudice	8	.82
IV	Black is inherently bad	4	.62
V	"Black" a negative term	3	.76
VI	White is beautiful	2	.57

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TABLE 4

The ESII-A: Items, Factors, and Factor Loadings

Item #		Factor	Loading
20	I wish I had light or white skin and could get a nice tan in the summertime.	I	.75
29	Very dark skinned Negroes should marry someone lighter than they are.	I	.67
27	I wish my hair was naturally straight.	I	.60
11	Sometimes I wish I was anything but a Negro.	I	.56
43	I wish my skin was lighter than it is.	I	.55
28	If you have very dark skin or are black, and you marry a white person you will have a pretty baby.	I	.54
22	I would rather not marry a person who has very kinky hair, wide nostrils, and thick lips.	I	.53
38	Nappy or kinky hair is bad unattractive hair and not as pretty as straight hair.	I	.45
18	I wish I were white.	I	.44
60	Blonde or red hair is prettier than brown or black hair.	I	.43
26	I used to be lighter than I am now, but something happened to turn me darker.	I	.43

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TABLE 4 (continued)

Item #		Factor	Loading
9	Negro people would be better off if modern medicine could invent something which would make them change color.	I	.42
49	"If you're white, you're right; if you're brown hang around; but if you're black stay back."	I	.41
52	Negroes will never get ahead because when one is succeeding the others pull him down.	II	.73
17	A great many Negroes become overbearing and disagreeable when given positions of responsibility and authority.	II	.72
65	Whites and Negroes can get along on jobs until too many Negroes try to push themselves in.	II	.57
14	One reason why racial prejudice still exists today is the fact that many Negroes are dirty, loud, and generally offensive in their ways.	II	.56
32	One trouble with Negores is that they are even more jealous of each others success than whites are.	II	.51
16	I would prefer to live in a neighborhood where there are not many Negroes.	II	.50
24	One important reason why Negroes are discriminated against in housing is that they don't keep up the property.	II	.47
3	Too many Negroes when they get a little money spend it all on whiskey, flashy cars, or expensive clothes.	II	.47

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TABLE 4 (continued)

Item #		Factor	Loading
10	Negroes would solve many of their social problems if so many of them were not so irresponsible lazy and ignorant.	II	.44
54	One is almost ashamed to be a Negro when he sees so many of them who look and act like cotton pickers fresh from the fields.	II	.41
31	A large part of the problems facing Negroes today are caused by Negroes themselves.	III	.61
63	It's bad when a group of Negroes get noisy and loud around white people.	III	.58
21	Negroes in this country need a lot more education before the white man gives them equal rights.	III	.54
59	Negro people can hardly be expected to gain social equality until many more of them exert some effort to better themselves and live more decently.	III	.47
42	I would prefer to work for a white person rather than a Negro.	III	.43
39	Small thin lips are more attractive than large thick lips.	III	.40
58	One big reason why racial prejudice is still so strong is that Negroes often offend people by being so sensitive about racial matters.	III	.40
62	Negroes would be better off if they acted more like white people.	III	.40

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TABLE 4 (continued)

Item #		Factor	Loading
19	God made a mistake when he created Negroes.	IV	.56
48	The Negro should aggressively exercise his civil rights.	IV	.50
25	Science will show that Negroes are just as intelligent as whites.	IV	.47
45	Negroes are mean and evil.	IV	.47
46	I prefer to be called black rather than colored or Negro.	V	.73
44	I prefer to be called Negro rather than black.	V	.63
34	When someone calls me black I get angry or become offended, or I am ready to fight.	V	.43
2	Straight pointy noses are more attractive than flat or broad noses.	VI	.47
8	When I get to heaven, I will be white as snow.	VI	.45

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Table 5 presents the sum of squares for each factor and the percentage and cumulative percentage of variance accounted for. Factors I and II account for the highest percentages of variances respectively. The total amount of variance accounted for by these six factors is 36.4%. Since Factor VI was omitted from the correlation analyses, the total amount of variance accounted for by the remaining five factors is 32.6%.

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TABLE 5

ESII-A Factor Sum of Squares and Percentage of Variance

Factor #	Sum of Squares	% of Variance	Cumulative % of Variance
I	5.7717	8.7	8.7
II	5.3953	8.2	16.9
III	4.1487	6.3	23.2
IV	3.3792	5.1	28.3
V	2.8303	4.3	32.6
VI	2.4793	3.8	36.4

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Table 6 reveals that the factors are relatively independent of each other.

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TABLE 6

ESII-A Intercorrelation Matrix of factors

	Intercorrelations				
Factor #	II	III	IV	V	VI
I	-.03	-.07	-.04	.06	.02
II		.23	-.45	-.25	-.30
III			-.28	-.22	-.24
IV				.17	.07
V					.10
VI					

For $p < .05$, r=.30

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The ESII-B. The 23 items constituting the ESII-B were intercorrelated and the factor matrix analyzed. One variable (variable 10) was omitted since it did not occur in any of the 96 cases. The computer was instructed to determine the number of significant roots. Following the rotation of the matrix using the PSTAT Varimax Program which assumes independence between factors, four significant factors were revealed. Items that loaded less than 0.40 were deleted.

Table 7 presents the labels for the four factors, their number of items, and reliability coefficients.

Table 8 presents the items contained in each factor on the ESII-B and the corresponding factor loadings.

Table 9 presents the sum of squares and percentage of variance accounted for by each of the four factors on the ESII-B. Factors III and IV on this instrument were omitted from the correlation analyses since their reliability coefficients were low.

Table 10 presents the intercorrelation matrix of factors on the ESII-B.

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TABLE 7

The ESII-B: Factors, Their Labels, Number of Items, and Reliability Coefficients

Factor	Label	#Items	Reliability Coefficient
I	Color delusions and denial	8	.71
II	Black is bad	6	.59
III	Not clear	3	.36
IV	Hair	3	.28

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TABLE 8

The ESII-B: Items, Factors, and Factor Loadings

Item#		Factor	Loading
3	Patient incorrectly labels whites and/ or blacks (e.g. calls whites black, or anything other than white or caucasian, and calls blacks anything other than black, Negro, colored or Afro-American)	I	.70
12	Patient has delusion that he is related to a famous white person or famous person of another race.	I	.67
13	Patient has or has previously had delusion of being white, pink, or something other than a member of the black ethnic group (i.e., purple, pink, French, Indian.) Include here, denial of membership in any race and/ or rationalizations regarding skin color and membership in the black ethnic group.	I	.67
11	Patient will not speak to other blacks and/or is unfriendly to other blacks, and/or derrogates blacks.	I	.64
22	Patient has delusion that his relatives are white or something other than black (e.g., Indian, red, "red niggers", pink, French).	I	.60
14	Patient has delusion about his last name giving a fictitious ethnic last name (e.g., a Jewish, Italian or Spanish name, and/or claims that his last name should be pronounced with a special accent because he belongs to a special ethnic group or nationality e.g., "I am French, so my name should be pronounced Jacksōne not Jackson.").	I	.57

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TABLE 8 (continued)

Item #		Factor	Loading
20	Patient makes jokes about his color or race (e.g., "I'm just a dark skinned white person.").	I	.51
1	Patient has delusion that something happened to or is happening to his skin, resulting in his skin turning darker (e.g., blames medication, food, people with extraordinary powers, weather conditions, etc.).	I	.45
17	Patient makes negative references to Negroid features.	II	.73
5	Patient makes negative verbal references to black being ugly, sinful, bad, etc., and/or states that black, Negro, colored, or Afro-American people are ugly, sinful, bad, evil, etc., and/or states that his blackness is bad.	II	.71
23	Patient has and/or talks about wanting to have a white mate or dating partner.	II	.56
8	Patient becomes aggressive and/or angry or offended when called black.	II	.47
15	Patient has delusion he or she has a white mate or a mate who is something other than black and/or believes his children are not black.	II	.44
2	Patient is preoccupied with telling whites and blacks that they should intermarry and/or applies this idea to himself.	II	.43
18	Patient is preoccupied with derogating blackpolitical leaders and/or organizations.	III	.69

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TABLE 8 (continued)

Item #		Factor	Loading
19	Patient complains about getting sun-burned and/or suntanned.	III	.56
4	Patient is preoccupied with cleanliness and/or is afraid of getting dirty (e.g., patient takes an excessive number of showers per day or washes some part of his body repeatedly and/or is always cleaning self or objects in his environment.).	III	.41
9	Patient with nappy kinky hair does not comb or wash hair and/or keeps it covered (i.e., with hat, rag, scarf, towel, wig).	IV	.56
7	Patient with nappy kinky hair (hair that is not naturally straight) wears straight hair style, e.g. straightens hair with hot comb, uses chemical hair relaxer, wears straight wig, or process, or slinks hair down with greasy hair dressing. Include here, patients who change hair style, i.e., one day wears afro, next day wears straight style. Also, include here, patients who wear afro or cornroll hair style only because they, while in the hospital,cannot get hair straightened or relaxed.	IV	.48
16	Patient complains about getting his hair wet and/or makes references to his hair "going back." Include negative references to nappy or kinky hair, and/or persons with nappy kinky hair.	IV	.48

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TABLE 9

ESII-B Factor Sum of Squares and Percentage of Variance

Factor #	Sum of Squares	% of Variance	Cumulative % of Variance
I	3.4756	15.8	15.8
II	2.6857	12.2	28.0
III	1.7006	7.7	35.7
IV	1.2198	5.5	41.3

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TABLE 10

ESII-B Intercorrelation Matrix of Factors

	Intercorrelations		
Factor #	II	III	IV
I	-0.02	-0.11	-0.46
II		-0.16	-0.33
III			-0.10
IV			

For $p < .05$, $r = 0.43$

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Psychopathology: The Dependent Variable

Psychopathology was measured by the WBI. Scores ranged from a low of two to a high of 92 out of a total possible score of 138. The higher the score the more psychopathology present. The sample $\overline{X}$ was 27.9 and the S.D. 17.63; the median was 25.

Ethnic Self-Hatred: The Independent Variable

Ethnic self-hatred was measured by the ESII-A and the ESII-B. While correlation analyses will not determine causality, it is necessary for conceptualization and theory construction to specify independent and dependent variables.

The ESII-A: Psychotics' Distribution for Total Score The psychotics' distribution of total scores, and factor scores is presented in Table 11 in terms of measures of central tendency and variability.

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TABLE 11

Measures of Central Tendency and Variability for ESII-A Total Score and Factor Score

ESII-A	Range	Mean	S.D.	Median
Total Score	67-176	129.2	25.58	130.0
Factor I	9-42	23.3	8.24	21.5
Factor II	6-36	23.0	6.14	23.5
Factor III	8-31	19.0	4.73	19.0
Factor IV	0-13	6.0	2.55	5.0
Factor V	1-12	6.1	2.51	6.0

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The Bronx State Hospital patients had a $\bar{X}$ total score of 127 on the ESII-A; while, the Manhattan State Hospital patients had a $\bar{X}$ of 132. An analysis of Variance of the Difference between $\bar{X}$ scores revealed no significant difference. ($F = 0.86$, d.f. = 1.94, $p = 0.355$).

The ESII-B: Psychotics' Distribution for Total Score The patients' total scores ranged on the ESII-B from a low of zero to a high of 15 out of a total possible score of 23. Fifty-eight percent (n=56) of the patients were rated as having at most one such behavioral sign (scores of 0-1); The $\bar{X}$ was 2.9 and the S.D. 3.07.

Bronx State Hospital patients had a $\bar{X}$ total score of 2.9; while Manhattan State Hospital patients had a $\bar{X}$ score of 1.9. An analysis of Variance of the Difference between $\bar{X}$'s showed there was no significant difference ($F = 1.42$, d.f. = 1.94, $p = 0.236$).

The ESII-B: Factor Scores. The range of scores on Factor I of the ESII-B were from a low of zero to a high of six out of a total possible score of eight. On Factor I of the ESII-B, 61.5% (n=59) of the patients were rated as having no symptoms; while, 38.5% (n=37) of the psychotics scored one to six. The $\bar{X}$ score was 0.96 and the S.D. 1.48.

On Factor II, the range of scores was from a low of zero to a high of four out of a total possible score of six. Seventy-seven patients (80.2%) had no symptoms; 19 patients (19.8%) scored one to four. The $\bar{X}$ was 0.31 and the S.D.=

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0.76.

Correlation Analyses for Psychopathology

Nominal Variables. Nominal level variables were analyzed through the use of bi-serial correlation. Correlations for demographic Variables and psychopathology are presented in Table 12.

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TABLE 12

Correlations[a] for Demographic Variables and Psychopathology

Variable	r
Sex	
Male	0.15
Female	-0.15
Religion	
Protestant	-0.13
Catholic	0.08
Muslim	0.06
Other	0.00
Unknown	0.13
Marital Status	
Single	0.20
Married	-0.09
Separated	-0.35[b]
Widowed	0.07
Divorced	-0.10
Unknown	0.19
Place of Birth	
North	0.15
South	-0.35[b]
Other U.S.	0.14
Canada	0.31[b]
West Indies	0.23[b]
Age	-0.37[b]
Education	-0.01

[a]Note.--Bi-serial correlations were used for all variables except age and education which are continuous variables for which Pearson Product Moment correlations were calculated.

[b] $p < .05$.

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Among the significant correlations for demographic variables at the .05 level of probability were: marital status (separated); place of birth (South, Canada, West Indies); age. Because of the large number of correlations any interpretation must be made with caution. In addition, some of the nominal variables are not independent.

Correlations of Behavioral, Physical Characteristics and, Interview Data. Correlations of behavioral manifestations of ethnic self-hatred, as measured by the ESII-B, physical characteristics, and responses to the five standard interview questions were analyzed and appear in Table 13.

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TABLE 13

Correlations of Behavioral Manifestations of Ethnic Self-Hatred, Physical Characteristics, and Interview Data and Psychopathology

Variable	r
Color delusion and denial[a] (ESII-B)	0.49[b]
Black is bad[a] (ESII-B)	0.45[b]
Diagnosis of Paranoid Schizophrenic	0.24[b]
Hair Style	
Afro	0.18
Straightened	0.04
Naturally Straight	-0.26[b]
Short Crop	-0.10
Straight Wig	-0.18
Straight Blonde or Red Wig	-0.18
Dyes Hair red or blonde	-0.05
Skin Color (Dark, Medium, Fair)[a]	0.11
"What race are you?"	
Labels self black	0.04
"What color are you?"	
Labels self black	0.04
Definition of Word Black	
Positive Meaning	0.42
Negative Meaning	-0.30[b]
A Color	-0.00
Unclear Meaning	-0.08
Denial of Question	-0.14
Awareness of Semantic Meaning of Word "Negro"	-0.05
Discovery of Blackness (When?)	
Childhood	0.02
Adulthood	-0.18
Don't Remember	0.10

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TABLE 13 (continued)

Variable	r
Discovery of Blackness (How?)	
From Parent	0.04
From School	-0.22[b]
From Physiognomy	0.10
From Black Muslims	0.17
From Racist Whites	-0.05
From Blacks with Black Pride	-0.14
Other	-0.11
Don't Remember	0.06
Discovery of Blackness (Traumatic?)	
Non-traumatic	0.38[b]
Traumatic	0.08
Unclear	-0.13
Presence of Ethnic or Color Delusion	0.12

[a]Pearson Product Moment correlations were calculated for these variables. All other variables are nominal and bi-serial correlations were calculated.

[b] $p < .05$,

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Because of the large number of correlations in Table 13, any interpretation must be made with caution. The variables that had significant correlations at the .05 level of probability were: color delusion and denial; black is bad; diagnosis of Paranoid Schizophrenic; hair style (naturally straight); definition of the word black (positive meaning, negative meaning); discovery of blackness, how? (from school); discovery of blackness, traumatic? (non-traumatic).

Forty-eight percent of the psychotics wore their hair in afros, and they had the highest $\bar{X}$ psychopathology score when compared to other patients with various other hairstyles. The $\bar{X}$ psychopathology score for patients who wore afros was 36.4. However, an Analysis of Variance of the difference between $\bar{X}$ psychopathology scores by hairstyle showed that there was no significant difference between $\bar{X}$ scores for psychopathology by hairstyle (F = 0.81, d.f. = 5, 90, p = 0.58).

Income as a variable was omitted from the correlation analyses since there was virtually no variation among patients who were all lower class, lower middle class, or recipients of public assistance, or Social Security Disability.

