International Journal of Social Psychiatry

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International Journal of Social Psychiatry 1969; 15; 5
DOI: 10.1177/002076406901500101

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WOMEN IN PSYCHOTHERAPY: A CROSS-CULTURAL COMPARISON*

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EPIDEMIOLOGICAL, diagnostic-comparative, and anthropological field studies have demonstrated cross-cultural differences in personality traits and in the prevalence, incidence, and etiology of various forms of psychopathology. (See, for example: Benedict, 1958; Cohen, 1961; Moffson, 1954; Opler, 1959; and Tooth, 1950.) A number of investigations have been conducted concerning such differences specially between Anglo-Americans and persons with Latin-American cultural backgrounds. (Abel and Calabresi, 1951; Jaco, 1959; Kaplan, 1954, 1955, 1956; Lewis, 1949, 1951, 1959, 1961, 1964; Meadow and Stoker, 1965; Meadow, Stoker, and Zurcher, 1967; and Stoker, 1963.)

This paper presents findings of cross-cultural differences (Anglo-Americans vs. Mexican-Americans) in psychopathological manifestations and, following the model of Opler (1959), sets these findings in a wide context of other relevant case data. The intention is to approach a more global picture of the cross-cultural differences in psychopathology, and to contribute toward an understanding of the multidimensional individual-social complex that is human personality.

METHOD

Subjects

The files of the Southern Arizona Mental Health Center, Tucson, Arizona, were examined for patients who had been seen in formal psychotherapy for at least fifteen sessions, and who were not diagnosed as nor suggestive of organic pathology of mental deficiency. In order to control for sex-influenced differences in patterns of psychopathology, only female cases were considered. The records finally yielded twenty-five Mexican-American patients who could be matched, one for one, with twenty-five Anglo-American patients on the bases of: age at first contact with the Center, family income, and years of education. (See Table 1 for these and other biographical data.)

Procedure

The case histories, including intake interview data and therapy progress notes, of the matched patients were analyzed independently by two raters for: diagnoses; referral source; school history; general form of family interaction; symptomatology; somatic complaints by system involved; exacerbating and/or precipitating factors; psychological traits; major defenses employed; psychological needs; relationship with mother; relationship with father; interpersonal relationships; and case out-

* This study is based in part upon the senior author's unpublished doctoral dissertation, University of Arizona, Tucson, Arizona, 1965, and was supported in part by N.I.M.H. Grant 2 RC-580 (240), Dr. Arnold Meadow, University of Arizona, Director. The cooperation of Robert J. Shearer, M.D., Director of the Southern Arizona Mental Health Center, is gratefully acknowledged.

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TABLE 1

BIOGRAPHICAL DATA

	Mexican-American Females		Anglo-American Females	
	N	%	N	%
Religion:				
Catholic	19	83	7	30
Protestant	4	17	13	56
Jewish	0	0	1	5
Other	0	0	2	9
Unknown	2		2	
Marital Status:				
Married	12	48	15	60
Single	5	20	4	16
Divorced	5	20	3	12
Separated	2	8	3	12
Widowed	1	4	0	0
Mean Yearly Income:	$3,037.04		$2,939.84	
Mean Years of Education:	9.88 Years		10.00 Years	
Mean Age at First Contact with the Center	29.96 Years		29.48 Years	

come. Inter-rater reliability was .90. When the frequencies allowed, statistical comparisons of cross-cultural differences were made by Chi-square test, Yates correction for continuity used wherever appropriate.

RESULTS AND DISCUSSION

Diagnoses

As indicated in Table 2, comparisons of diagnoses show a relatively higher frequency of *Character disorders* for the Anglo-American subjects and a relatively higher frequency of *Neurotic disorders* for the Mexican-American subjects. These findings are supported by those of Meadow and Stoker (1965), who interpret differences in hospitalized patients as reflecting a higher prevalence of *chronic* psychopathology among Anglos than among Mexican-Americans. This distinction will be further explored in the discussion of comparative symptomatology below.

Referral Source

A large percentage of the Mexican-American patients were, as shown in Table 3, self-referrals. None were referred by friends or relatives. A fairly large percentage of the Mexican-Americans were referred by public but non-psychotherapeutic agencies—i.e., Public Welfare, family service agencies, Public Health Service, and the County Hospital. By contrast, relatively fewer of the Anglo-Americans were self-referrals. Several were referred by friends or relatives, and a considerable number by other psychiatric facilities.

Altus (1949) and Simmons (1961) explored the social isolation the Mexican-Americans, as a group, experience in the Anglo community. The Mexican-American often has few people outside his own extended kinship system to whom he can turn in time of need. In the case of psychiatric need, the Mexican-American is not likely to be referred by friends or relatives since the extended family feels it should take care of its own in time of sickness, and the hospital or clinic is a far-removed place where people go only to die. The Anglo nuclear family or friendship group, on the other hand is not equipped to tolerate or absorb the deviant member and freely turns to society to provide proper care for the stricken.

