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SYMPTOMATIC BEHAVIOR:

Ego-Defensive, Adaptive, and Sociocultural Aspects

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Symptom, Defense, Culture, and Adaptation

A feeling, thought, or act designated "symptomatic" is considered reflective of something else. Just as fever, tachycardia, or tremor, it indicates an underlying process. This view assumes the existence of hidden (from both subject and observer) determinants and functions (probable consequences) of the visible behavior or reported subjective state. The psychoanalytically oriented (or psychodynamic) description of these determinants and functions is framed in terms of a conflict of unconscious or preconscious (more readily accessible to awareness) psychological forces. These forces may be two opposing but incompatible tendencies, e.g., a wish to be independent and autonomous versus a wish to be dependent (as upon a parent); or a wish to be passive, submissive, and compliant versus a wish to be active, dominant, and aggressive. Or they may be a socially unacceptable wish or drive (usually aggressive or sexual) versus an inhibiting force (often summarized in structural terms as the superego) on the other. The final behavioral pathway, i.e., the symptom, or index behavior itself, is shaped by the particular

tendencies involved, the anxiety generated by conflict between them, and the ego-defense mechanisms which it activates. These last function to keep anxiety at a manageable level and unacceptable vectors of conflict from erupting undisguised into consciousness or being translated into action. This behavioral formulation or psychodynamic description is based on a group of interlocking concepts developed by Sigmund Freud. Major milestones in understanding the symptomatic (hidden) significance of privately experienced or publicly observable events were publication of *The Interpretation of Dreams* in 1900, *The Psychopathology of Everyday Life* in 1901, and *Jokes and Their Relation to the Unconscious,* in 1905. These works provide a basic chart for discovering the messages hidden in dreams, fantasies, affective states, ideas, and acts, including the most ordinary communications. The messages are obscured by condensation, derivative formation, and a series of typical distortions, regularities which suggest that they are systematically produced. The hypothetical distortion-producing processes were assumed to defend the subject from being confronted or overwhelmed by his own threatening, unacceptable wishes, impulses, or memories, *ergo* "defense mechanisms." Defense mechanisms are concepts constructed on the basis of detailed psycho-biographies, with particular emphasis on inappropriate responses to external crises, or on psychological pain, or inappropriate behavior without apparent reason. The summary of psychoanalytic thinking forming the general basis of psychodynamics is

Freud's work, *Inhibitions, Symptoms, and Anxiety* published in 1926. Anna Freud's summary of defense mechanisms, published in 1936,32 also contains little which needs to be significantly modified. Psychological defense is conceived as one function of the ego: a coherent grouping or system of interrelated functions or activities, such as paying attention, making decisions, controlling motor action, or integrating whole complexes of thoughts, attitudes, and feelings, as well as managing anxiety and warding off impulses. Dysfunction in one aspect of the system is reflected in changes—sometimes of a compensatory nature—in the rest of the system. The defensive functions of the ego operate in concert with its integrative, executive, and other functions, conceived as part of this system of interrelated processes. Ego-functioning is also determined by a person's basic endowments, his equipment for receiving, processing, and integrating information from within and without, and for sending out new information. Perception, decision-making, defense, and conflict resolution depend to some degree on the intelligence, talent, knowledge, and special skills which the person has at his disposal.

Every element of a psychodynamic formulation of symptomatic behavior reflects immediate or remote cultural influences. Particular wishes or needs acquire significance, and ways of dealing with them and their associated tensions are based on a society's accepted rules for living. Nuclear families stimulate more intense attachments to and rivalries with the same

sex and opposite sex parent than do extended families, or where many surrogate parents are involved in childrearing. Independence-dependence conflicts reflect the roles of adolescents in particular cultures. Childrearing practices are among the most faithful reflectors of traditional values, espoused by adults who ignore them in the actual conduct of their own lives. One example of an articulating hypothesis linking early developmental experience to adult (possibly symptomatic) behavior is that of Weisman as summarized and interpreted by Caudill: "Adult behavior is 'colored' by a recognizably different— according to the culture—set of derivatives coming from the particular, for the culture, solutions to pre-genital phases of development." Caudill and colleagues, comparing Japanese and American mother-infant interaction, suggest strongly that differences in the motor and verbal behavior of Japanese and American infants during the first several months of life are learned (a function of culture), rather than genetic or maturational in origin. Caudill and Weinstein noted:

> If these distinctive patterns of behavior are well on the way to being learned by three-to-four months of age, and if they continue over the life span of the person, then there are very likely to be important areas of difference in emotional response in people in one culture when compared with those in another. Such differences are not easily subject to conscious control and, largely out of awareness, they accent and color human behavior.

The infants are considered by Caudill as having "learned some of the rudiments of their culture" by this age, "well before the development of the

ability to use language in the ordinary sense." He views this as the acquisition of some aspects of the "implicit culture," as Linton termed it, the ways of thinking and behaving which occur without conscious attention and are generally shared by people in the particular culture.

The core of the superego—the organized, internalized, unconscious standard-setting and inhibiting mechanisms—is what has been learned (during preverbal as well as later development) from culture-bearing parents. Socially transmitted values and symbols are crucial aspects of culture. The early acquisition of self-censoring and behavior-inhibiting tendencies (part of the process of socialization) was described by Wexler as incorporating the parent "garbed in the mythology of childhood." Devereux referred to the "relative degree of importance which a culture 'assigns' to various defense mechanisms," and utilized the concept of an "ethnic unconscious" composed ". . . of material which each generation teaches the next one to repress, in accordance with the basic demand patterns of the prevailing culture. . . . each society or culture permits certain impulses, fantasies and the like to become and remain conscious while requiring others to be repressed."

Wittkower and Fried concluded that different clinical syndromes prominent in differing cultures may be related to differences in (a) the amount of aggression, guilt, and anxiety generated in regularly encountered life situations, and (b) the accepted techniques used in dealing with

aggression, guilt, and anxiety. Thus, the relative acceptability of drives or wishes (the anxiety, guilt, shame, or disgust attached to them), as well as the repertory of defenses used to ward them off or manage the tension which they trigger, is culturally influenced. These factors are recognized in the large literature on basic personality types or modal personalities. The modal personality concept implies that people exposed to certain regularities in childrearing and constraints and reinforcements on their adult behavior share certain response tendencies. As C. P. Snow, quoted by Leighton and Murphy, has observed: "Without thinking about it, they respond alike. That is what culture means." Shared behavioral readinesses should logically be accompanied by shared vulnerability or resistance to particular types of symptomatic behavior. There is some support for this presumption, and an inpidual's habitual affective and cognitive styles developed within his familial or national cultural setting shape the form of his symptomatic behavior. Such patterns of shared behavior may, for example, increase the likelihood that any culture-bearer's overt disturbance will have a paranoid or an affective cast, or that his anxiety will be reflected in inner discomfort rather than outward action. However, the epidemiological evidence, especially in terms of the incidence of established syndromes, is as yet inconclusive.