Table 14 presents the Pearson Product Moment intercorrelation matrix of factor scores on the ESII-A, and the ESII-B. Inspection of Table 14 reveals low to moderate

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intercorrelations among the factors within the ESII-A. The two ESII-B factors were also correlated.

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TABLE 14

Pearson Product Moment Intercorrelation Matrix of Factor Scores on the ESII-A and the ESII-B

	ESII-A				ESII-B	
Factor	II	III	IV	V	I	II
(ESII-A) I	0.31	0.46	0.47	0.38	0.21	0.21
(ESII-A) II		0.45	0.11	0.14	0.07	0.20
(ESII-A) III			0.22	0.17	-0.03	0.03
(ESII-A) IV				0.30	0.18	0.11
(ESII-A) V					0.08	0.08
(ESII-B) I						0.66
(ESII-B) II						

For $p < .05$, $r = .21$

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Curvilinear Relationships. Non-linear data were analyzed through the use of eta correlation ratios. The independent variables analyzed were the factors on the ESII-A and the ESII-B in relation to their effectiveness in predicting psychopathology.

Table 15 presents the correlation ratios of eta for the ESII-A and the ESII-B factor scores and psychopathology and the *F* tests of significance to eta. Psychopathology was the dependent variable in the analyses, while the factors comprising the ESII-A and the ESII-B were the independent or predictor variables.

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TABLE 15

Correlation Ratios (eta), F, d.f., p, the ESII-A and the ESII-B Factor Scores and Psychopathology

Instrument & Factor	Eta	F	d.f.	p
ESII-A Physiognomy	0.54	0.99	27, 67	0.20
ESII-A Negative social characteristics	0.57	1.41	24, 70	0.10
ESII-A Blacks are source of prejudice	0.63	3.336	15, 79	<0.005
ESII-A Black is inherently bad	0.50	2.206	12, 82	0.025
ESII-A "Black" a negative term	0.55	3.433	10, 84	<0.005
ESII-B Color delusions and denial	0.83	25.40	5, 89	<0.005
ESII-B Hair	0.85	86.06	2, 92	<0.005

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The *F* tests of eta for Factors I and II on the ESII-A were nonsignificant. The Pearson Product Moment correlations for factors on the ESII-A were all non-significant, for Factors I, II, III, IV, and V as follows respectively: *r* = 0.0; -0.03; -0.14; -0.01; -0.11.

The psychopathology raw score ranges and the percentages of patients receiving relatively low, moderate, and high psychopathology scores are presented in Tables 16, 17, 18, 19, and 20 in regard to corresponding ranges of ethnic self-hatred raw score ranges for Factors III, IV, and V on the ESII-A, and Factors I and II on the ESII-B.

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TABLE 16

The ESII-A, Factor III: Psychopathology Score Ranges and Corresponding Percentages of Ethnic Self-Hatred for Psychotics

Psychopathology Score Range[a]	Ethnic Self-Hatred Score Range[b]					
	High 24-31	Moderately High 19-23	Moderate 14-18	Moderately Low 10-13	Low 5-9	None 0
(High) 46-92	3(3%)	7(7%)	4(4%)	3(3%)	0	0
(Moderately High) 28-45	5(5%)	6(6%)	10(10%)	2(2%)	2(2%)	0
(Moderate) 19-27	4(4%)	4(4%)	9(9%)	3(3%)	1(1%)	0
(Moderately Low) 10-18	7(7%)	8(8%)	5(5%)	2(2%)	0	0
(Low) 9-2	0	5(5%)	5(5%)	1(1%)	0	0
(None) 0	0	0	0	0	0	0

[a]Note.--Psychopathology score ranges were delineated according to standard deviations. Sample S.D.=18, $\overline{X}$=28.

[b]Note.--Ethnic Self-Hatred score ranges were delineated according to standard deviations. Sample S.D.=4.73, $\overline{X}$=19.

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TABLE 17

The ESII-A, Factor IV: Psychopathology Score Ranges and Corresponding Percentages of Ethnic Self-Hatred for Psychotics

Psychopathology Score Range[a]	Ethnic Self-Hatred Score Range[b]					
	High 10-13	Moderately High 8-9	Moderate 5-7	Moderately Low 3-4	Low 1	None 0
(High) 46-92	2(2%)	2(2%)	9(9%)	2(2%)	2(2%)	0
(Moderately High) 28-45	2(2%)	5(5%)	4(4%)	14(15%)	0	0
(Moderate) 19-27	0	4(4%)	7(7%)	8(8%)	1(1%)	1(1%)
(Moderately Low) 10-18	1(1%)	7(7%)	9(9%)	3(3%)	1(1%)	1(1%)
(Low) 9-2	1(1%)	3(3%)	1(1%)	6(6%)	0	0
(None) 0	0	0	0	0	0	0

[a]Note.--Psychopathology score ranges were delineated according to standard deviations. Sample S.D.=18, $\bar{X}$=28.

[b]Note.--Ethnic Self-Hatred score ranges were delineated according to standard deviations. Sample S.D.=2.55, $\bar{X}$=6.

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TABLE 18

The ESII-A, Factor V: Psychopathology Score Ranges and Corresponding Percentages of Ethnic Self-Hatred for Psychotics

Psychopathology Score Range[a]	Ethnic Self-Hatred Score Range[b]					
	High 10-12	Moderately High 8-9	Moderate 5-7	Moderately Low 2-4	Low 1	None 0
(High) 46-92	0	4(4%)	6(6%)	7(7%)	0	0
(Moderately High) 28-45	4(4%)	4(4%)	14(15%)	3(3%)	0	0
(Moderate) 19-27	1(1%)	3(3%)	9(9%)	7(7%)	1(1%)	0
(Moderately Low) 10-18	2(2%)	6(6%)	10(10%)	4(4%)	0	0
(Low) 9-2	0	4(4%)	5(5%)	2(2%)	0	0
(None) 0	0	0	0	0	0	0

[a]Note.--Psychopathology score ranges were delineated according to standard deviations. Sample S.D.=18, $\overline{X}$=28.

[b]Note.--Ethnic Self-Hatred score ranges were delineated according to standard deviations. Sample S.D.=2.51, $\overline{X}$=6.

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TABLE 19

The ESII-B, Factor I: Psychopathology Score Ranges and Corresponding Percentages of Ethnic Self-Hatred for Psychotics

Psychopathology Score Range[a]	Ethnic Self-Hatred Score Range[b]			
	High 3-6	Moderate 2	Low 1	None 0
(High) 46-92	9(9%)	1(1%)	4(4%)	4(4%)
(Moderately High) 28-45	7(7%)	2(2%)	2(2%)	14(15%)
(Moderate) 19-27	1(1%)	1(1%)	3(3%)	16(17%)
(Moderately Low) 10-18	2(2%)	0	4(4%)	15(16%)
(Low) 9-2	1(1%)	0	1(1%)	9(9%)
(None) 0	0	0	0	0

[a]Note.--Psychopathology score ranges were delineated according to standard deviations. Sample S.D.=18, $\overline{X}$=28.

[b]Note.--Ethnic Self-Hatred score ranges were delineated according to standard deviations. Sample S.D.=1.48, $\overline{X}$=.96.

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TABLE 20

The ESII-B, Factor II: Psychopathology Score Ranges and Corresponding Percentages of Ethnic Self-Hatred for Psychotics

Psychopathology Score Range[a]	Ethnic Self-Hatred Score Range[b]			
	High 4	Moderate 2	Low 1	None 0
(High) 46-92	2(2%)	3(3%)	5(5%)	7(7%)
(Moderately High) 28-45	0	1(1%)	5(5%)	19(20%)
(Moderate) 19-27	0	0	2(2%)	19(20%)
(Moderately Low) 10-18	0	0	0	22(23%)
(Low) 9-2	0	1(1%)	0	10(10%)
(None) 0	0	0	0	0

[a]Note.--Psychopathology score ranges were delineated according to standard deviations. Sample S.D.=18, $\overline{X}$=28.

[b]Note.--Ethnic Self-Hatred score ranges were delineated according to standard deviations. Sample S.D.=.76, $\overline{X}$=.31.

For Factor III (ESII-A), examination of Table 16 reveals that moderate to high ethnic self-hatred scores predicted moderate to high psychopathology scores for 52 (54%) of the cases in the sample; moderately low ethnic self-hatred scores predicted moderately low psychopathology scores for three (three percent) of the cases; moderate to moderately high ethnic self-hatred scores predicted low to moderately low psychopathology scores for 30 (31%) of the sample cases; low to moderately low ethnic self-hatred scores predicted moderate to high psychopathology scores for 11 (11%) of the sample.

In regard to Factor IV (ESII-A), examination of Table 17 shows that moderate to high ethnic self-hatred scores predicted moderate to high psychopathology scores for 35 (36%) of the cases; zero to moderately low ethnic self-hatred scores predicted low to moderately low psychopathology scores for 11 (11%) of the sample; moderate to high ethnic self-hatred scores predicted low to moderately low psychopathology scores for 22 (23%) of the cases; zero to moderately low ethnic self-hatred scores predicted moderate to high psychopathology scores for 28 (29%) of the sample.

For Factor V (ESII-A), examination of Table 18 reveals that moderate to high ethnic self-hatred scores predicted moderate to high psychopathology scores for 45 (47%) of the sample; moderately low ethnic self-hatred scores predicted low to moderately low psychopathology scores for

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six (six percent) of the cases; moderate to high ethnic self-hatred scores predicted low to moderately low psychopathology scores for 27 (28%) of the sample; zero to moderately low ethnic self-hatred scores predicted moderate to high psychopathology scores for 18 (19%) of the cases.

In regard to Factor I (ESII-B), inspection of Table 19 reveals that moderate to high ethnic self-hatred scores predicted moderate to high psychopathology scores for 21 (22%) of the sample; zero to low ethnic self-hatred scores predicted low to moderately low psychopathology scores for 29 (30%) of the cases; zero to low ethnic self-hatred scores predicted moderate to high psychopathology scores for 43 (45%) of the sample; high ethnic self-hatred scores predicted low to moderately low psychopatholgy scores for three (three percent) of the sample.

For Factor II (ESII-B), examination of Table 20 shows that moderate to high ethnic self-hatred scores predicted moderate to high psychopathology scores for six (six percent) of the sample; zero to low ethnic self-hatred scores predicted low to moderately low psychopathology scores for 32 (33%) of the cases; moderate ethnic self-hatred scores predicted low psychopathology for one (one percent) case; zero to low ethnic self-hatred scores predicted moderate to high psychopathology scores for 57 (59%) of the sample.

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Correlation Analyses for Ethnic Self-Hatred

Pearson Product Moment correlations for demographic variables and ethnic self-hatred as measured by the ESII-A and the ESII-B are presented in Table 21. Pearson Product Moment correlations for physical characteristics, interview data and ethnic self-hatred as measured by the ESII-A and the ESII-B are presented in Table 22.

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TABLE 21

Pearson Product Moment Correlations for Demographic Variables and Ethnic Self-Hatred

Variable	r (ESII-A Total Score)	r (ESII-B Total Score)
Sex		
Male	-0.05	-0.12
Female	0.05	0.12
Religion		
Protestant	0.09	-0.06
Catholic	-0.01	0.03
Muslim	-0.22	0.04
Other	-0.04	0.01
Unknown	0.03	0.03
Marital Status		
Single	-0.07	0.12
Married	0.13	0.01
Separated	0.08	-0.12
Widowed	-0.12	-0.04
Divorced	-0.10	-0.09
Unknown	0.05	0.01
Place of Birth		
North	0.03	0.14
South	0.04	-0.11
Other U.S.	0.04	-0.11
Canada	-0.02	0.13
West Indies	-0.17	-0.04
Age	0.13	-0.23
Education	0.06	0.10

For $p < .05$, $r = .21$

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TABLE 22

Pearson Product Moment Correlations for Physical Characteristics, Interview Data and Ethnic Self-Hatred

Variable	r (ESII-A Total Score)	r (ESII-B Total Score)
Diagnosis of Paranoid Schizophrenic	-0.11	0.26
Hair Style		
Afro	0.04	0.04
Straightened	0.08	0.14
Naturally Straight	-0.09	-0.14
Short Crop	-0.06	-0.16
Straight Wig	-0.00	-0.06
Straight Blonde or Red Wig	-0.15	0.06
Dyes Hair red or blonde	-0.15	0.06
Skin Color (Dark, Medium, Fair)	0.17	0.06
"What Race are You?"		
Labels Self black	0.32	-0.04
"What Color are You?"		
Labels self black	0.11	0.17
Definition of Word "Black"		
Positive Meaning	-0.19	0.24
Negative Meaning	0.09	-0.06
A color	-0.01	-0.08
Unclear Meaning	0.05	-0.02
Denial of Question	0.11	-0.09
Awareness of Semantic Meaning of Word "Negro"	0.06	-0.19

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TABLE 22 (continued)

Variable	r (ESII-A Total Score)	r (ESII-B Total Score)
Discovery of Blackness (When?)		
Childhood	0.04	-0.03
Adulthood	-0.05	0.05
Don't Remember	-0.02	-0.01
Discovery of Blackness (How?)		
From Parent	-0.05	-0.06
From School	0.05	-0.10
From Physiognomy	0.06	0.23
From Black Muslims	-0.06	0.01
From Racist Whites	0.01	0.13
From Blacks with Black Pride	0.06	-0.20
Don't Remember	-0.07	0.05
Discovery of Blackness (Traumatic?)		
Non-traumatic	-0.08	-0.06
Traumatic	0.03	0.19
Unclear	-0.01	-0.17
Presence of Ethnic or Color Delusion	0.22	0.22

For $p < .05$, $r = .21$

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The only significant correlation between ethnic self-hatred and demographic variables at the .05 level of probability for the ESII-A was religion (Muslim).

There was only one significant correlation at the .05 level of probability for the ESII-B, age.

The Pearson Product Moment Correlation for ethnic self-hatred, physical characteristics, and interview data revealed two significant correlations at the .05 level of probability, for the ESII-A as follows: "What race are you?" (Labels self black), and presence of ethnic or color delusions.

The significant correlations for ethnic self-hatred, physical characteristics, and interview data for the ESII-B were: diagnosis of Paranoid Schizophrenia, positive meaning of the word black, discovery of blackness from physiognomy, and presence of ethnic delusion.

Because of the large number of correlations any interpretation must be made with caution. In addition, some of the nominal variables are not independent.

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The ESII-A: Comparison of Psychotics and Non-Pyschotics

A one tail *F* test of the difference between psychotics' and non-psychotics' $\bar{X}$ responses to items on the ESII-A was performed as a measure of how well individual ESII-A items discriminated between psychotics and non-psychotics. The $\bar{X}$ total scores were also compared, as were the $\bar{X}$ factor scores for the ESII-A, which were derived from the five factors obtained in the factor analysis of the ESII-A for psychotics.

Results of an item by item analysis of the difference between psychotics' and non-psychotics' $\bar{X}$ scores showed that all but 12 items clearly differentiated between psychotics and non-psychotics in the predicted direction that psychotics would have significantly higher $\bar{X}$ ESII-A factor scores than non-psychotics. Comparison of the total $\bar{X}$ scores for psychotics and non-psychotics on the ESII-A similarly was significant in the predicted direction. (See Appendix E for *F* tests results for all items factor scores, and total scores).

The EFDT

The EFDT was not scored quantitatively for ethnic self-hatred as planned since only 15 (16%) of the patients followed instructions accurately. On the other hand, 47 (49%) attempted the test, but did not follow instructions accurately, while, 34 patients (35%) refused to take the

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test and/or did not complete it.

Inaccurate following of instructions was characterized chiefly by the refusal to use colored pencils in terms of hair, eye, and skin color. Other types of inability to follow instructions were refusal to draw requested figures, and the subsequent drawing of other objects, e.g. cars, houses, or schizophrenic type scribbling.

The EFDT was useful in eliciting color and ethnic delusions among some patients, and in eliciting associations regarding ethnicity. For instance, one female when asked to "draw a person," stated while drawing: "I started to draw my mother. She's a Cherokee Indian." One 37 year old dark skinned woman, asked to draw herself exactly as she looked (request 2), drew a picture of Veronica Lake and stated, "Here I am. Miss Veronica Lake. Tycoon." Asked to draw herself as she would like to look if she could change her appearance (request 3) this patient stated: "I wouldn't want to change the way I look! If you looked like Veronica Lake would you want to change the way you looked?!"