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TABLE 2

DIAGNOSES

	Mexican-American Females		Anglo-American Females	
	N	%	*N*	%
Schizophrenic reactions:				
Acute undifferentiated	1	5	2	8
Chronic undifferentiated	3	13	2	8
Paranoid	2	9	1	4
Schizo-affective	0	0	1	4
TOTAL Schizophrenic	6	27	6	24
Personality Pattern and Traits:				
Passive-Aggressive	2	9	4	16
Emotionally unstable	1	5	1	4
Schizoid personality	1	5	2	8
Sociopathic	0	0	2	8
Inadequate personality	0	0	1	4
TOTAL Character Disorder	4	19	10	40
Neurotic disorders:				
Anxiety reaction	2	9	1	4
Depressive reaction	7	31	3	12
Conversion reaction	1	5	0	0
Reactive depression	0	0	1	4
Mixed type	2	9	2	8
Other	0	0	2	8
TOTAL Neurotic	12	54	9	36
No clinical diagnosis	3		0	

TABLE 3

REFERRAL SOURCE

	Mexican-American Females		Anglo-American Females	
	N	%	*N*	%
Self	11	44	5	20
Private M.D. or Psychologist	4	16	7	28
Friends	0	0	3	12
Relatives	0	0	3	12
Welfare Department	1	4	0	0
Family Service Agency	3	12	0	0
School	1	4	1	4
State Hospital (Psychiatric)	1	4	5	20
Public Health Service	1	4	0	0
County Hospital	1	4	1	4
Clergy	2	8	0	0

The Mexican-American patients often come to the Mental Health Center almost by accident, several of them simply because they had noticed the Center's sign while they were walking past the building. The relatively high number of Mexican-Americans who were referred to the Center by non-clinical agencies or organizations suggests that the problems they manifest are such that they at least initially seem treatable by counselling rather than therapy (e.g., marital conflicts, economic problems, etc.). In other words, it may be that the Mexican-Americans first appear to be in acute situational difficulty, then are assessed to be mentally ill and are referred. Clinical experience further supports this interpretation.

School History

Table 4 indicates the academic performance of the Mexican-American patients to have been considerably better than the Anglo-American patients. Differences in

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social adjustment are even more marked, again in favor of the Mexican-Americans. Both of these findings, but especially the latter, may be an artifact of teacher response to the typically "well-behaved" Mexican-American female student, who generally manifests passivity to authority figures. On the other hand, the differences might be influenced by differential pre-morbid adjustment and the fact that the emerging symptomatology of the Mexican-American female may be less disruptive than the Anglo-American female to cognitive performance and interpersonal relations in the school setting. This interpretation is consistent with the authors' report of less interpersonal disruption among Mexican-American than Anglo-American child guidance patients (Stoker, Zurcher, and Fox, 1967).

TABLE 4

SCHOOL HISTORY

	Mexican-American Females *N*	*Anglo-American Females* *N*
Academic Performance		
good	5	4
average	11	9
poor	2	9
Social Adjustment		
good	10	3
average	3	5
poor	3	12

General Form of Family Interaction

As shown in Table 5 the differences in proportions for domineering wife/passive husband to authoritarian husband/passive wife, in both the patients' original family and with her husband, are not strikingly different between the Mexican-Americans and Anglo-Americans. However, the record analysis yielded considerably more data (on the issues of authority, discipline, and passiveness) for the Mexican-American subjects than for the Anglo-American subjects. This may point to the centrality of these dynamics in the Mexican-American family—to the fact that dominance-submission is a key psychological struggle, remembered and recounted by the patient during intake and therapy. On the other hand, as with other cross-cultural clinical data, the case histories may reflect a culturally biased Anglo therapist sensitivity—in this case to family patterns that do not reflect the "equality" expected in the Anglo Family.

TABLE 5

GENERAL FAMILY INTERACTION

	Mexican-American Females *N*	*Anglo-American Females* *N*
In patients' original family:		
Domineering, disciplining wife and weak, passive husband	11	4
Authoritarian husband; weak, passive wife	8	3
Patient and husband:		
Domineering, disciplining wife and weak, passive husband	8	3
Authoritarian husband; weak, passive wife	5	1

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The Mexican family is typically described as one in which the husband and father expects to play the role of the strong, dominant male (*macho*), but in reality often has a relatively minor, peripheral role in the decision-making processes of the family. Similarly, the cultural expectation is that the wife shall be submissive and passive to the demands of the husband, when actually she often undercuts the authority of the male and becomes the responsible figure in the day-to-day family dynamics. (Lewis, 1949, 1951, 1959; Meadow, Stoker, and Zurcher, 1967.)

Diaz-Guerrero (1955) sees interlocking and conflicting dependency needs as an important component in the etiology of mental illness among Mexicans. Dependency ambiguities remain in the interactions of a newly married (and inevitably young) couple, and are exacerbated by the immediate and successive production of children. The ensuing pattern of marital conflict includes a series of separations, reconciliations, and desertions, placing a heavy burden of family responsibility upon the woman.

Symptomatology

The Mexican-American patients, as indicated in Table 6, had significantly higher frequencies than the Anglo-Americans in the following seventeen symptom categories: *Agitation; Crying spells; Dependency; Depression; Eating difficulty; Hostility; Hyperactivity; Impulsivity; Irritability; Obesity; Overtalkativeness; Sleeplessness; Somatic complaints; Suicide attempts; Temper tantrums; Visual hallucinations;* and *Withdraws to bedroom, stays in bed*. These findings essentially duplicate those of Meadow and Stoker (1965) with a subject population of hospitalized psychiatric patients.