Following the Freudian formulae, a symptom is a compromise formation. Symptomatic behavior represents an unsatisfactory compromise between unconscious wishes, the demands of the superego, and of reality

(including aspects of culture and society). A series of defense mechanisms, with repression as the cornerstone, is activated by signal anxiety generated by the unconscious conflict. The final behavioral outcome, most prominently shaped by the leading defense mechanisms, reflects other factors as well. Significant among these are poorly dealt with anxiety or other tension emerging to the surface, and the disguised representation or gratification of the warded-off impulse. The symptom may have symbolic significance which allows it to function in this way; it may also be a symbolic communicative attempt, reflect unresolved identifications with important caretakers or love-objects, or involve culture-specific expressive or instrumental symbols. Psychological symptoms constitute a code to messages stated otherwise in cultural or inpidual historical terms.

Symptoms result in both primary and secondary gain. The former is the immediate intrapsychic consequence of the defensive process: anxiety and impulse control, as well as some disguised gratification of the warded-off wish. Because the latter gain is environmental, it provides another channel through which culture shapes symptoms. It includes the added control over important people which the person obtains by becoming sick. Reinforcing environmental rewards range from enslaving a dominant spouse—reversing roles—to temporary freedom from work demands.

The consequences of organic illness may be incorporated into a defense

system, enhancing both primary and secondary gain. If the illness has resulted in cerebral deficit with impaired memory or reality evaluation, the deficit may function as an aid to the processes of repression and denial with environmental consequences. During the peak of prefrontal lobotomy usage in the United States, in the late 1940s, a middle-aged man received the operation for a severe, chronic, obsessive tension state. He had lived alone with his elderly mother who suffered from painful arthritis. Although the examining psychiatrist inferred the presence of significant unconscious hostility toward the mother, the patient's overt behavior had been docile, conforming, and unnecessarily polite, revealing underlying anger only through an excessive concern with her health and the possibility of her sudden death. This was sufficiently obtrusive to make her uncomfortable at times. Following surgery and significant relief from symptoms, his docile conforming behavior was replaced by a tendency to be boisterous and use crude language. He sometimes shouted at his mother (which he had never done before) when he experienced her as frustrating, and now acknowledged feelings of anger toward her to the psychiatrist. His overt concern for her health and comfort, however, remained and he could not acknowledge an aggressive intent in one new pattern of behavior which occurred repeatedly. That is, he would forget to stoke the coal furnace before going to work in the morning; this meant that his mother, in her eighties, had painfully to crawl down the basement stairs and bit by bit fire the furnace herself. The patient

would say only that since the surgery his memory had been so impaired that he was unable to remember to care for the furnace. (Psychological tests revealed no significant impairment six months after surgery, although it had been present for several weeks earlier.)

An emergency room experience also illustrates some of the elements of primary and secondary gain. A young woman was admitted with a quadriplegia that began when her husband left town. Eventually, it became clear that she was struggling with her unconscious and unacceptable love for her brother-in-law. The quadriplegia represented a symptomatic compromise between her love and the self-censoring (guilt-producing) mechanisms which kept it from emerging into consciousness. Her paralysis made it impossible for her on the one hand to go to her brother-in-law when her husband left town; on the other hand, it required him to come to her and made it impossible for her to ward him off if he were to decide to make love to her. Her symptom symbolized her wish to submit while allowing her to abdicate any responsibility for physical contact with him, should he initiate it. Aside from the primary gain (anxiety and guilt reduction, impulse control, need gratification), it obtained for her the secondary gain of limiting her husband's resented traveling for a time, unconsciously stimulating his anxiety about her, and increasing her real-life dominance over him.

Massive conversion reactions, such as the above, are most frequently

reported in relatively unsophisticated populations. Hollingshead and Redlich suggested that, in general, upper-class (I and II) psychiatric patients tend to be obsessive or depressed, middle-class (III) anxious, lower-middle or upper-lower (IV) hypochondriacal or somatically expressive, and the lowest classes (V) aggressive ("acting out" their conflicts) or resigned. These socioeconomic class-linked behaviors reflect the relative priorities of defense mechanisms determined by different developmental experiences, including the educational, as well as by the innate capacities, knowledge, and skills acquired by the person during development. Beyond the early cultural impact on ego development and communicative capacity, people in different social strata have variable access to sources of power and help. Social imperatives confine the effective cry for help of the lower-prestige person to one which is loud, dramatic, and sometimes threatening.

Ego-defensive processes following the Freudian formulae function mainly to achieve an intrapsychic steady state. Sullivan's concept of security operations includes maneuvers aimed at interpersonal as well as intrapsychic factors. Hartman emphasized inpidual-societal relations, defining psychological adaptation as the process of establishing and maintaining a reciprocal relationship with the environment. This implies a more active, creative attempt at dealing with the environment and its crises: active information-seeking, circumventing, and modifying, rather than adjusting to social conditions. Adaptive-coping behavior is sometimes mistaken for the

symptomatic reflection of mechanisms defending against the emergence into consciousness or action of unacceptable unconscious wishes. A youngster growing up in a metropolitan ghetto, for example, may present himself to an examining doctor as wary, suspicious, and litigious. This behavior is the culmination of a long struggle to survive in a threatening environment in which readiness to attack is the best defense. It also reflects the hostile anxiety of a helpless person surrounded by strangers. The unaware physician may inadvertently describe the patient as paranoid, implying the presence of unconscious homosexual or aggressive wishes dealt with by disavowal and attribution to someone else (projection).

Some circumstances may require rigid self-monitoring to avoid the expression of hostile impulses. Over a period of time, having become habitual, adaptively necessary suppression may be confused with symptomatic defensive inhibition. This last involves the constant employment of repression and reaction-formation (resulting in a public display of inappropriate cheerfulness or docility), as a means of warding off the explosive eruption of unconscious hostile impulses. Behavior reflecting chronic reaction formation is often maladaptive in the long run, since it does not give others the responsive feedback which they need to maintain their own interpersonal orientation and security. This is an example of the way in which ego-defensive processes result in overt behavior which, evoking reactions from others, soon leads the patient to progressively disturbing and

burdensome relationships. On the other hand, seriously symptomatic acts may occur over a lifetime without such social consequences, and they may exist without obvious impairment of creative performance. For example, the novelist Graham Greene described his own patterns of risk-taking behavior aimed at relieving boredom and giving him the feeling of being alive. He feigned the symptoms of an abscess, deceiving a dentist into extracting a healthy tooth under ether: ". . . unconsciousness was like a holiday from the world. I had lost a tooth but the boredom was for the time being dispersed." Over several months he played solitary Russian roulette: "The discovery that it was possible to enjoy again the visible world by risking its total loss was one I was bound to make sooner or later. ... I remember an extraordinary sense of jubilation. .. . My heart knocked in its cage, and life contained an infinite number of possibilities."