The types of drawings elicited for each request on the EFDT irrespective of whether the patient completed the entire test or followed instructions accurately are presented in Table 23 in terms of type of drawing and characteristics of the drawings, as well as the percentages for each figure.

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TABLE 23

The EFDT: Types of Figures for Requests 1, 2, 3, 4, 5, and Corresponding Percentages of Subjects

Type of Figure / Request	1 (A Person) N=71	2 (Self) N=66	3 (Ideal Self) N=55	4 (A White) N=60	5 (A Negro) N=60
Scribbling or other object	0	1(1%)	0	0	1(1%)
Complete	17(23%)	10(15%)	10(18%)	9(15%)	2(3%)
Incomplete	54(76%)	55(83%)	45(81%)	51(85%)	57(95%)
Profile	24(33%)	16(24%)	15(27%)	18(30%)	17(28%)
Use of white pencil	2(2%)	0	3(5%)	7(11%)	2(3%)
Use of charcoal black penicil	0	1(1%)	1(1%)	1(1%)	3(5%)
Exaggeration of hair and/or blonde or red hair	38(53%)	39(59%)	37(67%)	40(66%)	33(55%)

TABLE 23 (continued)

Type of Figure	Request 1 (A Person) N=71	2 (Self) N=66	3 (Ideal Self) N=55	4 (A White) N=60	5 (A Negro) N=60
Scanty hair	5(7%)	8(12%)	2(3%)	1(1%)	14(23%)
Exaggerated nose and/or mouth	23(32%)	16(24%)	17(30%)	16(26%)	18(30%)
Other than Negroid, including lack of any color	47(66%)	50(75%)	39(70%)	17(28%)	41(68%)
Obviously Negroid	1(1%)	11(16%)	3(5%)	1(1%)	18(30%)
Blue or light eyes	20(28%)	12(18%)	14(25%)	17(28%)	7(11%)
Obviously white	23(32%)	5(7%)	13(23%)	42(70%)	1(1%)

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Asked to draw a person, three patients stated they could not draw a person, while 10 of the psychotics stated they could not draw figures representing themselves. Thirteen patients replied when asked to draw their ideal selves that they could not draw such a figure; while 10 patients could not draw a white person, and eight stated they could not draw a Negro person.

Two patients wrote or verbalized their wish to look like the investigator for request 3 ("Draw yourself as you would like to look if you could change your appearance."); and, four wrote or verbalized their desire to look like the investigator when requested to "draw a Negro."

Two patients stated in response to request one ("Draw a person.") that their production was representative of some well known white person. Similarly, for requests 2, 3, 4, and 5, two, one, two, seven, and two patients respectively stated their productions were representative of some well known white person, or white staff member on their ward whom they admired.

Two patients responded that their productions on request 1 ("Draw a person.") looked "bad"; while, six, three, one and one replied that their drawings "look bad" in response to requests 2, 3, 4, and 5 respectively.

Patients' Spontaneous Comments

Sixty-two (65%) of the patients spontaneously commented

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to questions on the ESII-A, at times giving their reasons for responses, and at other times verbalizing associations.

The comments revealed itense feelings underlying ethnic identity which in many cases had never been verbalized. Several of the heart-rending memories concerning the discovery of blackness and other associations are presented in Appendix F.

Types of Ethnic and Color Delusions Found

Thirty patients were found to have ethnic and/or color detlusions. These delusions were delusions of being "white, Spanish, Black American Indian, Blackfoot Indian, Indian, Cherokee Indian, Egyptian, mixed, a Chinese-Jewish-Cherokee person with some black, a dark skinned white man, who is part Irish, Italian, Indian and German;" delusions of having naturally straight hair, a delusion of having long, blond straight hair, delusions of having relatives who were other than black; delusions that bathing with the right type of soap and staying out of the sun would cause the skin to return to its previous white color, and delusions that something happened to turn one's skin darker than it was previously.

Patients generally tended to utilize rationalization and projection in explaining what had happened to them and/or why their skin color and their hair texture were

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were Negroid-looking. The most common explanation for not having white skin was that the sun had burned the skin, or that "I just stayed out in the sun too long and have a suntan." Patients also tended to explain the lack of white skin by projecting that certain medications and food had caused them to change color, and that if they did not take these medicines and ate properly, their skin would return to being white. Similar explanations were given as to why the hair was kinky or nappy and not in its true straight form.

Reactions of Staff to the Present Study

Staff reactions to the present study varied from positive responses and expression of attitudes that "it's about time somebody black studied this problem," to passive acceptance or tolerance of the study and the investigator, to overt expressions of anger, hostility, resistance, and on two known occasions attempts to put a stop to the research. The range of reactions to the research were true of both black and white staff irrespective of staff members' status position.

Favorable reactions frequently took the form of spontaneously gathering information or materials (i.e. books, articles, newspaper clippings) for the investigator, to intra and extra Hospital communication. Consequently,

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the investigator was invited to guest lecture at various places. Prior to periodical abstraction of the Journal of the Bronx State Hospital where the author's pilot study was published, word of mouth communication was also responsible for requests for copies of the investigator's pilot-study publication from varying parts of the country. Following the periodical abstraction of the Journal of the Bronx State Hospital, the investigator began to receive international requests for reprints of the pilot publication.

In instances of negative reactions to the research, both black and white staff were extremely instrumental in assisting the investigator to circumvent the resistance.

A Serendipitous Finding: Ethnic Self-Hatred and the Effect of the Structured Interview

A serendipitous finding was revealed by the effect of the structured interview upon 37 patients with ethnic self-hatred as it was operationally defined: (1) Sixteen patients with ethnic and color delusions that were previously fixed delusions vascillated in their delusions during the interview or admitted membership in the black ethnic group during the interview; (2) Twenty-one patients began to work out some of their conflicts with respect to ethnic self-hatred during the interview, at times verbalizing their realization that a major problem in their illnesses was

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the fact of their ethnicity.

An example of the effect of the structured interview is demonstrated in the illustration of the patient who believed she was Veronica Lake, and that she looked like Veronica Lake. This particular patient at the beginning of the interview when asked whether she preferred to be called by her first or last name, instructed the investigator to call her, "Miss Veronica Lake."

As the interview progressed with the administration of the ESII-A, it became apparent that the patient had multiple ethnic and color delusions, including the belief that she was white, and that the sun had somehow turned her dark brown in complexion, making her skin color that of "society brown."

During the administration of the EFDT, when asked to "draw yourself exactly as you look," this patient drew an artistically near-perfect production of Veronica Lake. Asked to "draw yourself as you would like to look if you could change your appearance," this patient looked at the examiner in amazement and replied, "If you looked like Veronica Lake would you want to change your appearance?"

By the time the interview had progressed to the five standard interview questions, this patient was able to admit to being "colored" when asked, "What race are you?"

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Asked, when and how she discovered she was "colored" she replied: "When I was a baby -- knew I was colored. Looked in mirror and saw had kinky, nappy hair that had to be straightened every month by a good beautician."

Finally, she was able to verbalize her membership in the black ethnic group:

> I have white and Indian in me, but have more colored. Want my race to be better so I can be proud of them.

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DISCUSSION

The crucial conceptual and empirical problem investigated by the present study was the extent to which ethnic self-hatred in hospitalized black psychotics could be viewed as an important independent variable in the psychopathology exhibited by this group. The roles of other relevant variables were also explored in terms of their relationship to the psychopathology exhibited by psychotic blacks.

Further, the roles of relevant demographic and other variables were examined in regard to ethnic self-hatred. A small sample of non-psychotic black paraprofessionals were compared to the psychotic sample as a mode of explicating the role of ethnic self-hatred among blacks in general, and psychotic blacks in particular.

In addition, the refinement of two major instruments developed by the author (Bailey, 1973), the ESII-A and the ESII-B was a focal point of the present study.

Summary of Major Findings

The Hypothesis. The hypothesis tested in this study was, in part, confirmed by the significant relationship between the degree of psychopathology, and the degree of ethnic self-hatred as measured by the ESII-B.

The ESII-B, as a measure of ethnic self-hatred, was

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also effective in predicting psychopathology at significant levels for the curvilinear aspect of the relationship between ethnic self-hatred and psychopathology. However, the exact curvilinear relationship was complex, and the shape of the curve vis-a-vis predicting psychopathology from ethnic self-hatred was unclear.

The hypothesis was not confirmed vis-a-vis the ESII-A in terms of the degree of psychopathology being directly related to the degree of ethnic self-hatred. However, there were significant curvilinear relationships between psychopathology and ethnic self-hatred as measured by three of the five ESII-A factors. Thus, three ESII-A factors were significantly effective in predicting psychopathology. However, the exact curvilinear relationship was complex, and the shape of the curve vis-a-vis predicting psychopathology from ethnic self-hatred was unclear.

<u>Reliability and Validity of the ESII-A and the ESII-B.</u> Results indicated that the ESII-A and the ESII-B were reliable instruments in regard to the obtained reliability coefficients where internal consistency of items was calculated by item analysis. Both instruments had construct validity, reflected in the factor analyses of the instruments. Also, the obtained eta ratios of correlation for three factors on the ESII-A, and for two factors on the ESII-B, in relation to predicting psychopathology, revealed criterion validity such that ESII-A Factors III, IV, V, and ESII-B Factors I and II

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as measures of ethnic self-hatred significantly predicted psychopathology.

Qualitative Analyses of the ESII-A, the ESII-B, the EFDT, and Interview Questions. Qualitative analyses of the patints' responses to the ESII-A, the ESII-B, the EFDT, and interview questions revealed that they were effective in eliciting relevant data pertaining to the genesis of ethnic self-hatred, its structural components, and the provision of empirical documentation of the nature and role of ethnic self-hatred in the symptom-complex of mentally ill blacks.

Comparison of Psychotics' and Non-Psychotics' Responses. Comparison of psychotics' and non-psychotic paraprofessionals' responses to the ESII-A revealed highly significant differences between the two groups in the predicted direction, providing further support for the proposition that ethnic self-hatred is a crucial variable in the psychopathology exhibited by black psychotics. Non-psychotics, however, did manifest some ethnic self-hatred on the ESII-A.

Significant Correlations Between Psychopathology and Ethnic Self-Hatred. There were significant relationships between psychopathology and place of birth such that southern born blacks exhibited less psychopathology than other groups. Another significant correlation was definition of the word black in a positive manner such that patients assigning a positive meaning to the word black

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displayed more psychopathology. Conversely,patients defining the word black negatively exhibited less psychopathology.

Age was inversely related to pathology such that younger patients were sicker than older patients. Another major correlation was that Paranoid Schizophrenics exhibited more psychpathology that others.

Patients possessing naturally straight hair had less psychopathology than others. There was a significant inverse correlation between discovery of blackness at school and psychopathology.

Significant Correlations Between Ethnic Self-Hatred, Demographic Variables, Physical Characteristics, and Interview Data. The only significant correlation between ethnic self-hatred as measured by the ESII-A and demographic variables was religion (Muslim). Similarly, there was only one significant correlation between ethnic self-hatred as measured by the ESII-B and demographic variables: age was inversely related to score on the ESII-B.

Correlations between ethnic self-hatred and physical characteristics, and interview data revealed two significant correlations when ethnic self-hatred was measured by the ESII-A: "What race are you?" (labels self black) was positively correlated with ethnic self-hatred; and, presence of ethnic or color delusions was positively correlated with ethnic self-hatred.

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The significant correlations between ethnic self-hatred as measured by the ESII-B in respect to physical characteristics and interview data were: diagnosis of Paranoid Schizophrenia, positive meaning of the word black, discovery of blackness from physiognomy, and presence of ethnic delusion. These correlations were all positive.

The Effect of the Structured Interview: A Serendipitous Finding. A serendipitous finding demonstrated that among 37 of the 96 patients studied, the structured interview was effective in assisting patients to discuss their ethnicity, their feelings of ethnic inferiority, feelings of anger towards in-group and out-group persons, and a concomitant beginnings of the working out of conflicts pertaining to ethnicity. Sixteen patients who exhibited previously fixed ethnic and/or color delusions were able to come to grips with their delusions during the interview and admitted during or at the end of the interview that indeed they did belong to the black ethnic group. Other patients (n=21) who did not possess color or ethnic delusions similarly verbalized their realization and perception of ethnic self-hatred, and the problems inherent in being black in contemporary American society during the structured interview, classifying conflicts about their ethnicity as a major contributing factor in their illnesses.

The effect of the structured interview was also seen in the positive relationship between presence of fixed color and ethnic delusions (prior to and during the administration

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of the ESII-A, and the EFDT) and the question, "What race are you?", where patients labeled themselves black (r=.23).

Differences in Psychopathology Scores for Bronx and Manhattan State Hospitals. Results of the present study indicated that there was a difference in $\bar{X}$ psychopathology scores for the Bronx State Hospital group and the Manhattan State Hospital group, such that Bronx State Hospital patients exhibited more psychopathology than Manhattan State Hospital psychotics. Differences in $\bar{X}$ psychopathology scores by hospital raises the question of whether there was a difference in raters, or whether differences in psychopathology between hospitals may be accounted for by differential demographic variables and/or other relevant variables.

Scrutiny of the data suggests that the difference in $\bar{X}$ psychopathology scores for Bronx State Hospital and Manhattan State Hospital psychotics is not due to rater differences, but may be accounted for by the following related findings:

(1) Forty-three percent of the Bronx State Hospital patients were between the ages of 16 and 29, as opposed to 20% of the Manhattan State Hospital patients who fell into this age range. Age was significantly correlated inversely with psychopathology for the total sample.

Since younger psychotic patients tend in general to exhibit more acute psychoses than older psychiatric patients who tend to be chronic, the fact that Bronx State Hospital patients were younger than Manhattan State Hospital patients

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suggests that the difference in $\overline{X}$ psychopathology scores is in part accounted for by this factor.

Younger patients might also be first admissions to a State Hospital, and thereby less cognizant of how to "play the rules of the game," in relation to implicit and explicit hospital regulations and cooperative behaviors psychiatric staff traditionally expect of patients inside the mental hospital, as a total institution (see Goffman, 1961 for a detailed discussion of staff expectations and perceptions of patient behaviors in mental hospitals).

Thus, younger patients might tend to be more active, more rebellious, non-conforming, and non-compliant, and hence be rated as more psychopathological on the WBI where such behaviors are classified as indicitave of psychopathology;

(2) Bronx State Hospital had less southern born patients (39%) than Manhattan State Hospital where 50% of the patients were southern born. The finding that there was a significant inverse relationship between psychopathology and being southern born in conjunction with the difference between $\overline{X}$ psychopathology scores for the two hospitals suggests again that differences in psychopathology scores may be accounted for by the following:

Blacks born in the South prior to the 1960's Civil Right Movement were taught at early ages to stay in their places, hide aggression and hostility, and be compliant in the face of white authority figures in order to decrease

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the possibilities of being victims of white racist violence and/or other punishments (e.g. loss of jobs). We may assume that individuals born in the South prior to the concrete changes that occured following the Civil Rights Movement may generalize their incorporation of docility as a coping device to other situations where they are subserviant, as in the instance of being a mental patient dependent almost totally upon staff who are authority figures.

Indeed, the incorporation of docility in the face of white authority figures characteristic of southern born blacks historically is parallel to being a mental patient in a total institution in many respects. For example, prior to the changes that resulted from the Civil Rights Movement of the 1960's southern blacks typically were addressed by first names and/or assigned whatever name a white person might choose to call the black individual (e.g. a five year old white child typically could address an adult black person by first name, and the black individual was powerless to express any dissatisfaction with being called by his or her first name by the child). Similarly, inside a total institution such as the mental hospital, patients generally are addressed by whatever name the staff chooses, and the patient is powerless to express any discontent he or she may feel at being called by his or her first name; and is generally not given the option of calling staff by first names, least he be considered disrespectful and therefore more deviant or

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psychopathological. (Again, see Goffman, 1961 for a detailed discussion of being a mental patient and the powerlessness of patients in a total institution).

Hence, the difference between psychopathology scores may in part be accounted for by the factor of docility among southern born patients in relation to state hospital ward regulations imposed by staff who are authority figures for the patients. Patients who are compliant, cooperative and docile--not "rocking the boat"--or disrupting ward routines might be rated as exhibiting less psychopathology on the WBI where cooperativeness, willingness to assist staff with other patients, cooperation in participating in ward chores (e.g. mopping, cleaning) are rated as indicative of mental health.

