# SOCIAL CLASS AND SOCIAL MOBILITY IN RELATION TO PSYCHIATRIC SYMPTOMATOLOGY IN ARGENTINA

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A considerable amount of information exists concerning the relationship of psychopathological manifestations to the socioeconomic context of their occurrence (e.g., Hollingshead and Redlich, 1958; Petras and Curtis, 1968; Senay and Redlich, 1968; Srole, Langer, Michael, Opler and Rennie, 1962). On the basis of this research, it is possible to sketch a number of trends. The clinically recognized maladaptation of the lower socioeconomic class tends either toward aggression or withdrawal. By contrast, the characteristic manifestations of abnormal behavior in middle-class individuals occur on the plane of affect or ideation and find their expression through the experience of conflict, anxiety, and dissatisfaction with oneself. At the risk of simplification, the site of disturbance in the case of lower-class individuals lies in the realm of relationship between the individual and the external world of objects and people. In the case of the middle class the focus of psychopathology shifts to the incompatible action tendencies within the individual.

Suggestive as this evidence is, it is limited in its cultural and geographical base. A disproportionate share of findings has come from the United States and Canada. What additional information has been reported from Latin America (e.g., Horwitz and Marconi, 1967; Ruiz, 1967), Europe and Asia (see Dohrenwend and Dohrenwend, 1967), is often incomparable with the North American research in concepts, procedures, and samples. Dohrenwend and Dohrenwend (1967) have reviewed much of this mosaic of data from a variety of countries, only to conclude that few worldwide generalizations are possible concerning socioeconomic class and psychopathology, except that severity of disorder is proportionate to degree of accumulated real-life stress.

Against this background, our study represents the first attempt

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at replicating in another geocultural locale the operations of a study on socioeconomic class and psychopathology in the United States. In addition to the empirical interest in such an undertaking, our work is relevant to a broader conceptual issue. On the one hand, theorists as different as Dohrenwend and Dohrenwend (1967), Lewis (1966), and Phillips (1968) have stressed the commonality of social class experience across national and cultural boundaries. Extrapolating from their positions, one would expect intercultural consistency in the relationship between socioeconomic status and maladaptive patterns as well. On the oter hand, the view of psychopathology is a deviation from the norm of the dominant social group, roughly compatible with Goffman's (1967) theoretical position, Berg's (1955) deviation hypothesis, and the broad position of cultural relativism (as reviewed by Germani, 1966), would postulate cultural specificity in the nature of association between social class and abnormal expressions of behavior. To elaborate, implicit norms as well as explicit behavior patterns differ across cultures (see, in the case of Argentina and the United States, Havighurst, Dubois, Czikszentmihalyi and Doll, 1963); maladaptive deviations might be understood as departures from these culturally determined anchors, and maladaptation of "deviant" socioeconomic groups might be expected to represent a dual departure, away from the standard of culturally agreed upon appropriateness and from pragmatically successful adaptation.

For the exploration of these two equally plausible expectations, our point of departure has been a recent study by Nutall and Phillips (1969) done at Worcester State Hospital in Massachusetts and concerned with the links between three indices of socioeconomic status and occurrence of discrete psychiatric symptoms. More specifically, Nuttall and Phillips studied differences in psychiatric symptomatology among groups of male hospitalized psychiatric patients varying in their fathers' occupational levels, their own occupational levels, and discrepancies between these two indicators. The latter measure was included in that study to provide an index of social mobility, a variable which, despite the presence of some pertinent research (e.g., Hollingshead and Redlich, 1955; Srole *et al.*, 1962), has received less psychiatric attention than social class itself.

We have obtained identical social status and symptomatology data on a group of phyciatrically hospitalized Argentine patients. In addition to replicating Nuttall and Phillips' work in another country of this hemisphere, we have added three new features to their study: (1) groups of female, as well as male, Argentine patients were investigated; (2) class and social mobility differences were ascertained not only for specific symptoms, but also for the more inclusive, derivative categories of role, sphere, and coping style, to be described

in greater detail below; (3) in addition to symptoms, information on precipitating circumstances was systematically explored in relation to each of the three social status indices.

## METHOD

### SUBJECTS

A total of 117 patients, 68 male and 49 female, constituted the pool of available subjects for this study. Biographical and symptom information on these individuals had been collected in the course of another investigation concerned with the direct comparison of the symptomatology in equated groups of Argentine and United States psychiatric patients (Fundia, Draguns and Phillips, 1969). Data on these subjects were collected at several public psychiatric institutions in and around Buenos Aires and Cordoba. The majority of the patients were hospitalized at Hospital Juan Fernandez in Buenos Aires. As in the Nuttall and Phillips study, the subjects of the present investigation were first or recent admission patients. Data were obtained through interviews with the patients and/or their nearest relatives and through abstracting information from their hospital records. This information was collected by trained psychiatric observers, all of them Argentine in nationality, who were professionally employed by the hospitals included in this study.