The overall group of symptoms for the Mexican-American patients suggests a basic disturbance in the sphere of affective functioning. This syndrome seems to have *depression* at its core, and in fact resembles the pathological pattern of the "agitated depression" clinical entity.

This pattern of psychopathology may be related to conflicts in the cultural role expectations for the female in Mexican and Mexican-American communities. She is expected to be a good mother, uncomplaining, and subservient to the males of the household. The wife should not overtly express hostility toward her husband, should not indulge in autonomous activities, and should be under the control and domination of her husband. Lewis (1949, 1959) and Diaz-Guerrero (1955) have observed considerable covert hostility felt by wives toward their husbands, and report that, since the hostility cannot be expressed, it may well result in affective disturbances. Meadow and Stoker (1965) saw similar patterns in the etiology of mental illness among a sample of Mexican-American hospitalized psychiatric patients and explained the high prevalence of catatonic symptomatology in terms of "frozen" hostility.

The origin of the hostility seems to be in good part a reaction to frustrated dependency needs. The conflict becomes "I cannot express my anger toward my husband because I need him. If I express my anger he will hate me and leave me." Reactions to the suppressed hostility do not seem to take the form of guilt or self-hate. Rather, the channel for the expression of hostility among the Mexican-American patients appeared to be an affective-depressive flow, largely "reactive" or "situational" in nature. The Mexican-American female seemed to pour affect

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TABLE 6

SYMPTOMATOLOGY

	Mexican-American Females		Anglo-American Females	
	N	*Sig. Lev.*	*N*	*Sig. Lev.*
Aggressiveness	9		3	
Agitation	18	.02	9	
Antagonism to family members	1		7	.05
Auditory hallucinations	5		4	
Chronic alcoholism	0		2	
Compulsive behavior	0		6	.05
Crying spells	19	.01	10	
Delusions of change in body	3		10	
Delusions of grandeur	0		0	
Delusions of persecution	0		6	.05
Delusions of reference	0		2	
Total paranoid delusions	(0)		(8)	.05
Dependency	12	.02	5	
Depression	23	.01	15	
Eating difficulty	15	.01	4	
Excessive fear of death	4		0	
Fear of homosexuality	1		1	
Flat affect	3		6	
Guilt	5		15	.01
Homosexual behavior	1		0	
Hostility	19	.01	10	
Hyperactivity	8	.02	0	
Imaginary enemies	0		6	
Immaturity	3		3	
Impulsivity	9	.05	2	
Irritability	19	.05	11	
Inappropriate affect	4		7	
Jealousy	7		1	
Narcissism	1		0	
Nervousness and tenseness	9		18	.02
Nightmares	1		2	
No or few friends	3		16	.001
Obesity	9	.05	2	
Obsessional thinking	0		6	.05
Occasional serious drinking	1		1	
Overtalkativeness	7	.02	0	
Passivity	2		1	
Phobias	5		1	
Poor self-control	0		3	
Post-partum psychosis	1		0	
Psychosis during pregnancy	2		0	
Raped or sexually assaulted	2		2	
Seclusiveness	1		0	
Sexual acting out	3		7	
Sexual difficulties	3		4	
Sleeplessness	14	.01	4	
Slow thoughts, movements, speech	0		7	.05
Somatic complaints	20	.01	10	
Suicidal (as judged by staff)	2		1	
Suicide attempt	8	.02	1	
Suicide threat only	1		0	
Suspicious and distrustful	2		8	.05
Temper tantrums	9	.05	2	
Violent behavior	3		0	
Visual hallucinations	6	.05	1	
Withdraws to bedroom, stays in bed	7	.05	1	
Anxiety	6		21	.001

into depressive episodes closely linked with external, relatively transient situations (e.g. death of a family member or friend, health problem, husband's behavior, etc.).

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Such a defense pattern fits with some of the Mexican cultural expectations for wife and mother—she is to be a "martyr" of her family, and like the "Mother of Sorrows" to endure the great sadnesses of life (Meadow, Stoker, and Zurcher, 1967). By contrast, the depressive states prevalent in the Anglo-American sample seemed to be more severe, and to be accompanied by strong feelings of guilt. Symptomatically, they resemble depressive states whose etiology is clinically linked to "guilt-punishment" dynamics and involve decrements in physical and psychic activity.

The relatively high frequency of *withdrawing to the bedroom and staying in bed* is supported by the investigators' clinical experience with Mexican-American female patients. When the women become distressed by their surroundings, they often "withdraw from the field" and take to a "sick bed". The clinical pattern includes the wish for warmth, comfort, and the attention of members of the extended family. A similar set of withdrawal behaviors has been observed in a sample of Mexican-American children (Stoker, Zurcher, and Fox, 1967).