The assumptions made by Burdock and Hardesty (1968) that cooperativeness, and acceptance of hospital routines and regulations (see WBI items 58, 67, 110, 118, for example) are behaviors which constitute mental health further supports the conclusion that the difference between psychopathology scores is in part accounted for by the variable of being southern born.

Unless, we, as behavioral scientists are willing to assume that lack of assertion and docility are representative of positive self-esteem and mental health, then we must conclude that in all likelihood the difference between $\bar{X}$ psychopathology scores is in part accounted for by the variable of being southern born, as opposed to differences in raters.

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Finally, the docility of many of the Manhattan State Hospital patients irrespective of place of birth may be related to the differences in physical structure of wards in the two hospitals and the relationship of physical and psychological space to withdrawal as a symptom among psychiatric patients in a mental hospital. (See Goffman, 1961; Ittelson et. al., 1970). Herein, withdrawal may be viewed as synonomous with docility since patients who withdraw generally do not disrupt ward routines, are passive, cooperative and compliant vis-a-vis implicit and explicit hospital regulations. Again, withdrawal-docility might be rated as healthy on the WBI.

Some evidence of the withdrawal-docility of Manhattan State Hospital patients as opposed to Bronx State Hospital patients was reflected on occasion at Manhattan State Hospital when the investigator was inadvertently locked inside the nurses' station with a patient she was attempting to interview. The patient appeared anxious and refused to be interviewed, stating she was afraid she would miss lunch if interviewed.

At this point, the investigator, upon discovering she was locked inside the room attempted to summon a staff member to open the door. Due to the fact that the nurses' stations at Manhattan State Hospital contain only one small window which overlooks the patients' dayroom, the investigator upon failing to summon someone to open the door de-

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cided to knock on the window and attract the attention of the approximately 20-25 patients in the dayroom at the time. To her surprise, not one patient responded to the investigator knocking on the window, or to her verbal request that they call a staff member. It was clear from the turning of the patients' heads to the direction of the nurses' station window that they heard the investigator's knocking and calling; however no patient moved.

Conversely, at Bronx State Hospital during periods of data collection, patients on occasion suggested to staff that they (staff) should find the investigator a quiet, private place for interviewing. Such suggestions may be viewed as indicative of assertion. For example, on occasion, one patient, upon being introduced to the investigator, while listening to staff and the investigator examine possibilities for where the investigator could interview patients in privacy, suggested to the staff that the staff coffee room could be used since it was not time for staff to be taking a coffee break, and their room should therefore be made available.

Discovery and Evaluation of Ethnicity: Comparison of Results of the Present Study and Literature Reports

Results of the present study are consistent with the findings of others in terms of when and how blacks become aware of ethnicity and what value they concomitantly place upon their minority group status. The data indicated that the patients learned of their blackness, the status position dele-

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gated to them by the dominant group, and the fact that their life chances were diminished by their minority group status during childhood.

They learned from a variety of sources (parents, schools, physiognomy, racist whites). This finding is consistent with the pioneering research of Clark and Clark (1947; 1950), and others (Goodman, 1952; McDonald, 1970; Moreland, 1958; Stevenson and Stevenson, 1960; Stevenson and Stewart, 1958). The data revealed that the psychotics incorporated negative valuations of blackness, and exhibited a simultaneous acceptance of whites and white standards, and an overidealization and emmulation of whites. The results here, are also consistent with the findings of others, most notably Clark and Clark 1950; Frazier, 1957; Fanon, 1967; Kennedy, 1952; McDonald, 1970. The emergence of conflicts with respect to ethnicity, beginning in childhood, and continuing from then on was empirically documented in this research, and is similar to the findings of others (Johnson, 1967; Johnson, 1958; Maliver, 1965).

It is striking to note that the verbalizations, rationalizations, projections, denial, thoughts, feelings, and performance on figure drawings in the present study were identical in nature, and, at times, in content to results obtained by others (Clark and Clark, 1950; Dennis, 1963; 1968; Frisch and Handler, 1967; Myers and Yochelson, 1948; Vitols et. al. 1963; Volkan, 1966). For example, the frequently

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verbalized rationalizations and/or projections with respect to delusions that something happened to turn one's skin darker, or from white to dark brown or black, found among the patients studied was in many instances identical to literature reports. Herein, the most frequently observed explanation in the present study, and in the literature was that of being suntanned, or sunburned. Also Volkan's study (1966) of two black patients with Leukoderma and his report that the two patients studied possessed patches of white skin, which contributed to their development of whole color delusions was identical to one case found in the present study: a black male patient stated his "white spots" were proof that he was really white, but that the sun was responsible for his dark skin.

Patients' performances on the EFDT were similar to results obtained by others (Dennis, 1963; 1968; Frisch and Handler, 1967), wherein the black patients studied tended to draw incomplete figures, to distort the hair-face ratio, and, in general to be preoccupied with the notion that the longer and straighter the hair, the more beautiful the person. In this context, one is reminded of a patient in the present study who expressed her dismay at not knowing whites' "secret" for growing long hair.

The Incorporation of White Beauty Standards: Some Cultural Considerations

The incorporation of white beauty standards refers to

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the rejection of those characteristics of ethnicity pertaining to physiognomy and, the simultaneous wish, and/or attempt to emmulate whites in regard to those characteristics of ethnicity that generally are found among the white ethnic group (e.g. white skin, keen noses, thin lips, long straight hair, and light eyes).

Some of the historical cultural values for the black ethnic group with respect to physiognomy and the incorporation of white beauty standards are provided her in order to afford reference points for understanding the relationship between the incorporation of white beauty standards and psychopathology found among the patients studied.

While characteristics of black or Negroid phsiognomy sometime overlap to some extent with characteristics of white physiognomy (e.g. a fair skinned black person with naturally straight hair, and/or keen features; a white skinned black person who could pass for white), we must recognize that historically, and, in contemporary American society, an individual is defined as black if any of his immediate relatives and/or ancestors were Afro-American, <u>and</u> if the knowledge of his Afro-American heritage is known by others.

Those characteristics of black ethnic physiognomy most relevant to a discussion of the incorporation of white beauty standards as it relates to psychopathology are: skin color, facial features, hair texture and lenght.

In respect to skin color and the acceptance and emmulation of white beauty standards, prior to the Black is Beautiful Movement of the 1960's, the word black was one of the worst

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epithets a black person could call another black person. Even worse was the reference to one's mother as black. Being called black often led to physical fights.

So hated was the quality of possessing dark skin that some blacks attempted to become lighter by utilizing skin bleachers. In this context, a notable example is provided by Kardiner and Ovesy (1962) in their presentation of the case of C.E.:

C.E., a fair skinned black woman, married to a light complexioned black man was so horrified by the fact that her first born child was dark brown skinned that she attempted to white-wash her infant by giving him daily baths with hydrogen peroxide, and when that failed, she tried clorox. (See Kardiner and Ovesey, 1962, pp. 248-257).

Prior to the Black is Beautiful Movement, and to some extent today among some black parents, as black people generally know, maternal and paternal concerns often reflected a preoccupation with whether a black infant born light in complexion would retain this characteristic. It is not uncommon, in this context, that black infants are sometimes born with light or white skin, due apparently to the fact that melanin production is not always present at birth.

However, as black people in general are aware, by the end of the first year of life, the infants skin tone is established. In other words, by the end of the first year of life, the infants skin color is as dark as it will become.

In relation to the facial features, and the rejection of the black ethnic physiognomy, it is no secret among many blacks

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that historically, prior to the Black is Beautiful Movement, some black mothers and fathers were preoccupied with their children's facial features, often to the extent that they engaged in attempts to change the flat noses of their infants by ritualistically pinching the noses of their infants, or restricting their infants sucking activities through omission of pacifiers, thumb sucking, etc. Two notable examples are provided by Engle (1969), and Barber (1974):

Engle's interview data revealed that one black mother reported she took her infant son's pacifier from him at an early age because she was afraid that if allowed to keep it, he would develop large, thick lips.

Barber (1974) in an interview with Jimmie Walker[1] provides relevant quotations from Walker's comedy routine:

> Let's face it. I am eb-o-ny genius. A bronzed Adonis. I have attained a new plane of blackery...But it wasn't always so 'in,' being black. When I was a kid, my mother used to say, 'Jimmie, you so dark--lighten up! Suck in you lips!'

With respect to hair texture and length, and the incorporation of white beauty standards, historically, some blacks have regarded naturally straight hair and long hair as desirable, attractive characteristics (see Angelou, 1970, for example).

Thus, the individual with the naturally straight hair and/or long hair was seen as being more attractive than the individual with nappy or kinky hair, and/or short hair. In this context, there is considerable controversy among some blacks as to whether there are genetic differences between ethnic groups vis-a-vis the amount of hair one can grow. The investi-

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[1]Jimmie Walker is a star of the CBS black television show, "Good Times," where he plays the role of J.J.

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gator knows of no study examining this question.

Black infants are sometimes born with straight hair; however, by the end of the first year of life, the hair texture is established, and either has remained straight or turned kinky.

The historical emphasis and importance given to straight hair and the perception of naturally straight hair as the most desirable type of hair is reflected in the in-group dicotomous labeling of straight and kinky hair. Historically, and among some blacks today, in-group members possessing naturally straight hair are said to have "good hair;" while those with kinky hair are said to have "bad hair." Indeed, prior to the in-group acceptance of the afro, women literally never appeared in public with unstraightened hair, or a straight wig; while men were not regarded as physically presentable unless their hair was closely cropped.

The Incorporation of White Beauty Standards and Psychopathology

The incorporation of white beauty standards was found among the patients studied, and is characteristic of ethnic self-hatred, which is psychopathological. The rejection of self and in-group members in relation to ethnic physiognomy was reflected by patients' acceptance of those ethnic characteristics common among the white ethnic group in terms of physiognomy.

The incorporation of white beauty standards was reflected in patients' color delusions of being white, as well as in their agreement with the ESII-A statement, "I wish I

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had light or white skin and could get a nice tan in the summertime." In fact, this ESII-A item had the highest factor loading of all items on the Inventory.

The absurdity of the above statement (blacks have ready-made or built-in tans), and the fact that black patients overwhelmingly agreed with it may be seen in part as a function of the communications received by blacks from mass media, especially television. Fanon's theoretical proposition of the "Collective Catharsis (Fanon, 1967, pp.145-146) is especially relevant here.

It should be obvious that a critical analysis of television advertisements would show that beauty products such as suntan lotion are aimed solely toward the dominant group.

Further, 50% of the patients in the present study drew figures that were void of any color, rather leaving the faces and bodies of their drawings white (figure drawings were done on white paper), in response to "draw yourself exactly as you look"; while 70% of the psychotics left their drawings white or void of any color in response to "draw yourself as you would like to look if you could change your appearance;" and 68% of the patients left their drawings white when asked to "draw a Negro person."

Conversely, when asked to "draw a white person," 70% of the patients were able to draw figures that clearly represented whites indicating that the majority of the psychotics knew the differences between black and white physiognomical

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characteristics.

The performance of patients on the EFDT suggests that they denied their blackness, and identified with whiteness, thus reflecting the incorporation of white beauty standards with respect to skin color.

It has been previously noted that black infants are sometimes born white or light complexioned due apparently to the fact that melanin is not always present at birth. Among the delusions found in the present study is the delusion that something had happened to turn one's skin from white or light in complexion to a darker color. In this context, it is conceivable that contributing factors in the development of this type of delusion may be that some of the patients had looked at pictures of themselves as infants and/or were told by their parents that at birth or as young infants they had light or white skin.

The incorporation of white beauty standards for straight hair was found among 44% of the patients who wore their hair in non-afro or natural hair styles, exclusive of those patients who had naturally straight hair. Further, patients' incorporation of white beauty standards was reflected in the delusions of possessing naturally straight hair, delusions of how straight hair could be grown (e.g. by eating properly and not taking certain medecines).

The case of the male patient who verbalized his wish to be white, and his reported combing of non-existent, long,

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blonde, straight hair daily in front of a mirror, illustrates a total acceptance of white beauty standards. (See Appendix F.)

As we have previously noted, black infants are sometimes born with straight hair and by the end of the first year of life, the hair has either remained straight or turned kinky. Herein, the finding that among the color and ethnic delusions found was the delusion that something had happened to turn one's naturally straight hair from straight to kinky, in part may etiologically stem in some patients from having viewed pictures of themselves as babies and/or being told by their parents that at birth they had straight hair.

The mass media communications received by blacks with respect to dominant group beauty standards may again afford clarification of how communications may contribute to the incorporation of white beauty standards and psychopathology.

Television commericals pertaining to hair products until relatively recently were aimed at the dominant group. It is obvious that slogans such as "blondes have more fun" are geared to the dominant white population since the combination of brown or black skin and blonde hair is genetically rare. Again we can understand the incorporation of white beauty standards and its relationship to psychopathology by Fanon's conceptualization of the "Collective Catharsis" (Fanon, 1967, pp. 145-146). Simplistically stated, if you are a black individual dissatisfied with your blackness and perceiving it as a source of a decrease in your life chances, constantly

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hearing the slogan "blondes have more fun," and seeing commercials depicting blondes having more fun, you may, on some level of intrapsychic functioning, conclude that being blonde-haired would magically make your life better. Where such an identification is made, the black individual might dye his of her hair blond.

Ethnic Self-Hatred and Ego Functions

Color Delusions and Denial. Color and ethnic delusions of whole or partial white lineage found among the psychotics studied are identical or similar to the types of delusions found during the pilot phase of the present study; and, they were also identical or similar to the kinds of delusions reported in the literature (Myers and Yochelson, 1948; Vitols et. al., 1963; Volkan, 1966). Further, the justifications given by psychotics to explain their delusions were in addition, either identical or similar to previous reports. (Bailey, 1973; Myers and Yochelson, 1948; Vitols et. al.; 1963; Volkan, 1966).

To explain the claim of belonging to "another race" patients commonly utilized the mechanisms of rationalization, projection, and/or denial (e.g. "I just have a sun tan; the sun burned me like this; my skin will turn white again if I wash with the right soap; we'll all grow straight hair again in five years if we eat the right food and don't take medecine"). These explanations were identical or

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similar in content to cases reported by others (Myers and Yochelson, 1948; Vitols et. al., 1963; Volkan, 1966).

Protest Reactions. Among the three male patients who gave their religion as Black Muslim, and the one case of a Protestant male who believed himself to be a "black supreme being" the coping mechanisms adopted to counter feelings of ethnic inferiority were similar to what has been called "the protest psychosis" by Bromberg and Simon (1968).

The symptom-pictures of these patients were replete with references to the superiority of blacks, an accurate awareness of the ways blacks have been oppressed and victimized by racism, a preoccupation, at times with the genesis of civilization, including the notion that ancient civilization began in Africa with black peoples, and the overt expression of anger toward whites.

While the protest psychosis syndrome was found among only four cases studied, there were numerous instances where attitudes of black nationalism including positive definitions of the word black, positive references to the black people, and a concomitant awareness of prejudice, discrimination, and racism inherent in contemporary American society were found. These patients' expressions were similar to some of the cases reported by Bromberg and Simon (1968), characterized by what they have called "protest reaction" (Bromberg and Simon, 1968, p.160); and what Thomas (1971, pp.273-274) had called "Stage one and Stage two reactions."

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<u>Hair Style as a Coping Device; Some Conceptual Propositions</u>.

The incorporations of white beauty standards with respect to straight hair, found in the patients studied may appear confusing in view of the finding that 48% of the psychotics wore their hair in an afro. This finding must be viewed within the present black acceptance of the afro, as well as in the context of conditions in New York State Hospitals.

The finding that 48% of the psychotics wore their hair in afros may appear unrelated, and anti-thetical to psychopathology and ethnic self-hatred; however, to understand its relevance, one must comprehend the general process blacks undergo in developing positive black egos in place of hostile white egos.

For example, few would argue that one effect of the Black Power and the "Black is Beautiful" Movement was the rejection of white beauty standards, white stereotyped attitudes regarding blacks, and a re-evaluation of blackness by some. This re-evaluation was perhaps most clearly exhibited by black college students in their demands for Black Studies Programs, and by black entertainers, poets, and writers during the late 1960's and early 1970's.

Thus the process of accepting one's blackness, and the concomitant dimunition or elimination of negative ethnic self-image frequently included the rejection of white beauty

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standards, reflected in the wearing of an afro. An afro may be viewed conceptually as a coping device among some in terms of a reaction-formation to the previous emulation of white beauty standards during the initial phase of accepting one's blackness.