Not all of the points of the biographical information needed for this study were available for each patient. Therefore, the number of subjects included in our several comparisons is smaller than the total subject pool and moreover varies across the several comparisons.

A conscious attempt was made to include in this study the entire range of socioeconomic, educational, marital, and with the exception of mental retardation and organicity, diagnostic characteristics of patients found in the institutions that were accessible to us. The total number of case records collected was determined by the requirements of the intercultural, comparative study described above. In age, the subjects of this research were restricted to the range between 17 and 55 years, as were those of Nuttall and Phillips' investigation.

### MEASURES

*Socioeconomic Class and Social Mobility.* The operational measure of socioeconomic class was based on occupational status, assessed on a seven-step scale devised by Warner, Meeker and Eels (1960). The use of these criteria was dictated by three considerations. First, we wanted to maximize the similarity of our investigation with Nuttall and Phillips' study. Second, we considered the use of this scale justified because of findings pointing to a high degree of concordance among occupational prestige ratings across culture in general (e.g.,

Inkeles and Rossi, 1956) and those of Latin America and North America (e.g., Barilari and Oxley, 1966). Finally, the seven-step scale selected by us is closely related to the six-step division of occupational ratings, employed in several recent studies of socioeconomic classes in Argentina and in several other countries of South America (Germani, 1963; Graciarena and Sauto, 1961; Hutchinson, 1962; Iutaka, 1962).

To divide our male subject population in socioeconomic class, we combined levels 1 through 4 to form the "high" group, allocated level 5 to the "middle" group and collapsed levels 6 ond 7 to make up the "low" group. This procedure was followed for both father's and patient's occupation and was identical to that of Nuttall and Phillips. With female patients, optimal points of division proved a little different: levels 1 through 3 for "high," 4 for "middle," and 5 through 7 for "low" group.

In social mobility, both male and female subjects were classified upward mobile, downward mobile, or stable depending on whether the patient's occupation, as compared to his or her father's, was higher, lower, or identical, on the Warner scale. Women without occupational history other than housework were excluded from all social class and social mobility comparisons.

*Symptomatology.* Symptoms for each patient were tabulated by means of the Symptom and Temperament Schedule described by Phillips (1968) and applied, in its current or earlier versions, in several intracultural (Phillips, Broverman and Zigler, 1966, 1968; Phillips and Rabinowitch, 1958; Phillips and Zigler, 1961, 1964; Zigler and Phillips, 1960, 1961, 1962) and intercultural (Draguns, Phillips, Broverman, Caudill and Nishimae, 1966; Draguns, Phillips, Broverman and Caudill, in press; Schooler and Caudill, 1964) investigations. The Spanish form of this instrument is identical to that used in two Argentine-United States comparisons (Draguns, Knobel, Fundia, Broverman and Phillips, 1966; Funda *et al.*, in press).

The Symptom and Temperament Scale provides for the separate listing of presence or absence of 178 symptoms (e.g., hallucination, phobia) and 27 temperaments (e.g., passive aggressive, domineering) for each subject.

In addition to the tallies of individual symptoms, dominance patterns in three sets of symptom categories: role, sphere, and coping style, were assigned to each subject. The procedure for determining the dominant sphere and role was similar or identical to that of a large number of studies with North American, Argentine, and other subjects that have already been cited. Briefly, we counted the number of symptoms exhibited by each patient in the three roles, or interpersonal modes of behaving; turning against self, turning against

others, and avoidance of others. The role in which a patient obtained his highest score was deemed to be his dominant one. In the case of sphere, or the symptom's channel of expression, the number of symptoms falling into the component categories, thought, affect, somatization, and action, was markedly unequal. For this reason we resorted to a more complicated method of establishing sphere dominance. Specifically, $Z$ scores ($Z = \frac{x-\bar{x}}{\sigma}$) were computed for each patient in every one of the four spheres; highest $Z$ score determined his dominant spehere.

Finally, the characteristic of coping style has been added to the other variables of this study. On the basis of Diaz Guerrero's (1967) formulations, we applied operational definitions of "active" and "passive" symptoms, established in another study (Fundia *et al.*, in press). Dominance of "active" over "passive" symptomatology, or vice versa, was determined exactly as for role.

*Precipitating Circumstances.* A checklist of precipitating circumstances, i.e., events in the individual's life space temporally connected with the onset of socially recognizable symptomatology, was also applied in this study. A description of this measure is found in Phillips (1968); present research constitutes its application in Spanish and beyond the boundaries of the United States for the first time.

## STATISTICAL ANALYSIS

Social class and social mobility were investigated in relation to presence of discrete symptoms and precipitating circumstances by means of 3 x 2 Chi-square matrices, constructed separately for male and female subjects. Symptoms exhibited by more than 90 or less than ten percent to the total subject pool were excluded from analyses. Upon this subtraction there remained 113 symptoms and temperaments for men and 123, for women; their investigation in relation to patient's occupational level, that of his father, and the difference between the two ratings, resulted in a total of 708 matrices. An additional set of 165 comparisons were performed involving precipitating circumstances, other than those falling outside of the 10-90 percent range (26 for men; 31, for women).