Table 6 reveals that the Anglo-American patients had significantly higher frequencies than the Mexican-Americans in the following ten symptom categories: *Antagonism to family members; Anxiety; Compulsive behavior; Delusions of persecution; Guilt; Nervousness and tenseness; No or few friends; Obsessional thinking; Slow thoughts, movements, and speech;* and *Suspicious and distrustful.*

The pattern of symptoms for the Anglo-American females suggests more severe and chronic psychopathology. Guilt feelings seem central to their clinical picture as shown in Table 6. The strikingly high relative frequency of *Antagonism to family members* and *No or few friends* suggests the alienative character of the Anglo-American symptom pattern. It is difficult to say to what proportion disturbances in interpersonal relations are cause or effect of psychopathology, but it is relatively clear in the present investigation with adults and a current study with children (Stoker, Zurcher, and Fox, 1967) that the Anglo-American subjects manifest relatively more defensive withdrawal into themselves and detachment from others. The Mexican-Americans appear also to withdraw, but *into dependency* upon significant others. One almost gets the feeling that the Anglo, reflecting his societal ethic, is saying "By God, becoming mentally ill is my own effort and I'll do it alone!" The Mexican-American, on the other hand, is saying, "Well, if it is ordained that I am to be mentally ill, then let me be so in the company of my *compadres*!" This manifests the strong value orientation for particularism (interpersonal dependency) described by other investigators as prevalent in Mexican culture (Cohen, 1961; Lewis, 1961; Zurcher, Meadow and Zurcher, 1965; Zurcher, 1967).

Somatic Complaints

As shown in Table 7, Mexican-American patients registered almost four times as many somatic complaints as Anglo-American patients, and similar to the Italians in Zola's (1966) Irish *vs* Italian symptom analysis, the Mexican-Americans had a relatively wider symptom spread throughout the body. Statistically significant differences were found for complaints involving the gastro-intestinal system and the head—in both cases the Mexican-Americans having the greater frequency of complaints.

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TABLE 7

COMPARISON OF SOMATIC COMPLAINTS BY SYSTEM INVOLVED

	Mexican-American Females		Anglo-American Females	
	N	*Sig. Lev.*	*N*	*Sig. Lev.*
Skeleto-muscular system: muscles, tendons, and joints	4		1	
Chest—upper respiratory system and neck	1		1	
Gastro-intestinal system	12	.01	2	
Head (not including sensory disturbances)	16	.05	9	
Integumentary system	3		0	
General or unspecified complaints such as weakness, fatigue, etc.	3		0	
Sensory disturbances	2		0	

The Mexican-American patients' gastro-intestinal involvements seem to be related to the kind of dependency-eating processes documented by Alexander (1934, 1950), Fenichel (1945), Mittlemann, *et. al.* (1942), and Wolf and Wolff (1942). The profile presented is one of an orally oriented personality structure, frustration of or conflict in dependency needs, and psychosomatic gastro-intestinal disturbances. The oral character of the Mexican-American patients will be further discussed below.

Anglo-American patients, within their own group, had a proportionately higher prevalence of headache complaints than the Mexican-American patients did within their own group (paralleling Zola's (1966) report of Irish symptom concentration in the head). Both of the present subject samples, however, showed high proportions of somatic symptoms involving the head, and the Mexican-Americans significantly more than the Anglos. One might have hypothesized that headaches are psychologically more sophisticated somatic complaints, involving the higher central nervous system, and thus Mexican-Americans would probably not manifest a significant number of such symptoms. These results are contrary to that assumption, but become clearer when the context of the headaches is further examined. The Anglo-American patients' headaches, as the television commercials tell us, most often were ascribed to "tension", "too much responsibility", "feeling all tight inside", "fighting against something", etc. The Mexican-American patients' headaches, by contrast, most often fit into a context of resignation, "what's the use", retreat, and then martyrdom. The language for such symptoms seems to reflect a qualitative difference in the experience of the symptoms. The Anglo term "*headache*" seems quite different from the Spanish *dolor de la cabeza. Dolor* connotes more than "pain", but suffering, offering up, sacrificing, etc. The Anglo-American's "splitting headache" splits her from others around her ("Sure you've got a headache; but why take it out on others?"). The Mexican-American's headache ties her more closely in a dependent relation to those around her. The pain is probably the same, but the function seems quite different and reflects a cultural pattern.

Exacerbating and/or Precipitating Factors

Table 8 shows two statistically significant differences between subject groups in factors exacerbating or precipitating mental illness: the Anglo-Americans more troubled by economic factors than the Mexican-Americans; the Mexican-Americans more troubled by husband's "acting out" behavior than the Anglo-

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Americans. Both of these findings yield to cultural interpretations. Money squabbles are repeatedly cited as major sources of marital disruption in the Anglo society, and are linked with the desire for status enhancement through material acquisition and display. Considering the category *General behavior of husband*, husbands seem to be at the vortex of their wive's mental illness for *both* subject groups. Closer analysis of such behavior demonstrates some cultural differences. The problems the Anglos perceive as husband-engendered more often than not reflect the economic conflicts described above. The Mexican-American patients, however, are primarily troubled by their husbands' "acting out" behavior. "Acting out" behavior as used here circumscribes that pattern of behaviors referred to as the *machismo*: sexual promiscuity; drunkenness; episodic desertion of family; physical assaults upon wife and children; and demonstrations of harshly punitive authoritarianism. The *machismo* has been described by Gilbert (1959), Iturriaga (1951) and Ramirez and Parres (1957), who observed it to be an overcompensatory reaction to the frustration of dependency needs, particularly around the time when the macho's wife is giving birth. Frequencies of "acting out" behavior were teased from the more general category, and cross-cultural differences became apparent. Virtually all of the Mexican-American married patients keenly expressed in one form or another the impact of the *machismo* upon their mental health. These expressions often accompanied the patient's wishes that they could "depend" more upon their husbands.