Coincident with the metamorphical process of developing positive black identity, there is also an initial period of anger towards whites (see Bromberg and Simon, 1968; Thomas, 1971).

The investigator asserts that there are three basic conditions that would explain why 48% of the patients wore afros despite the clear cut evidence that straight or straightened hair was the preferred: (1) There is an afro-psyche that is characterized by an acceptance of one's blackness and the preference for wearing one's hair as it naturally grows (kinky). The afro psyche would also encompass the wearing of an afro as a symbol of one's attitudes regarding black nationalism and pride. Thus, it is possible that some undetermined number of patients despite having ethnic self-hatred including the incorporation of white beauty standards might have the beginnings of an afro-psyche; (2) There is an afro hair-style whereby some blacks wear an afro because they view it as fashionable; thus, some unknown number of patients in the group wearing afros may have done so for this reason; and, (3) There is an afro-by-force, wherein State Hospital patients must comb their hair to be viewed by staff as presentable, or keep it covered.

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If one does not possess naturally straight hair, the process of straightening it by hot comb or chemical process is generally unavailable to patients. At Bronx State Hospital, for example, once a month each ward is permitted to send five female patients to the beauty parlor. Therefore, if a patient does not attain access to the beautician, and is not allowed home on day passes or week-end visits, the chances of getting her hair straightened are greatly diminished, and she is forced to wear an afro or keep her hair covered (e.g. with a wig, scarf, hat, etc.).

It should be noted also that the acceptance of the afro by blacks, an acceptance that began approximately 10 years ago led to a reversal of staff attitudes about how patients could wear their hair and still be viewed as presentable. For instance, prior to the acceptance of the afro, black female staff typically assumed the responsibility of straightening their female patients' hair by bringing sterno stoves, hot plates, and straightening combs, thereby straightening patients' hair on the ward. Throughout the period of the data collection for the present study, electrical appliances such as hot plates, and objects such as sterno stoves were forbidden on the wards.

Finally in regard to the 48% of the psychotics who wore afro hairstyles, it should be noted that since the "Black is Beautiful Movement" black males typically wear afros if they can grow them with the exception of some, who do not like the afro as a style. (See Kennedy, 1976).

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Implications For Future Research: Some Theoretical Considerations

Specification of Variables. As Schermerhorn (1956) points out, research pertaining to blacks should consider what variables are defined conceptually as dependent and independent in order that mistakes in diagnoses and treatment are not made.

The results of the present study indicate that ethnic self-hatred is an important factor in the psychopathology exhibited by black psychotics. The crucial question that emerges is whether ethnic self-hatred is a causal variable in psychopathology among blacks, as Fanon (1967) has theorized. While it is generally difficult, if not impossible, to demonstrate causality in social science research, it is suggested that future research in the field involve treatment-outcome studies where attempts are made to diminish ethnic self-hatred through psychotherapy where psychopathology would be defined as the dependent variable, and ethnic self-hatred as an important independent variable.

Measurement of Psychopathology. It is suggested that future research efforts consider how psychopathology, as the dependent variable, is measured. The WBI used in the present study appears to have limitations.

Specifically, the WBI, in part, measures how well a person conforms to implicit and explicit institutional policies. Burdock and Hardesty (1968) assume in their classi-

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fication of hostility, aggressiveness, rebelliousness, uncooperativeness, and uncommunicativeness as pathological behaviors that there are no instances where such behaviors would not only be socially and culturally acceptable, but indicative of mental health.

For example, WBI item # 58 ("Tries to help with ward chores"), is one item that is rated as indicative of psychopathology if a patient does not try to help with ward chores. Ward chores inside New York State operated psychiatric facilities historically pertain to cleaning the wards. Cleaning chores run the gamut from mopping, waxing, buffing, and sweeping floors through cleaning toilets, emptying ashtrays, and waste paper baskets, to washing walls and windows. These are some of the kinds of ward chores that patients may be assigened by staff who do not know and/or follow the Souder versus Brennan (1973) United States District Court decision; and, the New York State Department of Mental Hygiene Regulation (1975) which interprets the Souder versus Brennan (1973) Court decision:

The New York State Department of Mental Hygiene Regulation pertaining to the Souder versus Brennan Court decision prohibits patients, with the exception of routine maintenance of their own living quarter, from being assigned cleaning and work-maintenance activities.

The responsibility of cleaning psychiatric wards generally falls upon the paraprofessional nursing personnel who are held responsible by administrators if their wards

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are not kept clean. Therefore, given the number of other responsibilities paraprofessional nursing personnel are delegated, frequently staff utilize a variety of implicit and explicit rewards and punishments to induce patients to assist them with cleaning activities. (See Goffman, 1961 for a detailed description of systems of rewards and punishments inside total institutions such as mental hospitals.)

Hence, patients who are cognizant of their rights in relation to cleaning, and/or simply do not perceive that it is therapeutic for them to clean, refusing therefore to participate in ward chores when asked, may be rated by staff as psychopathological on the WBI item #58.

Public Versus Private Psychopathology. The finding that the relationships between ethnic self-hatred and psychopathology were cuvilinear on the ESII-A and ESII-B where high ethnic self-hatred predicted low psychpathology suggests that individuals are often adept at hiding psychopathological behaviors. Also, the measurement of psychopathology may often be influenced by the perception and keenness of the rater's observations; as well as by rater bias regarding what kinds of behaviors are psychopathological.

The fact that ethnic self-hatred was present among all the psychotics when measured by the ESII-A, a phenomenon that cannot be viewed as indicative of mental health, reflects the fact that psychopathological attitudes may not always be manifested behaviorally, or in observable signs.

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On the other hand, psychopathological attitudes or subjective symptoms (the self-report) in this case, the ESII-A, may represent the best mode of measuring ethnic self-hatred.

In terms of the relationship between ethnic self-hatred and psychopathology, methodological problems ensue when instruments, such as the WBI are used to measure psychopathology. For example, the WBI only contains one item (#130) that clearly pertains to low self esteem. The direct corelation between psychopathology and ethnic self-hatred as measured by the ESII-B obtained in the present study might have been higher if a different instrument had been used (e.g. various measures of self-esteem; The Wittenborn Psychiatric Rating Scales, Wittenborn, 1955).

Further, the curvilinear relationships between ethnic self-hatred and psychopathology in instances where patients exhibited moderate to high ethnic self-hatred but low psychopathology on the WBI reflects the fact that ethnic self-hatred has traditionally been regarded by some as an unimportant variable in psychopathology. In this context, it is interesting to note that our diagnostic classifications of psychiatric illness, and our traditional categorization of symptoms do not include the phenomenon of ethnic self-hatred.

Also, our traditional personality theories have given little emphasis to the role of culture and ethnicity as possible contributing factors in personality disorder.

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Thus, historically, we have attempted to fit patients to our ideal-typical models of behavior.

Hence, some diagnosticians and clinicians might consequently fail to ask a client a simple interview question of how he or she feels about his or her ethnicity.

It is noteworthy, herein, that during the pilot-phase of the present study (Bailey, 1973), the examination of case histories of patients with gross overt signs and symptoms of ethnic self-hatred (N=8) contained no record of the fact that these patients had ethnic self-hatred, including color and ethnic delusions; although staff knew of the delusions of ethnic self-hatred.

Docility Versus Assertion in Blacks: Psychopathology or Mental Health? The fact that there was an inverse relationship between WBI score and being southern born in the present study is understandable from an historical perspective. Historically, American black southerners were taught that in order to survive they had to be docile, free of hostility, aggression, assertion, and uncooperativeness in their interpersonal relationships with whites.

These modes of behaving were taught to black children by their parents in a multitude of verbal and nonverbal ways. They were learned also from the violence inflicted upon black children, women, and men by southern racist whites; violence that commonly resulted in death. (See Ginzburg, 1962)

It is noteworthy, in this context, that conditions for

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southern blacks changed concretely during the 1960's Civil Rights Movement when black southerners collectively refused to "stay in their places." The fight for civil rights can be seen as a factor in the beginnings of black pride and black nationalism; and, in the definition of blackness as positive by in-group members.

The positive correlation between defining the word black in a positive manner and psychopathology found in the present study may be understood by the general process of developing a positive black identity which at some point includes expressions of anger, and hostility, as well as assertiveness. When such types of behaviors occur inside a total institution such as the State Hospital, they may be viewed as pathological. Consequently, "protest reactions" (Bromberg and Simon, 1968 p.160) or "Stage one and two reactions" (Thomas 1971, pp.273-274) characterized by hostility towards whites might be rated as psychopathological.

Actually, as Bromberg and Simon (1968), Cross(1971), and Staples (1976) point out, such reactions and/or stages are necessary ingredients in developing positive black identities in place of ego-alien white identities. Perhaps, Staples (1976), in presenting Cross' conceptualizations,(Cross, 1971), summarizes best:

> As they [blacks] become involved in the Black Liberation struggle, their values and self-concepts began to undergo certain changes. Cross (1971) has described a series of well-defined stages each Black person must go through in order to achieve a Black

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> identity. In stage one, pre-encounter, he tends to think and act in a manner that degrades Blacks and sees all forms of white culture as a superior model. After going through three other intermediate stages, in the fifth stage, internalization-commitment, he uses both Western and non-Western referents to guide his values, thoughts, and acts. Other characteristics developed during this stage include (1) an inner security and satisfaction with himself, (2) great love and compassion for all oppressed people, and (3) active participation in the community for the purpose of making it better (pp. 81-82).

Some Practical Implications for Future Research and Conclusions

Future research investigations of the relationship between ethnic self-hatred and psychopathology migh examine whether there is a relationship between ethnic self-hatred and socioeconomic status among blacks. The present study did not examine this question, and results cannot be generalized to psychotic blacks in socioeconomic groups other than the lower and lower middle classes.

Further, given the finding that the relationship between ethnic self-hatred and psychopathology was curvilinear in part suggests that research efforts might use some of the more advanced multiple correlation analyses for curvilinear data in order to more precisely predict psychopathology from ethnic self-hatred, where ethnic self-hatred and other relevant variables would be defined as independent variables.

Another implication for future research in the empirical question of whether black and white researchers using identical methods would obtain similar or identical results; and, whether therapists' ethnicity and therapists' social class orientations and values are factors in treatment outcome for

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black patients in general, and low and lower middle class black psychotics in particular. This implication for future studies seems clearly in need of investigation given the serendipitous finding of the effect of the structured interview in the present study.

It seems clear from the results of the present study that ehnic self-hatred is an important variable in the psychopathology manifested by psychotic blacks, and is a contributiong factor in psychoses among this group.

It also seems clear from results of the research that treatment modalities must be developed to strengthen ego functions by diminishing ethnic self-hatred among psychotic blacks. A review of the literature revealed no such study, a finding which illustrates the apparent historical lack of concern with the problem on the part of some behavioral scientists or an inability to devise black-oriented therapies for black patients with ethnic self-hatred where therapy approaches and theoretical propositions are consistent as, Syngg and Combs (1949) have suggested. The Second Chance Black Family treatment approach is one suggested therapy approach. (See Appendix G.)

It seems obvious as Schermerhorn (1965) points out that to ignore the cultural factors in the treatment of mental illness among minorities based on the notion that our traditional personality theories are valid for all peoples irrespective of ethnicity and culture, is to increase

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the chances of making false theoretical propositions, false diagnoses, and rendering inadequate treatment.

Since bias, as distinguished from racism, is a natural component of human nature as Lundberg (1942) indicates, research efforts, and especially treatment approaches designed to diminish ethnic self-hatred among blacks must include black investigators and therapists. Blacks, like all other humans have biases by the very nature of being human. What is important, here, is that we all perceive selectively and from reference points based upon our own experience. Further, objectivity is a quality we as behavioral scientists strive to achieve; however, objectivity, the reverse of bias is an ideal state which humans cannot attain.

Thus, we must strive to gain as close an approximation of objectivity as is humanly possible. One way of approximating objectivity and hopefully acquiring some measure of scientific truth might be the exchange of biases between black and white investigators and therapists.

Finally, the results of the present study reflect the psychological bondage in which black psychotics are enslaved. It seems clear from patients' responses to the investigator during the structured interview that they are ammenable to discussions of their feelings of ethnic inferiority, and are asking for treatment and help with this central problem.

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APPENDICES

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APPENDIX A

THE ETHNIC SELF-IMAGE INVENTORY OF ATTITUDE

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Name.....
Age......
Sex......
Date.....
Ward.....

"I am interested in some of your ideas about Negro people. I will read some statements to you. For each statement, tell me how much you agree or disagree with the statement. In other words, tell me whether you strongly agree, agree, are undecided, disagree, or strongly disagree."

1. If I could be born again, I would like to be born white. __________

2. Straight pointy noses are more attractive than flat or broad noses. __________

3. Too many Negroes when they get a little money spend it all on whiskey, flashy cars, or expensive clothes. __________

4. White people are superior to Negro people. __________

5. Negroes blame whites for their position, but it is really their own fault. __________

6. Negroes are always shouting about their rights and have nothing or little to offer. __________

7. Black is beautiful. __________

8. When I get to heaven, I will be white as snow. __________

9. Negro people would be better off if modern medicine could invent something which would make them change color. __________

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10. Negroes would solve many of their social problems if so many of them were not so irresponsible, lazy and ignorant. __________

11. Sometimes I wish I were anything but a Negro. __________

12. Negroes may have black or brown skin, but their hearts are white. __________

13. Negroes should live around their own people. __________

14. One reason why racial prejudice still exists today is the fact that many Negroes are dirty, loud and generally offensive in their ways. __________

15. Negroes should keep up appearances so they won't reflect badly on the Negro race. __________

16. I would prefer to live in a neighborhood where there are not many Negroes. __________

17. A great many Negroes become overbearing and disagreeable when given positions of responsibility and authority. __________

18. I wish I were white. __________

19. God made a mistake when he created Negroes. __________

20. I wish I had light or white skin and could get a nice tan in the summertime. __________

21. Negroes in this country need a lot more education before the white man gives them equal rights. __________

22. I would rather not marry a person who has very kinky hair, wide nostrils, and thick lips. __________

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23. White neighborhoods are good and black neighborhoods are bad. __________

24. One important reason why Negroes are discriminated against in housing is that they don't keep up the property. __________

25. Science will show that Negroes are just as intelligent as whites. __________

26. I used to be lighter than I am now, but something happened to turn me darker. __________

27. I wish my hair was naturally straight. __________

28. If you have very dark skin or are black, and you marry a white person you will have a pretty baby. __________

29. Very dark skinned Negroes should marry someone lighter than they are. __________

30. Negro women look better with afros than when they straighten their hair. __________

31. A large part of the problems facing Negroes today are caused by Negroes themselves. __________

32. One trouble with Negroes is that they are even more jealous of each other's success than whites are. __________

33. With all of the drinking, cutting, and other immoral acts of some Negroes, white people are almost justified for being prejudiced. __________

34. When someone calls me black I get angry, or become offended, or I am ready to fight. __________

35. Negroes are usually lazier than whites. __________

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36. If Negroes would prepare themselves, the white man would give them good jobs. ___________

37. I often get reassurance from the thought that I am a member of a minority group that has withstood every sort of hardship... for hundreds of years. ___________

38. Nappy or kinky hair is bad, unattractive hair and not as pretty as straight hair. ___________

39. Small thin lips are more attractive than large thick lips. ___________

40. A large number of Negroes find themselves in jail because Negroes don't get fair treatment in the courts. ___________

41. Too many Negroes have abused the privilege of attending baseball games by being rowdy and noisy and cheering only for Negro ball players. ___________

42. I would prefer to work for a white person rather than a Negro. ___________

43. I wish my skin was lighter than it is. ___________

44. I prefer to be called Negro rather than black. ___________

45. Negroes are mean and evil. ___________

46. I prefer to be called black rather than colored or Negro. ___________

47. If you are a Negro and you change your name to an African name, that is a sign of pride and dignity in your ancestry. ___________

48. The Negro should aggressively exercise his civil rights. ___________

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49. "If you're white, you're right; if you're brown hang around; but if you're black stay back." __________

50. Negroes with some Indian or white blood in them are prettier than full-blooded Negroes. __________

51. Neither colored, Negro, black, nor Afro-American best describes my race, because I am a member of another race. __________