Adaptive behavior becomes symptomatic when it persists outside the context in which it was functional. The suspiciousness necessary for survival in an inner city alley is inappropriate in the hospital examining room. The tendency to blame misfortune on external occult forces, normative among the folk Catholics of rural Brazil, may interfere with survival in industrial Sao Paulo. United States paratroopers in World War II were rewarded for killing Germans. Those who persisted in attacking German civilians after the war ended were labeled as aggressive psychopaths. The behavior was no different, but it was no longer socially functional.

Behavior which is genuinely adaptive or coping may also have symptomatic significance or be incorporated into symptomatic fantasies. This can most readily be seen in the psychotherapeutic situation. A young professional man, for example, had realized for some time that he was entrapped in an unsatisfactory partnership arrangement. Although his self-esteem suffered because of the attitudes of his senior associate, he remained because of the financial security it offered. Finally, he severed the relationship, although not precluding the possibility of more favorable renegotiated terms. This was an overdue adaptive and coping act. In the course of the following therapeutic hours, however, its symptomatic significance became apparent through his repeated reference to the idea that he had "cut off" his income. At one level, it was an unconscious act of retaliation against his wife who had told him that she was stronger-willed than he and could control him. Now he had symbolically converted himself into a castrate, and she would not have the money she needed from him. He required her in concrete as well as symbolic terms to become the strongest. In the transference, his needs for the therapist were clear. He fantasied telling the therapist that he could not pay the bill, with the therapist agreeing in return to carry him without a fee as long as necessary. The unconscious need was for the therapist to express his love and his appreciation for him as a unique inpidual, not "just another patient," and someone of particular worth —in marked contrast to his father who always complained that he, the

patient, didn't accomplish what father wanted. The patient had also noted that father "never listened" when he tried to tell him something.

The borderline between adaptation and ego-defense is most difficult to ascertain when the demands for survival are so severe and prolonged as to produce major psychological distortions. This has been reported in combat situation, concentration camps, and shipwreck survivors.

An example is a woman of superior intelligence who spent two of her late childhood years in a Nazi concentration camp and a third recovering from tuberculosis contracted there. Her parents died in the camp and she recalls vividly the attention to minutiae necessary for her own survival. Narrowing of attention facilitated highly focused alertness; it also aided in repressing and denying information of catastrophic significance. This was part of what was called "getting yourself organized." The persisting need to be organized, to remain attentive to potentially life-threatening circumstances, to find food and warmth, were accompanied by a massive repression of hostility against the camp commanders, their underlings, and a more attractive female friend who had been able to prostitute herself for favors in an earlier camp. Despite her musical talent and opportunities to play, despite her high intelligence and opportunities for executive or scholarly work, she has remained a bookkeeper engaged in routine tasks. Her personality is obsessive-compulsive, meticulous in detail, intolerant of ambiguity, anxious in the face

of any uncertainty, mistrustful of the motives of others seeking her friendship, and wary of her own tremendous needs and capacity for unreal expectations and disappointment, should she allow a relationship to develop. Her obsessive-compulsive tendencies, social distancing behavior, and hypersensitivity to the possibly hidden motives of others, are symptomatic reflections of defensive processes which have their roots in her earlier adaptational struggle.

Ego-defensive behavior stemming from inner conflict may also be adaptive. Thus, the repression of unconscious sexual wishes could facilitate a stable reciprocal relationship with authoritative parents in a Victorian society. More commonly, obsessive-compulsive behavior which has not reached the point of producing paralysis is rewarded in those whose intelligence and talent, propelled in part by neurotic drives, lead them to complete arduous courses of study such as medicine or law, or, striving for unattainable perfection, to make scientific discoveries or achieve certain types of business success. Even more commonly, however, the behavior consequent to ego-defensive operations is maladaptive. A paranoid system based on projection may keep the person's anxiety at a manageable level, but as he acts upon it, he may alienate his boss, estrange his wife, and shatter his personal relations. The delusions and hallucinations as well as the physical immobility of the catatonic patient may help reduce his anxiety and ward off potentially explosive instinctual impulses. Without nursing care, however,

they are followed by physical illness and death.

A frequently used example of an ego-defensive mechanism employed with ultimately adaptive consequences is "regression in the service of the ego." Ernst Kris, following Freud's hypothesis that artists are characterized by a "flexibility of regression," formulated this concept as an expression of his idea that the creative process requires access to fantasies, feelings, thoughts, memories, images, and other mental phenomena which are usually not in awareness, i.e., which are preconscious or unconscious. Both Freud and Kris regarded the capacity to occasionally relinquish one's tight hold on reality as indicative of mature, creative persons. Kris proposed that the artist can deliberately regress while remaining receptive to the preconscious primary-process flow of psychological events. In this way, he can arrive at new insights, novel orderings of relationships, or previously unsuspected groupings. This contrasts with the psychotic whose inability to experience humor in response to cartoons reveals his anxiety about relinquishing his fragmented reality hold because of the risk of being unable to recapture it or of being totally overwhelmed by fantasy.

Social and Cultural Appraisal of Symptomatic Behavior

Human behavior—thinking, feeling, acting— is constantly evaluated by the actor himself and his audience. But the ongoing evaluative process is

usually outside the focus of awareness. The standards by which people categorize their experience are built into them through socialization and enculturation while they mature; sorting, matching, and classifying information, evaluating its congruence or fit with these standards, occur rapidly and automatically. The process is shared by most members of a community (because of regularities in developmental and adult experience) and operates silently. It is part of an institutionalized behavior pattern. Institutionalized behavior, in Talcott Parsons' words, provides "a mode of 'integration' of the actions of the component inpiduals" of society. Automatic consensus about the social significance of behavior is also implied by Clyde Kluckhohn's definition of culture as a society's blueprint for living: the socially transmitted behavior patterns utilized by everyone in relation to all of the important aspects of life from birth to death. The standards or values at its base, statements of what is considered worthwhile by the society, determine its normative guidelines for living, whether contained in institutionalized patterns of behavior or embodied in a system of external restraints, such as a legal code. Parsons regards moral or obligatory standards in particular as ". . . the core of the stabilizing mechanisms of the systems of social interaction." These, along with common knowledge, common psychological states, and common attitudes, constitute what Ralph Linton called the "covert or implicit aspects of culture."' Related is the definition of culture offered by Kroeber and Parsons: "the transmitted and

created content and patterns of values, ideas and other symbolic-meaningful systems as factors in the shaping of human behavior, and the artifacts produced through behavior." Jaeger and Selznick's definition of culture is more sharply focused as "everything that is produced by and capable of sustaining shared symbolic experience." In short, all human behavior occurs in a cultural symbolic-meaningful matrix, of which values are an essential part. Within this context, a person may categorize his own behavior as symptomatic if he experiences it as alien or a foreign body in himself— it is not congruent with his own internalized norms, values, and expectations of himself. Having labeled himself he may then seek professional assistance to rid himself of his subjectively experienced discomfort or ego-alien behavior, even though it may not be apparent to others. (L. S. Kubie once noted that the true heroes of this civilization are the people who continue to work and carry out their social responsibilities despite intense feelings of anxiety, depression, obsessive ideas, compulsive acts, phobias, or other neurotic symptoms.)