Finally, Chi squares were computed to relate the distributions of dominant roles, spheres, and coping styles to the three social variables of father's occupation, own occupation, and social mobility. This operation resulted in 9 more matrices, which conformed to the 4 x 3 for both roles[1] and spheres and to the 3 x 2 format for coping styles.

[1]In addition to the three roles, the category of indeterminate role was included for those patients whose role orientation could not be conclusively established on the basis of the procedures outlined.

As a supplement to all of the analyses involving symptoms, we computed *Gammas* according to Goodman and Kruskal (1954), to estimate the degree, and not only the presence vs. absence, of any linear relationships between symptom characteristics and social indices.

## RESULTS

Our findings are presented separately for the variables of father's social class, own social class, and social mobility. Given the exploratory character of our work, we have recorded results at a border line ($< .10$) as well as at a commonly acceptable ($< .05$, $< .01$) level of significance, a procedure in line with that of Nuttall and Phillips.

*Father's Social Class.* Table 1 contains symptoms related to father's occupational level and also includes, for the sake of ease of comparison, the corresponding findings of Nuttall and Phillips (in press). In the light of these results, Argentine males of high social class parentage suffer from thought and thought content disturbance; they experience fear, anxiety, alienation, and lack of confidence. By contrast, male patients whose fathers' occupational level was low bring to the fore symptoms of a behavioral rather than ideational nature; their common denominator seems to be loss of control over behavior, judgment, and perception. As far as the intermediate male group is concerned, one notes, not surprisingly, a mixture of features partaking of both low and high social class characteristics; on the one hand, there are symptoms bespeaking self-blame and, on the other hand, those expressive of impairment of reality testing. What differentiates the middle segment of our population from both extremes is the absence of aggressive acting-out or withdrawal. With women, the picture obtained is largely compatible with male findings; novel features include a focus upon intropunitive affect and somatization, as well as the eating process in the high, and absence of both aggression and faulty judgment, at the low level. On the plane of more inclusive symptom groupings there is only one significant finding to report: among men, the role of avoidance of others is disproportinately encountered in the subgroup based on father's high occupational level, turning against self is represented in the intermediate group, and the three roles have almost equal representation in the lowest segment of socioeconomic distribution.

*Own Social Class.* The pattern of findings relating to patient's own occupational level to symptoms is rather similar to that described

## TABLE 1

## Distribution of Symptoms That Differentiated Groups Based on Father's Class Level

| Symptom | Males H 23 | M 14 | L 14 | Gamma | Females H 18 | M 14 | L 13 | Gamma |
|---|---|---|---|---|---|---|---|---|
| **Symptoms of Highs** | | | | | | | | |
| Obsessive doubts | 16% | 8% | 0%* | 0.610 | | | | |
| Depersonalization | 14 | 0 | 4 | 0.504 | 9% | 3% | 0% | 0.786 |
| Disturbance of Vision | | | | | 11 | 0 | 4 | 0.397 |
| Free Floating Anxiety | 29 | 14 | 8 | 0.474 | | | | |
| Feels misunderstood (see middles) | 24 | 16 | 2** | 0.519 | | | | |
| Misunderstands others | 14 | 6 | 0 | 0.638 | | | | |
| Feelings of sexual inadequacy | | | | | 20 | 11 | 2* | 0.596 |
| Guilt, self accusatory (see lows) | | | | | 22 | 11 | 4 | 0.550 |
| Seeks approval or support | | | | | 20 | 4 | 11 | 0.299 |
| Crying, tearful | | | | | 24 | 7 | 16 | 0.165 |
| Overeating | 12 | 2 | 0 | 0.824 | | | | |
| Underweight | | | | | 16 | 4 | 2 | 0.620 |
| Blackouts, fainting spells | | | | | 13 | 0 | 7* | 0.297 |
| Vomiting, nausea | | | | | 13 | 0 | 7* | 0.297 |
| Psychogenic perspiration | 10 | 0 | 0 | 1.000 | | | | |
| Jealous | 16 | 6 | 0 | 0.686 | | | | |
| Seclusive (see riddles) | | | | | 20 | 7 | 5 | 0.550 |
| Self-conscious | | | | | 22 | 9 | 5* | 0.578 |
| Distractible | 24 | 4 | 6 | 0.532 | | | | |
| Fear of failure (see middles) | 20 | 6 | 2 | 0.632 | | | | |
| Symptoms in the Nuttall & Phillips study: does not eat, overdemanding. | | | | | | | | |
| **Symptoms of Highs and Middles** | | | | | | | | |
| Preoccupied | 24 | 20 | 6 | 0.303 | | | | |
| Lonely, wonders if belongs | | | | | 31 | 22 | 9* | 0.581 |
| Emotionally labile (see middles) | | | | | 16 | 13 | 2 | 0.640 |
| Indecisive | | | | | 24 | 20 | 4* | 0.519 |
| Symptoms in the Nuttall & Phillips: suicidal ideas, does not work | | | | | | | | |
| **Symptoms of the Middles** | | | | | | | | |
| Reasoning, abstract thought impaired | 6 | 18 | 6** | 0.269 | 2 | 11 | 2* | 0.156 |
| Circumstantial, ramoling | | | | | 2 | 9 | 0* | 0.049 |
| Fear of failure (see highs) | | | | | 20 | 29 | 9* | 0.137 |
| Feels misunderstood (see highs) | | | | | 27 | 27 | 11* | 0.891 |
| Depreciatroy ideas against self | | | | | 13 | 13 | 0* | 0.478 |
| Superficial, bland affect | 10 | 16 | 10 | -0.285 | | | | |
| Emotionally labile (see highs and middles) | 12 | 18 | 12 | -0.310 | | | | |
| **Symptoms of Middles and Lows** | | | | | | | | |
| Not interested in opposite sex | | | | | 0 | 7 | 7 | -0.649 |
| Symptoms in the Nuttall & Phillips study: loose associations, perplexed, delusions, emotional turmoil, seclusive, poor judgment, poor insight, confused. | | | | | | | | |
| **Symptoms of Lows** | | | | | | | | |
| Auditory hallucinations | 4 | 8 | 14* | -0.658 | | | | |
| Mutism | 6 | 4 | 12 | -0.506 | | | | |
| Destructive | 2 | 0 | 10** | -0.773 | | | | |
| Driven, hard-working | | | | | 7 | 0 | 11 | -0.374 |
| Symptoms in the Nuttall & Phillips study: guilt, self-accusatory, homosexuality | | | | | | | | |
| **Lacking in Middles** | | | | | | | | |
| Impulsive | 18 | 2 | 12 | 0.056 | | | | |
| Hostile aggression | 20 | 6 | 18 | -0.186 | | | | |
| No interest in, love for, or attachment to others | 6 | 0 | 8 | -0.308 | | | | |