52. Negroes will never get ahead because when one is succeeding the others pull him down. __________

53. Segregation and jimcrow will never end, unless the average colored person becomes better educated and better mannered. __________

54. One is almost ashamed to be a Negro when he sees so many of them who look and act like cotton pickers fresh from the fields. __________

55. I prefer to be called colored rather than black. __________

56. Compared to Negro social affairs, social affairs run by whites tend to be somewhat restrained and lacking in warmth. __________

57. Because of their own persecution, Negroes have learned to be more tolerant and understanding than most other groups in America. __________

58. One big reason why racial prejudice is still so strong is that Negroes often offend people by being so sensitive about racial matters. __________

59. Negro people can hardly be expected to gain social equality until many more of them exert some effort to better themselves and live more decently. __________

60. Blonde or red hair is prettier than brown or black hair. __________

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61. The white man is always trying to help the Negro, but the Negro won't try and help himself. __________

62. Negroes would be better off if they acted more like white people. __________

63. It's bad when a group of Negroes get noisy and loud around white people. __________

64. The lower class Negro is to blame for a lot of prejudice against Negroes. __________

65. Whites and Negroes can get along on jobs until too many Negroes try to push themselves in. __________

66. Negroes would be better off if they stopped trying to be like the white man. __________

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THE ETHNIC SELF-IMAGE INVENTORY OF ATTITUDES,
Items, Source, and Type

ITEM	SOURCE	TYPE (Positive or Negative)
1.	Bailey	Negative
2.	Bailey	Negative
3.	Steckler	Negative
4.	Bailey	Negative
5.	Johnson	Negative
6.	Johnson	Negative
7.	Bailey	Positive
8.	Bailey	Negative
9.	Bailey	Negative
10.	Steckler	Negative
11.	Johnson	Negative
12.	Bailey	Negative
13.	Johnson	Negative
14.	Steckler	Negative
15.	Johnson	Negative
16.	Johnson	Negative
17.	Steckler	Negative
18.	Bailey	Negative
19.	Bailey	Negative
20.	Bailey	Negative
21.	Johnson	Negative

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ITEM	SOURCE	TYPE (Positive or Negative)
22.	Steckler	Negative
23.	Bailey	Negative
24.	Steckler	Negative
25.	Maliver	Positive
26.	Bailey	Negative
27.	Bailey	Negative
28.	Bailey	Negative
29.	Bailey	Negative
30.	Bailey	Positive
31.	Steckler	Negative
32.	Steckler	Negative
33.	Steckler	Negative
34.	Bailey	Negative
35.	Bailey	Negative
36.	Johnson	Negative
37.	Maliver	Positive
38.	Bailey	Negative
39.	Bailey	Negative
40.	Maliver	Positive
41.	Steckler	Negative
42.	Johnson	Negative
43.	Bailey	Negative
44.	Bailey	Negative

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ITEM	SOURCE	TYPE (Positive or Negative)
45.	Bailey	Negative
46.	Bailey	Positive
47.	Bailey	Positive
48.	Maliver	Positive
49.	Bailey	Negative
50.	Bailey	Negative
51.	Bailey	Negative
52.	Johnson	Negative
53.	Steckler	Negative
54.	Steckler	Negative
55.	Bailey	Negative
56.	Maliver	Positive
57.	Maliver	Positive
58.	Steckler	Negative
59.	Steckler	Negative
60.	Bailey	Negative
61.	Johnson	Negative
62.	Johnson	Negative
63.	Johnson	Negative
64.	Steckler	Negative
65.	Steckler	Negative
66.	Maliver	Positive

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Scoring:

Positive Item Scored as Follows:

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
0	1	2	3	4

Negative Item Scored as Follows:

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
4	3	2	1	0

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APPENDIX B

THE ETHNIC SELF-IMAGE INVENTORY OF BEHAVIOR

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Name.......
Age........
Ward.......
Date.......
Rater......

THE ETHNIC SELF-IMAGE INVENTORY OF BEHAVIOR

INSTRUCTIONS:

Please place a check mark next to each of the following items that have been observed in the patient's behavior. Check whether the item is present or absent.

	PRESENT (yes)	ABSENT (no)
1. Patient has delusion that something happened to or is happening to his skin, resulting in his skin turning darker, e.g. blames medication, food, people with extraordinary powers, weather conditions, etc.	______	______
2. Patient is preoccupied with telling whites and blacks that they should intermarry and/or applies this idea to himself.	______	______
3. Patient incorrectly labels whites and/or blacks e.g. calls whites black, or anything other than white or Caucasian, and calls blacks anything other than black, Negro, colored or Afro-American.	______	______
4. Patient is preoccupied with cleanliness and/or is afraid of getting dirty, e.g. patient takes an excessive number of showers per day or washes some part of his body repeatedly, and/or is always cleaning self or objects in his environment.	______	______

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	PRESENT (yes)	ABSENT (no)
5. Patient makes negative verbal references to black being ugly, sinful, bad, etc. and/or states that black, Negro, colored, or Afro-American people are ugly, sinful, bad, evil, etc. and/or states that his blackness is bad.	_____	_____
6. Patient covers face and/or part of body with makeup and/or some other substance that is white or pink in tone, i.e. lotion, talcum powder, cold cream.	_____	_____
7. Patient with nappy, kinky hair (hair that is not naturally straight) wears straight hair style, i.e. straightens hair with hot comb, uses chemical hair relaxer, wears straight wig, or process, or slinks hair down with greasy hair dressing . Include here, patients who change hair style, i.e. one day wears afro, next day wears straight style. Also include here, patients who wear afro or cornroll hair style only because they, while in hospital, cannot get hair straightened or relaxed.	_____	_____
8. Patient becomes aggressive and/or angry or offended when called "black".	_____	_____
9. Patient with nappy, kinky hair does not comb or wash hair and/or keeps it covered, i.e. with hat, rag, scarf, towel, wig.	_____	_____

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	PRESENT (yes)	ABSENT (no)
10. Patient will only listen to white or Hispanic staff and/or will only accept things e.g. cigarettes, clothing, food, from whites or others who are not black.	________	________
11. Patient will not speak to other blacks and/or is unfriendly to other blacks and/or derrogates blacks.	________	________
12. Patient has delusion that he is related to a famous white person or famous person of another race.	________	________
13. Patient has or has previously had delusion of being white, pink, or something other than a member of the black ethnic group, (i.e. purple, pink, French, Indian). Include here, denial of membership in any race and/or rationalizations regarding skin color and membership in the black ethnic group.	________	________
14. Patient has delusion about his last name giving a ficticious ethnic last name, e.g. a Jewish, Italian or Spanish last name, and/or claims that his last name should be pronounced with a special accent because he belongs to a special ethnic group or nationality, e.g. "I am French, so my name should be pronounced Jacksōne, not Jackson."	________	________
15. Patient has delusion he or she has a white mate or a mate who is something other than black and/or believes his children are not black.	________	________

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	PRESENT (yes)	ABSENT (no)
16. Patient complains about getting his hair wet and/or makes references to his hair "going back." Include negative references to nappy or kinky hair, and/or persons with nappy kinky hair.	______	______
17. Patient makes negative references to Negroid features.	______	______
18. Patient is preoccupied with derogating black political leaders and/or organizations.	______	______
19. Patient complains about getting sunburned and/or suntanned.	______	______
20. Patient makes jokes about his color or race, e.g. "I'm just a dark skinned white person."	______	______
21. Patient dyes his hair blonde, red or light brown, and/or wears wig that is blonde, red, or light brown.	______	______
22. Patient has delusion that his relatives are white or something other than black, e.g. Indian red, red niggers, pink, French.	______	______
23. Patient has and/or talks about wanting to have a white mate or dating partner.	______	______

Scoring:

One point for each item marked Present. Sum all items marked Present.

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APPENDIX C

THE ETHNIC FIGURE DRAWING TEST

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THE ETHNIC FIGURE DRAWING TEST

INSTRUCTIONS:

"I am going to ask you to draw some pictures for me. You may use any of the colored pencils you wish. Please color in the faces and bodies of your drawings."

REQUESTS:

1. "Draw a person."
2. "Draw yourself, exactly as you look."
3. "Draw yourself as you would like to look, if you could change your appearance."
4. "Draw a white person."
5. "Draw a Negro person."

SCORING:

Request 1. Score for hair color, eye color, and skin color as follows:

Hair color: brown, black -- zero; all other colors, 1 point
Eye color: brown, black -- zero; all other colors, 1 point
Skin color: brown, black -- zero; all other colors, 1 point

NOTE: If subject has hair, skin and/or eyes that are in reality other than black or brown, score zero respectively for colors other than black or brown.

Where subject adds color to brown or black, score 1 point.

Request 2. Score same as above.

Request 3. Score same as above.

Request 4. Score for completeness of drawing, as follows:

Score zero for presence of each of the following:

1. hair
2. two eyes
3. nose
4. body (complete rather than stick figure).
5. two legs
6. two arms
7. two hands or five fingers on each hand
8. two feet
9. mouth
10. two eyebrows

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Score 1 point for the following:

1. one eye
2. stick figure or no body
3. one leg
4. one arm
5. missing hand or missing fingers
6. no hair
7. one foot
8. no nose
9. no mouth
10. no eyebrows or missing eyebrow.

Request 5. Score same as Request 4.

Total possible score: 29

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APPENDIX D

THE WARD BEHAVIOR INVENTORY

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APPENDIX E

COMPARISON OF PSYCHOTICS' AND 'NORMALS' RESPONSES ON THE ETHNIC SELF-IMAGE INVENTORY OF ATTITUDES

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1

Comparison of Psychotics' and 'Normals' Responses on the Ethnic Self-Image Inventory of Attitudes

	PSYCHOTICS		'NORMALS'				
ITEM	$\overline{X}$	S.D.	$\overline{X}$	S.D.	F	d.f.	p
1.	1.5	0.89	0.54	0.65	23.18	1,118	0.001
2.	2.1	0.98	1.3	0.81	12.19	1,118	0.001
3.	2.4	0.93	1.8	1.31	6.73	1,118	0.005
4.	1.8	1.07	0.5	0.88	29.57	1,118	0.001
5.	2.4	0.96	1.7	1.23	8.93	1,118	0.001
6.	2.0	1.01	0.9	0.99	25.60	1,118	0.001
7.	1.1	0.73	0.83	0.70	3.30	1,118	0.36
8.	1.7	0.90	0.6	0.71	32.73	1,118	0.001
9.	1.6	0.97	0.5	0.50	30.08	1,118	0.001
10.	2.4	0.94	1.2	1.1	27.92	1,118	0.001
11.	1.6	1.03	0.9	0.74	10.61	1,118	0.001
12.	1.9	0.99	0.9	0.92	18.92	1,118	0.001
13.	2.3	0.99	1.3	0.85	18.75	1,118	0.001
14.	2.5	1.04	1.0	1.06	22.89	1,118	0.001
15.	2.7	0.86	2.3	1.16	3.30	1,118	0.036
16.	1.8	1.03	1.4	0.71	3.61	1,118	0.030
17.	2.2	1.01	2.2	1.12	0.09	1,118	0.379
18.	1.3	0.84	0.4	0.50	21.31	1,118	0.001
19.	1.3	0.93	0.5	0.78	16.52	1,118	0.001
20.	1.9	1.09	0.8	0.44	26.38	1,118	0.001

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PSYCHOTICS			'NORMALS'				
ITEM	$\bar{X}$	S.D.	$\bar{X}$	S.D.	*F*	d.f.	*p*
21.	2.5	1.02	1.3	1.04	26.47	1,118	0.001
22.	1.7	0.93	1.2	1.09	5.12	1,118	0.013
23.	1.8	0.96	1.0	0.65	15.66	1,118	0.001
24.	2.3	1.02	1.6	1.17	6.72	1,118	0.005
25.	1.2	0.93	0.8	0.88	3.53	1,118	0.032
26.	2.0	1.02	0.9	0.67	25.92	1,118	0.001
27.	1.9	1.14	0.9	0.75	14.85	1,118	0.001
28.	2.2	1.03	0.8	0.65	40.67	1,118	0.001
29.	2.0	1.10	0.8	0.65	24.51	1,118	0.001
30.	1.7	1.00	2.0	0.95	2.03	1,118	0.078
31.	2.4	0.91	2.0	1.12	5.00	1,118	0.014
32.	2.4	1.01	2.0	1.19	2.19	1,118	0.071
33.	2.2	1.02	0.91	0.88	33.42	1,118	0.001
34.	1.9	1.15	0.6	0.50	30.25	1,118	0.001
35.	1.7	0.93	0.7	0.76	24.60	1,118	0.001
36.	2.4	1.00	1.3	0.85	25.97	1,118	0.001
37.	1.4	1.00	1.7	1.04	1.27	1,118	0.131
38.	1.9	1.10	1.1	0.97	11.47	1,118	0.001
39.	2.1	1.02	1.5	1.02	6.48	1,118	0.006
40.	1.3	1.00	1.3	1.22	0.15	1,118	0.348
41.	2.1	0.98	1.0	0.75	26.69	1,118	0.001
42.	2.0	1.01	1.0	0.55	21.36	1,118	0.001

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	PSYCHOTICS		'NORMALS'				
ITEM	$\bar{X}$	S.D.	$\bar{X}$	S.D.	F	d.f.	p
43.	1.8	1.05	0.6	0.57	26.42	1,118	0.001
44.	2.1	1.00	0.7	0.46	42.71	1,118	0.001
45.	1.8	0.99	0.5	0.50	34.69	1,118	0.001
46.	2.1	1.07	1.0	0.99	20.83	1,118	0.001
47.	1.7	1.11	1.9	1.15	0.28	1,118	0.299
48.	1.3	0.82	1.7	1.00	3.23	1,118	0.037
49.	1.8	1.06	0.6	0.77	27.95	1,118	0.001
50.	2.0	1.03	0.8	0.63	28.71	1,118	0.001
51.	1.6	1.03	0.9	0.74	11.75	1,118	0.001
52.	2.3	1.00	1.1	0.71	28.60	1,118	0.001
53.	2.5	0.85	1.4	0.92	30.17	1,118	0.001
54.	2.1	0.98	1.4	0.88	10.30	1.118	0.001
55.	2.1	0.96	0.8	0.53	42.03	1,118	0.001
56.	2.0	0.96	1.2	0.81	12.18	1,118	0.001
57.	1.3	0.86	1.2	1.00	0.59	1,118	0.001
58.	2.5	0.85	1.6	1.05	20.32	1,118	0.001
59.	2.7	0.84	2.0	1.04	13.30	1,118	0.001
60.	1.7	0.93	0.9	0.53	15.32	1,118	0.001
61.	2.0	1.09	0.7	0.62	32.80	1,118	0.001
62.	1.8	1.09	0.7	0.56	21.91	1,118	0.001
63.	2.5	0.92	1.4	0.97	24.64	1,118	0.001
64.	2.3	1.04	1.2	0.86	24.39	1,118	0.001

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	PSYCHOTICS		'NORMALS'				
ITEM	$\bar{X}$	S.D.	$\bar{X}$	S.D.	F	d.f.	p
65.	2.4	0.99	1.5	1.17	17.30	1,118	0.001
66.	1.4	0.88	1.3	0.96	0.06	1,118	0.400
Total Score	129.1	25.58	74.1	22.59	92.84	1,118	0.001
Factor I	23.3	8.23	10.3	4.89	54.91	1,118	0.001
Factor II	22.5	6.14	15.2	6.07	26.87	1,118	0.001
Factor III	18.6	4.73	11.5	4.52	43.82	1,118	0.001
Factor IV	5.6	2.55	3.5	2.06	14.20	1,118	0.001
Factor V	6.1	2.51	2.3	1.42	50.81	1,118	0.001

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APPENDIX F

PATIENTS' SPONTANEOUS COMMENTS TO THE ESII-A AND INTERVIEW

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Patients' Spontaneous Comments to the ESII-A and Interview

One 58 year old Southern born man stated, "What is this survey for?" Following an explanation of the purpose of the "survey," he replied, "Oh, that's good. If we all pull together, we can make it." He subsequently spoke extensively of having "a lot of thoughts and feelings inside" about "race that I couldn't tell no one."

A 47 year old Southern born female stated when asked, "When and how did you first discover you were a Negro?":

> My mother told me. Said, 'you're a colored girl and you should act like one'. And, I used to like to play with white girls. My mother sold cosmetics, and I used to go with her. She told me to 'stay in your place'.