Inpidual values are closely related to group values in this respect. For example, cultural factors, such as an emphasis on tolerance or stoicism, may determine subjective experience as well as the timing of help-seeking. Italian housewives with a tendency to focus on the immediacy of pain showed lower thresholds for electric shock according to Sternbach and Tursky than Jewish women with a future orientation or "Yankees" with a "matter of fact" orientation. These latter groups exhibited more rapid adaptation of the

diphasic palmar skin potential response to shock. Mechanic emphasized the role of fear, stigma, social distance, and feelings of humiliation in help-seeking, as well as the influence upon illness-linked behavior (particularly one's need to minimize it) of the extent to which a particular community holds its members accountable for fulfilling responsibilities, regardless of health status. This last is closely related to Parsons' earlier conception of the sick-role as a socially acceptable though sometimes temporary solution to psychosocial impasses. Parsons regarded exemption from the performance of certain normal social obligations, as well as from a certain type of responsibility for one's own state, as one of the features making it evident that "illness is not merely a 'condition' but also a social role." Different cultures and different social strata reinforce or counteract the sick-role in varying degrees. Self as well as other-appraisal of behavior as symptomatic will depend to some degree upon the guilt- and shame-free availability, the usefulness or necessity, of the sick role as a conflict-resolving or otherwise rewarding position. Beyond this, Zola has pointed out that signs ordinarily understood as indicating problems in one population may be ignored in others because of their congruence with dominant or major value-orientations. An example of the "fit" of signs with major social values is the acceptance (by subject as well as observer) of hallucinatory experience in some less industrialized societies, in contrast to the anxiety and symptomatic labeling accompanying such experience in societies with greater emphasis on

rationality and control. The variable appraisal of intense emotional display as symptomatic is illustrated by Anne Parsons' contrast between the prominence of dramatic expression as a preferred way of dealing with inner and outer conflict in Italian as compared with United States culture. The importance of culture-specific values is illustrated by the same investigator's account of an excited young woman of South Italian descent who was not regarded by her family as mentally ill until she violated two crucial norms, respect for the dead and family solidarity. Other illustrations include the location of bodily symptoms in accordance with dominant values inhibiting or permitting particular types of symbolic expression, and illness behavior and appraisal in relation to guilt and sin ideologies, with such associated needs as those for expiation, exhibition of one's worthlessness, and suffering, or ascetic self-abnegation.

Self-referral to mental health units, folk-healers, or their equivalents, may not always be a consequence of ego-alien behavior. People also refer themselves for psychological help because, of the secondary anxiety attendant upon ego-syntonic behavior. This usually refers to acts defined socially but not experienced personally as deviant, i.e., evaluated as such by observers (the audience) rather than the subject (the actor). These acts may include compulsive stealing, various sexual activities, repeated self-narcotization, impulsive risk-taking, or self-defeating occupational or interpersonal patterns. The inpidual engaging in ego-syntonic behavior does

not experience it as painful, alien, or symptomatic. In time, however, he may become anxious about its consequences: legal apprehension (as in the case of stealing), social condemnation (as in the case of a homosexual minister seducing adolescent male parishioners), the deterioration of physical health (as in chronic alcoholism), accidents (as in repeated speeding), unwanted pregnancy (as in impulsive intercourse without contraception), or economic failure (as in repeated job loss due to symptomatic errors or antagonizing superiors).

Such secondary anxiety can lead the person to appraise his own behavior as symptomatic, but his attention is usually focused on its symptomatic nature only between acts, especially in the somewhat depressed period which occasionally follows an episode.

Both ego-alien and ego-syntonic behavior may be subjectively appraised as sick or symptomatic in terms of the others, the referents, with whom the person compares himself. The major *comparative* reference group is usually the particular sub-community in which a person lives. Its institutional, organizational, and behavioral patterns are familiar, and a person has innumerable opportunities throughout the day and over years to evaluate, assess, and appraise himself, using intimately known others and patterns as standards. He receives constant affirmations of his stable identity from the responses of others to whose values and expectations he conforms.

Objectively minimal changes in this stable context can produce major interpersonal consequences which may force the inpidual into drastic reappraisals of himself. Beyond the comparative reference group, the persons behavior may be determined by that of a more distant community which he values highly, but to which he does not belong. This wealthier, better-educated, or somehow more advantaged community functions for him as an *emulative* reference group. Historically, the white middle-class community has had emulative significance for the American black; since he could not aspire to become a member of the group, some of whose goals and values he had acquired, this had an impact not only on his self- and other-appraisal (for example, hating and deprecating himself and others like him), but on his actual behavior, for example, unconscious emulative attempts based on fragmented and inaccurate information often resulting in caricatures eliciting humorous contempt from whites. Traditional goals of the dominant white North American, such as pecuniary, occupational, and educational achievement, are now being adopted and achieved, however, to an increasing degree by the black community. More significantly, with the increasing value of the black identity, fostered by socioeconomic and political militancy, whites *per se* have become less significant as an emulative reference group.

Still others who come to clinics or private mental health practitioners, or are extruded from society at large into mental hospitals, do not evaluate their own behavior in this manner. They evoke discomfort in others who

perceive them as socially or culturally alien. Socially identified as deviant, bizarre, or dangerous to themselves or others, they are ordered to go to the psychiatric facility; they may be forced to do so despite their vigorous resistance. In these instances the diagnosis of symptomatic behavior is made by the community. The line between self- and other-diagnosis is not totally clear, however, because the public expressions to which community agencies of social control respond can sometimes be understood as "cries for help." The communicative significance of the symptomatic act may be deeply repressed or accessible to the subject's awareness with little therapeutic effort. The cry for help is often not understood as such because community diagnoses and dispositions are capricious, reflecting prevalent beliefs and values. This is partly because the symptomatic or sick behavior series is logically continuous with other behaviors accepted as healthy (or customary), or defined in judgmental, religious, or other terms. Society's techniques for dealing with deviance, involving variable degrees of collaboration by the labeled deviant, include shunning, ridicule, nurturing, behavior change in place (as via outpatient treatment), extrusion from the system for punishment and deterrence (jail), or extrusion for behavior change (mental hospital). These are institutionalized ways of behaving which represent unthinking conformity to cultural norms defining proper, legitimate, or expected modes of action or social relationship. The choice of social action depends in part upon the existence of "resources" or "facilities," such as

mental hospitals, doctors, cult centers, and social agencies. These undertake many of the social control functions once carried out by families. Their presence as well as norms and attitudes reflect the developmental state of the behavioral setting.