Blank = $p > .10$
* = $p > .05$
** = $p > .01$

in the foregoing section. What we encounter, upon examining Table 2,

TABLE 2

Distribution of Symptoms That Differentiated Groups Based on Patient's Occupational Level

| | Males | | | | Females | | | |
|---|---|---|---|---|---|---|---|---|
| | H | M | L | Gamma | H | M | L | Gamma |
| Symptom | 35 | 6 | 23 | | 16 | 10 | 9 | |
| Symptoms of Highs | | | | | | | | |
| Evasive, guarded | | | | | 22% | 3% | 6% | 0.525 |
| Free-floating anxiety | 34% | 0% | 6% | **0.757 | | | | |
| Feels misunderstood | 31 | 3 | 5 | **0.713 | | | | |
| Feels threatened | | | | | 9 | 0 | 0 | 1.000 |
| Fear of failure | 22 | 0 | 5 | * 0.636 | | | | |
| Suspicious of Others | 19 | 5 | 5 | 0.391 | | | | |
| Sexual pre-occupation | 31 | 2 | 8 | * 0.612 | | | | |
| Feelings of sexual inadequacy | 12 | 2 | 0 | * 0.803 | | | | |
| Guilt, self-accusatory | | | | | 17 | 6 | 0 | 0.714 |
| Does not believe he can be helped | | | | | 17 | 0 | 3 | *0.688 |
| Tense, nervous, anxious | 38 | 6 | 14 | 0.464 | | | | |
| Overactivity | 8 | 5 | 5 | -0.038 | | | | |
| Suicidal attempt (see middles) | | | | | 14 | 0 | 9 | 0.119 |
| Vomiting | | | | | 14 | 0 | 9 | 0.119 |
| Domineering | | | | | 17 | 0 | 6 | 0.427 |
| Jealous | 18 | 2 | 2 | * 0.715 | | | | |
| Seclusive | | | | | 29 | 6 | 3 | *0.743 |
| Self-conscious | | | | | 23 | 6 | 3 | 0.636 |
| Symptoms in the Nuttall & Phillips study: excessive drinking, does not eat; ideas of grandeur and suicidal ideas were characteristic of both "High" & "Middle". | | | | | | | | |
| Symptoms of Middles | | | | | | | | |
| Afraid of opposite sex | | | | | 9 | 17 | 3 | *-0.061 |
| Feels perverted | | | | | 0 | 9 | 3 | -0.495 |
| Inappropriate affect | | | | | 3 | 20 | 6 | **-0.426 |
| Mourning | | | | | 9 | 11 | 0 | 0.219 |
| Irresponsivle behavior | | | | | 3 | 9 | 0 | 0.119 |
| Excessive masturbation | | | | | 0 | 11 | 3 | *-0.458 |
| Emotionally labile | | | | | 11 | 14 | 0 | * 0.255 |
| Symptoms in the Nuttall & Phillips study: suicidal attempts, destructive; shallow affect was characteristic of both Middles and Lows. | | | | | | | | |
| Symptoms of Lows | | | | | | | | |
| Poor Judgment | | | | | 6 | 6 | 14 | -0.624 |
| Poor orientation to time and place | 5 | 6 | 11 | **-0.035 | | | | |
| Reasoning, abstract thought impaired | 6 | 2 | 15 | *-0.529 | | | | |
| Confused | 6 | 5 | 12 | *-0.515 | | | | |
| Impoverished thought | 6 | 5 | 11 | *-0.455 | | | | |
| Memory impairment | | | | | 6 | 3 | 11 | -0.525 |
| Fear of injury | | | | | 14 | 0 | 11 | -0.057 |
| Hostile impulses | 2 | 3 | 6 | *-0.566 | | | | |
| Mutism | 3 | 2 | 12 | *-0.719 | | | | |
| Incoherent conversation | 5 | 3 | 12 | *-0.515 | | | | |
| No interest in, love for, or attachment to others | | | | | 3 | 9 | 11 | -0.663 |
| Tremors and tics | 3 | 2 | 11 | *-0.517 | | | | |
| Runs away[1] | 3 | 3 | 8 | -0.432 | | | | |
| Difficulties in menstruation | | | | | 14 | 0 | 14 | *-0.200 |
| Derogatory temperament | | | | | 0 | 6 | 9 | -0.793 |
| Symptoms in the Nuttall & Phillips study: homosexuality, migraine headaches | | | | | | | | |
| Missing from Middles | | | | | | | | |
| Migraine headaches (see lows) | | | | | 29 | 6 | 17 | 0.933 |
| Passive dependency | 11 | 6 | 11 | -0.258 | | | | |
| Lack of insight | 14 | 0 | 20 | **0.486 | | | | |
| Symptoms in the Nuttall & Phillips study: robbery, insomnia | | | | | | | | |