A 27 year old Northern born man stated following the instructions for the ESII-A, "Good, good! I'm very good on that. I see you like your work. I can't read Ebony Magazine, it tells all."

Several patients reported discovering their blackness when called nigger by white persons. One 37 year old female, for example stated, "When I first came to New York in 1957, a German girl called me 'black nigger' (where?) out on Long Island."

Many patients reported discovering their ethnicity from Black Muslims. For example, a 27 year old Northern born woman replied, "About 10 years ago. Went to the Temple one

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time. My brother was speaking. He was telling us that we were black not Negro. Describing it, it made sense."

Among the many patients elaborating in detail on responses to the ESII-A there were many cases which revealed thought processes, ethnic and color delusions, anger, ego mechanisms, and bewilderment about the conditions of poverty in conjunction with ethnicity. For example, a 32 year old Southern born man stated:

> I can't answer that question (question 8 ESII-A). My religious teaching is different. Started five years ago, when I saw a supreme being. And, he was identical to my daddy. He told me this -- that he was one of the supreme beings that planted people on this planet, and he put me here 500 years ago. Was dreaming. I was born in a manger with my mother and father standing over me. And, the supreme being told me that there were 5000 men and 5000 women in the manger, but I was the only holy pure one, and the others were racists. Was hearing voices and voices telling me I was a mind reader. Gave me a cold heart and a shield, an invisible shield. I was so powerful. The reason I can't read and write is because they were reading my brain like the supreme being. And when they gave me the shield and heart meant I had been born again like a newborn baby girl and boy. Can re-create flesh. Supreme being planted others here for us to dream of. Judge told me I own the whole United States. I told the supreme being I don't want to own the United States. Just have an income to support myself. Oldest creator is the black being and they work toward creating black children by controlling our mind.
>
> There's white supreme beings too. Come out of a white woman's body from a black daddy. Black and white supreme beings have one eye -- immortal dinosaur. Don't have no rectum. They invented white woman. Said she was the flame. Was only black women and black supreme being dinosaurs first. And, they created light from their eyeball and flesh. So they retraced them through the air.

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> Put the sun, moon and stars out there and that's when white woman and man came into being -- the flame. And, us children of God been crucified and killed ever since because they were flirting with white women. Solomon, Moses, all of them in the whole Bible. Bible written about black people. The white man wouldn't tell you he's Jesus. Tell you all those children in the manger are black.
>
> Can take poisonous medicine to grow straight hair. my hair was straight once, but I ate wrong food. They say five years we'll all grow straight hair by eating and taking medicine of the white race. See, their scientists was the only ones that knew this. Ever been to a Muslim Temple? See they been feeding us pork and this is why they been growing straight hair.
>
> Is anyway I can get more money to support myself? Can you help me? Just need enough money to survive. Please help me. One hundred and seventy-five dollars ain't much when you got to buy clothes, food, pay rent. When I came back North from the South -- wanted to take care of my daughter -- she and her mother -- they barely getting by. Then, the voices started again, and they said I had to come to the Hospital.

Another Southern born 42 year old male patient, following the question, "What does the word black mean to you?" stated:

> Well, I don't know what it mean. I'm white. It's just what the sun did to me. I have white spots. If I had of bathed right and didn't be so dirty wouldn't be this color. A lot of people don't know it, but we all mixed up. I don't accept black cause I'm really white.

Asked, what does Negro mean? This same patient stated:

> What is the reason for a Negro? You accept it. But then, they might be calling you something you really not, but don't mean you really is.

A 28 year old woman born in Michigan elaborated on her feelings and thoughts pertaining to ethnicity and racism when asked standard interview questions:

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> The word black -- it's the opposite to white in a sense. The term black doesn't mean skin wise. Anybody can be black as long as they have black blood. Come from Africa. White man uses term to separate us from white. Black man in America has white blood in him too, but isn't considered white. They overlook the white blood in you. Negro is a terminology given to black people that came from Africa to keep the black man from knowing who he really is. White man gave word Negro, when he brought him over from Africa instead of telling him he was black, and keeping him proud of his heritage, he brainwashed him.
>
> (Discovery of blackness?) Well, started long time ago. Guess I was in Junior High School -- late '60's. And, my father used to tell me what black man did in America from slavery until now. And, I became rebellious, and asked the teacher instead of keeping it to myself. My father told me about Negro colleges-- were very slow-- and he had to come North and get a better education. When I asked the teacher, she said, 'There's no such thing' as what I was learning about black people.
>
> And from then on, I stopped trying to learn, and they sent me to see a psychiatrist -- became a problem child. It really started in the second grade. Live in a fantasy world, cause I can't face all the things that happen in the white world.
>
> Were you asked by a white doctor to ask these questions?

Another patient, a 38 year old Canadian born male, required approximately two hours to interview due to his detailed responses and explanations to items on the ESII-A and the five standard interview questions:

> Here (in the Hospital), they mix up files. Put my file under Negro instead of white file. In European country up the river you're white. In Israel, they not even pure white cause they mixed up too. Put me in the Caucasian file. Some of the Egyptian people are dark, and go to Negro schools like I do. Here, they call me Egyptian, dark-white, not so pure man. Some fella told me it would be easier for me to get a job because I'm Egyptian.

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> Martin Luther King tried to force himself on whites. Wanted to marry a white woman -- why he got shot.
>
> When my people were fighting, I needed a job, and the Negro people gave me a job, and that's why I live in Harlem instead of downtown. I'm a dark white man. Part Italian, Indian and German.
>
> When I marry, I'm not going to marry white, Egyptian, German or Irish, so nobody can say I'm prejudiced. You can have thin lips, straight nose, but still not be white. Dark men pure. Up the river don't mess with Negroes. Egyptians can go to school. Book say marry darker people. I'd take a chance with a dark Negro woman, German woman, but not white. They would call me prejudiced, and then I couldn't go down South.
>
> Want to go home to Egypt or Montreal. I don't understand this country. This country is not civilized.

A 16 year old, fair skin black male patient, who reportedly stands in front of the mirror every morning combing his non-existent, "pretty, long, blond hair," when interviewed elaborated on his reasons for wanting to be white:

> I was jealous. I wanted to be white. I was 13 years old. Saw other people being white. I was always prejudiced to my mother and father. Would curse them out cause they weren't white. I wanted to live with white people. Was crying for it. Some black people get on my nerves. Don't talk to them unless they talk to me first. Don't even look at them. I've always dreamed I'm in some white lady's house having a good time. I cry to have white people, and they won't look right at me. Turn their face, and don't say nothing.

A 33 year old Northern born female, who reportedly has attempted to present the plight of blacks to the President of the United States on several occasions, consequently being

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involuntarily committed to various psychiatric facilities elaborated during the interview on the pain and suffering she experiences and attributes to her ethnicity:

> People on bus didn't want to sit next to me. Thought maybe I wasn't clean enough. Washed with germicidal [sic] in my hair and all over my body. Wasn't white people laughing at me. Was my own kind. Saying, 'hee, hee, hee. Look at her. Ain't she black.' So I stopped going out in the daytime.
>
> When I walked into the Welfare Department, Negroes looked at me and laughed, and said, 'look at her, ain't she black. I know she's suffered, she's so black.' I told the ward doctor, 'you took my blood test. You know, I've not got one ounce of black blood.
>
> You didn't ask about black history. Black history and black art. I would like to study them. Would like to read the black Bible. I've read the white Bible. Heard Elijah Muhammed -- had access to it.

Similarly, another female, dark skinned 21 year old patient expressed in detail the pain she experiences:

> I discovered I was black when I went to day camp, and a little white girl said, 'I can't swing in that swing anymore 'cause my mother said you're black.' Then, I had gone to Pennsylvania, and stayed with a white family. They washed my hair and it was all picky. And, they washed my skin. I thought all people were the same. Things like that really happen. I was eight years old. When I came home -- told my mother -- and she said, 'What did you say?' Just asked her why it made a difference. Why that little girl couldn't play with me anymore.
>
> How come all the pictures of God are white? Where did we come from? Did we come from white people? Adam and Eve -- they're always pictured white.
>
> Figure I was born poor and gonna die poor.

The ESII-A and the five standard interview questions frequently elicited patients' feelings of anger at whites

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as well as other blacks. For example, a 43 year old Northern born man stated:

> Now I see why all those questions, and drawings. One time before I was asked to do tests like these. (When?) When I joined the Black Panters. Panthers, to find out what's in the back of your head -- they found out that talking doesn't solve anything. Look at this country. When they want something and talking doesn't work, they starve you or go to war.
>
> Discovered I was black when I was a child. I asked my mother, 'Why is my brother over there so black and I'm so white looking?' And, my mother bust me in the mouth. She said, 'you're just as black as he is. A Chinaman had children.' And, that's the point. As a seed grows, you educate it. Only two races in the world.
>
> And, I'm angry with Dr. ______. He's a black man -- at the top -- and, he hasn't brought in enough black doctors. I know he's brought in a few, but we need more. In fact, a lot of black doctors are available, but would rather have that private practice. Make that money.
>
> Got a lot of anger in me. A lot of people asked me, 'Why don't you pass?' Don't want to. Wouldn't solve anything. I enjoyed talking with you sister.

The types of questions patients asked the examiner varied from questions about the research to questions about the oppression of blacks in America, to personal questions about the investigator (e.g. "How long did you go to school?"; "Did you go to college?"), to questions about the "color" of the Hospital Director in the case of patients at B.S.H. The most frequently asked question verbalized by patients from M.S.H. was "how long did you go to school." On the other hand, the most frequently asked question voiced by patients at B.S.H. was "Is Dr. ______ a black man?"

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Generally patients' overall response to the interview and the investigator was positive as measured by their willingness to be interviewed, the readiness with which they answered questions, and the candor of responses. Patients frequently commented that they had "enjoyed" the questions, and/or liked the interviewer as a person. One patient, for example, at the end of the interview when asked if he had any comments or questions replied:

> Those were some beautiful questions. Think I'll write a poem about you: Sandi, Sandi. She's for real, and nice as all outdoors.

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APPENDIX G

ILLUSTRATIONS OF THE SECOND CHANCE BLACK FAMILY

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Illustrations of the Second Chance Black Family

Clinical Illustrations. The clinical illustrations of therapists' and patients' interactions in the Second Chance Black Family and patients' responses to each other, and the terapists are presented in the hope that the reader may obtain a clear picture of what the Second Chance Black Family encompasses. Case history data regarding the patients in each of the sessions to be presented are provided first:

Case 1. M.#1 is a tall, medium brown complexioned female, age 28 who was born in the North. While completing the EFDT, she commented that she looked "bad," and wished for a "smaller nose, smaller lips, long straight blonde hair, and small feet." This is M#1's first hospitalization. She is unmarried and has three children. She stated during the interview that she believed that were she white, she "wouldn't have to put up with slums and slum landlords."

Case 2. M.#2 is a medium brown skinned female, age 58 who has been hospitalized repeatedly for lengthy periods. Presently, she has been hospitalized for four years. She is married, has no children and was born in the South. While M.#2 presently has no color delusions, she previously (during a prior hospitalization) believed she was white. On interview, M.#2 related while talking about the South

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that: "The South and the North are the same. Been called 'nigger' in both places." While completing the figure drawings she replied when asked to draw herself that she wanted more hair.

Case 3. J. is a dark brown skinned man, age 38 who presenly has been hospitalized for five consecutive years. He was born in the South and is one of five children. (His description is presented in detail at length, as it clearly illustrates the way in which many black psychotics manifest Ethnic Self-Hatred.) Data from his case history reveals previous hospitalization in the North. J. always felt as though he had an unhappy childhood, characterized by feelings of inadequacy in relation to his brother and sister, whom he felt were the favored children. At age eight, he was forced to quit school in order to go to work on what is described as a "plantation," in order to help support the family. J. reportedly always resented this fact and felt that he had lost the opportunity to 'make something' of himself. In this context, the resentment is directed toward his father whom he sees as irresponsible.

On interview, J. stated that he left the South and came North because the "millionaire DuPont" had taken his plantation. Therefore, he decided to come North to tell this to Henry Ford. J., at the time of the interview, had the color delusion he was a "bluish, greyish, white man." He related during the interview also that Abraham Lincoln was his brother, and that

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Lincoln had "freed all the slaves that the Negro people had." (In this context, he had reversed the facts of slavery, believing blacks had enslaved whites.) In addition, his delusional system involved the belief that President Nixon was a light complexioned "nigger," who had stolen his (J.'s) army. Also, when questioned about what he would do if he had possession of the army, J. stated he would put white people in the army, and "see that they have money and a car to ride in." He stated further that: "White people did everything for 'niggers,' who turn them around and gunned them down."

J. stated that an "uncle Tom" was "what colored people call white people," like him. He stated that Martin Luther King was responsible for keeping white people 'down', and had never done anything for whites, rather always "did things for 'niggers,' keeping them in front of white people.

Asked about his life in the South, J. stated:

> Down South, didn't get close to 'niggers'--stayed to myself. Couldn't find no white people to get close to. I'd never let a 'nigger' marry my daughter. Only a white man, and if my daughter married a black man, she'd be my daughter, but I wouldn't have anything to do with her 'cause she went away from my teachings.

J. refused to take the figure drawing test and stated that he would not come to any group with the therapist-investigator unless his "white wife" Miss D. said he should. (He believed he was married to Miss D. one of the Hospital's white nurses.)

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Case 4. F. is a 36 year old female, who has a history of multiple psychiatric admissions. She is single, and was born in the South. On interview she stated: "Whites are precious, wise, loving and intelligent; and, Negroes are blissful, willful, and don't need sufficient knowledge... are kind." F. has a history of covering her face with makeup pink in tone.

Case 5. C. is a dark complexioned 39 year old woman with multiple psychiatric admissions. She was born in a large urban city. During the interview, she stated:

> I have a mixed up family. My mother's part white, daddy is East Indian. Black people need freedom. A chance to stand up and tell white people what we feel. In the beginning, we had more than they did. Then they came and took everything. A white man's heaven is a black man's hell.

Case 6. P. is a fair skinned 49 year old woman who was born in the South. She was extremely guarded during the interview and spoke in her characteristic whisper of a voice. Much of what she said was inaudible. The most striking thing about P. is she wears three sets of clothing at a time, and refuses to uncover her hair, which she also refuses to wash.

Case 7. B. is a fair skinned 29 year old woman who was born in the West Indies. She is married and has four children. Among B.'s delusions are the delusions that she is white and is a college graduate. She stated that there was "no black blood" in her family, that her husband and children were also white. During the EFDT, while drawing

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the figure representing herself, she colored the face pink, the eyes blue, and the hair blonde.

Case 8. G. is a medium brown complexioned 40 year old woman, who has been hospitalized a number of times. She exhibited color delusions believing she was a "French, Cherokee Indian." In addition, she believed she was a college graduate, and a "special agent for the F.B.I." She claimed not to understand why she was hospitalized, stating she thought her black neighbors were in some way responsible for her committment. She described her black neighbors as "ignorant, lazy and junky." In addition, G. becomes perturned when staff mispronounce her name, since she believes it should be pronounced with a French accent since she believes she is a French Cherokee Indian. Also, to prove her Indian lineage, she wears bird feathers in her straight wig.

The First Session, 11/19/71.

All patients were picked up on their wards this morning by C. and I, except for J. who had previously refused to come unless Miss D. said it was "okay," and brought him to the meeting. Everyone was sitting and waiting for us, except F., who had to be cajoled into coming. We told her if she did not like the group she could leave.

Coffee and cookies were served to the group. C. volunteered to help me serve. Cigarettes were also available for those who had none. Everyone took coffee, cookies, and cigarettes except P., who remained outside the circle for the entire session.

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We began with everyone introducing himself. Everyone said they wanted to be called by first names and everyone except P., who remained silent, and J. thought it was good that they could call C. (co-therapist) and I by our first names. (The therapist-investigator is referred to as S. and C. is a male co-therapist in the text of diary process notes.)

S.--Most of you must be wondering why we're having this group. It's because on our Unit, there are a lot of people who feel bad about themselves because of their life outside, the fact that they're poor and because of their color. These are going to be some of the things we'll be talking about. We'll also be talking about what we can do about it.

(At this point, C. begins to tell the group about her previous hospitalizations and continues with a monologue for five to ten minutes. Most of what she says is told in a rambling way.)

S.--I wonder whether anyone else has had similar problems?

G.--No. None like that. My problems are very different.