Gibbs regards the likelihood of a person's being isolated for committing a deviant act as directly proportional to the degree to which he is a "social and cultural alien," i.e., one who differs in status and cultural traits from other members of the society, and particularly from the agents of social control and the power-holding dominant culture-bearers. In the United States, such persons have included those who are non-white, non-native, and in agricultural labor and other lower-class occupations. The validity of this proposition may rest upon the cumulative weight of a range of isolation stations. Thus, in Maryland a poor black man has been more likely to be sent to jail than a middle-class white exhibiting the same behavior who would more probably be sent to a hospital or a psychiatrist's office. In New Haven, the police and the courts were more often the gateway to the mental hospitals for lower-class than for middle-class whites who were more apt to be referred to private physicians. On the other hand, psychiatric diagnoses and hospitalizations (though not brief jail sentences for "disturbing the peace") were long delayed for Baltimore black men because of police tendencies to perceive their sick behavior as rule infractions requiring punitive action, family tendencies to see it (especially of a paranoid nature) as justified in

terms of the social situation, and tolerance by police of even bizarre behavior by known persons so long as it was confined within the ethnic community ("inner city"). This last reflected their view of lowest socioeconomic status blacks as primitive or childlike, as well as a relative lack of concern with the impact of their behavior on those around them. Similarly, in Rio de Janeiro, the subordinate status of women, blacks, and youths, reflecting the paternalistic attitudes and values of husbands, fathers, and whites, often delayed psychiatric hospitalization until deviant patterns had become severe or habitual. The families of the Rio de Janeiro patients, socialized largely in preindustrial semirural settings, often still living on the margin of the technological society, were more central decision-makers initiating the hospitalization process than often appears to be true for poor people in United States inner cities. This, along with the use of religious-spiritist centers rather than police stations as important relay points en route to mental hospitals, may account for the apparently high agreement between self and family or community appraisal, and the decision to seek professional assistance. The religious-spiritist centers are helping rather than disciplinary agencies and require the collaboration of the help seekers. As supportive and behavior-modifying systems they may indefinitely delay the isolation of deviants in hospitals or jails. Behavior regarded as deviant in the society at large may be freely emitted in the center, which also offers a variety of self-esteem-building gratifications making such behavior less necessary

elsewhere.

Within the lower-class community, impaired capacity to contribute to family support often determines the appraisal of behavior as symptomatic or intolerable. In Rio de Janeiro, refusal or inability to work precipitated mental hospitalization more frequently among the recently migrant than the settled, the non-literate than the literate, and the uneducated than those with more schooling. The common denominator is inability to care for a nonproductive family member, which may be associated with resentment at this further burden. The real threat, for which psychiatric hospitalization is the suggested cure, is to economic survival. This was also reported for Baltimore blacks. Rogler and Hollingshead in Puerto Rico and Lewis and Zeichner in the continental United States, however, have reported diminished expectations of the patient, leading at times to role substitution by family members, which could indefinitely delay hospital admission.

Status, Role, and Symptomatic Behavior

A person's ways of thinking, feeling, and acting reflect his perceptions of and relationships with others who have particular meaning, i.e., are "significant" for him. George Herbert Mead first stressed the importance of what he called the "generalized other," i.e., the interactive group to which an inpidual feels he belongs and which is basic to his sense of personal identity.

One perceives himself and significant others to an important degree in terms of the statuses which he and they occupy. Status refers to one's position in society and most people have several. These are achieved, the result of what one does with his life, and ascribed or given, existing by reason of the accident of birth. Social class status is ascribed if a person remains in the stratum into which he was born, but can be considered as achieved if he has been upwardly or downwardly mobile in the class structure. Ascribed statuses, important in all societies, are age and sex. Self-perceptions and expectations of others are always determined by whether one is male or female, child or adult, young or old. Other ascribed positions are color, native or immigrant, and religious or ethnic statuses, insofar as a person remains identified with the position of his parents. With time, practice, and intelligence, a person can abandon many of the socially visible behavioral concomitants (e.g., manner of speech, gestures, clothing, food preferences) of some statuses, such as ethnic or religious. In early life, religion usually remains ascribed, bounded by parental sanctions; later, people can change their religion just as they can change their names and deny their ethnic origins. Such changes evoke modifications in the ways in which others perceive them, and in their own self-percepts. Nonetheless, internal conflict regarding parental identifications and other relatively unmodifiable residuals of early life may remain at the root of symptomatic behavior, ranging from dreams and slips of the tongue, to periods of depression or localized phobias.

Achieved statuses are marital, occupational, educational, and some temporary states, such as that of a hospital or office patient. Education, occupation, and available economic resources help in the process of self-change and are important aids to personal coping and adaptation, especially in industrialized societies. In these latter, especially those in the process of rapid change, occupational status (e.g., as a physician or psychiatrist) often supersedes the ethnic and religious statuses so important in more traditional societies. The achievement of socially valued statuses reflects successful coping. It brings concrete rewards and may be accompanied by a sense of fulfillment. Despite rewards, however, it may be accompanied by discomfort, e.g., depression or anxiety. Socially reinforced behavior may be regarded in such instances as having symptomatic aspects. The label "overachiever" is sometimes applied to those, for example, whose incessant work reflects an unconscious need to prove their self-worth, to affirm their masculinity, to compete with a father perceived only through the eyes of childhood, or to attain some goal which can never be reached because it is unconscious and can be identified. As a rule, though, this appraisal is not made by the community which sees and responds only to the person's status, and contributes to the rewards reinforcing his work. The appraisal may be loosely made by psychiatrists viewing the person's work career in narrowly defensive terms. They may ignore certain regularities in such careers, i.e., the pleasure in creative work, and the often encountered upswing in production

in late middle life when the person becomes conscious of the limited time left him to accomplish certain projects. It is easier to appraise achieving behavior as symptomatic when it is accompanied by apparent costs, such as exhaustion in a person who compulsively overloads himself with too many tasks, or who does not have the capacity to accomplish the goals which he habitually sets for himself. In these instances, the psychiatrist is concerned with the person's hidden agenda: What are the unconscious goals he is trying to achieve in this way? Symptomatic achieving, while it may have defensive, anxiety-reducing, or impulse-controlling value despite its corollary discomfort, often has adaptive costs as well. These may be assessed in terms of disrupted relationships and broken families. These considerations are noted here, because achieved status often obscures underlying psychological pain.