[1]Also present in the Nuttall & Phillips study.

Blank = p.> .10
* = p.> .05
** = p.> .01

are again symptoms of anxiety, guilt, and felt inadequacy in the highest portion of the occupational distribution of both men and women, accompanied by such less expected manifestations as "vomiting" and

## TABLE 3

## Distribution of Symptoms That Differentiated Groups Based on Occupational Mobility

| Symptom | U 14 | S 14 | D 14 | Gamma | U 8 | S 16 | D 8 | Gamma |
|---|---|---|---|---|---|---|---|---|
| **Symptoms of Upwards** | | | | | | | | |
| Fears committing an abhorred act | | | | | 75 | 0% | 0% | * 1.000 |
| Drug addiction | 10% | 0% | 0% | * 1.000 | | | | |
| Destructive, manic attacks | 12 | 0 | 0 | ** 1.000 | | | | |
| Fatigue | | | | | 16 | 12 | 3 | 0.640 |
| Symptoms in the Nuttall & Phillips study: ideas of grandeur, believes he has no problem, lying; in both upward and stable, assaultive. | | | | | | | | |
| **Symptoms of Stables** | | | | | | | | |
| Disturbances of vision | 0 | 10 | 5 | -0.368 | 0 | 16 | 3 | -0.255 |
| Fear of injury, death | 2 | 14 | 2 | * 0.000 | | | | |
| Sexual preoccupation | 12 | 21 | 7 | 0.185 | | | | |
| Feelings of sexual inadequacy (see downwards) | 0 | 12 | 2 | * -0.177 | | | | |
| Feels perverted | | | | | 0 | 12 | 0 | * 0.000 |
| Aphasia | 0 | 10 | 0 | * 0.000 | | | | |
| Feels incapable of work | | | | | 6 | 36 | 16 | -0.419 |
| Apathetic, listless | | | | | 0 | 31 | 6 | ** 0.286 |
| Elated, euphoric | | | | | 0 | 12 | 0 | *-0.000 |
| Mourning | | | | | 3 | 19 | 0 | 0.222 |
| Voracious eater | | | | | 3 | 19 | 0 | 0.222 |
| Excessively busy, engrossed in plans | | | | | 0 | 9 | 0 | 0.000 |
| Overweight | | | | | 0 | 16 | 0 | * 0.000 |
| Emotionally labile | | | | | 0 | 22 | 6 | -0.374 |
| Hostile, aggressive | | | | | 0 | 16 | 3 | -0.255 |
| Overdescending | | | | | 0 | 16 | 3 | -0.255 |
| Passive-aggressive (symptoms of downwards) | | | | | 0 | 22 | 9 | -0.507 |
| Bitter | 0 | 10 | 5 | -0.368 | | | | |
| Symptom in the Nuttall & Phillips study: suicidal attempt | | | | | | | | |
| **Symptoms of Stable and Downward** | | | | | | | | |
| Lack attention | 2 | 12 | 14 | -0.551 | | | | |
| Impoverished thought | 2 | 10 | 14 | -0.583 | | | | |
| Depreciatory ideas eg. self | 2 | 10 | 14 | -0.583 | | | | |
| Shallow, dull, bland, flat affect (see downward) | 2 | 17 | 17 | *-0.571 | | | | |
| Immature | | | | | 3 | 31 | 16 | *-0.552 |
| **Symptoms of Downwards** | | | | | | | | |
| Lacks insight | 10 | 7 | 24 | *-0.538 | | | | |
| Reasonging, abstract thought impaired | 0 | 7 | 14 | **-0.824 | | | | |
| Feelings of sexual inadequacy (see stables) | | | | | 0 | 16 | 12 | - 0.706 |
| Talks loudly, shouts | | | | | 0 | 0 | 9 | ** .000 |
| Anorexia | | | | | 3 | 3 | 12 | *-0.610 |
| Irritable | 7 | 2 | 19 | *-0.526 | | | | |
| Passive-aggressive (see stables) | 0 | 5 | 10 | -0.737 | | | | |
| Symptoms in the Nuttall & Phillips study; shallow affect, robbery and stealing, running away. | | | | | | | | |
| **Lacking in Stables** | | | | | | | | |
| Evasive, guarded | 7 | 0 | 10 | -0.289 | | | | |
| Withdrawn, socially isolated | | | | | 12 | 9 | 16 | -0.141 |
| Hyperactive | 10 | 2 | 14 | -0.233 | | | | |