TABLE 8

EXACERBATING AND/OR PRECIPITATING FACTORS

	Mexican-American Females		*Anglo-American Females*	
	N	*Sig. Lev.*	*N*	*Sig. Lev.*
Economic factors	4		11	.05
Sickness or death in family	3		5	
Racial pressures	1		0	
General behavior of husband	11		15	
Husband's acting out behavior	11	02	3	
Behavior of children	3		3	
Physiological changes or sickness of patient	5		4	
Childbirth and/or pregnancy	8		6	
Marital sexual factors	0		3	

Psychological Traits

Inspection of Table 9 reveals the frequency of *Compulsive behavior* to be statistically significantly higher for the Anglo-American patients than the Mexican-American patients. The remaining categories of *Anal Traits*, though not reaching statistical significance, nonetheless clearly reveal a pattern of anality for the Anglo-Americans as compared with the Mexican-Americans. The complex of anal traits articulates with the Anglo-American patients' symptomatology (Table 6), and will be seen also to articulate with the Anglo patients' *Major Defenses* (Table 10) and *Needs* (Table 11).

Also as presented in Table 9, the Mexican-American patients had significantly higher frequencies than the Anglo-Americans in the *Oral Traits*: *Obesity; Dependency; Impulsivity;* and *Oral imagery significant in verbalizations*. Comparative frequencies in the remaining *Oral Traits* also are generally higher for the

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TABLE 9

PSYCHOLOGICAL TRAITS

	Mexican-American Females		Anglo-American Females	
	N	Sig. Lev.	N	Sig. Lev.
Anal Traits:				
obsessional thinking	0		3	
compulsive behavior	2		9	.05
orderliness	1		3	
stubbornness	0		2	
controlling others	2		3	
excessive religiosity	1		1	
isolation	0		2	
do-gooding	0		1	
intellectualization	2		7	
Oral Traits:				
sloppiness	0		8	.01
wanting to be free from all limitation	3		2	
obesity	9	.05	2	
dependency	12	.05	5	
love of food	11		6	
love of bodily comfort	0		3	
impulsivity	9	.05	2	
lateness	3		6	
oral aggressive dreams	5		1	
oral dependent dreams	1		0	
total oral dream content	6		1	
oral imagery significant in verbalizations	8	.01	0	
passivity	2		1	

Mexican-American patients. These findings correspond to the Mexican-Americans' symptomatology (Table 6), particularly the dependency nucleus, and will be seen to correspond to the Mexican-Americans' *Major Defenses* (Table 10) and *Needs* (Table 11).

The complex of oral traits may be suggestive of a less differentiated and less complex personality structure in the Mexican-American patients. One might hypothesize that such a personality structure and modes of functioning would be influenced by a folk culture in which there is, as dramatized by Lewis (1951, 1961) and others, encouragement to satisfy psychological needs in a direct and relatively undifferentiated fashion.

Sloppiness is usually taken to be an oral trait, and the Anglo-American *patients showed a markedly* higher frequency of *Sloppiness* than the Mexican-American patients. However, clinical observation suggested that this phenomenon might have been the result of specific psychological deterioration (regression) in the Anglo-Americans rather than a consistent personality trait.

Major Defenses Employed

Repression clearly was the major defense mechanism of the Mexican-American patients, and *Rationalization* the major defense mechanism of the Anglo-American patients. Both of these findings, as shown in Table 10, attained statistical significance in the cross-cultural comparison.

Associated with the elevated frequency of *Repression* among the Mexican-American patients was a slightly higher frequency of *Conversion*. By contrast, the more cognitively complex defense mechanisms of *Projection* and *Intellectualization*

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TABLE 10

MAJOR DEFENSES EMPLOYED

	Mexican-American Females		*Anglo-American Females*	
	N	*Sig. Lev.*	*N*	*Sig. Lev.*
Amnesia	0		1	
Conversion	8		6	
Reaction formation	0		1	
Projection	3		8	
Isolation	1		4	
Sublimation	0		1	
Regression	2		2	
Rationalization	0		11	.001
Repression	17	.001	5	
Intellectualization	1		5	
Denial	0		1	

showed elevated frequencies in association with *Rationalization* among the Anglo-American patients. These differences in defense complexity, plus the relatively wider variety of defense mechanisms utilized by the Anglo-American patients, again suggest the influence of cultural background upon personality structure and alternatives for dealing defensively with psychological conflict.