The concept of social role in relation to social status exemplifies the interrelations between society, culture, and behavior. The role is the expected behavior pattern attached to the status, and a person has several roles attached to his several statuses. Thus, the variability of his behavior during a day, at work, with his family, with friends, or strangers, can be understood in part as social role behavior. Behavior not congruent with a person's social role or status is apt to be perceived as deviant by others. A middle-aged, married male physician who behaves like an adolescent, unmarried chorus boy may be labeled at first as foolish or immature, and later as psychiatrically ill. In traditional societies, and more in the country than in the city, women

are expected to behave as subordinates. Aggressive, independent behavior in females is viewed by others as markedly deviant, and may well reflect the onset of a psychiatric disturbance. Even the patient role is culturally conditioned. In a series of private hospitals in Japan, Caudill, for example, observed that the emotionally disturbed person who enters a mental hospital slips smoothly into a passive, dependent role, modelled by the structure of kinship relations, as between older and younger brother. The doctor who, in terms of his own cultural norms, accepts and fosters this behavior would attribute special symptomatic significance to the egalitarian behavior of the middle-class United States analysand, should it occur in his own patient. One consequence of these role expectations has been that the Japanese patient's symptomatic behavior has been more apt to include irritation, depression, anxiety, and hypochondria, than open rage or anger. The disguised "cry for help," the open presenting complaint, and the nature of expressive behavior considered as sick, are influenced by the status and role of doctor and patient, and the way in which the doctor-patient relationship fits into the general social matrix of relationships.

When a person occupies statuses with incompatible social roles, the ensuing conflict may contribute to symptomatic behavior. Such problems are encountered on temporary bases in organizations. An example from the medical-psychiatric world is the man who acts simultaneously as departmental administrator and psychotherapist for a staff member. Efforts

to reconcile the conflicting therapeutic needs of his patient or counselee with the administrative requirements of the organization may lead him to countertransference distortions in his role as therapist, or to inappropriate (symptomatic) organizational assignments for the patient-staff member in his role as administrator.

In the broader society, the likelihood of role conflict is increased by the number of subgroups it contains and its rate of social change. The United States is a pluralistic, transitional society, in contrast to more isolated, primitive, or even to certain industrialized ones as Scandinavia, which is composed more of people of similar race, religion, and cultural heritage. The inhabitants of the various social worlds of the United States (based on national origin, race, and religion), especially growing children, are faced with the problem of reconciling the behavioral standards and goals acquired in families with those encountered in schools and elsewhere. As Shibutani noted: ". . . when participating in societies in which the component group norms are not mutually consistent, it becomes progressively more difficult for any man to integrate his various self-images into a single unit." This problem is most obviously present in marginal persons, those in transition between states. A marginal person, according to Kurt Lewin, is one who with a foot in each of two societies, does not feel completely at home in or belonging to either. Lewin was concerned with the children of immigrant European Jews coming to the United States at the beginning of the twentieth century. They

were caught between the culture and language of the parental home and those of the broader United States society. More recently, the concept has been applied to members of the Untouchable caste in India, who are experiencing the problems of upward mobility as the strictures of untouchability are loosened. Similarly, marginality has become a significant problem for American blacks only since the restraints of caste based on racial visibility have been relaxed. With this social change there appeared an increasing number of persons who were on the advancing "edge" or "margin" of their own sociocultural group as it was in contact with representatives of the surrounding power-holding white society. The marginal black person, as others in social transition, must be constantly vigilant for signs of avoidance, rejection, or hostility in his new (in this instance white) associates. Partial acceptance, with a chronic underlying threat of rejection, creates an ambiguous social situation, contributing to feelings of insecurity and an unstable sense of identity. Some specific symptomatic behaviors encountered in marginal persons have been: disgust for food characteristic of childhood, acute sensitivity to anything reminding them of their origins, and anger at less sophisticated members of the culture of origin, whose actions elicit the distaste or humorous contempt of the (white) social power-holders.

The marginal person is in double jeopardy because he is also in danger of alienation from his social world of origin which, like the new social world, sees him as deviant, nonconforming, not fully belonging, and may make him

the target of resentment generated elsewhere. Thus, the word "Oreo," a chocolate cookie with a white inner layer has been applied by blacks to their upwardly mobile fellows who relate to whites and behave according to middle-class values. Similarly, American Indians serving as representatives of their people to the white establishment have been called "apples"—red outside and white inside.

Symptomatic Participation in the Hospital Milieu

Mental hospitals have provided convenient settings for the study of patient behavior in relation to social and cultural factors. The statements and mood, actions and emotions of a hospitalized patient are not solely a function of his past personal history, his prior programming. They reflect, as well, the immediate social situation of which he is a part. Until the importance of the hospital context was recognized, behavior reflecting the patient's adaptation to this milieu was labeled as symptomatic, stereotyped, or repetitive, and not related to environmental demands. Interest in the hospital milieu accelerated with the employment of social scientists in psychiatric units, especially after World War II. Hospitals have been conceptualized by many investigators as social systems in which patients, as well as professional helpers, administrators, and others, are mutually influencing actors. Among the early students of the vicissitudes of symptomatic behavior in hospital wards viewed in this manner were Rowland, Devereux, and Caudill and associates;

later Caudill reviewed most of the significant literature before 1957. From the anthropological position, the hospital constitutes a subculture with its own values, belief-systems, myths, and norms, elements of which are transmitted from one generation of patients and staff to another. Stanton and Schwartz emphasized a particular dimension, the relationship of patient behavior, ordinarily interpreted in purely psychopathological terms (without reference to ongoing social phenomena), to covert conflict between staff members upon whom they were dependent. Thus, a previously unexplained period of excitement in a chronically schizophrenic patient can be seen as an aspect of a total social field disturbance, the key element of which is an unconfronted disagreement between ward personnel.

While Stanton and Schwartz's major book on the subject did not appear until 1954, it was preceded by a series of papers beginning in the late 1940s. These focused on the communicative and participative significance, in relation to the ward social process, of behavior such as incontinence, previously viewed by the staff in stereotyped pathological terms. A more recent study suggested that the patient's excitement following disagreement among staff members was due in part to the withdrawal from him of emotional support by a key staff member (now involved in conflict with a colleague) who was becoming a bridge for him to broader interpersonal involvement and reality contact. Cumming and Cumming offer a general ego-psychological framework for the practice of environmental therapy.

Their volume contains many examples of patient behavior which can be viewed as symptomatic in the sense of reflecting unresolved intrapsychic conflicts, but can be more profitably understood in relation to the hospital society and culture. As they note, . . the acting out of the patient role in complement to the roles of the others in the environment is the road to ego restitution" (p. 137).