Blank = p.< .10
* = p.< .05
** = p.< .01

"dominant" among women. The common features of symptomatology in the middle range include depression, withdrawal and socially inappropriate behavior; it is noteworthy that all of these differentiate middle-level women, but not men. An aggregate of hostile, disoriented, and withdrawn symptomatology is delineated at the lower end of the distribution in both sexes, albeit of different degrees. Analysis of the intergroup differences in the more inclusive symptom groupings contributes a significant chi-square in the distribution of role in men, with high occupational-level individuals tending toward turning against self, middle-level individuals, toward avoidance of others, and low-level patients almost equally distributed throughout the three divisions.

*Occupational Mobility.* A somewhat different configuration of symptoms has emerged in association with stable occupational level, as well as upward or downward occupational mobility. As we turn to Table 3, we are struck by the destructive and antisocial character of symptoms among upward mobile men while in women of the analogous group struggle against antisocial tendencies, as well as exhaustion, are apparent. A more self-critical theme, together with sensory-motor deficits is detected among men of a stable occupational level; quite by contrast, the characteristics of women's symptomatology in the parallel group can be described in terms of coexisting patterns of overactivity, apathy, hostility, and lack of self-restraint. As far as the low groups are concerned, the predominant features are those of confusion, withdrawal, disorganization, and indirectly expressed hostility. To supplement these results, we may mention the significant Chi-square associating occupational level with coping style; upwardly mobile women tend toward passivity, as do those of stable occupational level, with active coping style being dominant among downward mobile women.

*Precipitating Circumstances.* The results concerning these characteristics in relation to the three modes of social categorization are summarized in Table 4. The expectation, based more on common sense than formal theories, by which we were guided would predict a greated share of reality-stress at the lower socioeconomic levels and a preponderance of intrapsychic problems at the high end of the occupational distribution. This expectation is only partially borne out. It is true that in low and downward mobile groups physical illness disproportionately occurs but, beyond this observation, the picture becomes rather mixed. Thus we see premarital sexual adjustment as a source of problems in the high socioeconomic class, difficulty with in-laws among the upward mobile, and an inconsistent pattern of difficulties with parental family occurring at several occu-

## TABLE 4

## Distribution of Precipitating Circumstances that Differentiated Groups Based on Father's Occupational Level, Own Occupational Level, and Social Mobility

| | Males | | | | Females | | | |
|---|---|---|---|---|---|---|---|---|
| Precipitating Circumstance | H | M | L | Gamma | H | M | L | Gamma |
| | 23 | 14 | 13 | | 18 | 14 | 13 | |
| **Parental Social Class** | | | | | | | | |
| High | | | | | | | | |
| Difficulty in education or occupation unfulfilled ambitions for self | 20 | 4 | 0 | ** | | | | |
| Problems in pre-marital sexual adjustment, problems (eg. illegitimate pregnancy) | 10 | 2 | 0 | | | | | |
| Problems in parental family, parent "a failure" | 14 | 2 | 2 | | | | | |
| High and Middle | | | | | | | | |
| Problems in pre-marital sexual adjustment rejected by girl(boy) friend | 10 | 8 | 0 | | | | | |
| Problems in parental family, parent died (see low) | 14 | 10 | 4 | | | | | |
| Problems in parental family, emotional difficulties, cold relations | | | | | 20 | 16 | 4 | |
| Middle | | | | | | | | |
| Minor physical problems, minor surgery | 4 | 16 | 2 | ** | | | | |
| Problems in parental family, parent a heavy drinker | 2 | 6 | 0 | | | | | |
| Low | | | | | | | | |
| Problems in parental family, parent died | | | | | 9 | 4 | 16 | |
| **Social Mobility** | | | | | | | | |
| Upward | | | | | | | | |
| Problems with in-laws, emotional difficulties | | | | | 3 | 0 | 0 | |
| Major surgery | 10 | 5 | 0 | | | | | |
| Stable and Downward | | | | | | | | |
| Difficulties in education or occupation | 0 | 10 | 10 | | | | | |
| Problems in parental family, cold relations | 0 | 12 | 10 | | | | | |
| Downward | | | | | | | | |
| Major physical problems, handicapped by major physical disease or injury | 0 | 2 | 12 | * | | | | |
| Minor surgery | 5 | 2 | 15 | * | | | | |
| Problems in parental family, reports parents as cruel | 0 | 2 | 10 | * | | | | |
| **Own Social Class** | | | | | | | | |
| Highs | | | | | | | | |
| Difficulties in job or school | 33 | 2 | 18 | | | | | |
| Unfulfilled ambitions for self | 17 | 0 | 5 | | | | | |
| Premarital sex problems (eg. pregnant) | 10 | 0 | 2 | | | | | |
| Middle | | | | | | | | |
| Separated, divorced, getting divorced, etc. | | | | | 3 | 11 | 3 | |
| Low | | | | | | | | |
| Handicapped by major physical disease or injury | 2 | 0 | 11 | ** | | | | |
| Lacking in Middle | | | | | | | | |
| Sexual difficulties (miscarriage, etc.) | | | | | 14 | 0 | 9 | |