Psychological Needs

The Anglo-American patients' *Achievement*, *Dominance*, and *Infavoidance* needs, as presented in Table 11, were significantly higher than those of the Mexican-American patients. Consistent with this pattern are the Anglo-Americans' relatively elevated needs for *Order*, *Autonomy*, and *Defendence*. The constellation of needs reflects the impact, as described by McClelland (1955), of childhood training processes in the achieving society which stress independence, accomplishment, initiative, and control over the environment. The needs for *Infavoidance* (need to justify the self against criticism and blame) and *Defendence* (need to avoid humiliation, to avoid derision, scorn and to refrain from action because of the fear of failure) may be guilt components associated with non-striving or unsuccessful striving. Weber (1930) described the "Protestant Ethic" as a societal force which "rationalizes" the world of the perceiver and "eliminates magic as a means to salvation". By contrast Catholicism, particularly as practiced in Mexican culture, often implies individual passiveness to "magical" or supernatural intervention regarding material and/or spiritual rewards. As indicated in Table 1, the majority of the Mexican-American patients were Catholic and the majority of the Anglo-American patients were Protestant.

Patient's Relationship with Mother

As presented in Table 12, significantly more Anglo-American than Mexican-American patients saw their mothers as having been *Indifferent* to them. Similarly, more of the Anglo-Americans remember their mothers as *Continually rejecting*. This maternal pattern is consistent with the child rearing ethos in the Anglo culture.

More of the Mexican-American than Anglo-American patients perceived their mothers to have been *Over-protecting*, *Restrictive*, *Sporadically Rejecting*, *Punishing of daughter's sexual manifestations*, and *Domineering*—comparative frequencies in the first three of these categories statistically significantly higher for Mexican-Americans. This maternal pattern can be seen to foster the dependency conflicts central to the psychopathology of the Mexican-American patients.

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TABLE 11

NEEDS

		Mexican-American Females		Anglo-American Females	
		N	*Sig. Lev.*	*N*	*Sig. Lev.*
Abasement	Low	0		2	
	High	9		5	
Achievement	Low	4		1	
	High	0		6	.05
Affiliation	Low	1		4	
	High	6	.05	0	
Aggression	Low	1		2	
	High	3		7	
Autonomy	Low	4		1	
	High	1		5	
Counteraction	Low	2		0	
	High	0		2	
Defendence	Low	0		0	
	High	0		2	
Dominance	Low	1		4	
	High	1		6	.05
Exhibitionism	Low	1		0	
	High	4		7	
Harmavoidance	Low	0		0	
	High	3		5	
Infavoidance	Low	0		0	
	High	0		7	.05
Nurturance	Low	0		0	
	High	5		2	
Order	Low	2		0	
	High	0		3	
Play	Low	1		1	
	High	2		1	
Rejection	Low	0		0	
	High	2		3	
Sentience	Low	0		1	
	High	3		1	
Sex	Low	4		4	
	High	4		8	
Succorance	Low	0		0	
	High	13		14	
Understanding	Low	0		0	
	High	0		1	

TABLE 12

RELATIONSHIP WITH MOTHER: MOTHER'S ATTITUDES

	Mexican-American Females		Anglo-American Females	
	N	*Sig. Lev.*	*N*	*Sig. Lev.*
Indifferent	1		7	
Domineering	9		5	
Continually Rejecting	2		7	
Over-protecting	9	.05	2	
Restrictive	7	.05	0	
Restricted patient to home	5		3	
Sporadic rejection	6	.05	0	
Sporadic beatings	1		0	
Punished patient's sexual manifestations	10		4	
Did not trust her with boys	4		2	
Accused patient of sexual misconduct	1		0	

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The *Sporadic Rejection* responses of the Mexican-Americans are probably related to the ensuing births of siblings. Clark (1959), Iturriaga (1951), Ramirez (1960), and Ramirez and Parres (1957), describe the rapidity of family growth in Mexican culture and the deprivation impact this has upon the ex-baby of the family—feelings of rejection that may be re-kindled with the birth of each new sibling.

The *Restrictive/Over-protecting/Domineering* constellation is seen to be indi-
dedicates herself to protecting her daughter for as long as she can, and tries to
"cruel world", particularly from sexual exploitation by men. The mother has
experienced the *macho* behavior of men, observed her own mother's sufferings,
and has internalized the prevalent view that men are basically evil. She then
cative of the Mexican-American mother's desire to protect her daughter from the
prepare her to be a "little mother" (usually not including sexual information) with
the hope that she will make a good marriage. Stoker (1963) has observed that the
restrictive protection actually serves to encourage the daughter to act out in the
sexual sphere.

Patient's Relationship with Father

Inspection of Table 13 reveals that markedly more of the Anglo-American than Mexican-American patients (those whose father had not completely abandoned the family) reported their fathers to have been *Indifferent* or *Continually rejecting* towards them. Significantly more Mexican-Americans than Anglo-Americans, however, reported *Sporadic Rejection, Sporadic beatings*, and *Punishment of sexual manifestations*. Examination of case histories demonstrated the sporadic rejection and beatings invariably to be associated with the father's often drunken return from a period of abandonment. Upon his return he would attempt aggressively and sometimes physically to assert himself as head of the household. Typically, the father would demean the females of the family, accusing his wife of being unfaithful and his daughter of being a prostitute. The behavioral pattern is consistent with the *machismo* described above (Diaz-Guerrero, 1955; Gilbert, 1959; Iturriaga, 1951; and Ramirez and Parres, 1957) to be a reaction to frustrated or conflict engendering dependency needs. The sexual accusations made by the father are very probably projections of his own guilt feelings following *macho* sexual exploits. Stoker (1963) observed a clinical relationship between incestuous desires of Mexican-American fathers and their condemning their daughters for alleged promiscuity—a dynamic which may account in part for the reports of fathers' restrictive attitude toward sexual manifestation in the present sample of Mexican-American patients.