Ullman reviewed United States mental hospital statistics for the early nineteenth century showing discharge or recovery rates of 80 and 90 per cent. The "moral treatment" then in vogue was based on an expected and reinforced healthy role provided by the models of the superintendent, his family, and staff, who lived in close proximity to the patients. This treatment and its associated recovery rates declined after the 1850s with the building of large centralized hospitals and the increased inflow of immigrants, with whom the psychiatrist had difficulty communicating. The ensuing years witnessed a change in the expectations of physicians and their withdrawal as role models for institutionalized patients. This was due not only to the tremendous increases in the number of patients per doctor, but also to the rise of the medical model of illness. As Ullman noted, the patient was relegated to a passive role, awaiting the discovery of cure. Bockoven wrote: "The very idea of dead and decomposing brain cells carried with it the connotation of the patient's growing insensibility and unawareness of surroundings." All of these factors summarized by Ullman contributed to the

growth of what von Mering and King called the “Legend of Chronicity.”

The point of all of these studies for the present thesis is that the attitudes and behavior of staff reinforce particular aspects of patient behavior. In the era of moral treatment, patients were in effect taught to behave like integrated, healthy non-patients. Since then, particularly with the development of the aide culture, the predominance of the medical model, and the development of large custodial hospitals, they have been taught to behave as though they were sick and belonged in a hospital, i.e., as patients: conforming, submissive, suspicious, covertly circumventing. Occasionally, “crazy” ways of acting, with their thinking and feeling corollaries which might be legitimately called symptomatic, are reinforced and functional in the hospital context. Sometimes, these symptomatic patterns help the patient achieve a new identity to replace that stripped from him by the homogenizing process of the hospital. A familiar example is the elderly woman with hypomanic tendencies who, quite aware of her role as a “clown,” skillfully evokes the laughter and friendly interest, however patronizing, of the staff whom she meets at conferences. The staff, locked into this reciprocal perceptual and manipulative pattern, is amazed (and perhaps a little angry) to discover that an outside interviewer with a different set can evoke serious, coherent, and justifiably depressed responses from the patient who, it turns out, is highly sensitive to her hopeless role as a chronic inmate deserted by her relatives. Gentle probing clearly reveals the presence of unconscious and

unacceptable rage against these relatives. In this instance, euphoric, overactive, or grotesquely comic behavior can be viewed in several conceptual frameworks: It reflects the defensive processes of denial and repression which keep her anxiety, guilt, and anger at manageable levels and help her self-esteem, while it simultaneously symbolizes her own self-hatred (turning rage against herself) as a contemptible court-jester; it is adaptive, stabilizing her relationship with the staff, achieving an acceptable social role within the anonymous patient mass; it is coping, allowing her to circumvent many administrative barriers and staff indifference, and to obtain certain concrete privileges as well as the facsimiles of love and regard, which also aid her fragile self-esteem.

These phenomena have been studied by Goffman (with particular reference to the growth of the aide culture), Dunham and Weinberg, and others. Goffman has included the mental hospital in his category of "total institutions," i.e., jails, military units, and monasteries, in which the normally pided areas of living, such as working, playing, sleeping, and eating, are carried out together in one place under the guidance of an overall master plan. Under such circumstances, attempts at inpidual self-expression are viewed by those in control as deviant and non-normative and are treated as rule infractions. In this way, patients are encouraged to melt into the anonymous mass; those who have depended on social distancing mechanisms throughout life, especially those from the lower socioeconomic classes

already in awe of authority and reluctant to stand out from the group, easily sink out of sight. They engage in a type of withdrawal which, regarded as regressive or symptomatic by examining psychiatrists, represents in fact a type of adaptation to a particular environment. Specific variations are imposed by the differing value orientations of staff upon whom patients are dependent, and who function for them in the role of parent-surrogates. Considerable differences in attitudes of aides, nurses, and resident psychiatrists in a small university psychiatric unit, for example, were documented toward sexual, aggressive, and other types of sensitively noted patient behavior. Social attractiveness and consequent interpersonal choice among psychiatric patients and staff have also been demonstrated as a factor determining social isolation or acceptance, feelings of belonging or rejection, and even the determination of treatment goals by staff, and selection of patients for particular therapeutic attention. These factors, reflecting complex relationships between biographical characteristics and values, have powerful effects on patient behavior, which may be considered simultaneously from symptomatic, adaptive, coping, or other frames of references.

Society and Culture-Wide Forces and Symptomatic Behavior

Cross-cultural or Transcultural Approaches. Symptomatic behavior has been studied transculturally in the sense used by Wittkower to designate behavior which transcends a particular culture; it has also been studied in

terms of behavioral comparisons between or across cultures. Leighton and Murphy have summarized ideas as to how culture and cultural situations might exert causal or determining influences on psychiatric disorders. Aside from the production of specifically vulnerable basic personality types, culture has been, according to their review, conceived as determining the pattern of certain specific disorders, e.g., *latah* in Malaya; producing disorders, latent for a time, through childrearing practices; selectively influencing patterns of disorder through particular sanctions which engender shame or guilt; confronting people with stressful roles; perpetuating disorder by rewarding it with prestigeful roles, e.g., as the shaman; changing at a rate too rapid for personal accommodation; inculcating beliefs and values that produce damaging emotional states, e.g., fears and unrealistic aspirations; affecting the distribution of disorders through breeding patterns; influencing the amount and distribution of disorder through patterns of poor hygiene and nutrition. A number of these factors are less tied to specific cultures than to socioeconomic status-related variables which may have similar significance in a variety of cultural settings. Some have been touched upon in previous sections of this chapter, others will be considered in varying degree. In every instance, the "disorder" may be viewed as a patterned syndrome of symptomatic acts.

Migration.[1] Migration provides a set of concrete operations for the study of adaptation and defense in relation to social change. A shift in

residence involves not only new places, but new faces and new norms. As the person moves from one socio-culture to another, behavioral modes useful in the old setting may prove maladaptive in the new. Acute sensitivity which permits empathic understanding in one group may be perceived as discomfort-provoking vigilance or paranoia in another. The culturally supported tendency to deal with the unknown or with the consequences of one's own inadequacy by attributing malevolent control to external forces, reinforced by magical belief systems in rural areas, may interfere with the evaluation of one's actual capacities necessary for survival in the city. Under these circumstances, the person may so rationalize his adaptive failure in the new setting that he is not motivated to make the necessary coping effort. One index of such failure is incompatibility between the migrant's self-image on the one hand, and the status, of which he is unaware, given him by the new social system on the other.