Blank = p. < .10
* = p. < .05
** = p. < .01

pational or mobility levels. There is, frankly, little general sense that we can make out of this array of intergroup differences.

*Comparison with Nuttall and Phillips Findings.* To preserve the continuity of our account, we have so far refrained from a direct comparison of our results with those of Nuttall and Phillips, juxtaposed to our own in Tables 1, 2, and 3. Three general impressions emerge upon addressing ourselves to this comparison: (1) Very few of Nuttall and Phillips' findings are directly replicated in our store of results; in fact, there are only two symptoms that yield intergroup differences in both male population and ours. (2) The general character of symptom differences across class or social mobility lines is more similar than different; the nature of these similarities and differences will be more specifically analyzed in the remaining portion of this paper. (3) Quite apart from the content of intergroup differences obtained in the two investigations there is a striking difference in the number of significant differences; despite a considerably larger pool of subjects in the North American investigation, many more differentiating symptoms have been found in the Argentine study. Again, we intend to take note of this discrepancy as we discuss our findings.

## DISCUSSION

On a more general plane, the results that we have just enumerated warrant three conclusions. First, a large number of symptom differences exists among Argentines at several rungs of the occupational hierarchy and with different histories of occupational mobility. Second, almost none of these differences correspond directly to those noted within a similar group of United States patients. Third, there is a pattern of similarity between Argentine and North American findings on the level of theme and trend that transcend specific symptoms; in both countries, and, within the Argentine population, in male as well as female subgroups, we see a clustering of aggressive, overt, and bizarre manifestations at the lower end of the occupational distribution. In the highest socioeconomic status group, the pattern of ideational self-deprivation is detectable in both sites of investigation, but considerably more crystallized in Argentines, paralleling the results of some of the United States investigations (Hollingshead and Redlich, 1958, Srole, *et al.*, 1962) other than those of Nuttall and Phillips. In the domain of social mobility, there is less correspondence; in Argentina, the contrast between the upward and downward mobile groups is along the axis of behavioral self-expansion to confusion and disorientation while, in the United States, the differences could be expressed on the dimension of ideational grandiosity to behavioral rebellion and withdrawal. In addition to these commonalities, partial and suggestive though these be, there is a number of

apparently specifically Argentine trends. In particular, we would like to take note of some unanticipated similarities between our findings, pertaining to maladaptive behaviors, and the peculiarities of class-related "strategies of survival" formulated in a recent study by Moffatt (1967), of three sections of the population of Buenos Aires: the corporation executives, the salaried white-collar employees, and the unskilled migrants from the interior of the country ("cabecita"). According to Moffatt, social experience of these three groups breeds different modes of responding to frustration and of adapting to the environment. These take the form of violence and concrete manipulation at the lowest level, conformity, guilt, and emotional blocking at the middle one, and intellectualization with existential anxiety in the highest group. Moffatt's groups were more specifically defined than the threefold divisions of our study nor were the limits of the three groups identical in his work and ours. Nonetheless, there is some convergence between our findings and his observations. In particular, the emphasis upon guilt in the middle, and anxiety and alienation in the high groups constitute findings which nothing in the United States literature would have led us to expect. To expand on this theme, it would appear that, at middle levels, Argentine patients react pathologically to departures from explicit codes of conduct, thought, or feeling. At higher levels, patients in that country give vent to felt disorientation from the social matrix of relationships, goals, and values.