Interpersonal Relationships

As alluded to in the sections on *School History* and *Symptomatology*, the Anglo-American patients manifested considerably more interpersonal disruption than the Mexican-Americans. Table 14 presents significantly higher Anglo-American frequencies in the categories: *No friends; A few distant friends; Suspicious of others; Feels uncomfortable around other people; Oversensitive to criticism;* and *Heterosexual difficulties.*

Sullivan (1953) argues that etiology of psychopathology is centered upon disruption of interpersonal relationships. Though it is not clear to what proportion the disruption is cause or effect of mental illness, the Anglo-American data in the

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TABLE 13

RELATIONSHIP WITH FATHER: FATHER'S ATTITUDES

	Mexican-American Females		*Anglo-American Females*	
	N	*Sig. Lev.*	*N*	*Sig. Lev.*
Father Absent	11		6	
Indifferent	3		6	
Domineering	7		6	
Continually Rejecting	1		5	
Over-protecting	2		2	
Restrictive	9		3	
Restricted patient to home	7		2	
Sporadic rejection	9	.001	1	
Sporadic beatings	8	.02	1	
Punished patient's sexual manifestations	9	.05	2	
Did not trust her with boys	8		3	
Sexually molested her	0		1	

TABLE 14

INTERPERSONAL RELATIONSHIP

	Mexican-American Females		*Anglo-American Females*	
	N	*Sig. Lev.*	*N*	*Sig. Lev.*
No friends	0		6	.05
A few distant friends	3		10	.05
One or two close friends, no others	0		4	
Suspicious of others	1		10	.01
Constantly irritates others	0		1	
Constantly irritated by others	1		3	
Feels uncomfortable around other people	1		10	.01
Doesn't like or tries to avoid social events	1		6	
Introverted	0		2	
Oversensitive to criticism	2		11	.01
Feels others don't like her	1		3	
Feels others are against her or go out of their way to malign, badger, hurt her	2		6	
Secretive	0		1	
Jealous and resentful of others	4		5	
Socially isolated	7		3	
Heterosexual difficulties	2		10	.02
Prefers solitary activities	1		2	
Defensive and guarded with other people	1		5	

present study seem to fit Sullivan's assumptions. The Mexican-American patients, however, were for the most part able to carry out their daily activities, to maintain meaningful relationships with other people, and to sustain friendships. The same relatively stable interpersonal dynamics were found in Mexican-American as compared with Anglo-American child guidance patients (Stoker, Zurcher, and Fox, 1967).

The strong value for interpersonal dependency (Zurcher, 1967; Zurcher, Meadow, and Zurcher, 1965) that exists in Mexican and Mexican-American culture lends to the interpretation that the Mexican-American patients wove their defense systems around dependence upon significant others, and thus fractionation of interpersonal relationships appeared relatively minimal. The defense system, therefore, was influenced at least in part by a predominant cultural value orientation. Similarly the Anglo-American patients at least in part seem to have woven

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their defense systems around the Anglo value orientation for independency and autonomy.

The present and earlier studies have indicated that Mexican-American psychopathology was relatively less severe than that of Anglo-Americans (Meadow and Stoker, 1965; Meadow, Stoker, and Zurcher, 1967). It is suggested that the relative non-severity of the Mexican-American psychopathology may be a function of the patients' opportunity and ability to discharge affect and impulse upon the environment rather than solely upon their own self-structures.

Case Outcome

The strikingly higher proportion of Anglo-American than Mexican-American patients who were, as indicated in Table 15, *Discharged as improved* seems to be incongruent with the interpretation that the Mexican-American patients' psychopathology was relatively less chronic and severe. However, a question emerges concerning the kind of psychotherapy given, and whether or not the therapy met the needs of the patient. The psychotherapeutic technique used with the patients in this study is best described as "electric" but leaning toward the Rogerian non-directive approach. The authors were not able to observe directly the psychotherapeutic sessions, nor were tape recordings available—thus it is difficult to speculate on the efficacy of the technique. But the striking number of Mexican-American patients who, as shown in Table 15, dropped from therapy without arrangement with the therapist makes one wonder about the therapist-patient dyad. Is it possible that the Mexican-Americans dropped therapy when it became stressful to them—this would not be inconsistent with "withdraw from field" defense clinically noted among Mexican-Americans (Meadow and Stoker, 1965)? On the other hand is it possible that the Anglo therapists were hampered by their own cultural backgrounds or insensitive to that of their patients? Were there communication problems resulting from vocabulary or fluency differences? Does the treatment of, for example, dependency-centered psychopathology need to consider that the patient may be influenced by a cultural value for interpersonal dependency? Might the Mexican-American female patient have particular difficulty relating to a male therapist? To an Anglo therapist? What do the patient's extended family think about her seeking help "away from her own people" at a Mental Health Center? These questions are among a number that might be raised, urging intense research into treatment processes involving therapists and patients whose value orientations may be quite in conflict—as influenced by their differing cultural and/or socio-economic backgrounds. The importance of such research increases as the Community Health Center concept expands and such centers reach more deeply into the enclaves of entrapped ethnic minorities in the United States.