Behavior in the new environment is a function of the push factors that contribute to the migrant's decision to leave the culture of origin, the pull factors that lure him to the new, the transitional experiences en route, the receptor networks or resistances encountered upon entry into the host system, the talents and personal and economic assets he brings with him, congruencies between the old culture and the new, and internal motives for moving. Some of these last are the distillate of ungratified wishes and needs, undischarged tensions, and unresolved conflicts. Others are more easily

related to a person's place in his inpidual social change career. Potential migrants are differentiated from their fellows with the first stirrings of dissatisfaction with the status quo. Once in the new environment, personal change may continue indefinitely, with the greatest acceleration not reached for several years. It is often difficult, given the resistance and discomfort of family and friends, to differentiate behavior accompanying rapid personal growth and the achievement of a new identity (usually accompanied by a change in social statuses) from symptomatic behavior. Similar growth phenomena may be encountered during the course of psychotherapy. The personal growth of later life accompanying the move to a new setting, with its new occupations and new friends, can be as turbulent as the growth occurring in adolescence, and can create as much discomfort in spouse and children as it once did in parents.

Some migrants are risk-takers, people willing to go a step beyond the ordinary or expected; the appraisal of risk-taking as self-defeating symptomatic behavior or as exploratory growing behavior may not be possible without detailed longitudinal data. Some are geographical escapers, people who deal with personal or environmental disaster by physical flight; these often carry their problems with them wherever they go. In this category are those for whom the move may be understood as symptomatic of pre-existing psychiatric illness.

Detailed reviews of the particular factors influencing a migrant's capacity to interact with the opportunity structure of his environment, and of the particular stress points he will encounter, are available elsewhere.

Minority Status, Low Socioeconomic Status, and Powerlessness. Minority status may be most meaningfully defined on the basis of access to or distance from sources of societal power. Thus, "a set of people who, capable of being distinguished on the basis of some physical or cultural characteristic, are treated collectively as inferior," may be socially visible on the basis of skin color, physiognomy, or ethnically or socioeconomically linked appearance. The specific vulnerabilities of minority groups to behavioral disorganization, as well as the symptomatic nature of prejudiced behavior, have been reviewed in this Handbook and elsewhere. Exclusion from full participation in the majority culture, lack of economic potency, and awareness of blocked opportunities for upward mobility, all contribute to low self-esteem, retaliative anger against power holders, mistrust of those who do not belong to one's immediate social or family group, and a sense of alienation and powerlessness. A sense of powerlessness in the face of catastrophic natural as well as brutal or unpredictable human forces has been reported by Klein among Andean Indian serfs in Peru. The most deprived of a Rio de Janeiro psychiatric patient sample revealed themselves through Rorschach and TAT responses as feeling completely at the mercy of forces beyond their control. In both Peruvian non-patients and Brazilian patients, symptomatic behavior

patterns associated with lowest socioeconomic status and feelings of powerlessness were regressively defensive, withdrawn, self-insulating, inflexible. Non-hospitalized midtown Manhattan respondents of the lowest socioeconomic status studied by Langner and Michael were described by them as "probable psychotics," rigid, suspicious, and passive-dependent, with some related depressive features. In contrast to "probable neurotics" of higher socioeconomic status, they had suffered more devastating early life stress, experiences favoring dependence upon externalized versus internal controls, self-esteem and ego-strength-weakening experiences, and failures in training for identity, communication, relating sexually, obtaining or postponing gratification, and planning for the future. These elements have their counterparts in the socioculturally disintegrated as compared with more integrated communities described by Leighton et al. in the Stirling County study.

It is difficult to separate sub-culturally determined childrearing experiences from the social advantages and symbolic capacities associated with education and literacy as compared with partial or total lack of education and inability to read. The more capable and motivated literate Rio de Janeiro patients showed a higher prevalence of psychophysiological symptoms, such as tachycardia or gastrointestinal dysfunction (in contrast to somatic pain, body or organ anxiety), diffuse anxiety, and fear of loss of control than the non-literates. While the resemblance was less clear than it is

between the most deprived groups, they were more comparable in symptom formation to upper-class than lower-class New Haven patients and midtown Manhattan nonpatient respondents. Although the Rio patients showing these symptoms were not as socioeconomically privileged as the middle- and upper-class United States samples, in comparison to other groups in the Rio sample they were responsible, informed participants in the socio-culture, with actively self-critical standards, the capacity to inhibit direct expression of feelings through action, fear of status loss, and higher value placed on rational, conscious control of behavior. Diffuse anxiety and fear of loss of control were most prevalent among the whites, educated, better housed, and non-manually employed, as well as the more literate Rio patients. In contrast, acute anxiety attacks, as well as somatic complaints, and paranoid and other psychosis-related behavior were most prevalent among the least privileged, subject to the most pervasive social, economic, and physical survival threats. These were the patients most often described by projective testing as searching futilely for succor in an overwhelmingly stressful and coercive world. Those with acute anxiety attacks also exhibited situational fears about their jobs and families more frequently, often realistically. These observations fit the suggestion that behavioral consistency in the face of fluctuating environmental conditions is a function of an internalized set of evaluative standards. Conversely, behavioral dependence upon current environmental cues seems greatest in the absence of well-established internalized values

and standards.

Concluding Remarks

This chapter is one aspect of an introduction to the study of psychiatrically significant behavior. It does not consider the process or entity aspects of neurosis to be compared, for example, with psychosis or character disorder. The focus is, rather, on behavior—feeling, thinking, acting, publicly observed and subjectively reported—how it is experienced by the subject, evaluated by others, and whether it makes sense in terms of the environment in which it occurs. Behavior is viewed in its symptomatic sense, i.e., as it reflects a hidden or underlying problem, or psychological event or process, is "symptomatic of' something else. In medical language, that "something else" may be described in disease terms as a bacterially engendered inflammation (reflected in symptomatic fever or pain), a neurosis, or an incipient schizophrenia. In the present chapter, the "something else" is a human problem and the person's attempts to solve it. Attempts at problem-solving reflected in behavior identified or experienced as uncomfortable or deviant and hence symptomatic are usually not successful. Or, if they are successful in one sphere of life, they may lead to disaster in others. Therefore, a systematic description in human problem language requires the use of a group of related concepts. These are ways of systematizing—permitting abstraction and generalization about—what is happening inside an inpidual in relation to

what is going on outside. Inside and outside events are commonly referred to as "intrapsychic" and "interpersonal." Intrapsychic activity is conveniently described in psychodynamic conflictual terms, including ego-functioning, and particularly the operation of defense mechanisms. Interpersonal activity is conveniently described in adaptive and coping terms. The significance of the vectors of intrapsychic conflict, the use of defense mechanisms, characteristic cognitive, affective, and communicative styles, and the ability and opportunity to adapt and cope, are all influenced and shaped throughout life by society and culture. Society and culture are viewed longitudinally in relation to developing behavior patterns and potentials, and cross-sectionally in terms of behavior in a particular context, as a form of participating in an ongoing social process. The purpose of this chapter is to sensitize the student of psychiatry to these various ways of looking at behavior as he studies patterns identified as specific psychiatric disorders.

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Notes

1 The material in this section has been adapted from E. B. Brody, Ref. 13, Bibliography