Beyond these differences, the themes of genteel passivity, hunger for social contact, and somatization strike us as being selectively characteristic of Argentines of both high and middle levels. It may not be altogether coincidental that some of these trends also emerged as the differentiating features of both psychiatrically unimpaired (Havighurst, *et al.*, 1965) and incapacitated (Draguns, *et al.*, 1966; Fundia, *et al.*, 1967) Argentines in comparison with equated North American subjects. For a tentative explanation of this tendency we suggest that the upper and middle classes carry the culture and set the tone for the group as a whole. This notion is consonant with the formulations of Lewis (1966) on the "culture of poverty" which transcends national boundaries and represents an adaptive mechanism to make the stresses of socially and economically marginal living bearable.

So far, our concern has been with the qualitative aspects of our results. Let us now attend to their quantitative peculiarities, in particular, to the noticeably greater number of differentiating symptoms among Argentines of different status and mobility levels than among North Americans. The social structure of the two settings is alike in a number of important respects; both societies share the features

of social complexity, high status differentiation, and high social mobility (see Kahl, 1957, for the United States, and Cuevillas, 1967; Graciarena, 1967; Graciarena and Sautu, 1961; Hutchinson, 1963; Iutaka, 1962, 1963, for Argentina). Although direct comparative investigations of these sociological characteristics in Argentina and in the United States are lacking, it has been noted by several observers (Cuevillas, 1967; Graciarena, 1967) that the class lines in Argentina are more explicitly defined than they are elsewhere, including possibly the United States. If psychopathology constitutes the continuation of adaptive patterns of living, as our findings appear to suggest, then the larger number of differentiating symptoms in Argentina than in the United States may be a reflection of the greater crystallization of class-determined patterns of adjustment in Buenos Aires.

What are the implications of all these inferences for the broad theoretical issue that we sketched at the beginning of this paper? The findings obtained are neither identical nor unrelated to their analogies in other settings, notably in the United States. Perhaps an interaction position is, at this point, the easiest to uphold: intercultural similarity in symptoms is greater at the lowest, and least pronounced at the highest, levels of socioeconomic status. In this light, the cultural relativity or deviation position appears best applicable at the high subdivisions of our population while the view that postulates intercultural consistencies in the relationship between socioeconomic class and psychopathology receives verification at the lowest portion of the socioeconomic distribution. No more can be said on the basis of this exploratory study which has helped to crystallize, but is inadequate to resolve, these two opposing points of view.

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ABSTRACT

Symptoms, symptom dominance patterns, and precipitating circumstances were investigated in groups of male and female Argentine psychiatric patients divided on the basis of father's socioeconomic level, own socioeconomic level, and social mobility. Upon comparison of the results obtained with those of a closely related North American study, the conclusion was reached that virtually no findings were identical in the two investigations. There were, however, similarities in theme and character of the relationships between symptom and social class variables in the two countries. Overt, impulsive, and bizarre symptomatology predominated among lower class patients, intermediate levels of socioeconomic status tended toward self-blame and guilt, and the highest groups included in this study expressed anxiety, tension, and alienation. The interculturally consistent and the specifically Argentine components of these findings were discussed in relation to the available reports on the ways of life of normal Argentines at several levels of the socioeconomic hierarchy.

RESUMEN

Se estudiaron los síntomas, sus patrones y las circunstancias precipitantes en un grupo de pacientes psiquiátricos Argentinos que fueron clasificados en base a nivel socioeconómico y mobilidad social. Estos datos se compararon con una muestra paralela en los Estados Unidos llegándose a la conclusión que casi ninguno de los hallazgos eran idénticos. Sin embargo, hubo similitud en el tema y carácter de las relaciones entre síntomas y las variables de clase social en ambos países. Dentro de la clase baja predominó la sintomatología "abierta" impulsiva y bizarra. Los niveles intermedios de status socioeconómicos tendieron a culparse a sí mismos y entre los grupos más altos inculidos en este studio hubo expresiones de ansiedad de tensión y de aíslamiento. La consistencia intercultural y los com-

ponentes exclusivos Argentinos de estos hallazgos fueron discutidos en relación a los reportes disponibles sobre las formas de vida de poblaciones normales Argentinas en varios niveles dentro de la jerarquía socioeconómica.

RESUMO

Sintomas, padrões de dominância de sintomas e circunstâncias precipitantes foram investigados na Argentina com grupos de pacientes psiquiátricos de ambos os sexos, divididos segundo nível socio-econômico do pai, status socio-econômico próprio e mobilidade social. Ao comparar estes resultados com outros obtidos em estudo semelhante nos Estados Unidos, chegou-se a conclusão de que nada de paralelo revela-se nas duas pesquisas. Houve, porém, semelhanças nos temas e no carácter das relações entre sintoma e classe social nos dois países. Sintomatologia aparente impulsiva e bizarra predominou entre os pacientes da classe baixa; os pacientes de níveis médios de status social revelaram mais sentimentos de culpa e censura própria; os das classes mais elevadas incluídos neste estudo expressaram ansiedade, tensão e alienação. Os aspectos especificamente argentinos e os de consistência intercultural dêstes resultados são discultidos com relação a relatórios sôbre a vida argentina normal nos vários níveis de status socio-econômico.