SUMMARY AND CONCLUSIONS

Twenty-five Anglo-American and twenty-five Mexican-American female patients, all of whom had been in formal psychotherapy for at least fifteen sessions at the Southern Arizona Health Center, were matched on the basis of: (1) age at first contact with the Mental Health Center; (2) family income; and (3) years of education. The patients' intake interviews, case histories and therapy progress notes were analyzed, rated, and cross-culturally compared within the categories: *Diagnosis; Referral source; School history; General form of family interaction; Symptomatology; Somatic complaints by system involved; Exacerbating and/or*

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TABLE 15

CASE OUTCOME

	Mexican-American Females *N*	*Anglo-American Females* *N*
Discharged as improved	2	10
Discharged as unimproved	1	0
Referred to other agency	1	0
Currently in treatment	3	2
Institutionalized	1	0
Dropped without arrangement with therapist	13	8
Dropped with arrangement with therapist	4	5

precipitating factors; Psychological traits; Major defenses employed; Relationship with mother; Relationship with father; Interpersonal relationships; and *Case outcome.*

Comparisons of diagnoses show the Mexican-American patients to have a higher frequency of *Neurotic Disorders* than the Anglo-Americans, and the Anglo-Americans to have a higher frequency of *Character Disorders* than the Mexican-Americans. These differences correspond to the authors' findings with other cross-cultural samples and introduce the consistent pattern of contrasting category frequencies subsequently presented in this paper.

The Mexican-American patients' constellation of symptoms, traits, needs, and defenses suggests a prevalence of depression, agitation, somatic complaints, orality, and repression centered around dependency conflicts or frustrations. Data on family patterns indicate a climate favorable for the generation and exacerbation of dependency ambivalences. Mothers are often remembered to have been over-protecting, domineering, sporadically rejecting, and restricting (especially of daughters' sexual manifestations). Fathers and husbands are frequently reported to enact the *machismo* and to be authoritarian, abandoning, sporadically rejecting physically punitive, and deprecatory (especially with regard to daughters' sexual manifestations).

The Anglo-American patients' constellation of symptoms, traits, needs and defenses suggests a prevalence of compulsiveness, projection, suspiciousness, anality, rationalization, and achievement/autonomy/order needs centered around guilt feelings and doubts about self-worth. Data on the family patterns of the Anglo patients indicates a climate favorable for the generation and exacerbation of guilt and worthlessness feelings—both mothers and fathers are frequently reported to have been indifferent and/or continually rejecting.

Comparison of the patients' school histories, interpersonal relations, and symptomatology reveals an interesting difference between the Mexican-Americans and the Anglo-Americans. The Anglo-Americans manifest a consistent pattern of interpersonal disruption—e.g., *No or few friends; Antagonism to family members; Feel uncomfortable with others; Poor school social adjustment,* etc. Compared with the Mexican-Americans, the Anglo-American patients' mental illness was associated with withdrawal into themselves and alientation from others. A study conducted and cited by the authors suggests that cross-cultural difference in defensive detachment from others to exist among grade school children is therapy. Though further research is needed to determine to what degree interpersonal frac-

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tionation is cause and effect of mental illness, data from the present study suggest that cultural factors influence defense systems and both the structure and symptom manifestations of mental illness. The Mexican and Mexican-American cultural value for particularism, the cultural reinforcement for the female "martyr" role, and the male *machismo* are all seen to be reflected in the psychopathology constellations of the Mexican-American patients. The cultural value for achievement, the cultural reinforcement for interpersonal competition, and the impetus to "go it alone" are reflected in the psychopathology of the Anglo-Americans.

The Mexican culture supports, corresponding to a general world view of passivity to the environment, an understanding of mental illness as "fate" or "witchcraft", but certainly not something that the victim should be blamed for or feel guilty about—thus the family accepts and supports the afflicted. The Anglo culture by contrast supports a world view of control over the environment, and mental illness is often perceived to be the fault of the afflicted, a flaw in his "will power", and something worthy of blame and guilt. The family is not equipped nor willing to cope with the problem, and looks for help elsewhere. These cultural phenomena are reflected in the data on referral sources, the Mexican-Americans apparently being hesitant to refer kin to a Mental Health Center for treatment.

The case history analyses suggest that the Mexican-American patients' pathology is generally less chronic and severe than the Anglo-Americans' pathology. This conclusion is supported by data on academic performance, interpersonal relations, symptomatology, and initial diagnosis. The interpretation is offered that the relative non-severity of the Mexican-American psychopathology may be a function of the patients' opportunities and ability to discharge affect and impulses upon others rather than solely or primarily upon their own self-structures.

The Mexican-American case outcome is seen to be less successful than the Anglo-American, most of this negative finding accounted for by the high number of Mexican-Americans who summarily dropped out of therapy. If the conclusions concerning the relatively less severe and more situational psychopathology of the Mexican-American patients are accurate, then questions emerge about the appropriateness of the therapeutic techniques, the therapy setting, and the possible cultural chasm between therapist and patient.

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