(Two to three minute silence)

S.--M.#2 could you look up (she is sitting with her head bowed), and tell me what color everyone here is?

M.#2--Okay. (She does as requested, and accurately labels everyone.)

G.--<u>I'm not black</u>! I'm French Cherokee Indian.

C.--Yeah, she looks like she might have <u>some</u> Indian blood.

G.--Yes (Pointing toher cheeks) see, I have high cheek bones.

S.--M.#2 does she look like an Indian to you?

M.#2--She's a nigger.

(A few seconds of silence while G. looks at M.#2 in amazement)

S.--J., does G. look Indian to you?

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J.--She's a nigger. I'm the only cracker in this room.

(At this point, J. ang G. start to scream and argue with each other. G. argues that she is not a nigger and J. argues that he is the only white one in the room, that he and Miss D. are the only two white people in the Hospital. While G. and J. are having their debate, the rest of the patients are looking at them in amazement.)

S.--What do you all think?

M.#1--I think they're arguing 'cause both of them are ashamed of what they are.

G.--How you going to tell me what I am?! I got papers to prove I'm Indian.

M.#1--You don't have no black blood in you!? Just about all of us have some Indian in us.

C.--My grandmother was part Indian.

C.--You know how I see it. It's also a question of the haves and the have nots. Whites have most of the money, and the blacks have little money.

(This interpretation effectively changes the subject, and a discussion of poverty ensues.)

C.--How can I feel good. Look at me. This dress--I'm big, but not this big! Don't have no decent clothes.

G.--Well, I don't think I'm coming back to this group anymore. I didn't know everyone was going to try and tell me I'm Black, when I'm Cherokee Indian.

J.--I ain't coming next week either.

S.--Let's talk about it. G., you feel that everyone is attacking you.

G.--Yes.

S.--Well, you know sometimes we get angry when people tell us things we don't want to hear, but we are learning from you.

C.--Yes, she's a very interesting person, and we can learn from her. I think she should come back.

S.--How does everyone else feel about it?

M.#1--Well, I like the group, and I'll be back.

C.--We're going to be talking about other things too.

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S.--Yes. Like C. just talked about how bad she feels about not having decent clothes. How does everybody else feel? Do you all have enough clothes?

(At this point everyone shakes their head "no" including J. and G. and I proceed to write down everyone's sizes. C. and I explain that we'll try and get some clothes and/or money to buy clothes.)

G.--I don't want no hand-me-downs. No second hand stuff.

S.--In the beginning we might not be able to get new clothes. I know no one wants to wear second hand clothes. I'll see what we can do.

(The group ends with J. and G. saying that they will try to come next week. G. says if she isn't working outside the hospital she'll come back, and J. says he is coming only if Miss D. says he should.)

The Second Session, 11/25/71, Thanksgiving Day.

Present are: M.#2, P., G., J., C., and M. (the therapist-investigator's female co-therapist until the termination of the Second Chance Black Family in 1973). All the other patients have gone home for Thanksgiving Day dinner and the week-end.

Today, some of the patients were called for on their wards: P., and J. who were sitting in the visitor's room were brought by Miss D. G. arrived unescorted. Since it was Thanksgiving Day, we'd planned to have an informal meeting. Again, coffee and cake were served. Also, we'd received some donations of clothing already and we had planned to distribute them to the group. C., J., and G. picked out some of the clothing they could wear. J., after selecting four jackets and a sweater which all fitted him decided to wear the

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sweater, and one of the jackets for the remainder of the day (a hopeful sign, since J. reportedly has never accepted anything from anybody black since he's been hospitalized here, and he clearly knows I'm black).

Today, I brought a variety of records, rather than just the ones having special messages, and the group initially settled on the Nat King Cole albums with everyone expressing the feeling that those records brought back memories.

C. and B. danced periodically throughout the session which lasted today an hour and a half. J., who was asked by C. to dance, looked at C and replied that he did dance but couldn't dance with her today, saying, "maybe next time."

C. sang several songs for the group (she has a lovely voice). She sang an African song, which she sang in African dialect and two gospel songs. Then B., who was rather restless and having difficulty sitting still, sang a Jamaican song, and a song about peace and love. Afterward, the group was led in a Thanksgiving Day song by C. with everyone singing along. The members applauded each singer.

G. inquired as to whether it would be better to have an integrated group, that she was the only Indian in the group. At this point, a discussion of ancestry ensued between B. an G., the outcome of which was that G. decided the group was okay like it is.

The group continued until 11:45. At its end, everyone except P., who continued to huddle in the corner away from

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everyone, expressed a desire to have longer meetings. G. spoke briefly of how lonely she felt now that she is on an open-ward. She said she didn't know anyone downstairs on her new ward yet, and wished she could eat Thanksgiving dinner with all of us. M. and I arranged for her to eat with the rest of us.

J. smiled a great deal today and thanked me profusely for the clothing.

<u>The Third Session, 11/26/71</u>.

(Present are: M.#1, M.#2, C., B., J., G., S., and co-therapist, C. F. is still on home leave and P. refused to come. She said she had some clothes she had to wash.)

I called for everyone on their wards again today except G. who comes unescorted. When I got to J.'s ward, he was seated in the visitors' room waiting for me. He came without Miss D. for the first time.

The group began with my asking M.#1 how Thanksgiving had been, and with the others saying how they'd felt about not going home. For the most part, G. rationalized why her brother did not come to visit her yesterday. B. and M.#2 talked about how nice Thanksgiving dinner was at the Hospital.

M.#1 was told what had happened in yesterday's meeting she had missed, that we had some clothing donated to us. M.#1 stated that her Thanksgiving was "okay," but that she wasn't ready to talk about it yet, that

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"something" had happened.

At this point, G. inquired where the absent members were. After being told that C. and B. were not on the ward when I went to pick them up, she and M.#2 decided to go and look for them. A few minutes after they'd left, C. arrived alone, saying she had been downstairs in the chapel. She then sang her African song for C., and was asked where she had learned it. She memorized one of Miriam Mekeba's songs from a record. C. said she loves to sing and plays the piano by ear. By this point in the session, G. and M.#2 have returned with B.

B. comes in a initiates a conversation about why there were no "other white people in the group." To this G. replied; "Yeah, yeterday I asked the same thing too. We should have an integrated group."

M.#1 responds and says she likes things the way they are, that the "group doesn't need any white."

At this point, I interject an explanation, saying:

> One of the purposes of this group, one of the reasons that we're meeting is because some of us have problems, and the only way we can deal with them is to face them. If we ignore them, they won't go away. That is why part of the time we talk about race, and what it means to be black in this country. C. and I want to help everyone feel better about themselves as black people, so that when you go on the outside, you'll be able to deal with it.

After this explanation, G. nodded in agreement, and restated my explanation; while B. began to tell everyone what happened to her when she arrived in the United States

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from Jamaica. She explained that upon arriving at Miami Beach, Florida, she went to the travel aid office. She said that there were two offices, one for "colored and one for white." B. said that in Jamaica, she is considered white, so therefore, she went to the white travel aid office: "I went to the white office because I am white. Look at me." A man at the travel aid office, B. related, informed her she was to go to the "colored folks' office."

C. and I asked B. whether we could act out what had happened to her in Florida. C. and I played the role of a white couple, while B. played herself.

After the role playing, the group was asked what race they thought B. belonged to. Everyone told her they thought she "looked Negro." This led to B.'s arguing with the other patients and to her angrily asking me: "Why do we have to discuss race? Why we got to talk 'bout this? What difference does it make, and what color are you?"

At this point, C. changed the subject, and spent about three minutes telling us how she had been admitted to the Hospital. She was asked (by me) why she'd changed the subject, and the interpretation was made that sometimes people get uncomfortable when discussing race.

At this point, M.#2, who had her head lowered, raised it and replied: "Well, what can you do about it?" She then began to talk at length of her experiences in the

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South, saying she had come North where she thought things were "a little bit better."

Then B., who was still having difficulty sitting, replied to the group that her ancestors were not "colored," not "black," that her father and mother were both Jewish.

M.#2 then looked up again, and asked B. whether she hadn't any "black blood" at all. B. replied, "No."

At this point, C. interjected the idea that all black people have some white blood in them, but that that "doesn't make you white." Her explanation was agreed upon by M.#2 and G.

B. then turned to me and stated angrily that she didn't like me, that I was "prejudiced against" myself, that she didn't like the group and was leaving. Thereby, B. walked from the room, slamming the door.

Her outburst led to a spontaneous discussion between the patients as to why B. didn't want to be black. This discussion was initiated by M.#2 who stated: "She's all mixed up. Guess it's because she's so light, and is a 'white Negro'." At this point I explained that perhaps I should go and see what B. was doing, since, B. had left via the door which led to the locked ward, rather than by the door that would enable her to return to her ward. (Our meeting room had two doors.)

As I was about to open the door, B. burst through it in a fit of rage saying: "That goddamn Jewish bastard!

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He wouldn't let me out!" Apparently, she had encountered Dr. R., who refused to open the door for her. B. then turned to me, shook her finger at me, and reiterated that she thought I was prejudiced: "You prejudiced black bitch! Let me out. I'm not going to stay here!" B. then turned to C., and angrily called him a "black nigger," and said that both C. and I were "no good" and that we were trying to tell her she was a "colored person" when she was "a white person."

B. refused to sit down and talk about the incident and said that she was leaving, and would only return if C. and I left the group.

At this point, I noticed that C. was crying, and as I stood to escort B. back to her ward, I made the suggestion that the group members try to find out what C. was crying about.

When I returned, M.#1 and G. were patting C. on the back and had fixed her another cup of coffee. C. explained to me that she had been crying because: "I don't like to hear our people talk that way, calling names like that."

A group discussion ensued about how the group members felt about B. and her problems and feelings. The discussion revolved around the expression of anger, the fact that sometimes the truth hurts, and the need for the group members to help B. accept herself. Finally, it was suggested that we all go and tell B. that we wanted her to come back to

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the group next week, that we liked her and understood her feelings.

At this point, J. said he felt as though "the ladies" could better talk to B. The group agreed that it was better for the women to handle the matter.

Then, C., G., and M.#2 all inquired how C. and I felt about the names B. had called us. C. stated:

> I don't get angry when someone calls me black. That's what I am, and I'm proud to be black. As to the word nigger--she was angry--and anyone can be a nigger. You see, the truth hurts. B. is the one that feels bad about her race, not me.

At this point G. interjected that, "yes anyone can be a nigger," that even white people can be niggers, and she had looked the word up in Webster's Dictionary many times.

I then answered the question regarding how I felt about being called a "prejudiced black bitch.":

> Well, it's not the first time I've been called a bitch. As to the word black, I am black. I feel like a beautiful black woman. Really feel it. You are looking at beautiful black me! So, B.'s calling me black doesn't bother me, doesn't make me angry. And, I hope that she, and all of you can one day feel the same way, that you are black and beautiful.

At this point, M.#1 nodded "yes" and M.#2 smiled, clapped her hands and said: "Oh, I like that attitude, I like that attitude! I like this group!"

C. responded by making an analogy between B. and "Imitation of Life," saying B. was "like Pinky in the movie."

G. restated the idea that the group was important and

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everyone present, except for P. who remained silent, spontaneously expressed a wish for longer meetings.

The meeting ended with the patients going to B.'s ward to talk to her. C. inquired whether the members wanted to learn about their history. Everyone, including J., said "yes," they would like to learn. C. and I waited about 15 minutes before going to see B. to attempt to talk to her.

On the way to B.'s ward, we met C. and G. in the corridor. They explained that B. had cried while the group members were talking to her, and that she had apologized to them for her outburst.

Upon seeing C. an I, B. grabbed me, kissed me on the cheek, and shook hands with C. She apologized to us, and said she would see us at the next meeting.

The Fifth Session, 12/9/71.

I was out with the flu last week and consequently the group did not meet. As I arrived at each ward to gather the patients, each of them told me how glad they were that I was well again so we could have our group meetings.

J. insisted on carrying the coffee pot today, and said he was going to make that his responsibility. M.#2, who now comes to meetings unescorted and unreminded, arrived and related how "disappointed" she was to arrive for the meeting, and find the room empty last week. Apparently, she hadn't gotten the message that I was ill.

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The group opened with B. announcing that "black people must begin to form their own standards of beauty." She continued saying: "When I look in the mirror, I can't wish I had a pointier nose." B. then continued the discussion by saying that there were many differences between the United States, and the West Indies, that in the West Indies, there is no racial discrimination like there is in the United States, that "it is a class thing" in the West Indies.

The group members verbalized how "glad" they felt that B. had "come back to us," and wasn't "so upset anymore."

At this point, I remarked that M.#2's hair looked nice (she was wearing it in an afro for the first time in her 58 years). M#2 then began to talk, saying she had gone to the beauty parlor and instructed the beautician to "give me an afro."

Subsequently, a discussion ensued about the meaning of "good and bad hair." This topic led M.#2 to talk about her mother, and some of her recollections. She stated for example: "I remember when I was a little girl. Mamma used to rock me to sleep every night, singing 'Jesus wash her white as snow'." M.#2 then described the "confusion" she felt as a child at not knowing "why Mamma wanted me to be white as snow."

Today was M.#2's day. She talked more today than

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before, and led the group in a discussion of the nature of the English language, and how the word black is defined negatively. B. participated extensively in this discussion, saying that she too had looked up the word in Webster's Dictionary, and had been unable to find any "good" definition of the word.

The group also talked about life in the South. J. brought up the subject, saying he would like to return South and work on a farm (the first time he has not referred to farms as plantations). Also, someone asked me whether or not it was true that Africans are cannibals. C. and I clarified the issue and reiterated that we would talk about black history and Africa one day soon.

The group members expressed their surprise that M.#2 had begun to talk so much, and M.#2 stated in response: "I used to hold things in, and now that I'm letting it out, I feel better."

We had difficulty ending the session today. Each time we said it was time to stop, somebody would bring up another subject. Finally, they expressed the idea that "This group is different from the other groups..."

<u>The Seventh Session, 12/16/71.</u>

The main event of today's session was that J. 'opened up'. Since the first session, the women have been encouraging J. to talk more, and today he did. J. expressed all of his color delusions today. It appears that the fact we were

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discussing the approaching holidays 'set him off', for he began talking about the delusions when someone asked him whether he was going home for Christmas. J. stated that he had "no home to go to." When asked whether he could not go to his wife's house, J. then began to tell us about his "nigger wife" and about his other wife, Miss D. (the white nurse).

Finally, the patients realized J. was deluded, was talking about a white nurse on one of the wards. They decided with J's permission to invite Miss D. into the group to verify many of the things he has said, particularly the things he said about being married to Miss D., kissing her on the ward and having a child by her. They can not in this regard believe that J. has kissed Miss D., or is married to her. Consequently, the patients decided that either they were "crazy" or J. was "sicker" than they previously believed.

Miss D. came into the group at the patients' request. I attempted to get her to directly answer M.#2's and G's questions of whether it was true she had kissed J. on the ward and had sex with him. I attempt to no avail. She is evasive, J. keeps smiling at her, and the patients appear to be wondering whether there is some truth to J.'s verbalizations; so, I decided we had better thank Miss D. for taking the time to come to answer the patients' questions, and get her out of the room before things get more chaotic than they have become. By this point, the

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patients appeared anxious, and unable to trust their own perceptions.

One important factor we learned today was that the man J. found his wife in bed with (the incident precipitating this present hospitalization) was white.

The session ended, and J. stated he could not come back to the group with the "bunch of you niggers."

<u>The Eighth Session, 12/17/71.</u>

The session got off to a slow start today. None of the patients wanted to bring up the subject of J. and Miss D. M.#2 is most courageous and began to talk about what everyone was thinking about 15 minutes into the session. She initiated the discussion by asking where J. was (he had not yet arrived, requiring Miss D.'s permission to come once again). The patients said they did not believe the things J. said yesterday, but that they were not so certain about "the kissing on the ward part of his story."

Finally, while the discussion was going on, J. arrived, escorted by Miss D. He sat down, and M.#1 got up and fixed him a cup of coffee. Everyone told J. that they were glad he had come back to the group.

We played a lot of records today, and the patients allowed J. to hear all of the Nat King Cole records (they are his favorite). As the meeting adjourned, M.#2 stated that if she were ever absent someone should "please come and get me. I don't want to miss these meetings."

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As we left, J. said he would come back next week and insisted on carrying the coffee pot.

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